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42 CFR Parts 411, 412, 413, 422, and 489

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 412, 413, 422, and 489

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Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals

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

ACTION: Final rules.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems, and to implement certain provisions made by the Deficit Reduction Act of 2005, the Medicare Improvements and Extension Act, Division B, Title I of the Tax Relief and Health Care Act of 2006, the TMA, Abstinence Education, and QI Programs Extension Act of 2007, and the Medicare Improvements for Patients and Providers Act of 2008. In addition, in the Addendum to this final rule, we describe the changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are generally applicable to discharges occurring on or after October 1, 2008. We also are setting forth the update to the rate-of-increase limits for certain hospitals and hospital units excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits are effective for cost reporting periods beginning on or after October 1, 2008.

In addition to the changes for hospitals paid under the IPPS, this document contains revisions to the patient classifications and relative weights used under the long-term care hospital prospective payment system (LTCH PPS). This document also contains policy changes relating to the requirements for furnishing hospital emergency services under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA).

In this document, we are responding to public comments and finalizing the policies contained in two interim final rules relating to payments for Medicare graduate medical education to affiliated teaching hospitals in certain emergency situations.

We are revising the regulatory requirements relating to disclosure to patients of physician ownership or investment interests in hospitals and responding to public comments on a collection of information regarding financial relationships between hospitals and physicians. In addition, we are responding to public comments on proposals made in two separate rulemakings related to policies on physician self-referrals and finalizing these policies.

DATES: *Effective Dates:* This final rule is effective on October 1, 2008, with the following exceptions: Amendments to §§ 412.230, 412.232, and 412.234 are effective on September 2, 2008. Amendments to §§ 411.357(a)(5)(ii), (b)(4)(ii), (1)(3)(i) and (ii), and (p)(1)(i)(A) and (B) and the definition of entity in § 411.351 are effective on October 1, 2009.

Applicability Dates: The provisions of § 412.78 relating to payments to SCHs are applicable for cost reporting periods beginning on or after January 1, 2009. Our process for allowing certain hospitals to opt out of decisions made on behalf of hospitals (as discussed in section III.I.7. of this preamble) are applicable on August 19, 2008.

FOR FURTHER INFORMATION CONTACT: Gay Burton, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, and Postacute Care Transfer Issues.

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Thomas Valuck, (410) 786–7479, Hospital Value-Based Purchasing and Readmissions to Hospital Issues.

Rebecca Paul, (410) 786–0852, Collection of Managed Care Encounter Data Issues.

Jacqueline Proctor, (410) 786–8852, Disclosure of Physician Ownership in Hospitals and Financial Relationships between Hospitals and Physicians Issues.

Lisa Ohrin, (410) 786–4565, and Don Romano, (410) 786–1401, Physician Self-Referral Issues.

SUPPLEMENTARY INFORMATION:

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Acronyms

AARP American Association of Retired Persons
AAHKS American Association of Hip and Knee Surgeons
AAMC Association of American Medical Colleges
ACGME Accreditation Council for Graduate Medical Education
AF Artrial fibrillation
AHA American Hospital Association
AICD Automatic implantable cardioverter defibrillator
AHIMA American Health Information Management Association
AHIC American Health Information Community
AHRQ Agency for Healthcare Research and Quality
AMA American Medical Association
AMGA American Medical Group Association
AMI Acute myocardial infarction
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ASC Ambulatory surgical center
ASITN American Society of Interventional and Therapeutic Neuroradiology
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554

BLS Bureau of Labor Statistics
CAH Critical access hospital
CARE [Medicare] Continuity Assessment Record & Evaluation [Instrument]
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CCR Cost-to-charge ratio
CDAC [Medicare] Clinical Data Abstraction Center
CDAD *Clostridium difficile*-associated disease
CIPI Capital input price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Public Law 99–272
CoP [Hospital] condition of participation
CPI Consumer price index
CY Calendar year
DFRR Disclosure of financial relationship report
DRA Deficit Reduction Act of 2005, Public Law 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
DVT Deep vein thrombosis
ECI Employment cost index
EMR Electronic medical record
EMTALA Emergency Medical Treatment and Labor Act of 1986, Public Law 99–272
ESRD End-stage renal disease
FAH Federation of Hospitals
FDA Food and Drug Administration
FHA Federal Health Architecture
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HACs Hospital-acquired conditions
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HIC Health insurance card
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HPMP Hospital Payment Monitoring Program
HSA Health savings account
HSCRC [Maryland] Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
HWH Hospital-within-a hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Edition, Procedure Coding System
ICR Information collection requirement
IHS Indian Health Service
IME Indirect medical education
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS [Acute care hospital] inpatient prospective payment system
IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MRSA Methicillin-resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NQF National Quality Forum
NTIS National Technical Information Service
NVHRI National Voluntary Hospital Reporting Initiative
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
PE Pulmonary embolism
PMS As Primary metropolitan statistical areas
POA Present on admission
PPI Producer price index
PPS Prospective payment system
PRM Provider Reimbursement Manual
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PSF Provider-Specific File
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RAPS Risk Adjustment Processing System
RCE Reasonable compensation equivalent
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution
RRC Rural referral center
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Public Law. 110–09
TJA Total joint arthroplasty
UHDDS Uniform hospital discharge data set
VAP Ventilator-associated pneumonia
VBP Value-based purchasing

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I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus

any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate based on their costs in a base year. For example, sole community hospitals (SCHs) receive the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. (We note that, as discussed in section IV.D.2. of this preamble, effective for cost reporting periods beginning on or after January 1, 2009, an SCH's hospital-specific rate will be based on their costs per discharge in FY 2006 if greater than the hospital-specific rates based on its costs in FY 1982, FY 1987, or FY 1996, or the IPPS rate based on the standardized amount.) Until FY 2007, a Medicare-dependent, small rural hospital (MDH) has received the IPPS rate plus 50 percent of the difference between the IPPS rate and its hospital-specific rate if the hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 2002) is higher than the IPPS rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the IPPS rate plus 75 percent of the difference between the IPPS rate and its hospital-specific rate, if the hospital-specific rate is higher than the IPPS rate. SCHs are the sole source of care in their areas, and MDHs are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. However, as discussed in section V.B.2. of this preamble, the capital IME adjustment will be reduced by 50 percent in FY 2009 (as established in the FY 2008 IPPS final rule with comment period). In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR Part 412, subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the IPPS. These hospitals and units are: rehabilitation hospitals and units; long-term care hospitals (LTCHs); psychiatric hospitals and units; children's hospitals; and cancer hospitals. Religious nonmedical health care institutions (RNHCIs) are also excluded from the IPPS. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), LTCHs, and psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)), as discussed below. Children's hospitals, cancer hospitals, and RNHCIs continue to be paid solely under a reasonable cost-based system.

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR parts 412 and 413.

a. Inpatient Rehabilitation Facilities (IRFs)

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units (IRFs) have been transitioned from payment based on a blend of reasonable cost reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and the adjusted facility Federal prospective payment rate for cost reporting periods beginning on or after January 1, 2002 through September 30, 2002, to payment at 100 percent of the Federal rate effective for cost reporting periods beginning on or after October 1, 2002. IRFs subject to the blend were also permitted to elect payment based on 100 percent of the Federal rate. The existing regulations governing payments under the IRF PPS are located in 42 CFR Part 412, Subpart P.

b. Long-Term Care Hospitals (LTCHs)

Under the authority of sections 123(a) and (c) of Public Law 106–113 and section 307(b)(1) of Public Law 106–554, the LTCH PPS was effective for a LTCH's first cost reporting period beginning on or after October 1, 2002. LTCHs that do not meet the definition of ''new'' under § 412.23(e)(4) are paid, during a 5-year transition period, a LTCH prospective payment that is comprised of an increasing proportion of the LTCH Federal rate and a decreasing proportion based on reasonable cost principles. Those LTCHs that did not meet the definition of ''new'' under § 412.23(e)(4) could elect to be paid based on 100 percent of the Federal prospective payment rate instead of a blended payment in any year during the 5-year transition. For cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O.

c. Inpatient Psychiatric Facilities (IPFs)

Under the authority of sections 124(a) and (c) of Public Law 106–113, inpatient psychiatric facilities (IPFs) (formerly psychiatric hospitals and psychiatric units of acute care hospitals) are paid under the IPF PPS. For cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem payment amount established under the IPF PPS. (For cost reporting periods beginning on or after January 1, 2005, and ending on or before December 31, 2007, some IPFs received transitioned payments for inpatient hospital services based on a blend of reasonable cost-based payment and a Federal per diem payment rate.) The existing regulations governing payment under the IPF PPS are located in 42 CFR 412, Subpart N.

3. Critical Access Hospitals (CAHs)

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services are based on 101 percent of reasonable cost. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR parts 413 and 415.

4. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act. The amount of payment for direct GME costs

for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

B. Provisions of the Deficit Reduction Act of 2005 (DRA)

Section 5001(b) of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, requires the Secretary to develop a plan to implement, beginning with FY 2009, a value-based purchasing plan for section 1886(d) hospitals defined in the Act. In section IV.C. of the preamble of this proposed rule, we discuss the report to Congress on the Medicare value-based purchasing plan and the current testing of the plan.

C. Provisions of the Medicare Improvements and Extension Act Under Division B, Title I of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA)

Section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The Secretary was also instructed to consider MedPAC's recommendations on the Medicare wage index classification system in developing these proposals. In section III. of the preamble of this final rule, we summarize Acumen's comparative and impact analysis of the MedPAC and CMS wage indices.

D. Provision of the TMA, Abstinence Education, and QI Programs Extension Act of 2007

Section 7 of the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 (Pub. L. 110–90) provides for a 0.9 percent prospective documentation and coding adjustment in the determination of standardized amounts under the IPPS (except for MDHs, SCHs, and Puerto Rico hospitals) for discharges occurring during FY 2009. The prospective documentation and coding adjustment was established in FY 2008 in response to the implementation of an MS–DRG system under the IPPS that resulted in changes in coding and classification that did not reflect real changes in case-mix under section 1886(d) of the Act. We discuss our implementation of this provision in section II.D. of the preamble of this final rule and in the Addendum and in Appendix A to this final rule.

E. Issuance of a Notice of Proposed Rulemaking

On April 30, 2008, we issued in the **Federal Register** (73 FR 23528) a notice of proposed rulemaking that set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2009. We also set forth proposed changes relating to payments for GME and IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis that would be effective for discharges occurring on or after October 1, 2008. In addition, we presented proposed changes relating to disclosure to patients of physician ownership and investment interests in hospitals, proposed changes to our physician self-referral regulations, and a solicitation of public comments on a proposed collection of information regarding financial relationships between hospitals and physicians.

Below is a summary of the major changes that we proposed to make:

1. Proposed Changes to MS–DRG Classifications and Recalibrations of Relative Weights In section II. of the Preamble to the Proposed Rule, We Included—

- Proposed changes to MS–DRG reclassifications based on our yearly review.
- Proposed application of the documentation and coding adjustment to hospital-specific rates resulting from implementation of the MS–DRG system.
- Proposed changes to address the RTI reporting recommendations on charge compression.
- Proposed recalibrations of the MS–DRG relative weights.

We also proposed to refine the hospital cost reports so that charges for relatively inexpensive medical supplies are reported separately from the costs and charges for more expensive medical devices. This proposal would be applied to the determination of both the IPPS and the OPPS relative weights as well as the calculation of the ambulatory surgical center payment rates.

We presented a listing and discussion of additional hospital-acquired conditions (HACs), including infections, that were proposed to be subject to the statutorily required quality adjustment in MS–DRG payments for FY 2009.

We presented our evaluation and analysis of the FY 2009 applicants for add-on payments for high-cost new medical services and technologies (including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

We proposed the annual update of the MS–LTC–DRG classifications and relative weights for use under the LTCH PPS for FY 2009.

2. Proposed Changes to the Hospital Wage Index

In section III. of the preamble to the proposed rule, we proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed include the following:

- Proposed wage index reform changes in response to recommendations made to Congress as a result of the wage index study required under Public Law 109–432. We discussed changes related to reclassifications criteria, application of budget neutrality in reclassifications, and the rural floor and imputed floor budget neutrality at the State level.
- Changes to the CBSA designations.
- The methodology for computing the proposed FY 2009 wage index.
- The proposed FY 2009 wage index update, using wage data from cost reporting periods that began during FY 2005.
- Analysis and implementation of the proposed FY 2009 occupational mix adjustment to the wage index.
- Proposed revisions to the wage index based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for FY 2009 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data used to compute the proposed FY 2009 wage index.
- The proposed labor-related share for the FY 2009 wage index, including the labor-related share for Puerto Rico.

3. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

In section IV. of the preamble to the proposed rule, we discussed a number of the provisions of the regulations in 42 CFR Parts 412, 413, and 489, including the following:

- Proposed changes to the postacute care transfer policy as it relates to transfers to home with the provision of home health services.
- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Proposed changes in the collection of Medicare Advantage (MA) encounter data that are used for computing the risk payment adjustment made to MA organizations.
- Discussion of the report to Congress on the Medicare value-based purchasing

plan and current testing and further development of the plan.

- Proposed changes to the methodology for determining core staff values for the volume decrease payment adjustment for SCHs and MDHs.
- The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status.
- The statutorily required IME adjustment factor for FY 2009 and technical changes to the GME payment policies.
- Proposed changes to policies on hospital emergency services under EMTALA to address EMTALA Technical Advisory Group (TAG) recommendations.
- Solicitation of public comments on Medicare policies relating to incentives for avoidable readmissions to hospitals.
- Discussion of the fifth year of implementation of the Rural Community Hospital Demonstration Program.

4. Proposed Changes to the IPPS for Capital-Related Costs

In section V. of the preamble to the proposed rule, we discussed the payment policy requirements for capital-related costs and capital payments to hospitals. We acknowledged the public comments that we received on the phase-out of the capital teaching adjustment included in the FY 2008 IPPS final rule with comment period, and again solicited public comments on this phase-out.

5. Proposed Changes to the Payment Rates for Excluded Hospitals and Hospital Unit

In section VI. of the preamble to the proposed rule, we discussed proposed changes to payments to excluded hospitals and hospital units, proposed changes for determining LTCH CCRs under the LTCH PPS, and proposed changes to the regulations on hospitals-within-hospitals.

6. Proposed Changes Relating to Disclosure of Physician Ownership in Hospitals

In section VII. of the preamble of the proposed rule, we presented proposed changes to the regulations relating to the disclosure to patients of physician ownership or investment interests in hospitals.

7. Proposed Changes and Solicitation of Comments on Physician Self-Referral Provisions

In section VIII. of the preamble of the proposed rule, we proposed changes to the physician self-referral regulations relating to the ''Stand in Shoes'' provision and the period of disallowance for claims submitted in violation of the prohibition. In addition, we solicited public comments regarding physician-owned implant companies and gainsharing arrangements.

8. Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians

In section IX. of the preamble of the proposed rule, we solicited public comments on our proposed collection of information regarding financial relationships between hospitals and physicians.

9. Determining Proposed Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2009 prospective payment rates for operating costs and capital-related costs. We also established the proposed threshold amounts for outlier cases. In addition, we addressed the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2009 for hospitals and hospital units excluded from the PPS.

10. Impact Analysis

In Appendix A of the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected hospitals.

11. Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2009 for the following:

- A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs (and hospital-specific rates applicable to SCHs and MDHs).
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

12. Disclosure of Financial Relationships Report (DFRR) Form

In Appendix C of the proposed rule, we presented the reporting form that we proposed to use for the proposed collection of information on financial relationships between hospitals and physicians discussed in section IX. of the preamble of the proposed rule.

13. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2008 recommendations concerning hospital inpatient payment policies address the update factor for inpatient hospital operating costs and capital-related costs under the IPPS and for hospitals and distinct part hospital units excluded from the IPPS. We addressed these recommendations in Appendix B of the proposed rule. For further information relating specifically to the MedPAC March 2008 reports or to obtain a copy of the reports, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov*.

F. Public Comments Received on the FY 2009 IPPS Proposed Rule and Issues in Related Rules

1. Comments on the FY 2009 IPPS Proposed Rule

We received over 1,100 timely pieces of correspondence in response to the FY 2009 IPPS proposed rule issued in the **Federal Register** on April 30, 2008. These public comments addressed issues on multiple topics in the proposed rule. We present a summary of the public comments and our responses to them in the applicable subject-matter sections of this final rule.

2. Comments on Phase-Out of the Capital Teaching Adjustment Under the IPPS Included in the FY 2008 IPPS Final Rule With Comment Period

In the FY 2008 IPPS final rule with comment period, we solicited public comments on our policy changes related to phase-out of the capital teaching adjustment to the capital payment update under the IPPS (72 FR 47401). We received approximately 90 timely pieces of correspondence in response to our solicitation. In section V. of the preamble of the FY 2009 IPPS proposed rule, we acknowledged receipt of those public comments and again solicited public comments on the phase-out. We received numerous pieces of timely correspondence in response to the second solicitation. In section V. of this final rule, we summarize the public comments received on both the FY 2008 IPPS final rule with comment period and the FY 2009 IPPS proposed rule and present our responses.

3. Comments on Policy Revisions Related to Payment to Medicare GME Affiliated Hospitals in Certain Declared Emergency Areas Included in Two Interim Final Rules With Comment Period

We have issued two interim final rules with comment periods in the **Federal Register** that modified the GME regulations as they apply to Medicare GME affiliated groups to provide for greater flexibility in training residents in approved residency programs during times of disasters: On April 12, 2006 (71 FR 18654) and on November 27, 2007 (72 FR 66892). We received a number of timely pieces of correspondence in response to these interim final rules with comment period. In section IV.G. of the preamble of this final rule, we summarize and address these public comments.

4. Comments on Proposed Policy Revisions Related to Physician Self-Referrals Included in the CY 2008 Physician Fee Schedule Proposed Rule

On July 12, 2007, we issued in the **Federal Register** proposed revisions to physician payment policies under the CY 2008 Physician Fee Schedule (72 FR 38121). Among these proposed changes were a number of proposed changes relating to physician self-referral issues that we have not finalized: Burden of proof; obstetrical malpractice insurance subsidies; ownership or investment interest in retirement plans; units of service (per click) payments in space and equipment leases; ''set in advance'' percentage-based compensation arrangements; alternative criteria for satisfying certain exceptions; and services provided under arrangement. In section VIII. of the preamble to this final rule, we are addressing the public comments that we received on these proposed revisions, presenting our responses to the public comments, and finalizing these policies.

G. Provisions of the Medicare Improvements for Patients and Providers Act of 2008

After publication of the FY 2009 IPPS proposed rule, the Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275, was enacted on July 15, 2008. Public Law 110–275 contains several provisions that impact payments under the IPPS for FY 2009, which we discuss or are implementing in this final rule:

- Section 122 of Public Law 110–275 provides that, for cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on an FY 2006 hospital-specific rate (that is, based on their updated costs per discharge from their 12-month cost reporting period beginning during Federal fiscal year 2007), if this results in the greatest payment to the SCH. Therefore, effective with cost reporting periods beginning January 1, 2009, SCHs will be paid based on the rate that results in the greatest aggregate payment using either the Federal rate or their hospital-specific rate based on their cost per discharge for 1982, 1987, 1996, or 2006. We address this provision under section IV.D.2. of the preamble of this final rule.
- Section 124 of Public Law 110–275 extends, through FY 2009, wage index reclassifications for hospitals reclassified under section 508 of Public Law 108–173 (the MMA) and certain special hospital exceptions extended under the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173). We discuss this provision in section III.I.7. and various other sections of this final rule. We note that because of the timing of enactment of Public Law 110–275, we are not able to recompute the FY 2009 wage index values for any hospital that would be reclassified under the section 508 provisions in time for inclusion in this final rule. We will issue the final FY 2009 wage index values and other related tables, as specified in the Addendum to this final rule, in a separate **Federal Register** notice implementing this extension that will be published subsequent to this final rule.

II. Changes to Medicare Severity Diagnosis-Related Group (MS–DRG) Classifications and Relative Weights

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

B. MS–DRG Reclassifications

1. General

As discussed in the preamble to the FY 2008 IPPS final rule with comment period (72 FR 47138), we focused our efforts in FY 2008 on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its ''Report to the Congress, Physician-Owned Specialty Hospitals'' in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking severity of illness into account and applying hospital-specific relative value (HSRV) weights to DRGs.[1] We began this reform process by adopting cost-based weights over a 3-year transition period beginning in FY 2007 and making interim changes to the DRG system for FY 2007 by creating 20 new CMS DRGs and modifying 32 other DRGs across 13 different clinical areas involving nearly 1.7 million cases. As described in more detail below, these refinements were intermediate steps towards comprehensive reform of both the relative weights and the DRG system that is occurring as we undertook further study. For FY 2008, we adopted 745 new Medicare Severity DRGs (MS–DRGs) to replace the CMS DRGs. We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system, based on severity levels of illness, was established (72 FR 47141).

Currently, cases are classified into MS–DRGs for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of MS–DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

Comment: Several commenters expressed concern that only nine diagnosis codes and six procedure codes are used by Medicare to process each

[1] Medicare Payment Advisory Commission: *Report to the Congress, Physician-Owned Specialty Hospitals*, March 2005, page viii.

claim under the IPPS. The commenters stated that the implementation of new initiatives, such as the MS–DRG system, Present on Admission (POA) reporting, and the hospital-acquired condition (HAC) payment provision, depend on the capturing of all of the patient's diagnoses and procedures in order to fully represent the patient's severity of illness, complexity of care, and quality of care provided. In addition, the commenters stated that the adoption of ''component'' codes, such as the new ICD–9–CM codes for pressure ulcer stages, requires multiple diagnosis fields to represent a single diagnosis. The commenters recommended that CMS modify its systems so that the number of diagnoses codes processed would increase from 9 to 25 and the number of procedure codes processed would increase from 6 to 25. The commenters stated that hospitals submit claims to CMS in electronic format, and that the HIPAA compliant electronic transaction standard, HIPAA 837i, allows up to 25 diagnoses and 25 procedures. The commenters stated that CMS does not require its fiscal intermediaries (or MAC) to process codes beyond the first nine diagnosis codes and six procedure codes. The commenters indicated that complex classification systems such as the proposed MS–DRGs could use the information in these additional codes to improve patient classification.

Response: The commenters are correct that CMS does not process codes submitted electronically on the 837i electronic format beyond the first nine diagnosis codes and first six procedure codes. While HIPAA requires CMS to accept up to 25 ICD–9–CM diagnosis and procedure codes on the HIPAA 837i electronic format, it does not require that CMS process that number of diagnosis and procedure codes. We agree with the commenters that there is value in retaining additional data on patient conditions that would result from expanding Medicare's data system so it can accommodate additional diagnosis and procedure codes. We have been considering this issue while we contemplate refinements to our DRG system to better recognize patient severity of illness. However, extensive lead time is required to allow for modifications to our internal and contractors' electronic systems in order to process and store this additional information. We are unable to currently move forward with this recommendation without carefully evaluating implementation issues. However, we will continue to carefully evaluate this request to expand the process capacity of our systems.

The process of developing the MS–DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formulated by physician panels to ensure that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final MS–DRG could contain patients in different MDCs. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2008, cases are assigned to one of 745 MS–DRGs in 25 MDCs. The table below lists the 25 MDCs.

	Major Diagnostic Categories (MDCs)
1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.
24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to an MS–DRG. However, under the most recent version of the Medicare GROUPER (Version 26.0), there are 9 MS–DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These MS–DRGs are for heart transplant or implant of heart assist systems; liver and/or intestinal transplants; bone marrow transplants; lung transplants; simultaneous pancreas/kidney transplants; pancreas transplants; and tracheostomies. Cases are assigned to these MS–DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

	Pre-Major Diagnostic Categories (Pre-MDCs)
MS–DRG 103	Heart Transplant or Implant of Heart Assist System.
MS–DRG 480	Liver Transplant and/or Intestinal Transplant.
MS–DRG 481	Bone Marrow Transplant.
MS–DRG 482	Tracheostomy for Face, Mouth, and Neck Diagnoses.
MS–DRG 495	Lung Transplant.
MS–DRG 512	Simultaneous Pancreas/Kidney Transplant.
MS–DRG 513	Pancreas Transplant.
MS–DRG 541	ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
MS–DRG 542	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis without Major O.R.

Comment: One commenter noted that the MS–DRG titles for four MS–DRGs have changed in Table 5 (which lists all of the MS–DRGs) in the Addendum to the proposed rule: MS–DRG 154 (Other Ear, Nose, Mouth and Throat Diagnoses with MCC); MS–DRG 155 (Other Ear, Nose, Mouth and Throat Diagnoses with CC); MS–DRG 156 (Other Ear, Nose, Mouth and Throat Diagnoses without CC/MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC). The commenter stated that the current titles for these MS–DRGs are: MS–DRG 154 (Nasal Trauma and Deformity with MCC); MS–DRG 155 (Nasal Trauma and Deformity with CC); MS–DRG 156 (Nasal Trauma and Deformity without CC/MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI without MCC). The commenter inquired if these changes were discussed in the MS–DRGs section of the proposed rule.

Response: The commenter is correct in that we changed these MS–DRG titles to better reflect the modification we made when we adopted the MS–DRGs for FY 2008. Specifically, CMS DRGs 72 (Nasal Trauma & Deformity) and 73 and 74 (Other Ear, Nose, Mouth and Throat Diagnoses Age > 17, Age 0–17, respectively) were consolidated to create MS–DRGs 154, 155, 156 (72 FR 47156). There are other ear, nose, mouth, and throat diagnoses in addition to nasal trauma and deformity assigned to these MS–DRGs so we expanded the titles for MS–DRGs 154, 155, and 156. For MS–DRGs 250 and 251, ''or AMI'' was removed from the titles because these descriptors that were applicable in the CMS DRGs are no longer applicable in the MS–DRGs. We are making these corrections in this final rule.

In addition to these changes to the MS–DRG titles, we are also amending one other MS–DRG title. Due to the creation, after the proposed rule was published, of 6 new ICD–9–CM diagnosis codes for various types of fevers, we are revising the title for MS–DRG 864 from ''Fever of Unknown Origin'' to ''Fever''.

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on hospital resource consumption. Because the presence of a surgical procedure that required the use of the operating room would have a significant effect on the type of hospital resources used by a patient, most MDCs were initially divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (0 to 17 years of age or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or comorbidity (CC) or a major complication or comorbidity (MCC).

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect MS–DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones. Lithotripsy procedures are not routinely performed in an operating room. Therefore, lithotripsy codes are not classified as O.R. procedures. However, our clinical advisors believe that patients with urinary stones who undergo extracorporeal shock wave lithotripsy should be considered similar to other patients who undergo O.R. procedures. Therefore, we treat this group of patients similar to patients undergoing O.R. procedures.

Once the medical and surgical classes for an MDC were formed, each diagnosis class was evaluated to determine if complications or comorbidities would consistently affect hospital resource consumption. Each diagnosis was categorized into one of three severity levels. These three levels include a major complication or comorbidity (MCC), a complication or comorbidity (CC), or a non-CC. Physician panels classified each diagnosis code based on a highly iterative process involving a combination of statistical results from test data as well as clinical judgment. As stated earlier, we refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

A patient's diagnosis, procedure, discharge status, and demographic information is entered into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into an MS–DRG.

After patient information is screened through the MCE and any further development of the claim is conducted, the cases are classified into the appropriate MS–DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into an MS–DRG on the basis of the diagnosis and procedure codes and, for a limited number of MS–DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to an MS–DRG by the GROUPER, the PRICER software calculates a base MS–DRG payment. The PRICER calculates the payment for each case covered by the IPPS based on the MS–DRG relative weight and additional factors associated with each hospital, such as IME and DSH payment adjustments. These additional factors increase the payment amount to

hospitals above the base MS–DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible MS–DRG classification changes and to recalibrate the MS–DRG weights. However, in the FY 2000 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This date allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

As we indicated above, for FY 2008, we made significant improvement in the DRG system to recognize severity of illness and resource usage by adopting MS–DRGs that were reflected in the FY 2008 GROUPER, Version 25.0, and were effective for discharges occurring on or after October 1, 2007. The changes we proposed for FY 2009 (and are adopting in this final rule) will be reflected in the FY 2009 GROUPER, Version 26.0, and will be effective for discharges occurring on or after October 1, 2008. As noted in the FY 2009 IPPS proposed rule (73 FR 23538), our DRG analysis for the FY 2009 proposed rule was based on data from the September 2007 update of the FY 2007 MedPAR file, which contains hospital bills received through September 30, 2007, for discharges through September 30, 2007. For this final rule, our analysis is based on more recent data from the March 2008 update of the FY 2007 MedPAR file, which contains hospital bills received through March 31, 2008, for discharges occurring in FY 2007.

2. Yearly Review for Making MS–DRG Changes

Many of the changes to the MS–DRG classifications we make annually are the result of specific issues brought to our attention by interested parties. We encourage individuals with comments about MS–DRG classifications to submit these in a timely manner so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the MS–DRG recalibration process, comments about MS–DRG classification issues should be submitted no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the MS–DRGs was, and will likely continue to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. In the FY 2008 IPPS final rule (72 FR 47140 through 47189), we described in detail the process we used to develop the MS–DRGs that we adopted for FY 2008. In addition, in deciding whether to make further modification to the MS–DRGs for particular circumstances brought to our attention, we considered whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the MS–DRG. We evaluated patient care costs using average charges and lengths of stay as proxies for costs and relied on the judgment of our medical advisors to decide whether patients are clinically distinct or similar to other patients in the MS–DRG. In evaluating resource costs, we considered both the absolute and percentage differences in average charges between the cases we selected for review and the remainder of cases in the MS–DRG. We also considered variation in charges within these groups; that is, whether observed average differences were consistent across patients or attributable to cases that were extreme in terms of charges or length of stay, or both. Further, we considered the number of patients who will have a given set of characteristics and generally preferred not to create a new MS–DRG unless it would include a substantial number of cases.

C. Adoption of the MS–DRGs in FY 2008

In the FY 2006, FY 2007, and FY 2008 IPPS final rules, we discussed a number of recommendations made by MedPAC regarding revisions to the DRG system used under the IPPS (70 FR 47473 through 47482; 71 FR 47881 through 47939; and 72 FR 47140 through 47189). As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule.

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier). However, based on public comments received on the FY 2007 IPPS proposed rule, we decided not to adopt the CS DRGs (71 FR 47906 through 47912). Rather, we decided to make interim changes to the existing DRGs for FY 2007 by creating 20 new DRGs involving 13 different clinical areas that would significantly improve the CMS DRG system's recognition of severity of illness. We also modified 32 DRGs to better capture differences in severity. The new and revised DRGs were selected from 40 existing CMS DRGs that contained 1,666,476 cases and represented a number of body systems. In creating these 20 new DRGs, we deleted 8 existing DRGs and modified 32 existing DRGs. We indicated that these interim steps for FY 2007 were being taken as a prelude to more comprehensive changes to better account for severity in the DRG system by FY 2008.

In the FY 2007 IPPS final rule (71 FR 47898), we indicated our intent to pursue further DRG reform through two initiatives. First, we announced that we were in the process of engaging a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the CMS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990s in connection with adopting severity DRGs. We describe below the progress we have made on these two initiatives, our actions for FY 2008, and our proposals for FY 2009 based on our continued analysis of reform of the DRG system. We note that the adoption of the MS–DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these implications for FY 2009 in other sections of this preamble and in the Addendum to this final rule.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY 2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights are being adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) which we then applied to charges on the Medicare claims to determine the cost-based weights. The commenters were concerned about potential distortions to the cost-based weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International (RTI) to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this final rule for discussion of the issue of charge compression and the HSRV cost-weighting methodology for FY 2009.

We believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of the payment rates in the IPPS. We agree with MedPAC that these refinements should be pursued. Although we continue to caution that any prospective payment system based on grouping cases will always present some opportunities for providers to specialize in cases they believe have higher margins, we believe that the changes we have adopted and the continuing reforms we are making in this final rule for FY 2009 will improve payment accuracy and reduce financial incentives to create specialty hospitals.

We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

D. MS–DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount

1. MS–DRG Documentation and Coding Adjustment

As stated above, we adopted the new MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. By increasing the number of DRGs and more fully taking into account severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), which appeared in the **Federal Register** on August 22, 2007, we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. In that final rule with comment period, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the standardized amount to eliminate the effect of changes in coding or classification that do not reflect real changes in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010.

On September 29, 2007, the TMA, Abstinence Education, and QI Programs Extension Act of 2007, Public Law 110–90, was enacted. Section 7 of Public Law 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with section 7 of Public Law 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 payment rates, factors, and thresholds accordingly, with these revisions effective October 1, 2007.

For FY 2009, Public Law 110–90 requires a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As required by statute, we are applying a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amount. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 is in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent.

Comment: A number of commenters disagreed with the need for the documentation and coding adjustment and reiterated concerns about the documentation and coding adjustment expressed in prior comments on the FY 2008 IPPS proposed rule. Several of the commenters recommended that CMS not apply the documentation and coding adjustment to the national standardized amount in FY 2009.

Response: The FY 2008 IPPS final rule (72 FR 47175 through 47186) established a documentation and coding adjustment for FY 2008, FY 2009, and FY 2010. The establishment of the documentation and coding adjustment was subject to notice and comment rulemaking. When we established the documentation and coding adjustment in the FY 2008 IPPS final rule with comment period, we considered concerns about the adjustment expressed by commenters on the FY 2008 IPPS proposed rule and provided responses to those public comments in the corresponding rule. Subsequently,

Congress enacted Public Law 110–90, which mandated that the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period be changed to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. As required by law, we are applying the statutorily specified documentation and coding adjustment to the FY 2009 national standardized amount.

Comment: One commenter stated that Public Law 110–90 requires an adjustment of −0.9 percent for FY 2009, not a cumulative adjustment of −1.5 percent for FY 2009.

Response: The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. That final rule indicated that CMS believes that a −4.8 percent adjustment for documentation and coding is necessary (72 FR 47816). Rather than implement the full adjustment in 1 year, the final rule phased it in over 3 years: −1.2 percent in FY 2008, −1.8 percent in FY 2009, and −1.8 percent in FY 2010, for a total of −4.8 percent. Public Law 110–90 requires that in implementing the FY 2008 IPPS final rule with comment period, we substitute 0.6 percent for the 1.2 percent FY 2008 documentation and coding adjustment established in that final rule and 0.9 percent for the 1.8 percent FY 2009 documentation and coding adjustment established in that final rule. Public Law 110–90 did not make any change to the cumulative nature of the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period. Therefore, consistent with Public Law 110–90, we applied a −0.6 percent adjustment to the national standardized amount in FY 2008, and we are applying a −0.9 percent documentation and coding adjustment to the national standardized amount in FY 2009, which results in a cumulative effect of −1.5 percent by FY 2009.

Comment: Several commenters suggested that the documentation and coding adjustment is intended to address inappropriate upcoding, where a hospital's coding is not justified by the medical record. The commenters suggested that CMS undertake studies to identify inappropriate coding by individual providers.

Response: As we stated in the FY 2008 IPPS final rule with comment period, we do not believe there is anything inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment as long as the coding is fully and properly supported by documentation in the medical record.

The documentation and coding adjustment was developed based on the recognition that the MS–DRGs, by better accounting for severity of illness in Medicare payment rates, would encourage hospitals to ensure they had fully and accurately documented and coded all patient diagnoses and procedures consistent with the medical record in order to garner the maximum IPPS payment available under the MS–DRG system. For example, under the previous CMS DRGs, ''congestive heart failure, unspecified'' (code 428.0) was a CC. Under the MS–DRGs, this unspecified code has been made a non-CC, while more specific heart failure codes have been made CCs or MCCs. Because of this, hospitals have a financial incentive under the MS–DRG system, which they did not have under the previous CMS DRG system, to ensure that they code the type of heart failure a patient has as precisely as possible, consistent with the medical record.

The statute requires that DRG recalibration be budget neutral. Due to the standard 2-year lag in claims data, when we recalibrated the MS–DRGs in FY 2008, the calculations were based on FY 2006 claims data that reflected coding under the prior CMS DRG system. As a result, the claims data upon which the DRG recalibrations were performed in FY 2008 did not reflect any improvements in documentation and coding encouraged by the MS–DRG system. Thus, our actuaries determined that a separate adjustment for documentation and coding improvements would be needed in order to ensure that the implementation of the MS–DRG system was budget neutral. This determination led to the establishment of the documentation and coding adjustment established in the FY 2008 IPPS final rule with comment period and amended by Public Law 110–90.

As with any other DRG system, there is potential under the MS–DRG system for an individual provider to inappropriately code and bill for services. The MS–DRG documentation and coding adjustment was not developed to address such program integrity issues. Rather, the program integrity safeguards in place to address inappropriate billing under the CMS DRG system remain in place under the MS–DRG system.

2. Application of the Documentation and Coding Adjustment to the Hospital-Specific Rates

Under section 1886(d)(5)(D)(i) of the Act, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge. Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate based on the greater of either the FY 1982, 1987, or 2002 costs per discharge. In the FY 2008 IPPS final rule with comment period, we established a policy of applying the documentation and coding adjustment to the hospital-specific rates. In that rule, we indicated that because SCHs and MDHs use the same DRG system as all other hospitals, we believe they should be equally subject to the budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. In establishing this policy, section 1886(d)(3)(A)(vi) of the Act provides the authority to adjust ''the standardized amount'' to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix. However, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we rescinded the application of the documentation and coding adjustment to the hospital-specific rates retroactive to October 1, 2007. In that final rule, we indicated that, while we still believe it would be appropriate to apply the documentation and coding adjustment to the hospital-specific rates, upon further review, we decided that application of the documentation and coding adjustment to the hospital-specific rates is not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act, which only mentions adjusting ''the standardized amount'' and does not mention adjusting the hospital-specific rates.

In the FY 2009 IPPS proposed rule, we indicated that we continue to have concerns about this issue. Because hospitals paid based on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from coding improvements that do not reflect real increases in patients' severity of illness. In section 1886(d)(3)(A)(vi) of the Act,

Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rate should not have the potential to realize increased payments due to documentation and coding improvements that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. The special exceptions and adjustment authority authorizes us to provide ''for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate.'' In light of this authority, for the FY 2010 rulemaking, we plan to examine our FY 2008 claims data for hospitals paid based on the hospital-specific rate. In the FY 2009 IPPS proposed rule, we stated that if we find evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 hospital-specific rates under our authority in section 1886(d)(5)(I)(i) of the Act. As noted previously, the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. For example, the −0.9 percent documentation and coding adjustment to the national standardized amount in FY 2009 is in addition to the −0.6 percent adjustment made in FY 2008, yielding a combined effect of −1.5 percent in FY 2009. Given the cumulative nature of the documentation and coding adjustments, if we were to propose to apply the documentation and coding adjustment to the FY 2010 hospital-specific rates, it may involve applying the FY 2008 and FY 2009 documentation and coding adjustments (−1.5 percent combined) plus the FY 2010 documentation and coding adjustment, discussed in the FY 2008 IPPS final rule with comment period, to the FY 2010 hospital-specific rates.

Comment: A number of commenters opposed application of the documentation and coding adjustment to the hospital-specific rates. MedPAC supported application of a documentation and coding adjustment to the prospective payment rates and the hospital-specific rates for all IPPS hospitals that are paid based on their reported case-mix. Another commenter supported application of a documentation and coding adjustment to the hospital-specific rates if analysis of FY 2008 claims data supports a positive adjustment and recommended a transition be considered if the data support a negative adjustment.

Response: We appreciate the comments received. We did not propose to apply the documentation and coding adjustment to the hospital-specific rates for FY 2009. Instead, as we indicated in the proposed rule and reiterated above, we intend to consider whether such a proposal is warranted for FY 2010. To gather information to evaluate these considerations, we plan to perform analyses on FY 2008 claims data to examine whether there has been a significant increase in case-mix for hospitals paid based on the hospital-specific rate. If we find that application of the documentation and coding adjustment to the hospital-specific rates for FY 2010 is warranted, we would include a proposal in the FY 2010 IPPS proposed rule, which would be open for public comment at that time.

3. Application of the Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

Puerto Rico hospitals are paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As noted previously, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the authority to adjust ''the standardized amounts computed under this paragraph'' to eliminate the effect of changes in coding or classification that do not reflect real changes in case-mix. Section 1886(d)(3)(A)(vi) of the Act applies to the national standardized amounts computed under section 1886(d)(3) of the Act, but does not apply to the Puerto Rico-specific standardized amount computed under section 1886(d)(9)(C) of the Act. In calculating the FY 2008 payment rates, we made an inadvertent error and applied the FY 2008 −0.6 percent documentation and coding adjustment to the Puerto Rico-specific standardized amount, relying on our authority under section 1886(d)(3)(A)(vi) of the Act. However, section 1886(d)(3)(A)(vi) of the Act authorizes application of a documentation and coding adjustment to the national standardized amount and does not apply to the Puerto Rico-specific standardized amount. In this final rule, we are correcting this inadvertent error by removing the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific rates. The revised FY 2008 Puerto Rico-specific operating standardized amounts are: $1,471.10 for the labor share and $901.64 for the nonlabor share for a hospital with a wage index greater than 1 and $1,392.80 for the labor share and $979.94 for the non-labor share for a hospital with a wage index less than or equal to 1. The revised FY 2008 Puerto Rico capital payment rate is $202.89 (as discussed in section III.A.6.b. of the Addendum to this final rule). These revised rates are effective October 1, 2007, for FY 2008.

While section 1886(d)(3)(A)(vi) of the Act is not applicable to the Puerto Rico-specific standardized amount, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, discussed in section II.D.2. of this preamble, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding improvements that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and MDHs in section II.D.2. of the preamble of this final rule, for the FY 2010 rulemaking, we plan to examine our FY 2008 claims data for hospitals in Puerto Rico. As we indicated in the FY 2009 proposed rule, if we find evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 Puerto Rico-specific standardized amount under our authority in section 1886(d)(5)(I)(i) of the Act. As noted previously, the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. Given the cumulative nature of the documentation and coding adjustments, if we were to propose to apply the documentation and coding adjustment to the FY 2010 Puerto Rico-specific standardized amount, it may involve applying the FY 2008 and FY

2009 documentation and coding adjustments (−1.5 percent combined) plus the FY 2010 documentation and coding adjustment, discussed in the FY 2008 IPPS final rule with comment period, to the FY 2010 Puerto Rico-specific standardized amount.

Comment: Some commenters opposed application of the documentation and coding adjustment to the Puerto Rico-specific standardized amount. MedPAC supported application of a documentation and coding adjustment to the prospective payment rates and the hospital-specific rates for all IPPS hospitals that are paid based on their reported case-mix.

Response: We appreciate the comments. We did not propose to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount for FY 2009. Instead, as we indicated in the proposed rule, we intend to consider whether such a proposal is warranted for FY 2010. To gather information to evaluate these considerations, we plan to perform analyses on FY 2008 claims data to examine whether there has been a significant increase in case-mix for hospitals in Puerto Rico. If we find that application of the documentation and coding adjustment to the Puerto Rico-specific standardized amount for FY 2010 is warranted, we would include a proposal in the FY 2010 proposed rule, which would be open for public comment at that time.

4. Potential Additional Payment Adjustments in FYs 2010 Through 2012

Section 7 of Public Law 110–90 also provides for payment adjustments in FYs 2010 through 2012 based upon a retrospective evaluation of claims data from the implementation of the MS–DRG system. If, based on this retrospective evaluation, the Secretary finds that in FY 2008 and FY 2009, the actual amount of change in case-mix that does not reflect real change in underlying patient severity differs from the statutorily mandated documentation and coding adjustments implemented in those years, the law requires the Secretary to adjust payments for discharges occurring in FYs 2010 through 2012 to offset the estimated amount of increase or decrease in aggregate payments that occurred in FY 2008 and FY 2009 as a result of that difference, in addition to making an appropriate adjustment to the standardized amount under section 1886(d)(3)(A)(vi) of the Act.

In order to implement these requirements of section 7 of Public Law 110–90, we are planning a thorough retrospective evaluation of our claims data. Results of this evaluation would be used by our actuaries to determine any necessary payment adjustments in FYs 2010 through 2012 to ensure the budget neutrality of the MS–DRG implementation for FY 2008 and FY 2009, as required by law. In the FY 2009 IPPS proposed rule, we described our preliminary analysis plans to provide the opportunity for public input.

In the proposed rule, we indicated that we intend to measure and corroborate the extent of the overall national average changes in case-mix for FY 2008 and FY 2009. We expect part of this overall national average change would be attributable to underlying changes in actual patient severity and part would be attributable to documentation and coding improvements under the MS–DRG system. In order to separate the two effects, we plan to isolate the effect of shifts in cases among base DRGs from the effect of shifts in the types of cases within base DRGs. The shifts among base DRGs are the result of changes in principal diagnoses while the shifts within base DRGs are the result of changes in secondary diagnoses. Because we expect most of the documentation and coding improvements under the MS–DRG system will occur in the secondary diagnoses, we believe that the shifts among base DRGs are less likely to be the result of the MS–DRG system and the shifts within base DRGs are more likely to be the result of the MS–DRG system. We also anticipate evaluating data to identify the specific MS–DRGs and diagnoses that contributed significantly to the improved documentation and coding payment effect and to quantify their impact. This step would entail analysis of the secondary diagnoses driving the shifts in severity within specific base DRGs.

In the proposed rule, we also stated that, while we believe that the data analysis plan described previously will produce an appropriate estimate of the extent of case-mix changes resulting from documentation and coding improvements, we may also decide, if feasible, to use historical data from our Hospital Payment Monitoring Program (HPMP) to corroborate the within-base DRG shift analysis. The HPMP is supported by the Medicare Clinical Data Abstraction Center (CDAC). From 1998 to 2007, the CDAC obtained medical records for a sample of discharges as part of our hospital monitoring activities. These data were collected on a random sample of between 30,000 to 50,000 hospital discharges per year. The historical CDAC data could be used to develop an upper bound estimate of the trend in real case-mix growth (that is, real change in underlying patient severity) prior to implementation of the MS–DRGs.

In the FY 2009 IPPS proposed rule, we solicited public comments on the analysis plans described above, as well as suggestions on other possible approaches for conducting a retrospective analysis to identify the amount of case-mix changes that occurred in FY 2008 and FY 2009 that did not reflect real increases in patients' severity of illness.

Comment: A few commenters, including MedPAC, expressed support for the analytic approach described in the proposed rule. A number of other commenters expressed concerns about certain aspects of the approach and/or suggested alternate analyses or study designs. In addition, one commenter recommended that any determination or retrospective evaluation by the actuaries of the impact of the MS–DRGs on case-mix be open to public scrutiny prior to the implementation of final payment adjustments for FY 2010 through FY 2012.

Response: We thank the commenters for their comments. We will take all of the comments into consideration as we continue development of our analysis plans. Our analysis, findings, and any resulting proposals to adjust payments for discharges occurring in FYs 2010 through 2012 to offset the estimated amount of increase or decrease in aggregate payments that occurred in FY 2008 and FY 2009 will be discussed in future years' proposed rules, which will be open for public comment.

Comment: One commenter expressed concern about the impact that an adjustment to the FY 2010 through FY 2012 payment rates could have on small rural hospitals. The commenter stated that if CMS finds that there was an increase in aggregate payments in FY 2008 or FY 2009 that requires an offsetting adjustment to the FY 2010 through FY 2012 payment rates, CMS should consider a transition period before fully implementing such ad adjustment.

Response: If our analysis suggests that an adjustment to the FY 2010 through FY 2012 payment rates is necessary, a proposal would be made in a future proposed rule and the public would have an opportunity to comment on the proposal at that time.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

In the FY 2008 IPPS final rule with comment period (72 FR 47188), we

continued to implement significant revisions to Medicare's inpatient hospital rates by basing relative weights on hospitals' estimated costs rather than on charges. We continued our 3-year transition from charge-based relative weights to cost-based relative weights. Beginning in FY 2007, we implemented relative weights based on cost report data instead of based on charge information. We had initially proposed to develop cost-based relative weights using the hospital-specific relative value cost center (HSRVcc) methodology as recommended by MedPAC. However, after considering concerns raised in the public comments, we modified MedPAC's methodology to exclude the hospital-specific relative weight feature. Instead, we developed national CCRs based on distinct hospital departments and engaged a contractor to evaluate the HSRVcc methodology for future consideration. To mitigate payment instability due to the adoption of cost-based relative weights, we decided to transition cost-based weights over 3 years by blending them with charge-based weights beginning in FY 2007. In FY 2008, we continued our transition by blending the relative weights with one-third charge-based weights and two-thirds cost-based weights.

Also, in FY 2008, we adopted severity-based MS–DRGs, which increased the number of DRGs from 538 to 745. Many commenters raised concerns as to how the transition from charge-based weights to cost-based weights would continue with the introduction of new MS–DRGs. We decided to implement a 2-year transition for the MS–DRGs to coincide with the remainder of the transition to cost-based relative weights. In FY 2008, 50 percent of the relative weight for each DRG was based on the CMS DRG relative weight and 50 percent was based on the MS–DRG relative weight. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for more detail on our final policy for calculating the cost-based DRG relative weights and to the FY 2008 IPPS final rule with comment period (72 FR 47199) for information on how we blended relative weights based on the CMS DRGs and MS–DRGs.

As we transitioned to cost-based relative weights, some commenters raised concerns about potential bias in the weights due to ''charge compression,'' which is the practice of applying a higher percentage charge markup over costs to lower cost items and services, and a lower percentage charge markup over costs to higher cost items and services. As a result, the cost-based weights would undervalue high cost items and overvalue low cost items if a single CCR is applied to items of widely varying costs in the same cost center. To address this concern, in August 2006, we awarded a contract to RTI to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers. RTI issued an interim draft report in March 2007 which was posted on the CMS Web site with its findings on charge compression. In that report, RTI found that a number of factors contribute to charge compression and affect the accuracy of the relative weights. RTI found inconsistent matching of charges in the Medicare cost report and their corresponding charges in the MedPAR claims for certain cost centers. In addition, there was inconsistent reporting of costs and charges among hospitals. For example, some hospitals would report costs and charges for devices and medical supplies in the Medical Supplies Charged to Patients cost center, while other hospitals would report those costs and charges in their related ancillary departments such as Operating Room or Radiology. RTI also found evidence that certain revenue codes within the same cost center had significantly different markup rates. For example, within the Medicare Supplies Charged to Patients cost center, revenue codes for devices, implantables, and prosthetics had different markup rates than the other medical supplies in that cost center. RTI's findings demonstrated that charge compression exists in several CCRs, most notably in the Medical Supplies and Equipment CCR.

RTI offered short-term, medium-term, and long-term recommendations to mitigate the effects of charge compression. RTI's short-term recommendations included expanding the distinct hospital CCRs to 19 by disaggregating the ''Emergency Room'' and ''Blood and Blood Products'' from the Other Services cost center and by estimating regression-based CCRs to disaggregate Medical Supplies, Drugs, and Radiology cost centers. RTI recommended, for the medium-term, to expand the MedPAR file to include separate fields that disaggregate several existing charge departments. In addition, RTI recommended improving hospital cost reporting instructions so that hospitals can properly report costs in the appropriate cost centers. RTI's long-term recommendations included adding new cost centers to the Medicare cost report, such as adding a ''Devices, Implants and Prosthetics'' line under ''Medical Supplies Charged to Patients'' and a ''CT Scanning and MRI'' subscripted line under ''Radiology-Diagnostics''.

Among RTI's short-term recommendations, for FY 2008, we expanded the number of distinct hospital department CCRs from 13 to 15 by disaggregating ''Emergency Room'' and ''Blood and Blood Products'' from the Other Services cost center as these lines already exist on the hospital cost report. Furthermore, in an effort to improve consistency between costs and their corresponding charges in the MedPAR file, we moved the costs for cases involving electroencephalography (EEG) from the Cardiology cost center to the Laboratory cost center group which corresponds with the EEG MedPAR claims categorized under the Laboratory charges. We also agreed with RTI's recommendations to revise the Medicare cost report and the MedPAR file as a long-term solution for charge compression. We stated that, in the upcoming year, we would consider additional lines to the cost report and additional revenue codes for the MedPAR file.

Despite receiving public comments in support of the regression-based CCRs as a means to immediately resolve the problem of charge compression, particularly within the Medical Supplies and Equipment CCR, we did not adopt RTI's short-term recommendation to create four additional regression-based CCRs for several reasons. We were concerned that RTI's analysis was limited to charges on hospital inpatient claims, while typically hospital cost report CCRs combine both inpatient and outpatient services. Further, because both the IPPS and OPPS rely on cost-based weights, we preferred to introduce any methodological adjustments to both payment systems at the same time. We have since expanded RTI's analysis of charge compression to incorporate outpatient services. RTI has been evaluating the cost estimation process for the OPPS cost-based weights, including a reassessment of the regression-based CCR models using both outpatient and inpatient charge data. Because the RTI report was not available until after the conclusion of our proposed rule development process, we were unable to include a summary of the report in the FY 2009 IPPS proposed rule. The IPPS-related chapters of RTI's interim report were posted on the CMS Web site on April 22, 2008, for a 60-day comment period, and we welcomed comments on the report. In this final rule, we are providing a summary of RTI's findings and the public comments

we received in section II.E.2. of the preamble of this final rule.

2. Summary of RTI's Report on Charge Compression

As stated earlier, subsequent to the release of the FY 2009 IPPS proposed rule, we posted on April 22, 2008, an interim report discussing RTI's research findings for the IPPS MS–DRG relative weights to be available during the public comment period on the FY 2009 IPPS proposed rule. This report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200804.pdf*. The IPPS-specific chapters, which were separately displayed in the April 2008 interim report, as well as the more recent OPPS chapters, are included in the July 2008 RTI final report entitled, ''Refining Cost-to-Charge Ratios for Calculating APC and DRG Relative Payment Weights,'' that became available at the time of the development of this final rule. The RTI final report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*.

RTI's final report distinguished between two types of research findings and recommendations: Those pertaining to the accounting or cost report data and those related to statistical regression analysis. Because the OPPS uses a hospital-specific CCR methodology, employs detailed cost report data, and estimates costs at the claim level, CMS asked RTI to closely evaluate the accounting component of the OPPS cost-based weight methodology. In reviewing the cost report data for nonstandard cost centers used in the crosswalk, RTI discovered some problems concerning the classification of nonstandard cost centers that impact both the IPPS and the OPPS. RTI reclassified nonstandard cost centers by reading providers' cost center labels. Standard cost centers are preprinted in the CMS-approved cost report software, while nonstandard cost centers are identified and updated periodically through analysis of frequently used labels. Under the IPPS, the line reassignments only slightly impact the 15 national aggregate CCRs used in the relative weight calculation. However, improved cost report data for CT Scanning, MRI, Nuclear Medicine, Therapeutic Radiology, and Cardiac Catheterization through line reassignments allowed for the reduction in aggregation bias by expanding the number of national CCRs available to separately capture these and other services. Importantly, RTI found that, under the IPPS and the OPPS, this improvement to the cost reporting data reduces some of the sources of aggregation bias without having to use regression-based adjustments.

In general, with respect to the regression-based adjustments, RTI confirmed the findings of its March 2007 report that regression models are a valid approach for diagnosing potential aggregation bias within selected services for the IPPS and found that regression models are equally valid for setting payments under the OPPS. RTI also suggested that regression-based CCRs could provide a short-term correction until accounting data could be refined to support more accurate CCR estimates under both the IPPS and the OPPS. RTI again found aggregation bias in devices, drugs, and radiology and, using combined outpatient and inpatient claims, expanded the number of recommended regression-adjusted CCRs to create seven regression-adjusted CCRs for Devices, IV Solutions, Cardiac Catheterization, CT Scanning, MRI, Therapeutic Radiology, and Nuclear Medicine.

In almost all cases, RTI observed that potential distortions from aggregation bias and incorrect cost reporting in the OPPS relative weights were proportionally much greater than for MS–DRGs for both accounting-based and statistical adjustments because OPPS groups are small and generally price a single service. HCRIS line reassignments by themselves had little effect on most inpatient weights. However, just as the overall impacts on MS–DRGs were more moderate because MS–DRGs experienced offsetting effects in cost estimation among numerous revenue codes in an episode, a given hospital outpatient visit might include more than one service, leading to offsetting effects in cost estimation for services provided in the outpatient episode as a whole.

Notwithstanding likely offsetting effects at the provider-level, RTI asserted that, while some averaging is appropriate for a prospective payment system, extreme distortions in payments for individual services bias perceptions of service profitability and may lead hospitals to inappropriately set their charge structure. RTI noted that this may not be true for ''core'' hospital services, such as oncology, but has a greater impact in evolving areas with greater potential for provider-induced demand, such as specialized imaging services. RTI also noted that cost-based weights are only one component of a final prospective payment rate. There are other rate adjustments (wage index, IME, and DSH) to payments derived from the revised cost-based weights and the cumulative effect of these components may not improve the ability of final payment to reflect resource cost. With regard to APCs and MS–DRGs that contain substantial device costs, RTI cautioned that other prospective payment system adjustments (wage index, IME, and DSH) largely offset the effects of charge compression among hospitals that receive these adjustments. RTI endorsed short-term regression-based adjustments, but also concluded that more refined and accurate accounting data are the preferred long-term solution to mitigate charge compression and related bias in hospital cost-based weights.

As a result of this research, RTI made 11 recommendations. The first set of recommendations is more applicable to the OPPS because it uses more granular HCRIS data and concentrates on short-term accounting changes to current cost report data. This set includes a recommendation that CMS immediately implement a review of HCRIS cost center assignments based on text searches of providers' line descriptions and reassign lines appropriately. The second set addresses short-term regression-based and other statistical adjustments. The third set focuses on clarifying existing cost report instructions to instruct providers to use all applicable standard cost centers, adding new standard cost centers (for Devices, CT Scans, MRIs, Cardiac Catheterization, and Infusion Drugs), and creating new charge category summaries in the MedPAR to match the new cost centers on the cost report. Specifically, the new MedPAR groups would be for Intermediate Care (revenue codes 0206 and 0214), Devices (revenue codes 0274, 0275, 0276 and 0278), IV Solutions (revenue code 0258), CT Scanning (revenue codes 035x), Nuclear Medicine (revenue codes 034x, possibly combined with 0404), and Therapeutic Radiology (revenue codes 033x). RTI also recommends educating hospitals through industry-led educational initiatives directed at methods for capital cost finding, specifically encouraging providers to use direct assignment of equipment depreciation and lease costs wherever possible, or at least to allocate moveable equipment depreciation based on the dollar value of assigned depreciation costs. Lastly, although not directly the focus of its study, RTI mentions the problem of nursing cost compression in the relative weights, and notes that cost compression within inpatient nursing services is a significant source of distortion in the various IPPS' relative

weights, possibly more so than any of the factors studied by RTI. RTI suggests that it may be best for hospitals to agree to expand charge coding conventions for inpatient nursing, which would foster increased use of patient-specific nursing incremental charge codes in addition to baseline unit-specific per-diem charges.

Comment: One commenter agreed with the enhancements made by RTI (in the portion of the RTI report that was made available to the public in the April 2008 report) to the model for disaggregating CCRs in the Medical Supplies cost center, but was ''disappointed'' that CMS did not post the complete report, including the impact of charge ''decompression'' on the APC weights under the OPPS, and urged CMS to release the full report as soon as possible to allow a comprehensive review of the findings applicable to both the IPPS and the OPPS.

Response: Because the final RTI report was not scheduled to be completed before July 2008, we were unable to make the complete report, including sections focusing on the OPPS, available to the public in April 2008. Because we wanted to give the public the benefit of a 60-day comment period on the IPPS sections of the RTI report that would generally coincide with the 60-day comment period on the FY 2009 IPPS proposed rule, we chose to make available in April 2008 those sections of the RTI report that specifically dealt with the IPPS MS–DRG relative weights. We note that on July 3, 2008, we included on the CMS Web site the link to the complete RTI report: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*.

Comment: One commenter recommended that, for purposes of calculating the relative weights for FY 2009, CMS adopt RTI's recommendation to reassign cost center lines based on the provider's entered text description to correct errors in the assignment of costs and charges by hospitals in nonstandard cost centers on the cost report. The commenter also suggested that CMS adopt RTI's recommendation that, in the MedPAR file, intermediate care charges should be reclassified from the Intensive Care Unit cost center to the Routine cost center to correct a mismatch between where the intermediate care charges are assigned on the cost report (that is, in the Routine cost center) and where the charges are grouped in MedPAR (that is, with intensive care unit charges).

Response: The commenter's recommendations are important and are consistent with existing Medicare policy. Currently, the MedPAR file incorrectly groups intermediate care charges with intensive care unit charges; intermediate care charges and costs are, in fact, to be included in the General Routine (that is, Adults and Pediatrics) cost center on the cost report, in accordance with section 2202.7.II.B. of the PRM–1. However, in its July 2008 report, RTI found that HCRIS line reassignments by themselves had little effect on most inpatient weights (page 8). The impact of adopting these recommendations would likely be more pronounced if we were adopting regression-based CCRs for purposes of calculating the relative weights for FY 2009. However, because we are not using regression-based CCRs for FY 2009, we do not believe it is necessary to adopt the commenter's recommendations for the MS–DRG relative weights at this time, but will consider them for future rulemaking.

Comment: One commenter commended CMS for proposing to break out the existing line on the cost report for Medical Supplies Charged to Patients into two lines, one for costly devices and implants and the other for low-cost supplies, and for undertaking a comprehensive review of the cost report. However, the commenter observed that RTI's 2008 report demonstrates that additional lines are also needed to further break out drugs, radiology (CT scans and MRI scans) and cardiac catheterization because hospitals apply varying markups within these cost centers as well.

Response: We acknowledge, as RTI has found, that charge compression occurs in several cost centers that exist on the Medicare cost report. However, as we stated in the proposed rule, we proposed to focus on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the MS–DRG relative weights could result from correcting charge compression for devices and implants.

We note that in the CY 2009 OPPS/ASC proposed rule (73 FR 41490), we are proposing to break the single standard Drugs Charged to Patient cost center, Line 56, into two standard cost centers, Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients, to reduce the reallocation of pharmacy overhead cost from expensive to inexpensive drugs and biologicals. We use the term ''pharmacy overhead'' here to refer to overhead and related expenses such as pharmacy services and handling costs. This proposal is consistent with RTI's recommendation for creating a new cost center with a CCR that would be used to adjust charges to costs for drugs requiring detail coding. In the CY 2009 OPPS/ASC proposed rule, we note that comments on the proposed changes to the cost report for drugs should address any impact on both the inpatient and outpatient payment systems because both systems rely upon the Medicare hospital cost report for cost estimation. Furthermore, in that proposed rule, we specifically invited public comment on the appropriateness of creating standard cost centers for Computed Tomography (CT) Scanning, Magnetic Resonance Imaging (MRI), and Cardiac Catheterization, rather than continuing the established nonstandard cost centers for these services (73 FR 41431).

3. Summary of RAND's Study of Alternative Relative Weight Methodologies

A second reason that we did not implement regression-based CCRs at the time of the FY 2008 IPPS final rule with comment period was our inability to investigate how regression-based CCRs would interact with the implementation of MS–DRGs. In the FY 2008 final rule with comment period (72 FR 47197), we stated that we engaged RAND as the contractor to evaluate the HSRV methodology in conjunction with regression-based CCRs and we would consider their analysis as we prepared for the FY 2009 IPPS rulemaking process. We stated that we would analyze how the relative weights would change if we were to adopt regression-based CCRs and an HSRV methodology using fully-phased in MS–DRGs. We stated that we would consider the results of the second phase of the RAND study as we prepared for the FY 2009 IPPS rulemaking process. We had intended to include a detailed discussion of RAND's study in the FY 2009 IPPS proposed rule. However, due to some delays in releasing identifiable data to the contractor under revised data security rules, the report on this second stage of RAND's analysis was not completed in time for the development of the proposed rule. Therefore, we continued to have the same concerns with respect to uncertainty about how regression-based CCRs would interact with the MS–DRGs or an HSRV methodology, and we did not propose to adopt the regression-based CCRs or an HSRV methodology in the FY 2009 IPPS proposed rule. Nevertheless, we welcomed public comments on our proposals not to adopt regression-based CCRs or an HSRV methodology at that time or in the future. The RAND report on regression-based CCRs and the HSRV methodology was finalized at the conclusion of our proposed rule

development process and was posted on the CMS Web site on April 22, 2008, for a 60-day comment period. Although we were unable to include a discussion of the results of the RAND study in the proposed rule, we welcomed public comment on the report. We are providing a summary of the report and the public comments we received below.

RAND evaluated six different methods that could be used to establish relative weights: CMS' current relative weight methodology and five alternatives. In particular, RAND examined:

- How the relative weights differ across the alternative methodologies.
- How well each relative weight methodology explained variation in costs.
- Payment accuracy under each relative weight methodology and current facility-level adjustments.
- Payment implications of alternatives to the current methodology for establishing relative weights.

RAND examined alternative relative weight methodologies including either our current methodology of 15 national CCRs or 19 CCRs that are disaggregated using the regression-based methodology, or hospital-specific CCRs for 15 cost center groupings. The expansion from 15 to 19 cost center groupings is intended to reduce charge compression in the relative weights introduced by combining services with different rates of charge markups into a single cost center for purposes of estimating cost. The hospital-specific CCRs are intended to account for differences in overall charging practices across hospitals (that is, smaller nonteaching hospitals tend not to have as much variation in rates of markup as larger teaching hospitals).

In addition, RAND analyzed our standardization methodologies that account for systematic cost differences across hospitals. The purpose of standardization is to eliminate systematic facility-specific differences in cost so that these cost differences do not influence the relative weights. The three standardization methodologies analyzed by RAND include the ''hospital payment factor'' methodology currently used by CMS, where a hospital's wage index factor, and IME and/or DSH factor are divided out of its estimated DRG cost; the HSRV methodology that standardizes the cost for a given discharge by the hospital's own costliness rather than by the effect of the systematic cost differences across groups of hospitals; and the HSRVcc methodology, which removes hospital-level cost variation by calculating hospital-specific charge-based relative values for each DRG at the cost center level and standardizing them for differences in case mix. Under the HSRVcc methodology, a national average charge-based relative weight is calculated for each cost center.

RAND conducted two different types of analyses to evaluate 5 alternative relative weight methodologies that varied use of 19 national CCRs and 15 hospital-specific CCRs, and HSRV and HSRVcc standardization methodologies along with components of the current relative weight methodology using 15 national CCRs and hospital payment factor standardization. The first type of analysis compared the five alternative relative weight methodologies to CMS' current relative weight methodology and compared average payment under each relative weight methodology across different types of hospitals. The second analysis examined the relative payment accuracy of the relative weight methodologies. RAND used the costs under 15 hospital-specific CCRs as its hospital cost baseline. RAND noted that the choice for its baseline may affect the results of the analysis because relative weight methodologies that are similar to the 15 hospital-specific CCR methodology may be assessed more favorably because they are likely to have similar costs, while relative weight methodologies that are different from the 15 hospital-specific CCR methodology may not be as favorable. The payment accuracy analysis used a regression technique to evaluate how well the relative weight methodologies explained variation in costs and how well the hospital payments under the relative weight methodologies matched the costs per discharge. Finally, RAND examined payment-to-cost ratios among different types of hospitals.

Overall, RAND found that none of the alternative methods of calculating the relative weights represented a marked improvement in payment accuracy over the current method, and there was little difference across methods in their ability to predict cost at either the discharge-level or the hospital-level. In their regression analysis, RAND found that after controlling for hospital payment factors, the relative weights are compressed. However, RAND also found that the hospital payment factors increase more rapidly than cost, so while the relative weights are compressed, these payment factors offset the compression so that total payment increases more rapidly than cost.

RAND does not believe the regression-based charge compression adjustments significantly improve payment accuracy. RAND found that relative weights using the 19 national disaggregated regression-based CCRs result in significant redistributions in payments among hospital groupings. With regard to standardization methodologies, while RAND found that there is no clear advantage to the HSRV method or the HSRVcc method of standardizing cost compared to the current hospital payment factor standardization method, its analysis did reveal significant limitations of CMS' current hospital payment factor standardization method. The current standardization method has a larger impact on the relative weights and payment accuracy than any of the other alternatives that RAND analyzed because the method ''over-standardizes'' by removing more variability for hospitals receiving a payment factor than can be empirically supported as being cost-related (particularly for IME and DSH). RAND found that instead of increasing proportionately with cost, the payment factors CMS currently uses (some of which are statutory), increase more rapidly than cost, thereby reducing payment accuracy. Further analysis is needed to isolate the cost-related component of the IPPS payment adjustments (some of which has already been done by MedPAC), use them to standardize cost, and revise the analysis of payment accuracy to reflect only the cost-related component. Generally, RAND believes it is premature to consider further refinements in the relative weight methodology until data from FY 2008 or later that reflect coding improvement and other behavioral changes that are likely to occur as hospitals adopt the MS–DRGs can be evaluated.

Comment: A number of commenters submitted comments on RAND's report. Some commenters supported RAND's methodology and findings. These commenters agreed with RAND's findings that regression-based CCRs would not have a material impact on payment accuracy. These commenters also agreed with RAND that CMS should wait until FY 2008 data are available to consider further refinements to the relative weight methodology.

Some commenters disagreed with RAND's methodology and findings that the regression-based CCRs offer no improvement in payment accuracy. RAND found that regression-based CCRs result in significant redistributions in payment within hospital groups with increases in payments concentrated to the cardiac and orthopedic surgical DRGs. RAND's payment to cost ratio analysis, which measures payment equity across groups of hospitals, found that adopting regression-based CCRs led

to significant reductions in payment to cost ratio for rural hospitals. Commenters also indicated their belief that the payment-to-cost analysis is not the appropriate analysis to use because, in the hospital prospective payment system, costs at the DRG level are not precisely known. Furthermore, the commenters asserted RAND's analysis was flawed because, in its payment-to-cost analysis, RAND compared payment rates adjusted for charge compression with regression-based CCRs to payment rates unadjusted for charge compression. The commenters stated that when they compared payments adjusted for charge compression with regression-based CCRs to payment rates adjusted for charge compression, they found that regression-based CCRs improved payment accuracy. In addition, the commenters cited that RAND acknowledged that its choice for the baseline in comparing payment rates ''may affect the results and conclusions of our analysis''.

Response: We appreciate the comments on the RAND report. Given the move to the MS–DRGs and the concerns surrounding documentation and coding and the most appropriate approach to improving payment accuracy, we generally agree with RAND's recommendation that it would be premature to revise the relative weights methodology until additional data from FY 2008 are available. With respect to the comments on RAND's analysis related to the regression-based CCRs, we understand the commenters' reasons for disputing RAND's choice to use a relative weight methodology that does not incorporate regression-based CCRs as its baseline for hospital costs. In RAND's payment-to-cost analysis, RAND used the relative weight methodology with 15 hospital-specific CCRs to determine the hospital costs baseline. RAND noted that, while it believes its choice of cost measure is appropriate, it recognizes that ''the choice may affect the results of the analysis because relative weight methods that use the hospital-specific CCRs may be assessed more favorably than would have been the case had we used a different cost measure. Similarly, the use of 15 rather than 19 cost center CCRs may favor the relative weight methods that do not account for charge compression.'' If a single method existed that clearly yielded the best measure of cost, it seems unlikely that a study to evaluate five alternative methods of calculating cost for the MS–DRG relative weights would have been necessary. We believe that it was within RAND's discretion to decide how best to conduct its payment analyses, and while there may be benefits and drawbacks to alternative approaches (including whether to use a baseline that adjusts for charge compression), RAND's choice is defensible. Accordingly, RAND's finding that regression-based CCRs do not improve payment accuracy cannot be summarily dismissed.

Comment: Many commenters opposed the HSRV methodology for standardization. The commenters cited RAND's findings that the HSRV methodology inappropriately compresses the relative weights. They believed that the methodology only improves the accuracy of the relative weights under the unlikely situations where all hospitals have identical mix of patients and costs structures, or if all hospitals have identical costs across all cost centers or if all hospitals have the same case-mix and the costs differ by a constant factor across all DRGs and all cost centers. The commenters agreed with RAND that it would be premature to consider further refinements to the methodology for setting relative weights, including the HSRV method of standardization, until data from FY 2008 or later can be evaluated.

Response: We appreciate the comments on the HSRV methodology, and we understand that many commenters continue to oppose to the HSRV methodology. In FY 2007, we did not adopt the HSRV methodology after consideration of concerns raised by commenters' opposition to the methodology. Instead, in the FY 2007 IPPS final rule (71 FR 47897), we stated that we would undertake further analysis to study the payment impacts of the HSRV methodology with regression-based CCRs under the MS–DRGs. We engaged RAND as our contractor to conduct this analysis, and in its report, RAND observed that relative weights that were based on hospital-specific CCRs with 15 cost centers that were standardized using the current standardization methodology would warrant further consideration as an improvement over the current relative weights. RAND did not find the HSRV or HSRVcc standardization methods to be preferable to the hospital payment factor method. However, RAND also cautioned that its results reveal some significant limitations of the current hospital payment factor method. Specifically, current IME and DSH payment adjustments increase more quickly than their cost, and when used for standardization, compress the relative weights. We agree with RAND that our current standardization process requires additional analysis, and therefore, we are not changing our current method of standardizing for FY 2009. We will continue to consider various options for improving payment accuracy.

Comment: One commenter supported RAND's finding that CMS should revise its hospital payment factor method for standardizing claims charges to remove the effects of hospital-specific factors (that is, wage index, IME, and DSH) that affect cost estimates. The commenter recommended that CMS could improve its standardization process by removing the effects of these factors by using empirical estimates rather than using current policy adjustments. The commenter noted that MedPAC and CMS have done empirical estimates of these factors in the past.

Response: One of the issues that the RAND report specifically addressed was standardization methods that account for systematic cost differences across hospitals. These methods include what RAND called the hospital payment factor method, which is CMS' current approach to standardizing claims charges, the HSRV methodology, and the HSRVcc methodology. Although RAND's results do not indicate that the HSRV or HSRVcc standardization method is clearly preferable to the hospital payment factor method, RAND found that the current hospital payment factor standardization method has significant limitations. Specifically, RAND found that the hospital payment factor method ''over-standardizes'' by using a hospital payment factor that is larger than can be empirically supported as being cost-related (particularly for IME and DSH) and that has a larger impact on the relative weights and payment accuracy than other elements of the cost-based methodology. However, RAND cautions that ''re-estimating'' these payment factors ''raises important policy issues that warrant additional analyses'' (page 49), particularly to ''determine the analytically justified-levels using the MS–DRGs'' (page 110). In addition, we note that RTI, in its July 2008 final report, also observed that the adjustment factors under the IPPS (the wage index, IME, and DSH adjustments) complicate the determination of cost and these factors ''within the rate calculation may offset the effects of understated weights due to charge compression'' (page 109). We understand that MedPAC has done analysis of what the empirically-justified levels of the IME and DSH adjustment should be. We cannot propose to change the IME and DSH factors used for actual payment under the IPPS because these factors are

required by statute. After further studying the issue, we may consider proposing various options for improving payment accuracy when standardizing charges as part of the relative weights calculation.

Comment: Many commenters continued to oppose adoption of the regression-based CCRs, asserting that the charge compression issue is not urgent enough to warrant the use of substitute data for real cost and charge information. The commenters indicated that many hospitals believe that most increases or decreases in the MS–DRG relative weights will have a minimal dollar impact on their bottom line. They further stated that the RAND report asserts that the regression-based CCR adjustments would not materially impact payment accuracy. The commenters also agreed with CMS' position at the time of the proposed rule that there had not been sufficient time to evaluate the impact of a regression-based approach on inpatient or outpatient services, and on the MS–DRGs. The commenters further believed that calculating regression-based CCRs is ''excessively complicated,'' is difficult to validate, and may be flawed to the extent that the regressions would be based on data in which the mismatch between MedPAR charges and cost report costs and charges has not been corrected. The commenters believed that more accurate and uniform reporting and improvements to the cost report is the best approach to improving payment accuracy.

A number of commenters objected to the regression-based approach to break out the one CCR for all radiology services that CMS is currently using. The commenters noted that the RTI estimates suggest that hospitals mark up CT services on average by more than 1800 percent over cost (CCR 0.054), while routine radiology services are marked up by an average of more than 300 percent over cost. The commenters believed that this vast difference in the markup practices of hospitals seems implausible and, therefore, would result in significant payment distortions if CMS were to adopt RTI's disaggregated radiology CCRs or some related adjustment to the radiology CCR, for Medicare ratesetting. The commenters asserted that use of RTI's CCRs would significantly reduce payment for imaging-intensive DRGs in the inpatient setting for trauma services, but the impact on payments under the OPPS and the Medicare physician fee schedule (MPFS) imaging services capped by OPPS payments would be even more dramatic. The commenters believed that the CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. They further stated that this could indicate that many hospitals are reporting CT and MRI machines as fixed equipment and allocate the related capital costs as part of the facility's Building and Fixtures overhead cost center instead of reporting the capital costs directly in the Radiology cost center, resulting in RTI's estimate of the costs and CCRs for CT and MRI equipment to be too low. The commenters argued that, regardless of the reason for the low CCRs, the use of RTI's CCRs could result in aberrant payments for radiology services, where payments to a hospital for outpatient x-rays might be higher than the payment for a similar CT scan, and where the physician fee schedule rates for the technical component cost of the CT scan may also be less than the cost of these scans estimated by CMS, providing a disincentive for hospitals and physicians to provide these services. In concluding that RTI's analysis of the CCRs for imaging services is flawed, several commenters urged CMS to more carefully analyze CCRs for radiology before proposing any measures to change these CCRs. The commenters believed that if the underreported capital costs are considered, it is likely that the CCRs for CT scanning and MRI services would be approximately equal to the overall radiology CCR and no adjustment would be needed.

A significant number of commenters supported applying the regression-based CCRs as a temporary solution to address charge compression. The commenters believed that because CMS' proposed changes to the cost report would not have an impact on the relative weights until FY 2012, implementation of regression-based CCRs is necessary in the interim. The commenters cited what they believed is ample evidence, particularly from the RTI report and from MedPAC, that regression-based CCRs are appropriate as a short-term solution.

While several commenters agreed on the use of regression-based CCRs as a short-term solution to charge compression, many commenters gave varied suggestions as to how to implement these regression-based CCRs. The commenters suggested that CMS implement a 3-year phase-in of regression-based CCRs beginning in FY 2009 to mitigate any distributional impacts on hospitals. The commenters asked CMS to consider using a regression analysis for 25 percent of the estimated cost of medical supplies in FY 2009, then 50 percent in FY 2010, and 75 percent in FY 2011. The commenters further stated that once the data from the new cost centers for supplies and devices are available, the regression adjustments could be phased out, or remain in use even after FY 2012, should the data from the new cost centers still be incomplete at that time. Furthermore, the commenters believed that this transition would remove the need for a transition period to separate CCRs for medical devices and medical supplies once the cost report data are available.

Some commenters supported adoption of regression-based CCRs except for those within the radiology category. Other commenters suggested that CMS only implement regression-based CCRs for medical supplies and devices because the proposed changes to the cost report focused on the medical supplies and devices. They argued that CMS' proposed cost report changes for medical supplies and devices signifies that CMS believes it is most important to address charge compression in the medical supplies group.

One commenter recommended that, based on the findings in RTI's 2008 report, CMS should implement a total of 22 regression-based CCRs. (In its March 2007 report, RTI recommended that CMS expand the number of CCRs from 15 to 19 with the use of statistical adjustments to disaggregate medical devices from medical supplies, IV solutions and other drugs from drugs and CT scanning and MRI from radiology. In the interim RTI report posted on the CMS Web site on April 22, 2008, RTI increased the potential regression-based CCRs from 19 to 23 national CCRs after evaluating OPPS data with IPPS data.) The commenter believed that CMS should expand the number of CCRs from 15 to 22 with disaggregated CCRs for medical supplies, medical devices, IV solutions, other drugs and detail coded drugs, CT scans, MRI, therapeutic radiation and nuclear medicine. The commenter recommended implementing these regression-based CCRs to ensure payment equity across these types of services. Because of limited time to develop the final rule, the commenter recognized that it would be difficult for CMS to implement revised regression estimates. To account for this, the commenter recommended what the commenter believed is a relatively simple ratio technique, similar to RTI's methodology, to implement regression-based CCRs for the FY 2009 IPPS final rule. The commenter believed that CMS could use more detailed charge information from the Standard Analytic File (SAF) and the regression-based estimates from RTI's 2008 report to

calculate national CCRs for the subgroups within drugs, supplies and radiology. The commenter stated that CMS would then compare those CCRs under RTI's regression-based estimates to the RTI-estimated national CCR for the broader category. To further clarify its recommendation, the commenter stated that, for example, if CMS were to disaggregate the supplies CCR, CMS would create regression-based CCRs for medical supplies and medical devices based on RTI's regression-based CCRs for those subgroups. Then a ratio would be calculated comparing those CCRs to the original RTI-estimated national CCR for the broader supplies category. Those ratios would then be multiplied by their own national overall CCR for the broader supplies category to obtain national CCRs for the subgroup that reflect updated cost and charge data.

Response: In the FY 2009 IPPS proposed rule (73 FR 23543), we stated several reasons why we did not propose to adopt any regression-based CCRs for FY 2009. Specifically, because a number of commenters on the FY 2008 proposed rule objected to the adoption of the regression-based CCRs, and because, at the time the FY 2009 IPPS proposed rule was under development, we did not yet have the results of the RTI study analyzing the effects of charge compression on inpatient and outpatient charges as well as the results of the RAND study analyzing how the relative weights would change if we were to adopt regression CCRs while simultaneously adopting the HSRV methodology using fully phased in MS–DRGs, we did not propose to adopt regression-based CCRs in the FY 2009 IPPS proposed rule. However, we did solicit public comments on our proposal not to adopt regression-based CCRs in the FY 2009 IPPS proposed rule. Consequently, as was the case during the FY 2008 IPPS proposed rule comment period, we received numerous public comments both against and in favor of adopting regression-based CCRs. Once again, we have considered all of the public comments we received. We have also considered the findings of the RAND report, and note that RAND believes that it may be premature to consider further refinements in the relative weight methodology until data using MS–DRGs from FY 2008 or later can be evaluated (page 108). Also noteworthy is RAND's belief that regression-based CCRs may not improve payment accuracy, and that it is equally if not more important to consider revisions to the current IPPS hospital payment factor standardization method in order to improve payment accuracy. We appreciate the recognition by one commenter that the time in which CMS must develop the final rule is limited, and the consideration given by this commenter in recommending a relatively simple approach to implementing the regression-based CCRs for FY 2009. Nevertheless, we agree with the commenters that believe that the best approach at this time to addressing charge compression is to focus on improving the accuracy of hospital cost reporting, coupled with long-term changes to the cost report discussed below so that CMS can continue to rely on hospital's reported cost and charge data. With respect to the CCR for radiology services, we note that the 2008 RTI report found that significant improvements and refinements to the radiology CCR can be achieved without using regression-based CCRs, simply by reallocating the costs and charges from nonstandard cost centers on the cost report and using increased charge detail from the SAF to supplement the radiology charges in the MedPAR. Therefore, as we stated in the FY 2009 IPPS proposed rule (73 FR XXXXX), we believe that ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of the cost weights. Accordingly, we are not adopting regression-based CCRs for the calculation of the FY 2009 IPPS relative weights.

We received public comments on the FY 2008 IPPS proposed rule raising concerns on the accuracy of using regression-based CCR estimates to determine the relative weights rather than on the Medicare cost report. The commenters noted that regression-based CCRs would not fix the underlying mismatch of hospital reporting of costs and charges. Instead, the commenters suggested that the impact of charge compression might be mitigated through an educational initiative that would encourage hospitals to improve their cost reporting. The commenters recommended that hospitals be educated to report costs and charges in a way that is consistent with how charges are grouped in the MedPAR file. In an effort to achieve this goal, hospital associations have launched an educational campaign to encourage consistent reporting, which would result in consistent groupings of the cost centers used to establish the cost-based relative weights. The commenters requested that CMS communicate to the fiscal intermediaries/MACs that such action is appropriate. In the FY 2008 IPPS final rule with comment period, we stated that we were supportive of the educational initiative of the industry, and we encouraged hospitals to report costs and charges consistently with how the data are used to determine relative weights (72 FR 47196). We would also like to affirm that the longstanding Medicare principles of cost apportionment in the regulations at 42 CFR 413.53 convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another ancillary department (for example, combining the cost of Medical Supplies Charged to Patients with the costs of Operating Room or any other ancillary cost center). (We note that, effective for cost reporting periods starting on or after January 1, 1979, the departmental method of apportionment replaced the combination method of apportionment where all the ancillary departments were apportioned in the aggregate (Section 2200.3 of the PRM–I).)

Furthermore, longstanding Medicare cost reporting policy has been that hospitals must include the cost and charges of separately ''chargeable medical supplies'' in the Medical Supplies Charged to Patients cost center (line 55 of Worksheet A), rather than in the Operating Room, Emergency Room, or other ancillary cost centers. Routine services, which can include ''minor medical and surgical supplies'' (Section 2202.6 of the PRM–1), and items for which a *separate* charge is *not* customarily made, may be directly assigned through the hospital's accounting system to the department in which they were used, or they may be included in the Central Services and Supply cost center (line 15 of Worksheet A). Conversely, the separately chargeable medical supplies should be assigned to the Medical Supplies Charged to Patients cost center on line 55.

We note that not only is accurate cost reporting important for IPPS hospitals to ensure that accurate relative weights are computed, but hospitals that are still paid on the basis of cost, such as CAHs and cancer hospitals, and SCHs and MDHs must adhere to Medicare cost reporting principles as well.

The CY 2008 OPPS/ASC final rule with comment period (72 FR 66600 through 66601) also discussed the issue of charge compression and regression-based CCRs, and noted that RTI is currently evaluating the cost estimation process underpinning the OPPS cost-based weights, including a reassessment of the regression models using both outpatient and inpatient charges, rather than inpatient charges only. In

responding to comments in the CY 2008 OPPS/ASC final rule with comment period, we emphasized that we ''fully support'' the educational initiatives of the industry and that we would ''examine whether the educational activities being undertaken by the hospital community to improve cost reporting accuracy under the IPPS would help to mitigate charge compression under the OPPS, either as an adjunct to the application of regression-based CCRs or in lieu of such an adjustment'' (72 FR 66601). However, as we stated in the FY 2008 IPPS final rule with comment period, we would consider the results of the RAND study before considering whether to adopt regression-based CCRs, and in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66601), we stated that we would determine whether refinements should be proposed after reviewing the results of the RTI study.

On February 29, 2008, we issued Transmittal 321, Change Request 5928, to inform the fiscal intermediaries/MACs of the hospital associations' initiative to encourage hospitals to modify their cost reporting practices with respect to costs and charges in a manner that is consistent with how charges are grouped in the MedPAR file. We noted that the hospital cost reports submitted for FY 2008 may have costs and charges grouped differently than in prior years, which is allowable as long as the costs and charges are properly matched and the Medicare cost reporting instructions are followed. Furthermore, we recommended that fiscal intermediaries/MACs remain vigilant to ensure that the costs of items and services are not moved from one cost center to another without moving their corresponding charges. Due to a time lag in submittal of cost reporting data, the impact of changes in providers' cost reporting practices occurring during FY 2008 would be reflected in the FY 2011 IPPS relative weights.

Comment: One commenter urged CMS to audit cost reports closely to ensure initial and ongoing compliance with the new reporting requirements. Several commenters who, over the course of the past year, have supported an educational initiative to encourage hospitals to prepare their Medicare cost reports such that Medicare charges, total charges, and total costs are aligned with each other, and with the current categories in the MedPAR file, continued to believe that this educational initiative is an important effort. These commenters appreciated CMS' efforts to inform the fiscal intermediaries/MACs of this educational initiative and to work with hospitals to ensure proper cost reporting (in Transmittal 321, Change Request 5928, issued February 29, 2008). However, the commenters expressed concern that this transmittal did not address the need by some hospitals to elect a cost-estimated approach to ensure that costs and charges for supplies are aligned. The commenters urged CMS to instruct fiscal intermediaries/MACs not to reverse or undo reporting that relies on estimation approaches to achieve this alignment, provided that hospitals submit adequate documentation of their methodology.

Response: We agree that audit and compliance measures are important, and we will work within the audit budget to determine whether hospitals properly follow payment policies and the cost reporting instructions. With respect to Transmittal 321, Change Request 5928, CMS did remind fiscal intermediaries/MACs that ''providers may submit cost reports with cost and charges grouped differently than in prior years, as long as the cost and charges are properly matched and Medicare cost reporting instructions are followed. Medicare contractors shall not propose adjustments that regroup costs and charges merely to be consistent with previous year's reporting if the costs and charges are properly grouped on the as-filed cost report.'' However, Medicare payment is governed by longstanding principles contained in §§ 413.20 and 413.24 which we cannot instruct the fiscal intermediaries/MACs to overlook. In accordance with § 413.20, the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Furthermore, § 413.24(a) specifies that providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. In addition, § 413.24(c) states that adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which the data are intended. Adequate data capable of being audited are consistent with good business concepts and effective and efficient management of any organization. Furthermore, we note that these cost reimbursement principles continue to apply even under the IPPS. Specifically, § 412.53 states, ''All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.'' Therefore, CMS cannot instruct the Medicare contractors to disregard these longstanding policies when auditing and settling cost reports.

4. Refining the Medicare Cost Report

In developing the FY 2009 IPPS proposed rule, we considered whether there were concrete steps we could take to mitigate the bias introduced by charge compression in both the IPPS and OPPS relative weights in a way that balances hospitals' desire to focus on improving the cost reporting process through educational initiatives with device industry interest in adopting regression-adjusted CCRs. Although RTI recommended adopting regression-based CCRs, particularly for medical supplies and devices, as a short-term solution to address charge compression, RTI also recommended refinements to the cost report as a long-term solution. RTI's draft interim March 2007 report discussed a number of options that could improve the accuracy and precision of the CCRs currently being derived from the Medicare cost report and also reduce the need for statistically-based adjustments. As mentioned in the FY 2008 IPPS final rule with comment period (72 FR 47193), we believe that RTI and many of the public commenters on the FY 2008 IPPS proposed rule concluded that, ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of cost weights. Therefore, in the FY 2009 IPPS proposed rule (73 FR 23544), we proposed to begin making cost report changes geared to improving the accuracy of the IPPS and OPPS relative weights. However, we also received comments last year asking that we proceed cautiously with changing the Medicare cost report to avoid unintended consequences for hospitals that are paid on a cost basis (such as CAHs, cancer hospitals, and, to some extent, SCHs and MDHs), and to consider the administrative burden associated with adapting to new cost reporting forms and instructions. Accordingly, we proposed to focus in the FY 2009 proposed rule on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the relative weights could result from correcting charge compression for devices and implants. When examining markup differences within the Medical Supplies Charged to Patients cost center, RTI found that its

''regression results provide solid evidence that if there were distinct cost centers for items, cost ratios for devices and implants would average about 17 points higher than the ratios for other medical supplies'' (January 2007 RTI report, page 59). This suggests that much of the charge compression within the Medical Supplies CCR results from inclusion of medical devices that have significantly different markups than the other supplies in that CCR. Furthermore, in the FY 2007 IPPS final rule and FY 2008 IPPS final rule with comment period, the Medical Supplies and Equipment CCR received significant attention by the public commenters.

Although we proposed to make improvements to mitigate the effects of charge compression only on the Medical Supplies and Equipment CCR as a first step, we invited public comments as to whether to make other changes to the Medicare cost report to refine other CCRs. In addition, we indicated that we were open to making further refinements to other CCRs in the future. Therefore, in the FY 2009 IPPS proposed rule, we proposed to add only one cost center to the cost report, such that, in general, the costs and charges for relatively inexpensive medical supplies would be reported separately from the costs and charges of more expensive devices (such as pacemakers and other implantable devices). We indicated that we would consider public comments submitted on the proposed rule for purposes of both the IPPS and the OPPS relative weights and, by extension, the calculation of the ambulatory surgical center (ASC) payment rates (73 FR XXXXX).

Under the IPPS for FY 2007 and FY 2008, the aggregate CCR for chargeable medical supplies and equipment was computed based on line 55 for Medical Supplies Charged to Patients and lines 66 and 67 for DME Rented and DME Sold, respectively. To compute the 15 national CCRs used in developing the cost-based weights under the IPPS (explained in more detail under section II.H. of the preamble of the proposed rule and this final rule), we take the costs and charges for the 15 cost groups from Worksheet C, Part I of the Medicare cost report for all hospital patients and multiply each of these 15 CCRs by the Medicare charges on Worksheet D–4 for those same cost centers to impute the Medicare cost for each of the 15 cost groups. Under this proposal, the goal would be to split the current CCR for Medical Supplies and Equipment into one CCR for medical supplies, and another CCR for devices and DME Rented and DME Sold.

In considering how to instruct hospitals on what to report in the cost center for medical supplies and the cost center for devices, we looked at the existing criteria for the type of device that qualifies for payment as a transitional pass-through device category in the OPPS. (There are no such existing criteria for devices under the IPPS.) The provisions of the regulations under § 419.66(b) state that for a medical device to be eligible for pass-through payment under the OPPS, the medical device must meet the following criteria:

a. If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.

b. The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).

c. The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissues, and is surgically implanted or inserted whether or not it remains with the patient when the patient is released from the hospital.

d. The device is not any of the following:

- Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15–1).
- A material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than a radiological site marker).
- Material that may be used to replace human skin (for example, a biological or synthetic material).

These requirements are the OPPS criteria used to define a device for pass-through payment purposes and do not include additional criteria that are used under the OPPS to determine if a candidate device is new and represents a substantial clinical improvement, two other requirements for qualifying for pass-through payment.

For purposes of applying the eligibility criteria, we interpret ''surgical insertion or implantation'' to include devices that are surgically inserted or implanted via a natural or surgically created orifice as well as those devices that are inserted or implanted via a surgically created incision (70 FR 68630).

In proposing to modify the cost report to have one cost center for medical supplies and one cost center for devices, we proposed that hospitals would determine what should be reported in the Medical Supplies cost center and what should be reported in the Medical Devices cost center using criteria consistent with those listed above that are included under § 419.66(b), with some modification. Specifically, for purposes of the cost reporting instructions, we proposed that an item would be reported in the device cost center if it meets the following criteria:

a. If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.

b. The device is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).

c. The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, is surgically implanted or inserted through a natural or surgically created orifice or surgical incision in the body, and remains in the patient when the patient is discharged from the hospital.

d. The device is not any of the following:

- Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15–1).
- A material or supply furnished incident to a service (for example, a surgical staple, a suture, customized surgical kit, or clip, other than a radiological site marker).
- Material that may be used to replace human skin (for example, a biological or synthetic material).
- A medical device that is used during a procedure or service and does not remain in the patient when the patient is released from the hospital.

We proposed to select the existing criteria for what type of device qualifies

for payment as a transitional pass-through device under the OPPS as a basis for instructing hospitals on what to report in the cost center for Medical Supplies Charged to Patients or the cost center for Medical Devices Charged to Patients because these criteria are concrete and already familiar to the hospital community. However, the key difference between the existing criteria for devices that are eligible for pass-through payment under the OPPS in the regulations at § 419.66(b) and our proposed criteria stated above to be used for cost reporting purposes is that the device that is implanted remains in the patient when the patient is discharged from the hospital. Essentially, we proposed to instruct hospitals to report only implantable devices that remain in the patient at discharge in the cost center for devices. All other devices and nonroutine supplies which are separately chargeable would be reported in the medical supplies cost center. We believe that defining a device for cost reporting purposes based on criteria that specify implantation and adding that the device must remain in the patient upon discharge would have the benefit of capturing virtually all costly implantable devices (for example, implantable cardioverter defibrillators (ICDs), pacemakers, and cochlear implants) for which charge compression is a significant concern.

However, we acknowledge that a definition of device based on whether an item is implantable and remains in the patient could, in some cases, include items that are relatively inexpensive (for example, urinary catheters, fiducial markers, vascular catheters, and drainage tubes), and which many would consider to be supplies. Thus, some modest amount of charge compression could still be present in the cost center for devices if the hospital does not have a uniform markup policy. In addition, requiring as a cost reporting criterion that the device is to remain in the patient at discharge could exclude certain technologies that are moderately expensive (for example, cryoablation probes, angioplasty catheters, and cardiac echocardiography catheters, which do not remain in the patient upon discharge). Therefore, some charge compression could continue for these technologies. We believe this limited presence of charge compression is acceptable, given that the proposed definition of device for cost reporting purposes would isolate virtually all of the expensive items, allowing them to be separately reported from most inexpensive supplies.

The criteria we proposed above for instructing hospitals as to what to report in the device cost center specify that a device is not a material or supply furnished incident to a service (for example, a surgical staple, a suture, *customized surgical kit*, or clip, other than a radiological site marker) (emphasis added). We understand that hospitals may sometimes receive surgical kits from device manufacturers that consist of a high-cost primary implantable device, external supplies required for operation of the device, and other disposable surgical supplies required for successful device implantation. Often the device and the attending supplies are included on a single invoice from the manufacturer, making it difficult for the hospital to determine the cost of each item in the kit. In addition, manufacturers sometimes include with the primary device other free or ''bonus'' items or supplies that are not an integral and necessary part of the device (that is, not actually required for the safe surgical implantation and subsequent operation of that device). (We note that arrangements involving free or bonus items or supplies may implicate the Federal anti-kickback statute, depending on the circumstances.) One option is for the hospital to split the total combined charge on the invoice in a manner that the hospital believes best identifies the cost of the device alone. However, because it may be difficult for hospitals to determine the respective costs of the actual device and the attending supplies (whether they are required for the safe surgical implantation and subsequent operation of that device or not), we solicited comments with respect to how supplies, disposable or otherwise, that are part of surgical kits should be reported. We are distinguishing between such supplies that are an integral and necessary part of the primary device (that is, required for the safe surgical implantation and subsequent operation of that device) from other supplies that are not directly related to the implantation of that device, but may be included by the device manufacturer with or without charge as ''perks'' along with the kit. If it is difficult to break out the costs and charges of these lower cost items that are an integral and necessary part of the primary device, we would consider allowing hospitals to report the costs and charges of these lower cost supplies along with the costs and charges of the more expensive primary device in the cost report cost center for implantable devices. However, to the extent that device manufacturers could be encouraged to refine their invoicing practices to break out the charges and costs for the lower cost supplies and the higher cost primary device separately, so that hospitals need not ''guesstimate'' the cost of the device, this would facilitate more accurate cost reporting and, therefore, the calculation of more accurate cost-based weights. Under either scenario, even for an aggregated invoice that contains an expensive device, we believe that RTI's findings of significant differences in supply CCRs for hospitals with a greater percentage of charges in device revenue codes demonstrate that breaking the Medical Supplies Charged to Patients cost center into two cost centers and using appropriate revenue codes for devices, and crosswalking those costs to the proposed new ''Implantable Devices Charged to Patients'' cost center, will result in an increase in estimated device costs.

In summary, we proposed to modify the cost report to have one cost center for ''Medical Supplies Charged to Patients'' and one cost center for ''Implantable Devices Charged to Patients.'' We proposed to instruct hospitals to report only devices that meet the four criteria listed above (specifically including that the device is implantable and remains in the patient at discharge) in the proposed new cost center for Implantable Devices Charged to Patients. All other devices and nonchargeable supplies would be reported in the Medical Supplies cost center. This would allow for two distinct CCRs, one for medical supplies and one for implantable devices and DME rented and DME sold.

Comment: Many commenters supported the proposed cost reporting refinements to address charge compression in the medical supplies and devices CCR. However, most commenters stated that they preferred a more ''comprehensive'' approach to reforming the cost report, expressing concern that CMS is taking a ''piecemeal'' approach which does not address the underlying problem of using an ''antiquated'' cost reporting instrument to collect cost data that neither suits the needs of CMS in calculating the relative weights, nor does it fit with the current accounting practices of hospitals. One commenter stated generally that the cost report and MedPAR data sources were never intended to be integrated, which affects the accuracy of the DRG recalibration. The commenter wanted CMS to improve the accuracy of the cost report by incorporating a new schedule to ''continue the reporting of revenue by UB revenue code by cost report line'' and to calculate a weighted CCR by UB

revenue code. The commenter believed this is a ''major area of reform'' to the cost report that would ''greatly enhance the accuracy of costing data'' not only for inpatient and outpatient PPS hospitals, but also for CAHs and children's and cancer hospitals. Nevertheless, these commenters supported CMS' proposal to split the ''Medical Supplies Charged to Patients'' cost center into one cost center for ''Medical Supplies Charged to Patients,'' and one for ''Implantable Devices Charged to Patients'' as a short-term approach, believing that this measure may help address charge compression in the relative weights of MS–DRGs that include medical supplies and devices. Another commenter encouraged CMS to complete a thorough review of charge compression and then separately propose rules that would provide hospitals with adequate notice to make the necessary changes, with implementation of those changes occurring no earlier than FY 2010. One commenter qualified its support for CMS' proposal on the contingency that CMS commits to working with the hospital industry to address the larger issues surrounding the cost reports as a data collection tool. Another commenter added that it did not oppose CMS' proposal, but stated that its ''comments should not be viewed as an endorsement to adding additional cost centers in the future'' and that CMS should ''proceed with extreme caution with any additional incremental changes.'' Other commenters were disappointed in what they characterized as ''CMS' failure to work with the hospital field from the outset on such an important endeavor.'' Another commenter suggested that CMS may want to use its database to run further analyses on charge compression because the majority of hospitals submitting clinical and financial data to the commenter have cost accounting systems. The commenters generally urged CMS to provide adequate notice to hospitals before making any changes to the cost report because hospitals will need to make significant revisions to their accounting and billing systems before the start of their fiscal years.

One commenter supported CMS' proposal for using the existing requirements for determining which devices qualify for pass-through payment under the OPPS, and whether a device is implantable and remains in the patient upon discharge, as the criteria for determining what types of implantable devices would be reported in the proposed new cost center. The commenter believed that the proposed criteria are objective and most accurately describe the type of medical devices that are most impacted by charge compression. However, a large number of commenters opposed CMS' proposed criteria for distinguishing between low-cost supplies and high-cost devices for reporting in the proposed new cost report cost centers. Rather than using CMS' proposed criteria which are based on the existing requirements for determining which devices qualify for pass-through payment under the OPPS, and whether a device is implantable and remains in the patient upon discharge, in addition to use of existing revenue codes, most commenters preferred that the cost report cost centers be defined exclusively based on the use of existing revenue codes and associated definitions. The commenters pointed out that using existing revenue codes and definitions as they have been currently established by the National Uniform Billing Committee (NUBC) makes sense, as these definitions have been in place for some time and are used across all payers, not just by CMS. The commenters believed that introduction of exceptions by CMS to what hospitals may include in certain revenue codes can be disruptive to hospitals' billing and accounting systems. Furthermore, they added, this method is consistent with the analytic approach and revenue centers used by RTI to develop the regression-based CCRs for medical devices. Accordingly, the commenters recommended that the proposed new cost centers on the cost report for ''Medical Supplies Charged to Patients'' and ''Implantable Devices Charged to Patients'' be defined exclusively on the following revenue code criteria: Specifically, revenue codes 0275 (Pacemaker), 0276 (Intraocular lens), 0278 (other implants), and 0624 (FDA investigational devices) would be used in the proposed new cost center for high-cost devices. The commenters noted that revenue code 0624 generally consists of higher cost implants, but indicated that this revenue code could be refined at a later point by the NUBC to provide a revenue code that could be reported when the FDA investigational device does not include implants. According to the commenters, all other revenue codes in the device/supply category (in 027x and 062x) would be reported in the lower cost medical supplies cost center on the cost report. The commenters acknowledged that distinguishing between low-cost supplies and high-cost devices through exclusive use of the existing revenue codes will not thoroughly separate low and high-cost items, and therefore, some amount of charge compression will remain in the proposed new ''Implantable Devices Charged to Patients CCR.'' Nevertheless, the commenters believed that use of existing revenue codes and definitions represents the most administratively simple and least burdensome approach to addressing charge compression; the incremental improvements of a more refined approach do not warrant more wholesale changes. One commenter, however, did recommend that CMS request new revenue codes from the NUBC as needed to identify all devices that would be reported in the new implantable devices cost center under the revised cost report definition of implantable device so as to minimize exclusion of innovative technologies and mitigate the impact of charge compression.

Response: In the FY 2009 IPPS proposed rule (73 FR 23546), we stated that we have begun a comprehensive review of the Medicare hospital cost report, and our proposal to split the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients'' is part of that initiative to update and revise the cost report. Under the effort to update the cost report and eliminate outdated requirements in conjunction with the PRA, changes to the cost report form and cost report instructions would be made available to the public for comment. Thus, the commenters would have an opportunity to suggest the more comprehensive reforms that they are advocating, and would similarly be able to make suggestions for ensuring that these reforms are made in a manner that is not disruptive to hospitals' billing and accounting systems, and are within the guidelines of GAAP, Medicare principles of reimbursement, and sound accounting practices. However, we note that while the commenters on the FY 2009 IPPS proposed rule appear to be advocating a more comprehensive and thorough approach to reforming the cost report, the public comments we received on the FY 2008 proposed rule urged us to proceed cautiously with changing the Medicare cost report to avoid unintended consequences for hospitals that are paid on a cost basis (such as CAHs, cancer hospitals, and, to some extent, SCHs and MDHs), and to consider the administrative burden associated with adapting to new cost report forms and instructions (73 FR 23544 and 72 FR 47193). We explained that because of these comments on the FY 2008 IPPS proposed rule, we

decided to start out slowly with modifying the cost report to improve the data used in calculating the cost-based weights. Specifically, we chose to focus initially on the cost center for Medical Supplies Charged to Patients, because RTI found that the largest impact on the DRG relative weights could result from correcting charge compression for devices and implants. We are willing to work with and consider comments from finance and cost report experts from the hospital community as we work to improve and modify the hospital cost report. As noted above, in the CY 2009 OPPS/ASC proposed rule (73 FR XXXXX), we also are proposing to break the single standard pharmacy cost center 5600 into two standard cost centers, Drugs with High Overhead Cost Charged to Patients and Drugs with Low Overhead Cost Charged to Patients, and we are specifically inviting public comment on the appropriateness of creating standard cost centers for Computed Tomography (CT) Scanning, Magnetic Resonance Imaging (MRI), and Cardiac Catheterization, rather than continuing the established nonstandard cost centers for these services. Proposed changes to the cost report will impact both IPPS and OPPS, and public comments should address both systems.

We have considered the comments in favor of finalizing our proposal to split the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients,'' and the comments recommending that these cost centers be defined based solely on existing revenue codes. Although we believed that adopting the existing criteria for determining whether a device is eligible for pass-through payment under the OPPS to identify devices for the ''Implantable Devices Charged to Patients'' cost center was a reasonable proposal because the criteria are concrete and already familiar to the hospital community, we understand that hospitals are already familiar with the definitions of the existing revenue codes as well because they have been in place for some time. In addition, identifying devices based only on the existing revenue code definitions is more straightforward than also incorporating the criteria for devices that qualify for OPPS pass-through payment. Therefore, we agree with the commenters that use of the existing revenue code definitions is the simplest and least burdensome approach for hospitals to implement that would concretely, although not completely, address charge compression.

Accordingly, in this final rule, we are finalizing our proposed policy to split the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients.'' However, when determining what should be reported in these respective cost centers, rather than finalize our proposed policy to use existing criteria for determining which devices qualify for OPPS pass-through payment, with the modification that the implantable device must remain in the patient at discharge, we are instead adopting the commenters' recommendation that hospitals should use revenue codes established by the NUBC to determine what should be reported in the ''Medical Supplies Charged to Patients'' and the ''Implantable Devices Charged to Patients'' cost centers. We note that use of the existing revenue codes will still generally result in implantable devices being reported in the ''Implantable Devices Charged to Patients'' cost center because revenue codes 0275 (Pacemaker), 0276 (Intraocular lens), 0278 (other implants), and 0624 (FDA investigational devices) for the most part, generally would be used for reporting higher cost implants. However, use of the existing NUBC definitions would not require that the implantable device remain in the patient when the patient is discharged; therefore, in this respect, the policy we are finalizing differs from the one we proposed.

In the FY 2009 IPPS proposed rule (73 FR 23547), in an effort to improve the match between the costs and charges included on the cost report and the charges in the MedPAR file, we recommended that certain revenue codes be used for items reported in the new ''Medical Supplies Charged to Patients'' cost center and the new ''Implantable Devices Charged to Patients'' cost center, respectively. These recommendations were similar to the commenters' suggested method for use of existing revenue codes in determining whether an item should be reported in the proposed new supply or device cost center in the cost report. In this final rule, we are finalizing our policy to create a cost center for implantable devices. Under this policy, charges reported with revenue codes 0275 (Pacemaker), 0276 (Intraocular Lens), 0278 (Other Implants), and 0624 (Investigational Device (IDE)) would correspond to implantable devices reported in the new ''Implantable Devices Charged to Patients'' cost center. Items for which a hospital may have previously used revenue code 0270 (General Classification), but actually are an implantable device, should instead be billed with an implantable device revenue code. Conversely, items and supplies that are not implantable would be reported in the new ''Medical Supplies Charged to Patients'' cost center on the cost report. We would expect these items and supplies to be billed with revenue codes 0270 (general classifications), 0271 (nonsterile supply), 0272 (sterile supply), and 0273 (take-home supplies). In the proposed rule, we indicated that revenue code 0274 (Prosthetic/Orthotic Devices) and revenue code 0277 (Oxygen—Take Home) might be associated with the cost centers for Durable Medical Equipment (DME)-Rented and DME-Sold on the cost report. We received comments that indicated that all other (not implantable) supply revenue codes, including 0274, 0277, 0621, and 0622, should be associated with the new ''Medical Supplies Charged to Patients'' cost center. For the purpose of this final policy, we are most concerned with identifying the revenue code costs and charges that define the new ''Implantable Devices Charged to Patients'' cost center. With the exception of the present proposal, CMS typically does not specify a revenue code-to-cost center crosswalk that hospitals must adopt to prepare their cost report. Beyond the supply revenue codes we identified above for ''Medical Supplies Charged to Patients,'' we assume hospitals will include other appropriate supply revenue codes in this new cost center, which may or may not include 0621, 0622, 0274, and 0277.

Hospitals must continue to report ICD–9–CM codes and charges with an appropriate UB revenue code consistent with NUBC requirements. When reporting the appropriate revenue codes for services, hospitals should choose the most precise revenue code, or subcode if appropriate. As NUBC guidelines dictate: ''It is recommended that providers use the more detailed subcategory when applicable/available rather than revenue codes that end in ''0'' (General) or ''9'' (Other).'' Furthermore, hospitals are required to follow the Medicare cost apportionment regulations at 42 CFR 413.53(a)(1), which convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another department. In order to comply with the requirements of this regulation,

hospitals must follow the Medicare payment policies in section 2302.8 of the PRM–I and the PRM–II in order to ensure that their ancillary costs and charges are reported in the appropriate cost centers on the cost report. We rely on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies.

In general, proper reporting would dictate that if an item is reported as an implantable device on the cost report, it is an item for which the NUBC would require use of revenue code 0275 (Pacemaker), 0276 (Intraocular Lens), 0278 (Other Implants), or 0624 (Investigational Device). Likewise, items reported as Medical Supplies should receive an appropriate revenue code indicative of supplies. We did indicate in the proposed rule that we might consider requesting additional revenue codes from the NUBC, but we note that because the majority of commenters have requested that they be allowed to use existing revenue codes to distinguish between the low cost supplies and high cost devices, we may wait and see what the results of that approach are before we request the creation of additional codes from the NUBC.

We would also like to caution that, as the commenters themselves acknowledged, the use of existing revenue code definitions to crosswalk devices and supplies to the device cost center and supplies cost center, respectively, will not separate high and low cost items as thoroughly as would the use of the proposed criteria for implantable devices that remain in the patient at discharge. Therefore, some degree of charge compression will remain in the medical devices cost center. Furthermore, this methodology, and the accuracy of the relative weights, is heavily dependent upon hospitals' reporting practices. While CMS is responsible for issuing cost reporting instructions that are clear, hospitals are responsible for ensuring that their cost reporting and billing practices are consistent and conform to Medicare policy.

Comment: A few commenters, who supported the proposal that only devices that are implantable and that remain in the patient at discharge should be reported in the new ''Implantable Devices Charged to Patients'' cost center, also expressed concern that there are instances where these criteria are too narrow. One commenter mentioned various types of implantable devices that do not remain in the patient at discharge, including atherectomy and thrombectomy catheters, laser sheaths for removal of pacemaker and defibrillator leads, and thrombolysis catheters. Two commenters mentioned one product, an external fixation device that is used to treat trauma of the upper and lower extremities and to assist in the treatment of severe fractures, and noted that this device is commonly removed from patients prior to discharge. The commenters believed that if this device is not assigned to a revenue code for an ''implantable device,'' the true implant costs for many of these discharges may not be recognized. One of the commenters asked that CMS consider exempting external fixation devices from the proposed ''implantable device'' standard, or provide another appropriate mechanism to ensure accurate cost reporting for this device. The other commenter also supported the creation of the devices cost center based on the use of existing revenue codes and associated definitions established by the NUBC. Another commenter stated that CMS' proposed definition of device as one that must remain in the patient at discharge could result in inconsistent billing and reporting because whether a device remains in the patient could depend on the particular patient's length of stay. The commenter used the example of an implantable port for medication delivery, where one patient is well enough to be discharged from the hospital but needs the port at home for extended IV therapy. Another patient with the same implantable medication port, however, may have additional complications and need to stay in the hospital longer, but may ultimately improve to the extent where he or she is discharged without the port. The commenter observed that, as a result, there could be a device that would qualify as an implant for some patients but not for others.

Response: In the FY 2009 IPPS proposed rule (73 FR 23545), we acknowledged that a definition of a device based on whether it is implantable and remains in the patient at discharge could, in some cases, include some relatively inexpensive items, and could also exclude some expensive items. Therefore, some charge compression could continue for these technologies. We also acknowledge the point of one of the commenters that depending upon a patient's severity of the illness and length of stay, a device may or may not qualify as an implantable device based on our proposed criteria. However, we note that, in response to the many comments we received as summarized previously, we have decided not to finalize our proposed definition of a device, which was based on the existing OPPS criteria for identifying devices that qualify for pass-through payment, with the additional requirement that the device must remain in the patient at discharge. Instead, as suggested by the vast majority of commenters, we are finalizing a policy that would distinguish between supplies and devices based on the existing revenue codes and definitions. Therefore, while the device must still be implantable to map to the new implantable device cost center, our final policy no longer includes the requirement that the device remain in the patient at discharge. We expect hospitals to follow the revenue code definitions in assigning the costs and charges of devices.

Comment: Commenters asked CMS to provide a contingency plan if the medical device CCR is substantially lower than the regression-based device CCR estimate or the current supplies CCR, once the data become available.

Response: We agree that we will need to evaluate the medical supply and device CCRs once the data become available for FY 2012 ratesetting. At that point and forward, we will continue to analyze the cost report data. However, we point out that we do not believe it is appropriate to ''pick and choose'' between CCRs; rather, the determining factor should be payment accuracy, regardless of whether one method increases or decreases payment for devices.

Comment: One commenter supported CMS' proposal to split the medical supplies cost center. However, the commenter stated that CMS' proposal could result in the relative weight for MS–DRG 001 (Heart Transplant or Implant of Heart Assist with MCCs) being reduced because the weight for MS–DRG 001 is not ''device-driven'' due to the presence of a large number of hospitalizations with relatively low device costs (heart transplant and combined heart-lung transplant), which could weaken the effect of the proposed cost center changes with respect to the relative weight for MS–DRG 001. To remedy this, the commenter requested, in part, that CMS create a cost center on the cost report that would enable CMS to capture more accurate data on LVADs. In addition, the commenter noted that CMS should remain open to cost centers that capture devices in the $500–$2,500 range (Class I implantable devices), and separate cost centers for devices in the $2,500–$100,000 range (Class II implantable devices). The commenter stated that it would continue to monitor CMS' policy changes in the coming years and will provide input to the CMS regarding the

''impact to hospitals that provide lifesaving LVAD therapy to Medicare beneficiaries.''

Response: We do not believe it is appropriate at this time to create a new cost center, or further refine the device cost center based on cost categories, so as to capture data more accurately for LVADs. Instead, as an initial step, we believe it would be better to finalize the broader proposal of creating one cost center for supplies, and a cost center for implantable devices, which would include LVADs. We are receptive to the commenter's input to CMS regarding the impact to hospitals that provide LVAD therapy as part of our own monitoring and analyses of the cost-based relative weights, and if appropriate, we may consider further refining the implantable devices cost center in the future.

Comment: A number of commenters focused on the section of the 2007 RTI report that highlighted the problem of nursing care cost compression. The report found that nursing care represents about 41 percent of hospitals' costs, and these costs are allocated as fixed daily room rates, despite substantial evidence that daily nursing care hours and costs vary substantially among patients. As a result, the current DRG relative weights do not reflect differences in nursing care, leading to payment inaccuracy. One commenter noted that this creates a ''perverse incentive for hospitals to cut nursing staff as reimbursement is not matched to the average amount of nursing time and costs within each DRG as are the ancillary services.'' Some commenters reiterated their comments submitted on the FY 2008 IPPS proposed rule, recommending that CMS study adoption of Nursing Intensity Weights (NIWs), which is in use in the New York State Medicaid program. The commenters suggested that unbundling nursing care from current routine and intensive care daily rates and billing for nursing using the 023X revenue code for actual daily nursing time (nursing intensity) expended for individual patients provides a reasonable solution to the problem of nursing cost compression. Specifically, the commenters urged CMS to reconsider its proposal for FY 2009 and explore ways to:

(a) Implement the recommendations of the RTI report to unbundle nursing care from current accommodation (room and board) revenue codes using the 023X Nursing Incremental Charge UB04 revenue code.

(b) Modify the Medicare cost report to separate out nursing costs and hours of care to allow construction of a nursing cost to charge ratio within the existing routine and intensive care cost centers.

(c) Develop a method to evaluate nursing performance by case mix within the new severity adjusted DRGs using the unbundled 023X nursing hours and costs data.

(d) Incorporate the inpatient nursing performance measure into the emerging value-based purchasing effort in the coming fiscal years to identify low performing hospitals relative to the mean nursing intensity within MS–DRG and high cost hospitals.

The commenters believed that accomplishing these four recommendations will ''improve overall payment accuracy, lead to a better understanding of how nursing care hours and costs are allocated to individual patients and by DRG within and across hospitals, identify hospital nursing performance, and inform policy makers on the state of inpatient nursing care in the United States.''

Response: The commenters raised similar concerns in response to the FY 2008 IPPS proposed rule. In response to those comments, we acknowledged RTI's finding in its January 2007 report that ''because intensity of nursing is likely correlated with DRG assignment, this could be a significant source of bias in DRG weights,'' and agreed that this issue should be studied further. We appreciate that the commenters have also given more thought to methods of addressing nursing cost compression, but we note that the initiation and eventual success of much of these efforts lie within the hospital community. In its July 2008 report, RTI states that, ''the best long-term solution would be for the industry to agree to expand charge coding conventions for inpatient nursing, which would foster increased use of patient-specific nursing incremental charge codes in addition to baseline unit-specific per-diem charges. Additional detail in revenue codes would permit inpatient charges to be converted by CCRs in the same way as charges for ancillary service use are converted, to more accurately aggregate costs at the level of the system payment unit.'' (page 118) Therefore, whether the preferred method would be to separate charges for nursing care from the accommodation revenue codes using the existing 023X (Incremental Nursing Care) revenue codes, or some other approach, we believe the hospital community must take the initiative to decide upon a uniform method of reporting nursing charges in such a manner that reflects the varying nursing intensity in caring for individual patients.

The commenters requested that the cost report be modified to separate nursing costs and hours of care to allow for the calculation of CCRs for routine care and intensive care, and we believe this could possibly be a long-term goal. We note that RTI observes that given the inconsistent use of patient-level nursing acuity data systems, ''it is difficult to imagine an administratively feasible way to incorporate nursing acuity measures into standard Medicare reporting as a long-term solution for reducing nursing cost compression'' (page 118). However, we encourage the nursing community, the hospital industry, and others to consider researching ideas for how nursing intensity can be recognized in the cost weights.

Comment: Several commenters responded to our solicitation for comments on how to report supplies that are part of surgical kits. The commenters generally did not support our proposal to require hospitals to separate the costs of supplies from devices within surgical kits. Some commenters recommended using the existing revenue codes so as not to increase the documentation burdens for hospitals. That is, the costs and charges of the kit should be reported consistent with the use of the revenue code, such that, for example, if the kit is billed with revenue code 0278 (Other Implants), it would be reported in the new ''Implantable Devices Charged to Patients'' cost center. These commenters acknowledged that this approach will not separate all low cost items, but will still reduce charge compression.

Another commenter stated that ''unbundling'' the device from the surgical kit would increase administrative costs for hospitals and vendors, and that more medical errors would likely result, which surgical packs were designed to reduce. Another commenter noted the terms CMS used in describing the supplies that are part of surgical kits, such as ''integral to'' or ''unrelated to,'' and ''free'' or ''bonus'' items. The commenter recommended that CMS consider clarifying these terms via an issuance such as a transmittal or an MLN Matters article rather than the **Federal Register** because all healthcare providers do not read it, and that CMS' clarification provide ''rationale that is vital to understanding underlying compliance concerns associated with supply charge practices.'' This commenter further recommended that as a long-term solution, CMS and the NUBC develop a revenue code called ''Integrated Supplies'' specifically to report supplies in customized kits, packs, and trays. This new revenue code

would capture all of the routine supplies that are part of the package in one charge, except for the charge for the implantable device, which would be itemized separately on the invoice The commenter noted that most hospitals' chargemaster software allows multiple charges to be linked together as part of a ''panel master.'' Therefore, the Integrated Supplies revenue code could be linked with the various revenue codes used for implantable devices (0275, 0276, and 0278), without requiring vendors and hospitals to itemize every single supply in a kit separately on an invoice or the chargemaster.

One commenter stressed the value that packaging such items together has for hospitals, arguing that the kits reduce labor hours associated with the procedure, and that ''hospitals do not purchase these packages for what CMS refers to as 'bonus' items, but for the efficiencies gained though the packaging of the items.'' The commenter did not believe such kits should be considered a violation of the anti-kickback statute.

Response: In the FY 2009 IPPS proposed rule (73 FR 23545), we discussed how hospitals could accurately report the costs of an expensive device and the costs of less expensive supplies needed to implant that device on the cost report, given that often the device and the supplies are included on a single invoice from the manufacturer, making it difficult for the hospital to determine the cost of each item in the kit. We suggested that one option is for the hospital to split the total combined charge on the invoice in a manner that the hospital believes best identifies the cost of the device alone. However, because it may be difficult for hospitals to determine the respective costs of the actual device and the attending supplies (whether they are required for the safe surgical implantation and subsequent operation of that device or not), we solicited comments with respect to how supplies, disposable or otherwise, that are part of surgical kits should be reported. We distinguished between such supplies that are an integral and necessary part of the primary device (that is, required for the safe surgical implantation and subsequent operation of that device) from other supplies that are not directly related to the implantation of that device, but may be included by the device manufacturer with or without charge as ''perks'' along with the kit. We stated that if it is difficult to break out the costs and charges of these lower cost items that are an integral and necessary part of the primary device, we would consider allowing hospitals to report the costs and charges of these lower cost supplies along with the costs and charges of the more expensive primary device in the cost report cost center for implantable devices. However, we stated that to the extent that device manufacturers could be encouraged to refine their invoicing practices to break out the charges and costs for the lower cost supplies and the higher cost primary device separately, so that hospitals need not ''guesstimate'' the cost of the device, this would facilitate more accurate cost reporting and, therefore, the calculation of more accurate cost-based weights.

We have considered the public comments which essentially recommended that hospitals should not attempt to break out the costs of the expensive device from the attending supplies, but instead, that hospitals report the entire kit based on the single revenue code used for the device in the kit. We still believe that device manufacturers could make a better effort at refining their invoices to separately break out the charges and costs of the high-cost device from the low-cost supplies because this would likely lead to more accurate cost reporting and a further mitigation of charge compression. Certainly, if the supplies that are included in the kit are not integral to and necessary for the safe, surgical implementation of the device, we believe that it would be best for hospitals to report those costs and charges separately from the costs and charges for the implantable device. Nevertheless, because commenters are generally satisfied with an approach for reporting the costs and charges of the entire kit based on the revenue code that is used for the device in that kit, we will accept the commenters' recommendation and permit hospitals to follow this approach in reporting the costs and charges of surgical kits. As we noted in the proposed rule, even for an aggregated invoice that contains an expensive device, we believe that RTI's findings of significant differences in supply CCRs for hospitals with a greater percentage of charges in device revenue codes demonstrate that breaking the Medical Supplies Charged to Patients cost center into two cost centers, using appropriate revenue codes for devices, and mapping those costs to the new ''Implantable Devices Charged to Patients'' cost center, will result in an increase in estimated device costs that could lead to more accurate payment for those costs. However, we do appreciate the acknowledgement from the commenter that it is important for the industry to understand the rationale for compliance requirements and the recommendation of the commenter that a new revenue code for Integrated Supplies be created as a long-term solution for capturing costs and charges of incidental supplies, and we may consider this as part of other changes that may or may not require NUBC approval.

With respect to the commenter that argued that such kits should not be considered a violation of the anti-kickback statute, we note that we did not state that surgical kits should necessarily be considered a violation of the anti-kickback statute. The commenter made the point that hospitals do not purchase the kits for the value of the ''bonus items,'' but rather because of the increased efficiencies that result from packaging all the items necessary for a particular surgical procedure together. However, we point out that the IPPS proposed rule refers specifically to ''free or 'bonus' items that are *not* an integral and necessary part of the device (that is, not actually required for the safe surgical implantation and subsequent operation of that device)'' (73 FR 23545, emphasis added). Therefore, the parenthetical sentence in the proposed rule that follows the reference to ''free'' or ''bonus'' items refers to those free or bonus items that are *not* an integral and necessary part of the device implantation procedure and subsequent operation of that device. Specifically, we stated that ''arrangements involving *free or bonus* items or supplies *may* implicate the Federal anti-kickback statute, *depending on the circumstances*'' (73 FR 23545, emphasis added). That is, hospitals should be aware that, depending on the circumstances, kits that include other items that are unrelated to the safe implantation or operation of a device could possibly implicate the Federal anti-kickback statute.

Comment: One commenter advised that many hospitals do not report some charges in the Medical/Surgical Supplies revenue codes when they consider those items to be part of hospital room and board (that is, blood transfusion administration). The commenter stated that hospitals seek guidance from CMS to avoid discrepancies in reporting, and recommended that CMS define what is included in ''room and board'' to further standardize billing practices and promote consistency and continuity across all hospitals.

Response: CMS' longstanding policy with respect to what constitutes a routine service (sometimes called ''room and board'') as compared to an ancillary

service is discussed in the regulations at § 413.53(b) and in the PRM–I under Section 2202.6 (Routine Services) and Section 2202.8 (Ancillary Services). If an item is not specifically enumerated as a routine item or service in Section 2202.6, or an ancillary item or service in Section 2202.8, then the rules in Section 2203 of the PRM–I apply. This section requires that the common or established practice of providers of the same class in the same State should be followed. If there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program.

With respect to blood transfusion/administration, to which the commenter refers, this service should not be billed under the Medical/Surgical Supplies code, regardless of the hospital's accounting system. ''Blood Transfusion/Administration'' is a service rather than an item, and the blood itself is also not treated as a medical supply item. The cost report includes a standard cost center for ''Blood Storing, Processing, and Transfusion'' (Line 47 of Worksheet A, under the ''Ancillary Service Cost Centers''), and there is a UB revenue code 0391 for Blood Administration, in addition to revenue codes in the 038X category for various blood products. However, the revenue codes for Medical/Surgical Supplies fall within another category, 027x. Because blood transfusion and blood products are not specifically mentioned in the definition of ''routine services'' in the PRM–1 under Section 2202.6, or in the definition of ''ancillary services'' in Section 2202.8, the commenter is asking whether it is appropriate not to bill a separate ancillary charge for the transfusions occurring in the routine cost centers, but to consider that the charge is encompassed in the routine Room and Board Charge under one of the Room and Board UB revenue codes.

In accordance with PRM–I, Section 2202.8, if the provider does not impose a separate charge in addition to a routine service charge, the service is considered not to be ''ancillary''. As mentioned above, under PRM–I, Section 2203, the provider must consider the established practice of the same class of providers in the same State as to whether to include blood transfusion in the routine service charge (for both Medicare and non-Medicare patients). For blood transfused in the Operating Room, Emergency Room, or other ancillary cost centers, providers should be billing a separate charge (just as for implantable devices in case of Implantable Devices Charged to Patients) under UB revenue code 0391 (Blood Administration), and the cost and charges should be reported on Line 47 of the cost report.

Comment: A few commenters indicated that, with the changes that CMS is proposing to the reporting of costs and charges of medical devices on the cost report, the quality of the cost data that CMS will be collecting will improve. Accordingly, they stated that, the CCR for the new ''Implantable Devices Charges to Patients'' cost center will improve to the extent that applying it to the reported charges for devices from the cost report will generate an actual device cost and that this actual device cost should be an accurate reflection of the hospital's device acquisition cost. Therefore, the commenter suggested that this cost should be determined and incorporated into the process for calculating the relative weights, and that CMS should use the actual cost in the relative weight calculation rather than an imputed cost estimated by applying a national CCR to claims charge data, in instances where the imputed cost is lower than the cost reported by the hospital on its cost report.

Response: While we are optimistic that the addition of a new cost report line for implantable devices should certainly allow for the collection of more accurate cost data, we do not believe we can use this aggregate actual cost amount for setting relative weights. The costs and charges for all implantable devices for the hospital across all payers are collected and aggregated on the cost report. However, the cost of a specific device cannot be determined from this aggregated information. We have to estimate the cost of devices for each MS–DRG in each claim in order to estimate an average imputed cost for the entire MS–DRG, including device costs. Different MS–DRGs will include different kinds of devices, each with a different cost. We also do not believe it is appropriate to use the actual cost in the relative weight calculation rather than the imputed cost in instances where the imputed cost is lower than the cost reported by the hospital on its cost report, as the commenter suggested.

We also solicited comments on alternative approaches that could be used in conjunction with or in lieu of the four proposed criteria for distinguishing between what should be reported in the new cost centers for Implantable Devices and Medical Supplies, respectively. Another option we considered would distinguish between high-cost and low-cost items based on a cost threshold. Under this methodology, we would also have one cost center for Medical Supplies and one cost center for Devices, but we would instruct hospitals to report items that are not movable equipment or a capital expense but are above a certain cost threshold in the cost center for Devices. Items costing below that threshold would be reported in the cost center for Medical Supplies.

Establishing a cost threshold for cost reporting purposes would directly address the problem of charge compression and would enable hospitals to easily determine whether an item should be reported in the supply or the device cost center. A cost threshold would also potentially allow a broader variety of expensive, single use devices that do not remain in the patient at discharge to be reported in the device cost center (such as specialized catheters or ablation probes). While we have a number of concerns with the cost threshold approach, we nevertheless solicited public comments on whether such an approach would be worthwhile to pursue. Specifically, we are concerned that establishing a single cost threshold for pricing devices could possibly be inaccurate across hospitals. Establishing a threshold would require identifying a cost at which hospitals would begin applying reduced markup policies. Currently, we do not have data from which to derive a threshold. We have anecdotal reports that hospitals change their markup thresholds between $15,000 and $20,000 in acquisition costs. Recent research on this issue indicated that hospitals with average inpatient discharges in DRGs with supply charges greater than $15,000, $20,000, and $30,000 have higher supply CCRs (Advamed March 2006).

Furthermore, although a cost threshold directly addresses charge compression, it may not eliminate all charge compression from the device cost center because a fixed cost threshold may not accurately capture differential markup policies for an individual hospital. At the same time, we also are concerned that establishing a cost threshold may interfere with the pricing practices of device manufacturers in that the prices for certain devices or surgical kits could be inflated to ensure that the devices met the cost threshold. We believe our proposed approach of identifying a group of items that are relatively expensive based on the existing criteria for OPPS device pass-through payment status, rather than adopting a cost threshold, would not

influence pricing by the device industry. In addition, if a cost threshold were adopted to distinguish between high-cost devices and low-cost supplies on the cost report, we would need to periodically reassess the threshold for changes in markup policies and price inflation over time.

Comment: Several commenters addressed the use of a cost threshold to determine whether an item should be categorized in the medical device cost center of the cost report. Some commenters believed that establishing a cost threshold to determine whether an item should be reported as a device or a supply would be inappropriate because it is difficult to ensure that charges are properly reported because there would not be any specific revenue codes for these high-cost and low-cost items. Further, commenters disagreed about what the threshold should be. (In the proposed rule, we had discussed that we have anecdotal evidence that inpatient discharges in DRGs with supply charges greater than $15,000, $20,000 and $30,000 have higher supply CCRs.) However, the commenters stated that if CMS used a cost threshold, it should be set lower at a range of $1,000 to $2,000. Another commenter recommended that CMS set a cost threshold at $4,000, so its nonimplantable device could qualify as a device for cost reporting purposes.

Response: In the proposed rule, we proposed to instruct hospitals to report only devices that met our criteria (including that a device is implantable and remains in the patient upon discharge) in the new cost center for ''Implantable Devices Charged to Patients'' and to report all other devices and supplies in the new ''Medical Supplies Charged to Patients'' cost center. However, we also solicited comments on alternative approaches that could be used in conjunction with or in lieu of our proposed criteria to distinguish between the new cost center for Implantable Devices and the new cost center for Medical Supplies. One alternative could have been that hospitals report items above a certain cost threshold in the Medical Devices cost center while items costing below the threshold would be reported in the Medical Supplies cost center. The few commenters on this proposal were generally opposed to establishing a cost threshold to differentiate between medical devices and medical supplies. As discussed in our proposed rule (73 FR 23546), we continue to be concerned that a cost threshold may affect pricing practices of device manufacturers where prices of certain devices could be inflated to ensure the item met the threshold to be classified as a device. Further, we believe it would be difficult to establish a cost threshold because we currently have no empirical data from which to establish one, and the commenters disagreed with the anecdotal evidence we presented that a potential cost threshold for devices could be between $15,000 and $20,000. Therefore, the policy that we are finalizing in this final rule does not include a cost threshold to determine whether items should be reported as a medical device or a medical supply.

Another option for distinguishing between high-cost and low-cost items for purposes of the cost report would be to divide the Medical Supplies Charged to Patients cost center based on markup policies by placing items with lower than average markups in a separate cost center. This approach would center on documentation requirements for differential charging practices that would lead hospitals to distinguish between the reporting of supplies and devices on different cost report lines. That is, because charge compression results from the different markup policies that hospitals apply to the supplies and devices they use based on the estimated costs of those supplies and devices, isolating supplies and devices with different markup policies mitigates aggregation in markup policies that cause charge compression and is specific to a hospital's internal accounting and pricing practices. If requested by the fiscal intermediaries/MACs at audit, hospitals could be required to submit documentation of their markup policies to justify the way they have reported relatively inexpensive supplies on one line and more expensive devices on the other line. We believe that it should not be too difficult for hospitals to document their markup practices because, as was pointed out by many commenters since the implementation of cost-based weights, the source of charge compression is varying markup practices. Greater knowledge of the specifics of hospital markup practices may allow ultimately for development of standard cost reporting instructions that instruct hospitals to report an item as a device or a supply based on the type of markup applied to that item. This option related to markup practices, the proposal to define devices based on four specific criteria, and the third alternative that would establish a cost threshold for purposes of distinguishing between high-cost and low-cost items could be utilized separately or in some combination for purposes of cost report modification. Again, in the proposed rule, we solicited comments on these alternative approaches. We also expressed interest in other recommendations for appropriate cost reporting improvements that address charge compression.

Comment: One commenter supported the use of the markup threshold to separate medical supplies from medical devices because, according to the commenter, it would be the most accurate way to mitigate charge compression as the source of charge compression is hospitals' varying markup practices. However, the commenter noted that establishing a markup threshold would require additional documentation from hospitals that could be burdensome. Other commenters believed that a markup threshold would likely separate medical devices that were very expensive or very inexpensive, but would not address medical devices that are moderately priced. The commenters who opposed a markup threshold noted that because there is great variability in markup practices among hospitals, it would be difficult to apply a national markup threshold. The commenters also noted that urban hospitals compared to rural hospitals would have very different charging practices.

Response: In the FY 2009 IPPS proposed rule, we listed several reasons why adopting a policy where high and low cost items would be divided based on markup policy could be appropriate (73 FR 23546). We also stated that this option would focus on documentation requirements, although we did not believe these documentation requirements would be too difficult. However, the commenters believed that this approach is too burdensome, and that it would be difficult to apply a national markup threshold given the varying markup practices among hospitals. Therefore, because most commenters approved of a revenue code-based approach to distinguishing between high-cost and low-cost items, we are not adopting a policy based on markup practices at this time.

5. Timeline for Revising the Medicare Cost Report

As mentioned in the FY 2008 IPPS final rule with comment period (72 FR 47198), we have begun a comprehensive review of the Medicare hospital cost report, and the finalized policy to split the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients,'' as part of our initiative to update and revise the hospital cost

report. Under an effort initiated by CMS to update the Medicare hospital cost report to eliminate outdated requirements in conjunction with the PRA, we plan to propose the actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapter 36 of the Medicare PRM, Part II. We expect the proposed revision to the Medicare hospital cost report to be issued sometime after publication of this final rule. Because we are finalizing our proposal to create one cost center for ''Medical Supplies Charged to Patients'' and one cost center for ''Implantable Devices Charged to Patients'' in this final rule, the cost report forms and instructions should reflect those changes. In the FY 2009 IPPS proposed rule (73 FR 23547), we stated that we expect the revised cost report would be available for hospitals to use when submitting cost reports during FY 2009 (that is, for cost reporting periods beginning on or after October 1, 2008). We now believe the revised cost report may not be available until cost reporting periods starting after the Spring of 2009. Because there is approximately a 3-year lag between the availability of cost report data for IPPS and OPPS ratesetting purposes in a given fiscal year, we may be able to derive two distinct CCRs, one for medical supplies and one for devices, for use in calculating the FY 2012 or FY 2013 IPPS relative weights and the CY 2012 or CY 2013 OPPS relative weights.

Comment: Commenters generally expressed concern with the timeframe in which we proposed to implement the cost report changes. One commenter questioned hospitals' ability to quickly change their chargemaster to ensure that revenue codes are always reported in MedPAR consistently with the cost centers in which they are reported on the cost report. The commenter cautioned that initial calculations of the relative weights may not be accurate if hospitals do not have sufficient time to adapt to the new reporting requirements. Another commenter did not believe that the time between issuance of the final rule and October 1, 2008, is enough time for hospitals to make the changes to their processes and systems necessary to conform to the new cost reporting procedures. The commenter pointed out that hospital employees may need to be retrained, and new cost reporting technology may need to be purchased, all of which is costly to hospitals operating on tight margins. The commenter requested that CMS provide no less than 6 months lead time, but preferably 1 year, before implementing any changes to the cost report, asserting that an ''overly-aggressive'' timeframe in which to implement changes to the cost report may lead to inaccurate data, which runs counter to CMS' goal of improving the accuracy of its CCR data.

Response: We are sympathetic to the commenter's concerns, but we note that, thus far, we have not proposed to implement drastic changes to the cost report and cost reporting procedures that warrant overhaul of hospitals' current accounting systems. As we stated in the FY 2009 IPPS proposed rule (73 FR 23543), longstanding Medicare policy has been that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another ancillary department. Hospitals must include the cost and charges of separately ''chargeable medical supplies'' in the Medical Supplies Charged to Patients cost center (line 55 of Worksheet A), rather than in the Operating Room, Emergency Room, or other ancillary cost centers. Routine services, which can include ''minor medical and surgical supplies'' (Section 2202.6 of the PRM, Part 1), and items for which a separate charge is not customarily made, may be directly assigned through the hospital's accounting system to the department in which they were used, or they may be included in the Central Services and Supply cost center (line 15 of Worksheet A). Conversely, the separately chargeable medical supplies should be assigned to the Medical Supplies Charged to Patients cost center on line 55. Our proposal to split the existing Medical Supplies Charged to Patients cost center into two cost centers, one specifically for ''Implantable Devices Charged to Patients,'' is simply a refinement of what should be hospitals' existing cost reporting practices, wherein, rather than reporting all separately chargeable supplies and devices in one cost center, the devices would be reported in a separate, new cost center. We do not view this as a significant shift in cost reporting policy. Further, our adoption of the commenters' suggested method of separating supplies and devices based on existing revenue codes and NUBC definitions, with which all hospitals are already familiar, should minimize the disruption to hospitals' accounting and billing systems. Lastly, we note that, although participation in the hospital associations' educational initiatives has been voluntary, efforts have certainly been made by the hospital community over the past year to increase awareness and improve the accuracy of hospitals' cost reporting practices. Also, with respect to the commenter that questioned hospitals' ability to quickly change their chargemaster to ensure that revenue codes are always reported in the MedPACR file consistently with the cost centers in which they are reported on the cost report, as we stated in response to a previous comment, hospitals must use the billing codes as directed by the NUBC, regardless of the cost center in which the cost is reported on the cost report. Hospitals must continue to report ICD–9–CM codes and charges with an appropriate UB revenue code, consistent with NUBC requirements. When reporting the appropriate revenue code for services, hospitals should choose the most precise revenue code, or subcode if appropriate. As NUBC guidelines dictate: ''It is recommended that providers use the more detailed subcategory when applicable/available rather than revenue codes that end in ''0'' (General) or ''9'' (Other).'' Furthermore, with respect to the cost report, hospitals are required to follow the Medicare cost apportionment regulations at 42 CFR 413.53(a)(1) which convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than combined with another department. In order to comply with the requirements of this regulation, hospitals must follow the Medicare payment policies in Section 2302/8 of the PRM–I and the PRM–II in order to ensure that their ancillary costs and charges are reported in the appropriate cost centers on the cost report. We rely on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies.

Therefore, we do not believe that it is necessary to significantly delay availability of the revised cost reporting form beyond the date that we proposed; that is, for cost reporting periods starting after the Spring of 2009. In practice, hospitals need not have modified their systems (to the extent necessary) by the Spring of 2009, but rather, by the time they are completing and submitting cost reports for cost reporting periods beginning after the Spring of 2009. Further, as we have stated previously, no change to the actual cost reporting form will be undertaken without first going through notice and comment procedures in accordance with the PRA.

6. Revenue Codes Used in the MedPAR File

An important first step in RTI's study (as explained in its March 2007 report) was determining how well the cost report charges used to compute CCRs matched to the charges in the MedPAR file. This match (or lack thereof) directly affects the accuracy of the DRG cost estimates because MedPAR charges are multiplied by CCRs to estimate cost. RTI found inconsistent reporting between the cost reports and the claims data for charges in several ancillary departments (Medical Supplies, Operating Room, Cardiology, and Radiology). For example, the data suggested that some hospitals often include costs and charges for devices and other medical supplies within the Medicare cost report cost centers for Operating Room, Radiology, or Cardiology, while other hospitals include them in the Medical Supplies Charged to Patients cost center. While the educational initiative undertaken by the national hospital associations is encouraging hospitals to consistently report costs and charges for devices and other medical supplies only in the Medical Supplies Charged to Patients cost center, equal attention must be paid to the way in which charges are grouped by hospitals in the MedPAR file. Several commenters on the FY 2008 IPPS proposed rule supported RTI's recommendation of including additional fields in the MedPAR file to disaggregate certain cost centers. One commenter stated that the assignment of revenue codes and charges to revenue centers in the MedPAR file should be reviewed and changed to better reflect hospital accounting practices as reflected on the cost report (72 FR 47198).

In an effort to improve the match between the costs and charges included on the cost report and the charges in the MedPAR file, in the FY 2009 IPPS proposed rule, we recommended that certain revenue codes be used for items reported in the proposed Medical Supplies Charged to Patients cost center and the proposed Implantable Devices Charged to Patients cost center, respectively. Specifically, under the proposal to create a cost center for implantable devices that remain in the patient upon discharge, revenue codes 0275 (Pacemaker), 0276 (Intraocular Lens), and 0278 (Other Implants) would correspond to implantable devices reported in the proposed Implantable Devices Charged to Patients cost center. Items for which a hospital may have previously used revenue code 0270 (General Classification), but actually meet the proposed definition of an implantable device that remains in the patient upon discharge should instead be billed with the 0278 revenue code. Conversely, relatively inexpensive items and supplies that are not implantable and do not remain in the patient at discharge would be reported in the proposed Medical Supplies Charged to Patients cost center on the cost report, and should be billed with revenue codes 0271 (nonsterile supply), 0272 (sterile supply), and 0273 (take-home supplies), as appropriate. Revenue code 0274 (Prosthetic/Orthotic devices) and revenue code 0277 (Oxygen—Take Home) should be associated with the costs reported on lines 66 and 67 for DME-Rented and DME-Sold on the cost report. Charges associated with supplies used incident to radiology or to other diagnostic services (revenue codes 0621 and 0622 respectively) should match those items used incident to those services on the Medical Supplies Charged to Patients cost center of the cost report, because, under this proposal, supplies furnished incident to a service would be reported in the Medical Supplies Charged to Patients cost center. (We refer readers to item b. as listed under the proposed definition of a device in section II.E.4. of the preamble of this final rule.) A revenue code of 0623 for surgical dressings would similarly be associated with the costs and charges of items reported in the proposed Medical Supplies Charged to Patients cost center, while a revenue code of 0624 for FDA investigational device, if that device does not remain in the patient upon discharge, could be associated with items reported on the Medical Supplies Charged to Patients cost center as well.

In general, proper reporting would dictate that if an item is reported as an implantable device on the cost report, it is an item for which the NUBC would require use of revenue code 0275 (Pacemaker), 0276 (Intraocular Lens), 0278 (Other Implants), or 0624 (Investigational Device). Likewise, items reported as Medical Supplies Charged to Patients should receive an appropriate revenue code indicative of supplies. We understand that many of these revenue codes have been in existence for many years and have been added for purposes unrelated to the goal of refining the calculation of cost-based weights. Accordingly, in the proposed rule, we acknowledged that additional instructions relating to the appropriate use of these revenue codes may need to be issued. In addition, CMS or the hospital associations, or both, may need to request new revenue codes from the NUBC. In either case, we do not believe either action should delay use of the new Medical Supplies and Implantable Devices CCRs in setting payment rates. However, in light of our proposal to create two separate cost centers for Medical Supplies Charged to Patients and Implantable Devices Charged to Patients, respectively, we solicited comments on how the existing revenue codes or additional revenue codes could best be used in conjunction with the revised cost centers on the cost report.

Comment: Two commenters supported CMS' efforts to better match costs and charges and reduce charge compression, but remained concerned about ''three key problems'' that result from using two different data sources (MedPAR and the cost report) to calculate relative weights:

- First, the method used by CMS to group hospital charges for the MedPAR files differs from that used by hospitals to group Medicare charges, total charges, and overall costs on the cost report.
- Second, hospitals group their Medicare charges, total charges, and overall costs in different departments on their cost reports for various reasons.
- Third, hospitals across the country complete their cost reports in different ways, as allowed by CMS. In addition, interpretations of Medicare allowable costs vary from one fiscal intermediary/MAC to another.

The commenters were concerned that CMS' proposal might require hospitals to manually track a patient bill through several departments of the hospital to obtain information about implantable devices used, an effort that is difficult and inefficient. The commenters also stated that the combined use of hospital-specific charges and a national CCR result in a distortion of the MS–DRG relative weights and a shifting of Medicare payments among hospitals, not based on resource utilization, but rather on a mathematical calculation. One commenter recommended that CMS continue to collaborate with the workgroup heading up the educational initiative to develop a mechanism for determining the cost of implantable devices.

Response: The commenters are correct that hospitals do have some flexibility in how they report and group charges, but we note that hospitals must separately apportion the costs of each ancillary department and not combine them with other ancillary departments (Section 2200.3 of the PRM–I). Further, hospitals must include costs and charges of separately chargeable medical supplies in the cost center for Medical Supplies Charged to Patients (Section 2202.6 of the PRM–I), and effective for

cost reporting periods beginning after the Spring of 2009, hospitals must include separately chargeable implantable medical devices in the new ''Implantable Devices Charged to Patients'' cost center. Further, because we are finalizing the policy that the existing revenue codes and definitions are to be used to determine whether an item is reported as a supply or an implantable device on the cost report, hospitals must ensure that they choose the most appropriate revenue codes in the 027x and 062x series to report supplies and implantable devices and subsequently matched to the appropriate cost center. As evidenced in the preceding comment summary, the vast majority of commenters believe that this is the least administratively burdensome approach for hospitals, and therefore, we are optimistic that the commenters' hospitals also have the capability to adapt to more careful cost reporting practices that are aligned with Medicare policy and the method used by CMS to group costs and charges in the relative weight calculation. We also do not believe that the use of hospital-specific charges together with national average CCRs redistributes Medicare payments among hospitals merely based on a mathematical calculation. As we stated in the FY 2008 IPPS final rule with comment period (72 FR 47197), ''on the contrary, a system that improves payment accuracy and moderates the influence of *individual* hospital reporting practices on a national payment system is not one which haphazardly redistributes payments. We note that, in a report issued in July 2006, the GAO found that CMS' system of national CCRs shows promise to improve payment accuracy because it reduces the impact that individual hospital-reporting practices has on the DRG relative weights (GAO–06–880, ''CMS's Proposed Approach to Set Hospital Inpatient Payments Appears Promising'').''

Comment: One commenter recommended that CMS revise the MedPAR file to be consistent with the 23 revenue center groups identified by the RTI report. The commenter believed this is a feasible long-term step because the MedPAR file is derived from a larger claims data set that has more detailed charge information that can be matched to the 23 revenue centers analyzed by RTI.

Response: In RTI's 2008 report, RTI recommended, as a medium-term goal, that CMS expand the MedPAR file to include separate fields that disaggregate several existing charge departments. RTI recommended that the new fields should include those used to compute the statistically disaggregated CCRs. To expand MedPAR, we would have to get detailed charge information from the Standard Analytic File. We agree that more detailed charge information on the MedPAR file would allow us to create more refined CCRs to mitigate charge compression. As we indicated in the FY 2008 final rule with comment period (72 FR 47198), we will consider suggestions for modifying the MedPAR in conjunction with other competing priorities we have for our information systems.

Comment: One commenter recommended that CMS update its device-dependent MS–DRG tables with a crosswalk to the specific Level II HCPCS device codes used in the associated surgical procedures. The commenter stated that although inpatient claims do not report HCPCS codes, most hospital chargemasters list device charges with the associated HCPCS codes and UB revenue center. The commenter further stated that when a device HCPCS code is entered on an inpatient claim, the HCPCS code is repressed but the device UB revenue code is shown on the claim along with the corresponding charge. The commenter believed the development of a HCPCS code to MS–DRG crosswalk would help providers validate that device charges are being uniformly captured on patients' claims, regardless of their inpatient or outpatient status. The commenter believed this crosswalk could also support development of a claim edit for both inpatient and outpatient claims based on the reporting of specific UB revenue codes and device HCPCS codes that would result in payment of a device-dependent MS–DRG or device-dependent APC.

Response: As the commenter noted, unlike the OPPS, payments under the IPPS are not based on HCPCS codes. The IPPS also differs from the OPPS in that under the IPPS, the costs of individual services, even those using expensive devices, are components of the costs of a much larger group of services provided to a particular patient, and therefore, larger payment groups using more claims insure against bias in an MS–DRG weight despite possible errors in reporting the charge for an expensive device. Further, adoption of such a claim edit policy could require burdensome changes in coding practices by some hospitals. Therefore, we are not adopting the commenter's recommendation.

Comment: One commenter urged CMS to undertake an analysis of the FY 2007 fourth quarter MedPAR claims to determine whether documentation and coding-related payment increases are evident, and whether they are peculiar to most hospitals or only to a subset of hospitals. The commenter asked that if CMS observes that only a subset of hospitals are driving the documentation and coding-related increases, CMS hold the blend of the CMS DRG and the MS–DRG relative weights at 50/50 for FY 2009. Another commenter recommended that, in FY 2009, CMS continue to blend the CMS DRG and MS–DRG relative weights at 50/50 because the FY 2007 MedPAR claims that are used to calculate the FY 2009 relative weights do not reflect the significant changes that were made to the IPPS in FY 2008 (that is, the move to MS–DRGs and the revised CC list). The commenter believed that delaying full implementation of the MS–DRG weights until FY 2010 would allow use of the FY 2008 MedPAR claims data, which would reflect a full year of services coded under the new MS–DRGs and CC list. The commenters argued that this will, in turn, help improve the accuracy and consistency of the cost-based MS–DRG relative weights.

Response: Because of the limited time we had available to address the public comments as well as analyze the FY 2007 fourth quarter MedPAR data, we were unable to perform an indepth analysis of where documentation and coding-related payment increases were most evident. However, we did perform some analysis, which did not show any obvious trends in subsets of hospitals. Furthermore, use of the FY 2007 MedPAR claims to set the FY 2009 MS–DRG relative weights represents the most recent and best data available from which to do so. Therefore, because we did not propose to delay the full implementation of the MS–DRGs and their attending relative weights in FY 2009, we are finalizing the transition to 100 percent MS–DRGs in FY 2009.

Comment: One commenter expressed concern about the effect that a new CCR for Medical Devices might have on its Medicaid reimbursement because Medicaid does not pay for devices and the CCR for Medical Supplies and Equipment would be diluted.

Response: The cost-based relative weights were developed solely using Medicare data. We are concerned that non-Medicare payers may be using our payment systems and rates without making refinements to address the needs of their own populations. We encourage non-Medicare payers to adapt the MS–DRGs and the relative weight methodology to better serve their needs.

Comment: Numerous commenters asked that CMS make changes to the cost report or other changes to resolve concerns with charge compression in

hospital OPPS weights for pharmacy services, radiology services, radiopharmaceuticals, drugs and biologicals, and other services paid under the OPPS.

Response: These comments are out of the scope of this final rule because we proposed only to change the cost report to address charge compression for devices under both the IPPS and the OPPS. The CY 2009 OPPS/ASC proposed rule was published in the **Federal Register** on July 18, 2008 (73 FR 41416), and public comments on the effects of charge compression on the OPPS weights for items and services other than devices should be made in response to that proposed rule. The comment period for the OPPS/ASC proposed rule closes at 5 p.m. E.S.T. on September 2, 2008.

F. Preventable Hospital-Acquired Conditions (HACs), Including Infections

1. General Background

In its landmark 1999 report ''To Err is Human: Building a Safer Health System,'' the Institute of Medicine found that medical errors, particularly hospital-acquired conditions (HACs) caused by medical errors, are a leading cause of morbidity and mortality in the United States. The report noted that the number of Americans who die each year as a result of medical errors that occur in hospitals may be as high as 98,000. The cost burden of HACs is also high. Total national costs of these errors due to lost productivity, disability, and health care costs were estimated at $17 to $29 billion.[2] In 2000, the CDC estimated that hospital-acquired infections added nearly $5 billion to U.S. health care costs every year.[3] A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths.[4] Research has also shown that hospitals are not following recommended guidelines to avoid preventable hospital-acquired infections. A 2007 Leapfrog Group survey of 1,256 hospitals found that 87 percent of those hospitals do not follow recommendations to prevent many of the most common hospital-acquired infections.[5] The costs associated with hospital-acquired infections are particularly burdensome for Medicare, as Medicare covers a greater portion of patients with hospital-acquired infections than other payers. One study found that the payer mix for patients without infections was 37 percent Medicare, 28 percent commercial, 21 percent other, and 14 percent Medicaid, while the payer mix for patients with hospital-acquired infections was 57 percent Medicare, 17 percent commercial, 15 percent other, and 11 percent Medicaid.[6]

As one approach to combating HACs, including infections, in 2005 Congress authorized CMS to adjust Medicare IPPS hospital payments to encourage the prevention of these conditions. The preventable HAC provision at section 1886(d)(4)(D) of the Act is part of an array of Medicare value-based purchasing (VBP) tools that CMS is using to promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through Quality Improvement Organization (QIO) activities. CMS' application of VBP tools through various initiatives, such as this HAC provision, is transforming Medicare from a passive payer to an active purchaser of higher value health care services. We are applying these strategies for inpatient hospital care and across the continuum of care for Medicare beneficiaries.

Additionally, the President's FY 2009 Budget outlines another approach for addressing serious preventable adverse events (''never events''), including HACs (see section II.F.9. below for a discussion regarding which HACs are included in the list of Serious Reportable Adverse Events). The President's Budget proposal would: (1) Prohibit hospitals from billing the Medicare program for ''never events'' and prohibit Medicare payment for these events and (2) require hospitals to report any occurrence of these events or receive a reduced annual payment update.

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length and in the services provided, which gives hospitals an incentive to avoid unnecessary costs in the delivery of care. In some cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for uncomplicated cases paid under the same DRG. To this extent, the IPPS encourages hospitals to avoid complications. However, complications, such as infections acquired in the hospital, can generate higher Medicare payments in two ways. First, the treatment of complications can increase the cost of a hospital stay enough to generate an outlier payment. However, the outlier payment methodology requires that a hospital experience a large loss on an outlier case, which serves as an incentive for hospitals to prevent outliers. Second, under the MS–DRGs that took effect in FY 2008, there are currently 258 sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a complicating condition (CC) or a major complicating condition (MCC). If a condition acquired during a hospital stay is one of the conditions on the CC or MCC list, the hospital currently receives a higher payment under the MS–DRGs (prior to the October 1, 2008 effective date of the HAC payment provision). Medicare will continue to assign a discharge to a higher paying MS–DRG if the selected condition is present on admission. (We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a discussion of DRG reforms (72 FR 47141).) The following is an example of how an MS–DRG may be paid under the HAC provision:

[2] Institute of Medicine: To Err Is Human: Building a Safer Health System, November 1999. Available at: *http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf.*

[3] Centers for Disease Control and Prevention: Press Release, March 2000. Available at: *http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm.*

[4] Klevens et al. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports.* March–April 2007. Volume 122.

[5] 2007 Leapfrog Group Hospital Survey. The Leapfrog Group 2007. Available at: *http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf.*

[6] 1.6 Million Admission Analysis, MedMined, Inc. September 2006.

Service: MS–DRG assignment * (examples below with CC/MCC indicate a single secondary diagnosis only)	Present on admission (status of secondary diagnosis)	Median payment
Principal Diagnosis: • Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC—MS–DRG 066		$5,347.98
Principal Diagnosis: • Intracranial hemorrhage or cerebral infarction (stroke) with CC—MS–DRG 065 Example Secondary Diagnosis: • Dislocation of patella-open due to a fall (code 836.4 (CC))	Y	6,177.43
Principal Diagnosis: • Intracranial hemorrhage or cerebral infarction (stroke) with CC—MS–DRG 065 Example Secondary Diagnosis: • Dislocation of patella-open due to a fall (code 836.4 (CC))	N	5,347.98
Principal Diagnosis: • Intracranial hemorrhage or cerebral infarction (stroke) with MCC—MS–DRG 064 Example Secondary Diagnosis: • Stage III pressure ulcer (code 707.23 (MCC))	Y	8,030.28
Principal Diagnosis: • Intracranial hemorrhage or cerebral infarction (stroke) with MCC—MS–DRG 064 Example Secondary Diagnosis: • Stage III pressure ulcer (code 707.23 (MCC))	N	5,347.98

* Operating amounts for a hospital whose wage index is equal to the national average. Based on FY 2008 wage index.

This example illustrates a payment scenario in which the CC/MCC indicates a single secondary diagnosis only. It is atypical for a hospitalized Medicare beneficiary to have only one secondary diagnosis.[7]

2. Statutory Authority

Section 1886(d)(4)(D) of the Act required the Secretary to select at least two conditions by October 1, 2007, that are: (a) High cost, high volume, or both; (b) assigned to a higher paying MS–DRG when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher paying MS–DRG if a selected HAC is not present on admission. That is, the case will be paid as though the secondary diagnosis were not present. Medicare will continue to assign a discharge to a higher paying MS–DRG if the selected condition is present on admission. However, if any nonselected CC/MCC appears on the claim, the claim will be paid at the higher MS–DRG rate; to cause a lower MS–DRG payment, all CCs/MCCs on the claim must be selected conditions for the HAC payment provision. Section 1886(d)(4)(D) of the Act provides that the list of conditions can be revised from time to time, as long as the list contains at least two conditions.

Beginning October 1, 2007, we required hospitals to begin submitting information on Medicare claims specifying whether diagnoses were present on admission (POA).

The POA indicator reporting requirement and the HAC payment provision apply to IPPS hospitals only. At this time, non-IPPS hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's inpatient hospitals, and hospitals in Maryland operating under waivers, are exempt from POA reporting and the HAC payment provision. Throughout this section, ''hospital'' refers to IPPS hospitals.

3. Public Input

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought public input regarding conditions with evidence-based prevention guidelines that should be selected in implementing section 1886(d)(4)(D) of the Act. The public comments we received were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053). In the FY 2008 IPPS proposed rule (72 FR 24716), we sought formal public comment on conditions that we proposed to select. In the FY 2008 IPPS final rule with comment period (72 FR 47200 through 47218), we summarized the public comments we received on the FY 2008 IPPS proposed rule, presented our responses, selected eight conditions to which the HAC provision will apply, and noted that we would be seeking comments on additional HAC candidates in the FY 2009 IPPS proposed rule.

In the FY 2009 IPPS proposed rule (73 FR 23547), we proposed several candidate HACs in addition to proposing refinements to the previously selected HACs. In this FY 2009 IPPS final rule, we summarize the public comments we received on the FY 2009 IPPS proposed rule, present our responses, select additional conditions to which the HAC payment provision will apply, and note that we will be seeking comments on additional HAC candidates in the FY 2010 IPPS proposed rule.

4. Collaborative Process

CMS experts worked closely with public health and infectious disease professionals from the CDC to identify the candidate preventable HACs, review comments, and select HACs. CMS and CDC staff also collaborated on the process for hospitals to submit a POA indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications of the various POA reporting options.

On December 17, 2007, CMS and CDC hosted a jointly-sponsored HAC and POA Listening Session to receive input from interested organizations and individuals. The agenda, presentations, audio file, and written transcript of the listening session are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp*. CMS and CDC also received verbal comments

[7] Medicare Payment for Selected Adverse Events: Building the Business Case for Investing in Patient Safety. *Health Affairs*. Zhan et al. September 2006.

during the listening session and subsequently received numerous written comments.

Comment: Several commenters recommended that CMS develop an advisory panel of clinicians and scientists to provide the agency with guidance on which conditions are appropriate for inclusion under this policy.

Response: We are committed to working with stakeholders as we refine and make additions to the HAC list each year. We intend to engage the public through rulemaking as discussed in section II.F.3. of this preamble and other mechanisms similar to those discussed above.

5. Selection Criteria for HACs

In selecting proposed candidate conditions and finalizing conditions as HACs, CMS and CDC staff evaluated each condition against the criteria established by section 1886(d)(4)(D)(iv) of the Act.

• Cost or Volume—Medicare data [8] must support that the selected conditions are high cost, high volume, or both. We have not yet analyzed Medicare claims data indicating which secondary diagnoses were POA because POA indicator reporting began only recently; therefore, the currently available data for candidate conditions includes all secondary diagnoses.

• Complicating Condition (CC) or Major Complicating Condition (MCC)—Selected conditions must be represented by ICD–9–CM diagnosis codes that clearly identify the condition, are designated as a CC or an MCC, and result in the assignment of the case to an MS–DRG that has a higher payment when the code is reported as a secondary diagnosis. That is, selected conditions must be a CC or an MCC that would, in the absence of this provision, result in assignment to a higher paying MS–DRG.

• Evidence-Based Guidelines—Selected conditions must be considered reasonably preventable through the application of evidence-based guidelines. By reviewing guidelines from professional organizations, academic institutions, and entities such as the Healthcare Infection Control Practices Advisory Committee (HICPAC), we evaluated whether guidelines are available that hospitals should follow to prevent the condition from occurring in the hospital.

• Reasonably Preventable—Selected conditions must be considered reasonably preventable through the application of evidence-based guidelines.

6. HACs Selected During FY 2008 IPPS Rulemaking and Changes to Certain Codes

The conditions that were selected for the HAC payment provision through the FY 2008 IPPS final rule with comment period are listed below. The HAC payment provision implications for these selected HACs will take effect on October 1, 2008. We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) for a detailed analysis supporting the selection of each of these HACs.

Selected HAC	Medicare data (FY 2007)	CC/MCC (ICD–9–CM codes)	Selected evidence-based guidelines
Foreign Object Retained After Surgery.	• 750 cases * • $63,631/hospital stay.**	998.4 (CC) or 998.7 (CC)	NQF Serious Reportable Adverse Event. NQF's Safe Practices for Better Healthcare available at the Web site: *http://www.ahrq.gov/qual/nqfpract.htm.*
Air Embolism	• 57 cases • $71,636/hospital stay.	999.1 (MCC)	NQF Serious Reportable Adverse Event. NQF's Safe Practices for Better Healthcare available at the Web site: *http://www.ahrq.gov/qual/nqfpract.htm.*
Blood Incompatibility	• 24 cases • $50,455/hospital stay.	999.6 (CC)	NQF Serious Reportable Adverse Event. NQF's Safe Practices for Better Healthcare available at the Web site: *http://www.ahrq.gov/qual/nqfpract.htm.*
Pressure Ulcer Stages III & IV	• 257,412 cases *** • $43,180/hospital stay.	707.23 (MCC) or 707.24 (MCC)	NQF Serious Reportable Adverse Event. Available at the Web site: *http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409.*
Falls and Trauma: —Fracture. —Dislocation. —Intracranial Injury. —Crushing Injury. —Burn. —Electric Shock.	• 193,566 cases • $33,894/hospital stay.	Codes within these ranges on the CC/MCC list: 800–829, 830–839, 850–854, 925–929, 940–949, 991–994.	NQF Serious Reportable Adverse Events address falls, electric shock, and burns. NQF's Safe Practices for Better Healthcare available at the Web site: *http://www.ahrq.gov/qual/nqfpract.htm.*
Catheter-Associated Urinary Tract Infection (UTI).	• 12,185 cases • $44,043/hospital stay.	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC).	Available at the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_catheter_assoc.html.*
Vascular Catheter-Associated Infection.	• 29,536 cases • $103,027/hospital stay.	999.31 (CC)	Available at the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html.*

[8] For the HAC section of this FY 2009 IPPS final rule, the DRG analysis is based on data from the September 2007 update of the FY 2007 MedPAR file, which contains hospital bills received through September 30, 2007.

Selected HAC	Medicare data (FY 2007)	CC/MCC (ICD–9–CM codes)	Selected evidence-based guidelines
Surgical Site Infection-Mediastinitis After Coronary Artery Bypass Graft (CABG).	• 69 cases ..... • $299,237/hospital stay.	519.2 (MCC) ..... And one of the following procedure codes: 36.10–36.19.	Available at the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html.*

* A case represents a patient discharge identified from the MedPAR database that met the associated HAC diagnosis/procedure criteria (a secondary diagnosis on the HAC list and, where appropriate, a procedure code described in conjunction with a specific HAC).

** Standardized charge is the total charge for a patient discharge record based on the CMS standardization file. The average standardized charge for the HAC is the average charge for all patient discharge records that met the associated HAC criteria.

*** The number of cases of pressure ulcers reflects CC/MCC assignments for codes 707.00 through 707.07 and 707.09, which are currently being reported. New MCC codes 707.23 and 707.24 will be implemented on October 1, 2008.

In the FY 2009 IPPS proposed rule (73 FR 23552), we sought public comments on the following refinements to two of the previously selected HACs:

a. Foreign Object Retained After Surgery

In the FY 2009 IPPS proposed rule (73 FR 23552), we solicited public comments regarding the inclusion of ICD–9–CM diagnosis code 998.7 (Acute reaction to foreign substance accidentally left during a procedure) to more accurately and completely identify foreign object retained after surgery as an HAC.

Comment: Commenters universally supported the addition of ICD–9–CM code 998.7 to identify foreign object retained after surgery as an HAC. The commenters also reiterated their support for recognizing foreign object retained after surgery as an HAC.

Response: We appreciate the commenters' support. We refer readers to a more detailed discussion of HAC coding for foreign object retained after surgery in section II.F.10.a. of this preamble.

After consideration of the public comments received, we are finalizing our proposal to include diagnosis code 998.7 as an additional code to code 998.4 selected in FY 2008 to identify foreign object retained after surgery as an HAC under the HAC payment provision.

FOREIGN OBJECT RETAINED AFTER SURGERY

ICD–9–CM codes	Code descriptor
998.4	Foreign body accidentally left during a procedure.
998.7	Acute reaction to foreign substance accidentally left during a procedure.

b. Pressure Ulcers

In the FY 2009 IPPS proposed rule (73 FR 23552), we proposed that, beginning October 1, 2008, the codes used to make MS–DRG adjustments for pressure ulcers under the HAC provision would include proposed MCC codes 707.23 and 707.24 (pressure ulcer stages III and IV).

Comment: Commenters supported the creation of the new ICD–9–CM codes 707.23 and 707.24 to capture the stage of the pressure ulcer and supported the use of these codes to identify pressure ulcer stages III and IV as HACs. However, some commenters expressed concern about the proposal to classify ICD–9–CM codes 707.23 and 707.24 as MCCs and to remove the CC/MCC classifications from the existing pressure site codes.

Response: We appreciate the commenters support for using codes 707.23 and 707.24 to identify pressure ulcer stages III and IV as HACs.

In response to the commenters' concerns regarding the CC/MCC classification for these codes, we refer readers to section II.G.12. of this preamble where we address specific concerns about the creation of new codes for identifying pressure ulcers.

After consideration of public comments received, we are adopting as final our proposal that, beginning October 1, 2008, the codes used to identify pressure ulcer stages III and IV as HACs include the following MCC codes:

PRESSURE ULCERS

ICD–9–CM codes	Code descriptor
707.23	Pressure ulcer, stage III.
707.24	Pressure ulcer, stage IV.

7. Candidate HACs

CMS and CDC have diligently worked together and with other stakeholders to identify and select candidates for the HAC payment provision. The additional candidate HACs selected in this FY 2009 IPPS final rule will have payment implications beginning October 1, 2008.

As in the FY 2009 IPPS proposed rule, we present in this final rule the statutory criteria for each HAC candidate in tabular format. Each table contains the following:

- HAC Candidate—We sought public comment on all HAC candidates.
- Medicare Data—We sought public comment on the statutory criterion of high cost, high volume, or both as it applies to each HAC candidate.
- CC/MCC—We sought public comment on the statutory criterion that an ICD–9–CM diagnosis code(s) clearly identifies the HAC candidate.
- Selected Evidence-Based Guidelines—We sought public comment on whether guidelines are available that hospitals should follow to prevent the condition from occurring in the hospital.
- Reasonably Preventable—We sought public comment on whether each condition could be considered reasonably preventable through the application of evidence-based guidelines.

Comment: Many commenters recommended various general standards for determining which conditions could reasonably have been prevented through the application of evidence-based guidelines. The majority of commenters favored a zero, or near zero, standard for those conditions to be considered reasonably preventable when evidence-based guidelines are followed.

Response: We did not propose and did not specifically seek public comments on a general standard for reasonably preventable through the application of evidence-based guidelines in the FY 2009 IPPS proposed rule, and we are not setting a general standard in this final rule. We further note that the statute does not require that a condition be ''always preventable'' in order to qualify as an HAC, but rather that it be ''reasonably preventable,'' which necessarily implies something less than 100 percent.

After consideration of the public comments received and in light of the three statutory criteria, we are finalizing several additional conditions for the HAC payment provision. The additional conditions are defined by specific codes within the broad categories of manifestations of poor glycemic control, surgical site infections, and deep vein thrombosis/pulmonary embolism, as discussed below.

a. Manifestations of Poor Glycemic Control

Hyperglycemia and hypoglycemia are extremely common laboratory findings in hospitalized patients and can be complicating features of underlying diseases and some therapies. However, we believe that extreme manifestations of poor glycemic control are reasonably preventable through the application of evidence-based guidelines and sound medical practice while in the hospital setting; specifically, we believe that they are preventable through the use of routine serum glucose measurement and control which are basic elements of good hospital care.

We originally proposed the diagnosis codes representing four extreme manifestations of poor glycemic control as HACs, but we are not finalizing the following codes representing diabetic coma because the codes are nonspecific and more precise, specific codes are available to describe the condition: (1) Diabetes with coma, type II or unspecified type, not stated as controlled (250.30); (2) diabetes with coma, type I, not stated as controlled (250.31); (3) diabetes with coma, type II or unspecified type, uncontrolled (250.32); and (4) diabetes with coma, type I, uncontrolled (250.33).

Comment: Commenters generally considered all of the manifestations of poor glycemic control together. The majority of commenters agreed that these extreme manifestations of poor glycemic control are reasonably preventable through the application of evidence-based guidelines. In support of selecting this condition, one commenter provided additional evidence-based guidelines addressing glycemic control.

Response: We agree with commenters that extreme manifestations of poor glycemic control are reasonably preventable through the application of evidence-based guidelines. We are including the additional evidence-based guidelines submitted by a commenter in the chart for manifestations of poor glycemic control below.

Comment: Of the proposed codes representing the manifestations of poor glycemic control, hypoglycemic coma received the most attention from commenters. Many commenters considered hypoglycemic coma to be a strong candidate because it is included in the NQF's list of Serious Reportable Adverse Events.

Response: We agree with commenters that hypoglycemic coma is reasonably preventable through the application of evidence-based guidelines.

Comment: Although the majority of commenters supported the selection of diabetic ketoacidosis, nonketotic hyperosmolar coma, and hypoglycemic coma as HACs, CMS received a small number of comments opposing the selection of codes from the manifestations of poor glycemic control category. Some commenters expressed that recent studies demonstrate that tight glycemic control in septic patients leads to poorer outcomes. One commenter identified the diabetic patient population as high risk, citing an estimate that any person with insulin-treated diabetes will experience 0.5 to 1.0 severe hypoglycemic events annually, which appears to not necessarily be within the control of caregivers.[9]

Response: We have addressed the commenters' concerns about tight glycemic control and hypoglycemic events by selecting specific, narrow codes representing extreme manifestations as HACs. For example, the commenter's concern about the preventability of all hypoglycemic events is addressed by selecting as an HAC only the code representing hypoglycemic coma (251.0), an extreme manifestation. We further note that the statute does not require that a condition be ''always preventable'' in order to qualify as an HAC, but rather that it be ''reasonably preventable,'' which necessarily implies something less than 100 percent.

Comment: Commenters supported adding the following four secondary diabetes diagnosis codes: (1) ICD–9–CM code 249.10 (Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified); (2) ICD–9–CM code 249.11 (Secondary diabetes mellitus with ketoacidosis, uncontrolled); (3) ICD–9–CM code 249.20 (Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified); and (4) ICD–9–CM code 249.21 (Secondary diabetes mellitus with hyperosmolarity, uncontrolled). These new secondary diabetes codes will be effective on October 1, 2008.

Response: We agree with commenters that the secondary diabetes codes should be included to capture the full range of extreme manifestations of poor glycemic control as HACs. The secondary diabetes codes are clinically similar to the proposed codes and including these codes more accurately captures the range of manifestations of poor glycemic control.

We are finalizing manifestations of poor glycemic control as an HAC because we have determined after considering the comments received that these conditions meet the statutory criteria. The following chart includes the codes that describe manifestations of the poor glycemic control as an HAC:

[9] The Diabetes Control and Complications Trial. New England Journal of Medicine, 1993, Vol. 329, pp. 977–986.

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Manifestations of Poor Glycemic Control:		A code from the following range:	NQF Serious Reportable Adverse Events addresses hypoglycemia.
- Diabetic Ketoacidosis	Diabetic Ketoacidosis • 11,469 cases • $42,974/hospital stay	Diabetic Ketoacidosis: 250.10 – 250.13 (MCC)	Available at the Web site: http://www.diabetes.org/uedocuments/InpatientDMGlycemicControlPositionStmt02.01.06.REV.pdf
- Nonketotic Hyperosmolar Coma	Nonketotic Hyperosmolar	Nonketotic Hyperosmolar Coma: 250.20 – 250.23	
Selected HAC	**Medicare Data (FY 2007)**	**CC/MCC (ICD-9-CM Code)**	**Selected Evidence-Based Guidelines**
	Coma • 3,248 cases • $35,215/hospital stay	(MCC)	Available at the Web site: http://www.hospitalmedicine.org/ResourceRoomRedesign/GlycemicControl.cfm
- Hypoglycemic Coma	Hypoglycemic Coma • 212 cases • $36,581/hospital stay	Hypoglycemic Coma: 251.0 (CC)	
- Secondary Diabetes with Ketoacidosis*		Secondary Diabetes with Ketoacidosis: 249.10 (MCC) or 249.11 (MCC)	
- Secondary Diabetes with Hyperosmolarity*		Secondary Diabetes with Hyperosmolarity: 249.20 (MCC) or 249.21 (MCC)	

*Note: Medicare data are not available for FY 2007 because ICD-9-CM codes are not effective until October 1, 2008.

MANIFESTATIONS OF POOR GLYCEMIC CONTROL

ICD–9–CM code	Code descriptor
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified.
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled.
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified.
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled.
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled.
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled.
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled.
250.13	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled.
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled.
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled.
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled.
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled.
251.0	Hypoglycemic coma.

b. Surgical Site Infections

In the FY 2009 IPPS proposed rule (73 FR 23553), we requested public comments on the applicability of each of the statutory criteria to surgical site infections following certain procedures. We were particularly interested in receiving comments on the degree of preventability of these infections. We also requested, and received, public comment on additional surgical procedures that would qualify for the HAC provision by meeting all of the statutory criteria.

Comment: Numerous commenters raised issues regarding the applicability of each statutory criterion to surgical site infections generally, especially with regard to degree of preventability. Commenters raised concerns that patient characteristics and other factors can put patients at risk for surgical site infections regardless of the application of evidence-based guidelines. Commenters asserted that elective procedures have a tendency to be short-stay admissions or outpatient procedures, and if a surgical site infection presents after discharge, this HAC would not be captured under the inpatient provision.

Response: We agree that the risk of a typical patient undergoing a procedure is a factor in determining whether these conditions are reasonably preventable (see discussion of risk adjustment in section II.F.9. of this preamble), but we do not agree that the average length of stay following the procedure or the ability to perform the procedure at an alternative site are determinative factors for selecting HACs.

Comment: Some commenters emphasized that certain procedures typically thought of as elective by clinicians are not necessarily elective by patients. Two commenters noted that even if total knee replacement is considered nonemergent and therefore elective from a clinician's perspective, a patient may consider the surgery critical and urgent to avoid pain and immobility.

Response: We agree with the commenters that procedures typically thought of as elective based on urgency are not necessarily viewed as elective from the perspective of the patient's quality of life. Given lack of consensus regarding the classification of procedures as elective, we have discontinued referring to this broad category of surgical site infections as ''following elective procedures.''

Comment: Many commenters asserted that surgical site infections following total knee replacement could be considered reasonably preventable, however those commenters questioned why CMS proposed this HAC because the candidate codes are CCs, and total knee replacement procedures typically map to MS–DRGs that only split to MCCs.

Response: We are unable to select this condition as an HAC because, as commenters noted, surgical site infection is a CC that does not trigger the higher paying MCC MS–DRG payment for total knee replacement procedures; thus, it does not meet the second statutory criterion. If a change to the MS–DRGs results in total knee replacement procedures mapping to MS–DRGs that split to CCs in the future, we could reconsider adding surgical site infections following total knee replacement as an HAC. In addition, we will be reviewing other ICD–9–CM MCC codes relevant to total knee replacement, and we will consider proposing those codes as future HAC candidates.

Comment: Commenters addressed the discrepancy between the proposed CC code (Other postoperative infection) and the MS–DRG split only to MCC for total knee replacement and suggested that CMS review and consider adding other procedures that map to MS–DRGs that split by CC. One commenter referenced a 2002 meta-analysis finding that antibiotic prophylaxis is successful in significantly reducing the rates of postoperative spinal infections.[10]

Response: We agree with the commenters' recommendations and considered additional orthopedic procedures. We identified the following MS–DRGs that split by CC:

- MS–DRGs 453, 454, and 455 (Combined Anterior/Posterior Spinal Fusion with MCC, CC and without CC/MCC);
- MS–DRGs 471, 472, and 473 (Cervical Spinal Fusion, with MCC, CC and without CC/MCC);
- MS–DRGs 507 and 508 (Major Shoulder or Elbow Joint Procedures, with CC/MCC and without CC/MCC).

In response to commenters' suggestions, we are selecting certain orthopedic procedures that fall within the MS–DRGs listed above in the HAC surgical site infection category. The category of surgical site infection following certain orthopedic surgeries includes selected procedures that are often elective and that involve the repair, replacement, or fusion of various joints including the shoulder, elbow, and spine. In future rulemaking, we will work with stakeholders to identify additional procedures, orthopedic and other types, for which surgical site infections can be considered reasonably preventable through the application of evidence-based guidelines.

The following chart includes the codes that describe surgical site infection following certain orthopedic procedures as an HAC:

SURGICAL SITE INFECTION FOLLOWING CERTAIN ORTHOPEDIC PROCEDURES

ICD–9–CM code	Code descriptor
996.67	Infection and inflammatory reaction due to other orthopedic device and implant graft.
	—OR—
998.59	Other postoperative infection.
	—AND—
81.01	Atlas-axis fusion.
81.02	Other cervical fusion anterior.
81.03	Other cervical fusion posterior.
81.04	Dorsal/dorsolum fusion anterior.

[10] Baker, F.G.: Efficacy of prophylactic antibiotic therapy in spinal surgery: A meta-analysis. Neurosurgery. 51(2): 391–400 (2002).

SURGICAL SITE INFECTION FOLLOWING CERTAIN ORTHOPEDIC PROCEDURES—Continued

ICD–9–CM code	Code descriptor
81.05	Dorsal/dorsolum fusion posterior.
81.06	Lumbar/lumbosac fusion anterior.
81.07	Lumbar/lumbosac fusion lateral.
81.08	Lumbar/lumbosac fusion posterior.
81.23	Arthrodesis of shoulder.
81.24	Arthrodesis of elbow.
81.31	Refusion of atlas-axis.
81.32	Refusion of other cervical spine anterior.
81.33	Refusion of other cervical spine posterior.
81.34	Refusion of dorsal spine anterior.
81.35	Refusion of dorsal spine posterior.
81.36	Refusion of lumbar spine anterior.
81.37	Refusion of lumbar spine lateral.
81.38	Refusion of lumbar spine posterior.
81.83	Shoulder arthroplast NEC.
81.85	Elbow arthroplast NEC.

We proposed surgical site infections following ligation and stripping of varicose veins as an HAC, but we are not finalizing this procedure because these MS–DRGs do not currently split into severity levels based on the presence of a CC, and the surgical site infection code is a CC. Thus, surgical site infection following ligation and stripping of varicose veins does not currently meet the second statutory HAC selection criterion of triggering the higher-paying MS–DRG.

We solicited comments on each of the statutory criteria as they apply to surgical site infections following laparoscopic bypass and gastroenterostomy. Laparoscopic gastroenterostomy (44.38) includes several different types of gastric bypass procedures, all of which are done using a laparoscope to avoid surgically opening the abdomen (laparotomy). Gastroenterostomy (44.39) is a general term that describes surgically connecting the stomach to another area of the intestine.

Comment: Some commenters pointed out that the 208 cases cited in the FY 2009 IPPS proposed rule (73 FR 23553) is a relatively small number of cases, which may not meet the statutory criterion of high cost, high volume, or both.

Response: As noted in the FY 2009 IPPS proposed rule, the average cost of a case with a surgical site infection following laparoscopic gastric bypass and gastroenterostomy is $180,142 per hospital stay, which we consider high cost. Thus, this condition meets the high cost statutory criterion.

Comment: Many stakeholders from provider organizations, including medical specialty societies, cited that the population undergoing bariatric surgery for obesity is a high risk population per se; thus, the condition may not be considered reasonably preventable through the application of evidence-based guidelines. Commenters noted that these patients commonly have conditions, such as diabetes and hypertension, in addition to obesity, which are well-known risk factors for infections and other post-operative complications.

Response: We recognize that patients undergoing this procedure may typically be high risk; however, (1) selecting this procedure as an HAC will have the positive effect of encouraging attention to risk assessment prior to surgery and (2) conditions such as complicated forms of diabetes, hypertensive heart and kidney disease, and a body mass index of 40 or higher are CCs or MCCs under the IPPS payment system that, when present on the claim, will continue to trigger the higher-paying MS–DRG. Thus, the usual presence of additional CC/MCCs on claims for these procedures serves as an ''inherent risk adjuster'' to payment for typical bariatric surgery cases for obese patients. We further note that the statute does not require that a condition be ''always preventable'' in order to qualify as an HAC, but rather that it be ''reasonably preventable,'' which necessarily implies something less than 100 percent.

Comment: One commenter noted that gastroenterostomy is routinely used to bypass a damaged or obstructed duodenum in high risk populations such as cancer patients.

Response: In 2007, CMS issued Change Request (CR) 5477 regarding the proper use of ICD–9–CM codes for bariatric surgery for morbid obesity, available on the Web site at: *http://www.cms.hhs.gov/Transmittals/downloads/R1233CP.pdf.* This CR addresses the comment above by focusing on only those procedures with a primary diagnosis of obesity (278.01). Further, as referenced in CR 5477, bariatric surgery for obesity contains the following procedures: (1) Laparoscopic gastric bypass (44.38), (2) gastroenterostomy (44.39), and (3) laparoscopic gastric restrictive procedure (44.95). Laparoscopic gastric restrictive procedure (44.95) refers to the laparoscopic placement of a restrictive band around the stomach to reduce the effective size. By adopting the coding scheme laid out in CR 5477, we are finalizing not only 44.38 and 44.39, but also 44.95, as procedures within the HAC category of surgical site infections following bariatric surgery for obesity. The addition of Laparoscopic gastric restrictive procedure (44.95) more completely and accurately captures the range of surgical site infection following bariatric surgery for obesity as an HAC.

The following chart includes the codes that describe surgical site infection following bariatric surgery for obesity as an HAC:

SURGICAL SITE INFECTION FOLLOWING BARIATRIC SURGERY FOR OBESITY

ICD–9–CM code	Code descriptor
278.01*	Morbid obesity.
	—AND—
998.59	Other postoperative infection.
	—AND—
44.38	Laparoscopic gastroenterostomy.
	—OR—
44.39	Other gastroenterostomy.
	—OR—
44.95	Laparoscopic gastric restrictive procedure.

*As principal diagnosis.

In the FY 2009 IPPS proposed rule, we requested, and received, public comment on additional surgical procedures that would meet the statutory criteria for a surgical site infection HAC.

Comment: A commenter recommended that CMS add surgical site infection following implantation of cardiac devices as an HAC. The commenter noted a recent estimate of approximately 300,000 pacemaker implants performed in 2007.[11] In addition, the commenter referenced that the estimated rate of infection following cardiac device implantation is 4 percent and that the cost to treat each pacemaker infection is approximately $25,000.[12] Further, the commenter cited evidence-based guidelines for preventing these infections.[13 14 15]

[11] Morgan, J.P.: Cardiac Rhythm Management, Market Model, August 31, 2007.

[12] Darouiche, R.O.: Treatment of Infections Associated with Surgical Implants, *New England Journal of Medicine,* 350:1422–9 (2004).

[13] Bratzler, D. *et al.:* Antimicrobial Prophylaxis for Surgery: An Advisory Statement from the National Surgical Infection Prevention Project, *American Journal of Surgery,* 189:395–404 (2005).

[14] Da Costa, A *et al.:* Antibiotic Prophylaxis for Permanent Pacemaker Implantation: A Meta-Analysis, *Circulation*; 97:1796–1801 (1998).

[15] Klug, D. *et al.:* Risk Factors Related to Infection of Implanted Pacemakers and Cardioverter-

Response: We agree with the commenter that surgical site infection following certain cardiac device procedures is a strong candidate HAC. The condition is high cost and high volume, triggers a higher-paying MS–DRG, and may be considered reasonably preventable through the application of evidence-based guidelines. We did not propose this specific condition in the FY 2009 IPPS proposed rule; however, we expect to propose surgical site infection following certain cardiac device procedures, as well as surgical site infections following other types of device procedures, as future candidate HACs.

We are selecting surgical site infections following certain orthopedic procedures, and bariatric surgery for obesity. These procedures will join mediastinitis following coronary artery bypass graft (CABG), which was selected in the FY 2008 IPPS final rule with comment period, as surgical site infection HACs. We look forward to working with stakeholders to identify additional procedures, such as device procedures, in which surgical site infections can be considered reasonably preventable through the application of evidence-based guidelines.

Defibrillators: Results of a Large Prospective Study, *Circulation,* 116:1349–55 (2007).

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Surgical Site Infections:			Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html
- Certain Orthopedic Surgeries	Certain Orthopedic Surgeries • 269 cases • $148,172/hospital stay	Surgical site infection 996.67 (CC) **OR** 998.59 (CC) **AND** Certain Orthopedic Surgeries one of the following procedure codes: (81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85)	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html
- Bariatric Surgery for Obesity	Bariatric Surgery for Obesity • 37 cases • $233,614/hospital stay	*Principal diagnosis of obesity (278.01)* **AND** Surgical Site Infection 998.59 (CC) **AND** Bariatric Surgery (44.38, 44.39, or 44.95)	

c. Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)

In the FY 2009 IPPS proposed rule, we proposed DVT/PE as a candidate HAC. We solicited comments on each of the statutory criteria, with particular focus on the degree to which DVT can be diagnosed on hospital admission and can be considered reasonably preventable. DVT occurs when a blood clot forms in the deep veins of an extremity, usually the leg, and causes pain, swelling, and inflammation. PE occurs when a clot or piece of a clot migrates from its original site to the lungs, causing the death of lung tissue, which can be fatal.

Comment: The majority of commenters emphasized the inability to determine whether DVT was present on admission. The commenters were concerned about the lack of a standard clinical definition and diagnostic criteria, as well as difficulty in identifying at-risk patients. One commenter suggested that nearly half of all DVT/PEs are asymptomatic on admission. One commenter explained that obtaining the most accurate results would require expensive diagnostic testing of all patients, implying that this strategy would not be cost-effective and would, therefore, be unreasonable.

Response: The commenters' concerns about the ability to diagnose DVT do not preclude DVT/PE from being selected as an HAC, as the attending physician determines whether the condition was present on admission (''Y'' POA reporting option) or whether presence on admission cannot be determined based on clinical judgment (''W'' POA reporting option). Hospitals will continue to be paid the higher MS–DRG amount for HACs coded as ''Y'' or ''W'' (we refer readers to section II.F.8. of this preamble).

Comment: Regarding the preventability of DVT/PE, one commenter cited reduction of DVT/PE occurrence through mentoring and onsite consultation as a particularly effective intervention strategy.

Response: We agree that the occurrence of DVT/PE can be significantly reduced through the use of intervention strategies, including mentoring and onsite consultation.

Comment: A large proportion of commenters underscored the importance of considering risk factors in weighing the degree of preventability. Commenters noted that common risk factors, some of which cannot be modified, include clotting disorders, obesity, hypercoagulable state, cancer, HIV, or rheumatoid arthritis.

Response: We agree with commenters that the risk factors of a typical patient are important to consider when weighing the degree of preventability as it applies to DVT/PE (discussion of risk adjustment in section II.F.9. of this preamble). Selecting DVT/PE for these procedures as an HAC will have the positive effect of encouraging attention to risk assessment prior to surgery. Further, conditions such as clotting disorders, obesity, hypercoagulable state, cancer, HIV, and rheumatoid arthritis are CCs or MCCs under the IPPS payment system that, when present on the claim, will continue to trigger the higher-paying MS–DRG. Thus, the usual presence of additional CC/MCCs on claims for these procedures serves as an ''inherent risk adjuster'' to payment for total knee replacement and hip replacement cases.

Comment: Although no commenters submitted quantitative data to establish a rate of preventability, many commenters noted that adherence to evidence-based pharmacologic and nonpharmacologic interventions will not prevent all DVTs. One commenter suggested that DVT/PE should only be considered for the HAC payment provision when a patient did not receive proper prophylaxis.

Response: The fact that prophylaxis will not prevent every occurrence of DVT/PE does not preclude its selection as a reasonably preventable HAC. Further, as discussed in section IV.B. of this preamble, the Reporting Hospital Quality Data for the Annual Payment Update program includes a process of care measure regarding venous thromboembolism (VTE) prophylaxis within 24 hours prior to or after surgery. An analysis of publicly available data on *Hospital Compare* indicates that the national rate for the VTE prophylaxis measure for the third quarter of 2007 is approximately 82 percent.[16] We have concluded from these data that a significant number of patients are not receiving the recommended evidence-based prophylaxis. We further note that the statute does not require that a condition be ''always preventable'' in order to qualify as an HAC, but rather that it be ''reasonably preventable,'' which necessarily implies something less than 100 percent.

Comment: Commenters also noted that, in some cases, anticoagulation prophylaxis may be contraindicated based on individual patient factors, including an increased risk of bleeding in postoperative patients.

Response: We agree with commenters that, in some cases, anticoagulation prophylaxis may be contraindicated. However, we do not view this as precluding the selection of DVT/PE as an HAC, as evidence-based interventions beyond pharmacologic prophylaxis, such as mechanical prophylaxis and early movement, should also be applied.

Comment: Some commenters supported DVT/PE as reasonably preventable through the application of evidence-based guidelines for certain subpopulations, specifically following certain orthopedic procedures.

Response: We agree with commenters that DVT/PE is reasonably preventable in specific subpopulations, and we are therefore selecting DVT/PE following certain orthopedic surgeries, specifically certain hip and knee replacement surgeries, as HACs. Total knee replacement is a surgery performed to replace the entire knee joint with an artificial internal prosthesis because the native knee joint is no longer able to function, because it is very painful, or both, usually due to advanced osteoarthritis, and total hip replacement is the analogous operation involving the hip joint. Our decision may be construed as only applying to the MCC PE, rather than DVT/PE, following certain hip and knee replacement surgeries as HACs because of coding considerations. The MS–DRGs that these procedures typically map to do not currently split based on CCs, and DVT is a CC.

The following chart includes the codes that describe DVT/PE following certain orthopedic surgeries as an HAC:

Selected HAC	Medicare data (FY 2007)	CC/MCC (ICD–9–CM codes)	Selected evidence-based guidelines
Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) —Total Knee Replacement. —Hip Replacement.	• 4,250 cases ..... • $58,625/hospital stay.	*DVT:* 453.40–453.42 (CC) OR *PE:* 415.11 (MCC) or 415.19 (MCC) AND *Total Knee Replacement:* (81.54) OR *Hip Replacement:* (00.85–00.87, 81.51–81.52).	Available on the Web site: *http://www.chestjournal.org/cgi/reprint/126/3_suppl/172S*. Available on the Web site: *http://orthoinfo.aaos.org/topic.cfm?topic=A00219*.

[16] *Hospital Compare* available at the Web site: *http://www.hospitalcompare.hhs.gov*. Reviewed July 8, 2008.

DEEP VEIN THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)

ICD–9–CM codes	Code descriptors
00.85	Resurfacing hip, total, acetabulum and femoral head.
00.86	Resurfacing hip, partial, femoral head.
00.87	Resurfacing hip, partial, acetabulum.
81.51	Total hip replacement.
81.52	Partial hip replacement.
81.54	Total knee replacement.
415.11	Iatrogenic pulmonary embolism and infarction.
415.19	Other pulmonary embolism and infarction—other.
453.40	Venous embolism and thrombosis of unspecified deep vessels of lower extremity.
453.41	Venous embolism and thrombosis of deep vessels of proximal lower extremity.

DEEP VEIN THROMBOSIS (DVT)/PULMONARY EMBOLISM (PE)—Continued

ICD–9–CM codes	Code descriptors
453.42	Venous embolism and thrombosis of deep vessels of distal lower extremity.

d. Delirium

Delirium is a relatively abrupt deterioration in a patient's ability to sustain attention, learn, or reason. Delirium is strongly associated with aging and treatment of illnesses that are associated with hospitalizations. Delirium affects nearly half of hospital patient days for individuals age 65 and older, and approximately three-quarters of elderly individuals in intensive care units have delirium. About 14 to 24 percent of hospitalized elderly individuals have delirium at the time of admission. Having delirium is a very serious risk factor, with 1-year mortality of 35 to 40 percent, a rate as high as those associated with heart attacks and sepsis. The adverse effects of delirium routinely last for months. Delirium is a clinical diagnosis, commonly assisted by screening tests such as the Confusion Assessment Method. The clinician must establish that the onset has been abrupt and that the deficits affect the ability to maintain attention, maintain orderly thinking, and learn from new information. Delirium is substantially under-recognized and is regularly conflated with dementia. Because of the high rate of mortality and incidence noted above, we proposed delirium as a candidate HAC, and provided the following information for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Delirium	• 480 cases • $23,290/hospital stay.	293.1 (CC)	Available on the Web site: *http://www.ahrq.gov/clinic/ptsafety/chap28.htm*.

We solicited comments on each of the statutory criteria, with particular focus on the degree to which delirium can be considered reasonably preventable through the application of evidence-based guidelines.

Comment: Most commenters strongly opposed placing delirium on the HAC list. Citing a study mentioned in the FY 2009 IPPS proposed rule (73 FR 23555), commenters emphasized that the ability to prevent only 30 to 40 percent of all delirium cases through the application of evidence-based guidelines does not, in their opinion, meet that statutory criterion. Many commenters stated that evidence-based guidelines, such as reducing certain medications, reorienting patients, assuring sleep and sensory input, and improving patient nutrition and hydration, were more appropriately used as process rather than outcome measures.

A number of commenters stated that it is difficult to define and diagnose a condition that varies in degree, such as delirium. They stated that symptoms of delirium may be intermittent. In addition, the commenters indicated that it may be difficult to differentiate between delirium and intensive care unit psychosis resulting from pre-admission hypoxia. Many commenters noted that delirium may be caused by many factors unrelated to clinical treatment. For example, commenters stated that delirium is a common symptom in Alzheimer's patients, who are likely to become disoriented in unfamiliar hospital surroundings. One commenter also noted that the diagnosis is difficult to make if a patient is intoxicated.

In addition to those commenters who expressed blanket support for selecting all candidate HACs, a few commenters explicitly supported inclusion of delirium as an HAC. One commenter suggested that delirium resulting from medication error could be reasonably prevented by implementation of computerized physician order entry systems. Another commenter suggested that prevention based on the six factors in the Confusion Assessment Model would improve intake assessment and health care quality.

Response: After consideration of the public comments received, we have decided not to select delirium as an HAC in this final rule. We will continue to monitor the evidence-based guidelines surrounding prevention of delirium. If evidence warrants, we may consider proposing delirium as an HAC in the future. Although we are not selecting delirium as an HAC, we would like to recognize two additional ICD–9–CM codes 292.81 (CC) and 293.0 (CC) that the commenters suggested to identify delirium and note that their input will be taken into account in any future reconsideration.

DELIRIUM

ICD–9–CM codes	Code descriptors
292.81	Drug-induced delirium.
293.0	Delirium due to conditions classified elsewhere.
293.1	Subacute delirium.

e. Ventilator-Associated Pneumonia (VAP)

VAP is a serious hospital-acquired infection associated with high mortality, significantly increased length of stay, and high cost. It is typically caused by the aspiration of contaminated gastric or oropharyngeal secretions. The presence of an endotracheal tube facilitates both the contamination of secretions and aspiration. We presented the following information in the FY 2009 IPPS proposed rule for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Ventilator-Associated Pneumonia (VAP).	• 30,867 cases ..... • $135,795/hospital stay.	997.31 (CC)	Available on the Web site: *http://www.rcjournal.com/cpgs/09.03.0869.html.*

VENTILATOR-ASSOCIATED PNEUMONIA

ICD–9–CM code	Code descriptor
997.31	Ventilator-associated pneumonia.

The CDC recently updated the ICD–9–CM coding guidelines for proper use of code 997.31, which goes into effect on October 1, 2008. The ICD–9–CM Official Coding Guidelines are available at: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpICD9/ftpICD9.htm.*

We solicited comments on each of the statutory criteria, with particular focus on the degree to which evidence-based guidelines can reasonably prevent VAP.

Comment: The majority of commenters addressed whether or not VAP could be considered reasonably preventable through the application of evidence-based guidelines. Citing literature mentioned in the IPPS FY 2009 proposed rule, commenters noted that VAP is only preventable 40 percent of the time, which, in their opinion, does not meet the statutory requirement for reasonably preventable through the application of evidence-based guidelines. (The proposed rule referenced the American Association of Respiratory Care (AARC) Evidence-Based Clinical Practice Guidelines as one example of an existing evidence-based standard designed to prevent VAP.) A few commenters questioned the narrow focus of the AARC's guidelines.

In addition to problems related to its preventability, many commenters also argued that VAP may be difficult to diagnose based on shortfalls associated with clinical definitions and diagnostic tests. The commenters stated that clinical cultures are not predictive for pneumonia, radiographic evidence of pneumonia is difficult to standardize, and vaccines do not protect against infection during the current hospital stay. The commenters pointed out that no standard definition of VAP exists—the definition is constructed of nonspecific clinical signs common to many complications; thus, because of its imprecise definition, selection of VAP as an HAC could be especially susceptible to unintended consequences. One commenter stated that the flexibility inherent to VAP's imprecise definitions coupled with threat of nonpayment created a ''perverse incentive'' to diagnose VAP as another condition. Commenters noted that patient risk factors may also impact the risk of developing VAP. For example, burn patients are especially susceptible to infections.

While some commenters indicated that VAP is a serious condition and could be a good candidate HAC in the future, the many commenters argued that current evidence and technology are not well-enough developed at this time to meet the statutory requirement of reasonably preventable through the application of evidence-based guidelines. One commenter pointed out that the Institute for Healthcare Improvement and the Joint Commission are currently evaluating alternative standards for VAP prevention.

Response: In light of the public comments that we received, we are not selecting VAP as an HAC. We will work in partnership with the CDC and closely monitor the evolving literature addressing the prevention of VAP through the application of evidence-based guidelines. If evidence warrants, we may consider proposing VAP as an HAC in the future.

f. *Staphylococcus aureus* Septicemia

Staphylococcus aureus is a bacterium that lives on multiple anatomic sites in most people. It usually does not cause physical illness, but it can cause a variety of infections ranging from superficial boils to cellulitis to pneumonia to life-threatening bloodstream infections (septicemia). It typically becomes pathogenic by infecting normally sterile tissue through traumatized tissue, such as cuts or abrasions, or at the time of invasive procedures and can be both an early and/or late complication of trauma or surgery. *Staphylococcus aureus* septicemia can also be a late effect of an injury or a surgical procedure. Risk factors for developing *Staphylococcus aureus* septicemia include advanced age, debilitated state, immunocompromised status, and history of an invasive medical procedure.

In the IPPS FY 2009 proposed rule, we presented the following information for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM codes)	Selected evidence-based guidelines
Staphylococcus aureus Septicemia.	• 27,737 cases ..... • $84,976/hospital stay.	038.11(MCC) or 038.12 (MCC) Also excludes the following from acting as CC/MCC: 995.91 (MCC) 995.92 (MCC) 998.59 (CC).	Available on the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_isolation.html.* Available on the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html* (Intravascular catheter-associated *Staphylococcus aureus* Septicemia only).

STAPHYLOCOCCUS AUREUS SEPTICEMIA

ICD–9–CM codes	Code descriptors
038.11	*Staphylococcus aureus* septicemia.
038.12	Methicillin-resistant *Staphylococcus aureus* septicemia.
995.91	Sepsis.

STAPHYLOCOCCUS AUREUS SEPTICEMIA—Continued

ICD–9–CM codes	Code descriptors
995.92	Severe sepsis.
998.59	Other postoperative infection.

We solicited comments on each of the statutory criteria, with particular focus on the degree to which this condition can be considered reasonably preventable through the application of evidence-based guidelines.

Comment: Many commenters described difficulty in determining whether an infection was present upon admission, as the development of

infection while in a hospital may not necessarily indicate that the infection was hospital-acquired. The commenters suggested that *Staphylococcus aureus* septicemia may also result from permanent tunneled and nontunneled catheters used in cancer patients or through dialysis shunts. The commenters asserted that the risk of infection may be higher for different subpopulations of patients.

A large number of commenters suggested that the CDC's guidelines specific to vascular catheter-associated infections do not extend to *Staphylococcus aureus* septicemia generally. However, because the majority of *Staphylococcus aureus* septicemia events are related to catheters and skin lesions, commenters also argued that the previously selected HAC, vascular catheter-associated infections, will already capture the vast majority of preventable *Staphylococcus aureus* septicemia events. According to the commenters, adopting *Staphylococcus aureus* septicemia as an additional condition would yield little quality improvement but could cause expensive and unnecessary treatments for both hospitals and patients.

Response: In light of these public comments, we are not selecting *Staphylococcus aureus* septicemia as an HAC in this final rule. If evidence warrants, we may consider proposing *Staphylococcus aureus* septicemia as an HAC in the future. We note that several commenters recognized that *Staphylococcus aureus* septicemia cases are being addressed through the vascular catheter-associated infection HAC that was selected in the FY 2008 IPPS final rule with comment period.

g. *Clostridium difficile*-Associated Disease (CDAD)

Clostridium difficile is a bacterium that colonizes the gastrointestinal (GI) tract of a certain number of healthy people as well as being present on numerous environmental surfaces. Under conditions where the normal flora of the gastrointestinal tract is altered, *Clostridium difficile* can flourish and release large enough amounts of a toxin to cause severe diarrhea or even life-threatening colitis. Risk factors for CDAD include the prolonged use of broad spectrum antibiotics, gastrointestinal surgery, prolonged nasogastric tube insertion, and repeated enemas. CDAD can be acquired in the hospital or in the community. Its spores can live outside of the body for months and thus can be spread to other patients in the absence of meticulous hand washing by care providers and others who contact the infected patient.

In the IPPS FY 2009 proposed rule, we presented the following information for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Clostridium difficile-Associated Disease (CDAD).	• 96,336 cases ..... • $59,153/hospital stay.	008.45 (CC)	Available on the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_isolation.html*. Available on the Web site: *http://www.cdc.gov/ncidod/dhqp/id_CdiffFAQ_HCP.html#9*.

Clostridium difficile-ASSOCIATED DISEASE

ICD–9–CM code	Code descriptor
008.45	*Clostridium difficile*.

We solicited comments on each of the statutory criteria, with particular focus on the degree to which CDAD can be reasonably prevented through the application of evidence-based guidelines.

Comment: The majority of commenters addressed preventability and the inability to distinguish between community-acquired and hospital-acquired infections without culturing each patient to determine strain or type of infection. The commenters emphasized that CDAD is a known adverse side effect of appropriate broad spectrum antibiotic use. One commenter suggested establishing a unique ICD–9–CM code to identify cases of CDAD that occur other than as a side effect of broad spectrum treatment to distinguish situations of patient-to-patient transmission of *Clostridium difficile* that are more likely to be considered reasonably preventable. Commenters further asserted that the appropriate use of proton pump inhibitors and H2 blockers is also associated with CDAD infections and outbreaks. Many commenters stated that no specific evidence-based prevention guidelines are currently available, rather the CDC guidelines apply to patient-to-patient transmissions generally and do not apply to CDAD specifically. Many commenters addressed the difficulty of distinguishing between community-acquired and hospital-acquired infection as a barrier to adopting CDAD as an HAC.

Response: In light of these public comments, we are not selecting CDAD as an HAC in this final rule. However, we continue to receive strong support from consumers and purchasers to include CDAD as an HAC, and we will continue to consult with the CDC regarding the evidence-based prevention guidelines and coding for CDAD. If evidence warrants, we may consider proposing CDAD as an HAC in the future.

h. Legionnaires' Disease

Legionnaires' Disease is a type of pneumonia caused by the bacterium *Legionella pneumophila*. It is contracted by inhaling contaminated water vapor or droplets. It is not spread person-to-person. The bacterium thrives in warm aquatic environments and infections have been linked to large industrial water systems, including hospital water systems such as air conditioning cooling towers and potable water plumbing systems.

In the FY 2009 IPPS proposed rule, we presented the following information for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Legionnaires' Disease	• 351 cases ..... • $86,014/hospital stay	482.84 (MCC)	Available at the Web site: *http://www.cdc.gov/ncidod/dbmd/diseaseinfo/legionellosis_g.htm*.

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
			Available at the Web site: *http://www.legionella.org/.*

LEGIONNAIRES' DISEASE

ICD–9–CM code	Code descriptor
482.84	Legionnaires' disease.

We requested public comment regarding the applicability of each of the statutory criteria to Legionnaires' Disease, particularly addressing the degree of preventability of this condition through the application of evidence-based guidelines and the degree to which hospital-acquired Legionnaires' Disease can be distinguished from community-acquired cases. We also sought comments on additional water-borne pathogens that would qualify for the HAC provision by meeting the statutory criteria.

Comment: Many commenters noted that Legionnaries' Disease is not a high volume condition and questioned whether it should be prioritized as an HAC. In addition, the commenters emphasized that CDC's Environmental Infection Control Guidelines recognize that the mere presence of the bacterium *Legionella* in the water supply is not necessarily associated with Legionnaires' Disease, and that without evidence of a dose-response relationship, surveillance and treatment is not recommended. The commenters stated that even when decontamination efforts are pursued, there is no guarantee that treatment will ensure *Legionella* can be completely eradicated from hospital water intakes without damaging infrastructures. In addition, many commenters expressed concern regarding the unintended consequence of increasing the use of costly sterile water in hospitals.

When addressing the degree to which hospital-acquired Legionnaires' Disease can be distinguished from community-acquired cases, the commenters noted that the epidemiologic strain causing the disease is widespread in the community.

Response: In light of these public comments, we are not selecting Legionnaires' Disease as an HAC in this final rule. Although we are not selecting Legionnaires' Disease as an HAC in this final rule, we will continue to consult with the CDC about the evidence-based prevention guidelines. If evidence warrants, we may consider Legionnaires' Disease and other water-borne pathogens suggested by commenters and noted in section II.F.9. of this preamble (Enhancement and Future Issues) as HACs in the future.

i. Iatrogenic Pneumothorax

Iatrogenic pneumothorax refers to the accidental introduction of air into the pleural space, which is the space between the lung and the chest wall, by medical treatment or procedure. When air is introduced into this space, it partially or completely collapses the lung. Iatrogenic pneumothorax can occur during any procedure where there is the possibility of air entering the pleural space, including needle biopsy of the lung, thoracentesis, central venous catheter placement, pleural biopsy, tracheostomy, and liver biopsy. Iatrogenic pneumothorax can also occur secondary to positive pressure mechanical ventilation when an air sac in the lung ruptures, allowing air into the pleural space. In the FY 2009 IPPS proposed rule, we presented the following information for consideration:

HAC candidate	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Iatrogenic Pneumothorax	• 22,665 cases ..... • $75,089/hospital stay.	512.1 (CC)	Available at the Web site: *http://www.ncbi.nlm.nih.gov/pubmed/1485006.*

IATROGENIC PNEUMOTHORAX

ICD–9–CM code	Code descriptor
512.1	Iatrogenic pneumothorax.

We solicited public comment on the applicability of each of the statutory criteria to this condition. We were particularly interested in receiving comments on the degree to which iatrogenic pneumothorax could be considered reasonably preventable through the application of evidence-based guidelines.

Comment: Most commenters opposed the selection of iatrogenic pneumothorax as an HAC. They indicated that the evidence-based guidelines often acknowledge that iatrogenic pneumothorax is a known, relatively common risk for certain procedures. Further, with regard to evidence-based guidelines, many commenters opposed designation of this condition as an HAC due to a lack of consensus within the medical community regarding its preventability.[17] Some commenters offered suggestions to exclude certain procedures or situations, including central line placement, thoracotomy, and use of a ventilator, if iatrogenic pneumothorax were to be selected as an HAC.

Response: In light of these public comments, we are not selecting iatrogenic pneumothorax as an HAC in this final rule. Although we are not selecting iatrogenic pneumothorax as an HAC in this final rule, we do recognize this as an adverse event that occurs frequently. We will continue to review the development of evidence-based guidelines for the prevention of iatrogenic pneumothorax. If evidence warrants, we may consider iatrogenic pneumothorax as an HAC in the future.

j. Methicillin-Resistant *Staphylococcus aureus* (MRSA)

In October 2007, the CDC published in the *Journal of the American Medical Association* an article citing high mortality rates from MRSA, an antibiotic-resistant ''superbug.'' The article estimates 19,000 people died from MRSA infections in the United States in 2005. The majority of invasive MRSA cases are health care-related—contracted in hospitals or nursing homes—though community-acquired MRSA also poses a significant public health concern. Hospitals have been focused for years on controlling MRSA through the application of CDC's evidence-based guidelines outlining best practices for combating the bacterium in that setting. In the proposed FY 2009 IPPS rule, we

[17] Accidental Iatrogenic Pneumothorax in Hospitalized Patients. Zhan et al., Medical Care 44(2):182–6, 2006 Feb.

presented the following information for consideration:

Condition	Medicare data (FY 2007)	CC/MCC (ICD–9–CM code)	Selected evidence-based guidelines
Methicillin-resistant Staphylococcus aureus (MRSA) (Code V09.0 includes infections with microorganisms resistant to penicillins).	• 88,374 (V09.0) cases ..... • $32,049/hospital stay.	No CC/MCC	Available at the Web site: *http://www.cdc.gov/ncidod/dhqp/gl_isolation.html.*

During its March 19–20, 2008 meeting, the ICD–9–CM Coordination and Maintenance Committee discussed several new codes to more accurately capture MRSA. The following new codes will be implemented on October 1, 2008:

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS

ICD–9–CM codes	Code descriptors
038.12	Methicillin-resistant *Staphylococcus aureus* septicemia.
041.12	Methicillin-resistant *Staphylococcus aureus* in conditions classified elsewhere and of unspecified site.
482.42	Methicillin-resistant Pneumonia due to *Staphylococcus aureus*.
V02.53	Carrier or suspected carrier of Methicillin-susceptible *Staphylococcal aureus*.
V02.54	Carrier or suspected carrier of Methicillin-resistant *Staphylococcal aureus*.
V12.04	Personal history of Methicillin-resistant *Staphylococcal aureus*.

Though we did not propose MRSA as a candidate HAC in the FY 2009 IPPS proposed rule, MRSA can trigger the HAC payment provision. For every infectious condition selected as an HAC, MRSA could be the etiology of that infection. For example, if MRSA were the cause of a vascular catheter-associated infection (one of the eight conditions selected in the FY 2008 IPPS final rule with comment period), the HAC payment provision would apply to that MRSA infection. As we noted in the FY 2008 IPPS final rule with comment period (72 FR 47212), colonization by MRSA is not a reasonably preventable condition according to the current evidence-based guidelines. Therefore, MRSA does not meet the ''reasonably preventable'' statutory criterion for an HAC.

Comment: The majority of commenters strongly supported the CMS decision not to propose MRSA as an HAC candidate.

Response: We appreciate the support of the commenters and reiterate that MRSA is addressed by the HAC payment provision in situations where it triggers a condition that we have identified as an HAC. We also direct readers to a detailed discussion regarding coding of MRSA in section II.F.10.b. of this preamble. As we noted in the FY 2009 IPPS proposed rule (73 FR 23559), we are pursuing collaborative efforts with other HHS agencies to combat MRSA. The Agency for Healthcare Research and Quality (AHRQ) has launched a new initiative in collaboration with CDC and CMS to identify and suppress the spread of MRSA and related infections. In support of this work, Congress appropriated $5 million to fund research, implementation, management, and evaluation practices that mitigate such infections.

CDC has carried out extensive research on the epidemiology of MRSA and effective techniques that could be used to treat the infection and reduce its spread. The following Web sites contain information that reflect CDC's commitment: (1) *http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html* (health care-associated MRSA); (2) *http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca_public.html* (community-acquired MRSA); (3) *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4908a1.htm;* and (4) *http://www.cdc.gov/handhygiene/.*

AHRQ has made previous investments in systems research to help monitor MRSA and related infections in hospital settings, as reflected in material on its Web sites at: *http://www.guideline.gov/browse/guideline_index.aspx* and *http://www.ahrq.gov/clinic/ptsafety/pdf/ptsafety.pdf.*

8. Present on Admission Indicator Reporting (POA)

Collection of present on admission (POA) indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request (CR) No. 5679 (released June 20, 2007), CMS issued instructions requiring IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims. CMS also issued CR No. 6086 (released June 30, 2008) regarding instructions for processing non-IPPS claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD–9–CM Official Guidelines for Coding and Reporting, available at the CDC Web site: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf* (POA reporting guidelines begin on page 92). Additional information regarding POA indicator reporting and application of the POA reporting options is available at the CMS Web site: *http://www.cms.hhs.gov/HospitalAcqCond.* CMS has historically not provided coding advice, rather we collaborate with the American Hospital Association (AHA) through the *Coding Clinic* for ICD–9–CM. CMS has been collaborating with the AHA to promote the *Coding Clinic* for ICD–9–CM as the source for coding advice about the POA indicator.

There are five POA indicator reporting options, as defined by the ICD–9–CM Official Coding Guidelines:

Indicator	Descriptor
Y	Indicates that the condition was present on admission.

Indicator	Descriptor
W	Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
1	Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD–9–CM diagnosis codes is available in the *ICD–9–CM Official Coding Guidelines.*

In the FY 2009 IPPS proposed rule for the HAC payment provision (73 FR 23559), we proposed to pay the CC/MCC MS–DRGs only for those HACs coded with ''Y'' and ''W'' indicators.

Comment: Commenters overwhelmingly supported payment for both the POA ''Y'' and ''W'' options.

Response: We agree with commenters and are finalizing our proposal to pay for both the POA ''Y'' and ''W'' options. We plan to analyze whether both the ''Y'' and ''W'' indicators are being used appropriately. Medicare program integrity initiatives closely monitor for inaccurate coding and coding that is inconsistent with medical record documentation.

We proposed to not pay the CC/MCC MS–DRGs for HACs coded with the ''N'' indicator.

Comment: Commenters were in favor of not paying for the POA ''N'' indicator option.

Response: We agree with the commenters and are finalizing our proposal to not pay for the POA ''N'' indicator option.

Comment: The majority of commenters opposed not paying for the POA ''U'' indicator option. Commenters expressed that the reporting of the POA indicators is still new, and hospitals continue to learn how to apply them, as well as educate their physicians on the required documentation without which POA reporting is impossible.

Response: Although we recognize that POA indicator reporting is new for some IPPS hospitals, we are finalizing the proposed policy of not paying for the ''U'' option. We believe that this approach will encourage better documentation and will result in more accurate public health data.

We plan to analyze whether both the ''N'' and ''U'' POA reporting options are being used appropriately. The American Health Information Management Association (AHIMA) has promulgated Standards of Ethical Coding that require accurate coding regardless of the payment implications of the diagnoses. That is, diagnoses and POA indicators must be reported accurately on claims regardless of the fact that diagnoses coded with an ''N'' or ''U'' indicator may no longer trigger a higher paying MS–DRG. Medicare program integrity initiatives closely monitor for inaccurate coding and coding inconsistent with medical record documentation.

Although we proposed, and are now finalizing, the policy of not paying the CC/MCC MS–DRGs for HACs coded with the ''U'' indicator, we recognize that there may be some exceptional circumstances under which payment might be made. Death, elopement (leaving against medical advice), and transfers out of a hospital may preclude making an informed determination of whether an HAC was present on admission. We sought public comments on the potential use of patient discharge status codes to identify exceptional circumstances.

Comment: The majority of commenters did not address the patient discharge status codes as an exception for payment when the ''U'' POA indicator is used. The commenters who did address this issue were in favor of using patient discharge status codes as an exception for payment.

Response: We will monitor the extent to which and under what circumstances the ''U'' POA indicator code is used. In the future, we may consider proposing use of the patient discharge status codes to recognize exceptions for payment.

9. Enhancement and Future Issues

In section II.F.9. of the FY 2009 IPPS proposed rule (73 FR 23560), we encouraged the public to provide ideas and models for combating preventable HACs through the application of VBP principles. We note that we are not proposing Medicare policy in this discussion. However, we believe that collaborating with stakeholders to improve the HAC policy is another step toward fulfilling VBP's potential to provide better health care for Medicare beneficiaries.

To stimulate reflection and creativity, we presented several enhancement options, including: (a) Applying risk adjustment to make the HAC payment provision more precise; (b) collecting HAC rates to obtain a more robust longitudinal measure of a hospital's incidence of these conditions; (c) using POA information in various ways to decrease the incidence of preventable HACs; (d) adopting ICD–10 to facilitate more precise identification of HACs; (e) applying the principle of the IPPS HAC payment provision to Medicare payments in other care settings; (f) using CMS' authority to address events on the NQF's list of Serious Reportable Adverse Events; and (g) additional potential candidate HACs, suggested through comment, for future consideration.

a. Risk-Adjustment of Payments Related to HACs

In the FY 2009 IPPS proposed rule, we suggested that payment adjustments made when one of the selected HACs occurs could be made more precise by reflecting various sources and degrees of individual patient or patient population risk. For example, a patient's medical history, current health status (including comorbidities), and severity of illness can affect the expected occurrence of conditions selected as HACs. Rather than not paying any additional amount when a selected HAC occurs during a hospitalization, payment reductions could be related to the expected occurrence of that condition (that is, the less likely the complication, the greater the payment reduction).

In general, most commenters supported the idea of risk-adjusted payments for HACs, noting that proportional payments could reduce the risk of unintended consequences, as compared to the current HAC payment policy, through more equitable treatment of both hospitals and patients. Specifically, a few commenters expressed concern that all-or-nothing payment for HACs may disproportionately impact urban, teaching, and academic hospitals that treat under-served populations. Commenters stated that, because these populations may be at greater risk for HACs, risk-adjusted payments could allow all hospitals to continue treating high-risk populations without being penalized for treating riskier patients.

Commenters proposed addressing patient risk factors on both the individual and population levels. The majority of commenters supported assessing risk at the individual patient level. Although this approach may offer

the most precise risk adjustment, current technology and resources limit the ability to risk adjust at this level, as we discussed in the FY 2009 IPPS proposed rule. Risk adjustment at the subpopulation level, however, could capture and correct for high patient risk related to specific medical conditions. For example, many commenters noted that burn patients in particular are at high risk for some of the selected HACs, including infections. Other high-risk patient populations mentioned by commenters included trauma, immunosuppressed, and palliative care patients.

Other commenters emphasized that for certain HACs, risk adjustment strategies would not be appropriate. Commenters stated that payments for ''never events,'' such as retention of a foreign object after surgery, air embolism, and blood incompatibility, should never be adjusted for risk because such occurrences can be considered absolutely preventable.

b. Rate-Based Measurement of HACs

In the FY 2009 IPPS proposed rule, we suggested that a hospital's rates of HACs could be included as a measurement domain within each hospital's total performance score under a pay-for-performance model like the Medicare Hospital Value-Based Purchasing Plan. (We refer readers to section IV.C. of this preamble for a discussion of the Plan.) We asserted that measurement of rates over time could be a more meaningful, actionable, and fair way to adjust a hospital's MS–DRG payments for the incidence of HACs. The consequence of a higher incidence of measured conditions would be a lower VBP incentive payment, while public reporting of the measured rates of HACs would give hospitals an additional, nonfinancial incentive to prevent occurrence of the conditions.

The majority of commenters preferred a standardized framework for rate-based measurement and VBP payment implications for HACs, as opposed to not being paid the higher MS–DRG amount. Many commenters suggested determining expected rates of HACs and using those expected rates as benchmark targets for comparison, rewarding providers who stay at or below benchmark, while decreasing payment for those who exceed the benchmark.

Though the majority of commenters supported rate-based measurement of HACs, some commenters raised issues. A number of commenters noted that the extremely low incidence of ''never events'' could preclude meaningful rate-based measurement of the occurrence of those events. Other commenters opposed public reporting of the rates as a nonfinancial VBP incentive.

c. Use of POA Information

In the FY 2009 IPPS proposed rule, we asserted that POA data could be used to better understand and prevent the occurrence of HACs. Medicare data could be analyzed separately or in combination with private sector or State POA data, which are currently available in certain States. Health services researchers could use these data in a variety of ways to assess the incidence of HACs and to identify best practices for HAC prevention. In addition, publicly reported POA data could also be used to support better health care decision making by Medicare beneficiaries, as well as other health care consumers, professionals, and caregivers.

Commenters addressed various uses of POA data, including informing risk adjustment, making benchmark comparisons between and within hospitals, and public reporting. Commenters noted that POA data have important applications to risk adjustment for quality measurement. In the absence of risk adjustment mechanisms, one commenter suggested that CMS expand POA codes beyond those discussed in section II.F.8. of the preamble of the proposed rule to include a code that would preclude reduced payment if the provider attests that ''the HAC is believed to be the result of a natural disease process/severe patient condition and is not believed to be indicative of the level of the quality of care provided.'' Nearly all commenters addressing the use of POA data urged CMS to provide hospitals with timely feedback of POA information. Specifically, many commenters wanted CMS to provide each hospital with its POA rates and comparisons to peer hospitals.

Commenters' responses to publicly reporting POA data were mixed. A large number of commenters opposed public reporting of POA data, arguing that only measures endorsed by the NQF and adopted by the HQA should be considered for public reporting. A few commenters voiced concern that public reporting would discourage hospitals from accurately reporting POA data. A few commenters suggested a phased-in public reporting timeline for POA data, allowing hospital data to remain confidential for a period while hospitals adjust to new coding and reporting requirements. Nearly all commenters stated that, if POA data were to be publicly reported, the data should be posted on *Hospital Compare*.

d. Transition to ICD–10

In the FY 2009 IPPS proposed rule, we suggested that adopting ICD–10 codes to replace the outdated, vague codes of ICD–9–CM would allow CMS to capture more accurate and precise information about HACs.[18] Noting that the current ICD–9–CM codes are over three decades old, we proposed that ICD–10 codes more precisely capture information using current medical terminology. For example, ICD–9–CM codes for pressure ulcers do not provide information about the size, depth, or exact location of the ulcer, while ICD–10 has 125 codes to capture this information.

A number of commenters supported the adoption of ICD–10. Many of the commenters pointed out that the adoption of ICD–10 would facilitate more precise identification of HACs. Several commenters supported the adoption of ICD–10 with an appropriate 2-year transition period. Commenters stated that they have known since the 1990's that the ICD–9–CM coding structure was reaching its limits, and it was becoming increasingly difficult to identify new technologies that are commonly used in today's medical practices. The commenters stated that there is a critical need to move in a timely manner to CM and ICD–10–PCS because hospitals would have the ability to capture data more accurately, thus providing higher quality and more accurate data for reporting. Commenters urged the implementation of ICD–10 to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions and care provided. Commenters asserted that this would allow the nation to better measure quality, implement value-based purchasing, identify hospital-acquired conditions, and continue to refine a prospective payment system that improves recognition of variances in severity of illness.

One commenter expressed concern about the benefit of moving to ICD–10 and believed that its benefit in the outpatient setting had not been demonstrated. The commenter expressed concern about the cost of moving to a new coding system with the need to update software and redraft policies.

[18] In the FY 2009 IPPS proposed rule, there is a typographical error such that the rule refers to ICD–10–PCS (procedure codes) rather than ICD–10 (diagnosis codes).

e. Healthcare-Associated Conditions in Other Payment Settings

In the FY 2009 IPPS proposed rule, we suggested that the broad principle of Medicare not paying for preventable healthcare-associated conditions could potentially be applied in Medicare payment settings beyond IPPS hospitals, including for example, hospital outpatient departments, SNFs, and physician practices. Although the implementation would be different for each setting, alignment of incentives across settings of care is an important goal for all of CMS' VBP initiatives. To stimulate public input, we have included a discussion in several Medicare payment regulations regarding application of the broad principle of Medicare not paying for preventable healthcare-associated conditions in payment settings beyond IPPS. The discussion was included in the following regulations: FY 2009 IRF proposed rule (73 FR 22688), the CY 2009 OPPS/ASC proposed rule (73 FR 41547), the FY 2009 SNF proposed rule (73 FR 25932), and the FY 2009 LTCH final rule (73 FR 26829).

Commenters' reaction to the notion of applying the IPPS HAC payment provision to other settings was mixed. A number of commenters recognized that this use of payment incentives could promote better continuity of care (including documentation) and a reduction in avoidable readmissions. Commenters noted that aligned payment incentives would force pre- and post-acute care settings to share accountability for preventing healthcare-associated conditions. One commenter who supported expanding the policy to nursing homes suggested that CMS consider including dehydration measures for nonpayment in that setting.

While many commenters recognized potential benefits, many other commenters raised concerns or opposed implementing the IPPS HAC payment provision in other settings. Generally, commenters who were opposed to expanding the policy's reach believed that doing so would be premature until CMS assesses the impacts of the policy in the IPPS setting. Commenters also raised concerns about applying the policy in particular settings. For example, many commenters stated that Medicare payment for the physician setting is extremely different from that of the IPPS setting and that attribution issues in particular would make the policy difficult to accurately and fairly implement.

Commenters suggested that, if CMS did implement a similar policy in the physician setting, the agency should ensure that the policy does not create disincentives for treating high-risk patients. From the long-term care perspective, one commenter noted that the risk of an adverse event occurring increases with the duration of the stay and so such a policy would be particularly concerning for LTCHs.

f. Relationship to NQF's Serious Reportable Adverse Events

In the FY 2009 IPPS proposed rule, we discussed how CMS has applied its authority to address the events on the NQF's list of Serious Reportable Adverse Events (also known as ''never events''). We have adopted a number of items from the NQF's list of events as HACs. However, we also discussed that the HAC payment provision is not ideally suited to address every condition on the NQF's list.

Commenters unanimously asserted that CMS should not pay for never events. However, many commenters were concerned about the widespread misperception that HACs are never events, which can be considered absolutely preventable. Commenters urged CMS to explicitly differentiate its ''reasonably preventable'' HACs from the ''never events'' on the NQF's list of Serious Reportable Adverse Events.

Commenters suggested alternatives to Medicare's existing authority under the HAC provision to address never events. One commenter suggested that no higher CC/MCC MS–DRG payment should be made for claims including a selected HAC if that HAC overlaps with a never event. This would preclude a higher MS–DRG payment regardless of whether any other CC/MCCs that would otherwise trigger a higher MS–DRG payment are present on the claim.

g. Additional Potential Candidate HACs, Suggested Through Comment

We received the following suggestions of potential candidates for the HAC payment provision:

- Surgical site infection following device procedures
- Failure to rescue
- Death or disability associated with drugs, devices, or biologics
- Events on the NQF's list of Serious Reportable Adverse Events, not previously addressed by the HAC payment provision
- Dehydration
- Malnutrition
- Water-borne pathogens, not previously addressed by the HAC payment provision.

We reiterate that we are not making policy in this subsection; rather, we are providing a summary of the comments. We would like to thank commenters for the thoughtful comments received, and we will take this input into consideration as we develop any future regulatory and/or legislative proposals to refine and enhance the HAC payment provision.

10 HAC Coding

This HAC coding section addresses additional coding issues that were raised by commenters regarding the selected and candidate HACs.

a. Foreign Object Retained After Surgery

Comment: One commenter requested that CMS provide technical guidance on how to address certain situations related to retained foreign objects. According to the commenter, in certain circumstances, it may be in the best interest of the patient not to remove the object. For example, the commenter stated that leaving a patient under anesthesia for a prolonged period of time and displacing internal organs in search of a surgical object left in the body may be more harmful than leaving the object inside the patient and completing a surgery in an expedited fashion. The commenter suggested that CMS clearly specify that the policy applies to an unintended retention of a foreign object, to allow physicians to exercise clinical judgment regarding the relative risk of leaving an object versus removing it.

Response: We believe that ICD–9–CM codes 998.4 and 998.7 clearly describe the application of the HAC provision to a foreign body ''inadvertently'' or ''accidentally'' left in a patient during a procedure.

b. MRSA

Comment: Commenters raised issues regarding the MRSA coding. One commenter stated that the recent addition of unique MRSA ICD–9–CM codes will allow for improved tracking of MRSA infections and will complement the surveillance efforts underway at the CDC and the AHRQ. The commenter stated that the creation of new MRSA-specific codes will generate better data on which to base important MRSA prevention and management policy decisions, and will allow the health care community to more effectively address this growing public health problem. The commenter stated that CMS could reflect the increased utilization of resources associated with MRSA diagnoses by making CC/MCC classifications for the following three MRSA codes: Code 038.12 (Methicillin-resistant *Staphylococcus aureus* septicemia—MCC); code 482.42 (Methicillin-resistant

pneumonia due to *Staphylococcus aureus*—MCC); and code 041.12 (Methicillin-resistant *Staphylococcus aureus* in conditions classified elsewhere and of unspecified site—CC).

As justification for this request, the commenter pointed out that the predecessor codes for 038.12 and 482.42 are MCCs. The predecessor code for 038.12 is 038.11 (*Staphylococcus aureus* septicemia), which is an MCC. The predecessor code for 482.42 is 482.41 (Pneumonia due to *Staphylococcus aureus*), which is also an MCC.

The commenter's justification for making 041.12 a CC is not based on the predecessor code's CC/MCC assignment. The commenter acknowledged the predecessor code, 041.11 (*Staphylococcus aureus*) is a non-CC. The commenter reviewed data provided in the development of the original CC/MCC classifications for the MS–DRGs and acknowledged that the data did not clearly support making predecessor code 041.11 a CC. The commenter also recognized that clinical judgment was also used in deciding the non-CC/CC/MCC classification of each diagnosis code. Given CMS' use of both data and clinical evaluation, the commenter stated that code 041.11 ''captures many minor and routine bacterial infections that are relatively simple and inexpensive to treat—in other words, diagnoses that do not lead to substantially increased use of hospital resources.'' Therefore, the commenter found it understandable that the predecessor code, 041.11, was classified as a non-CC.

However, the commenter believed that the new MRSA specific code, 041.12, will allow differentiation between MRSA and other infections and will likely show that these MRSA infections are significantly more difficult and expensive to treat. Therefore, the commenter requested that code 041.12 be classified as a CC.

Response: The final CC/MCC classifications for new ICD–9–CM diagnosis codes are shown in Table 6A of the Addendum to this final rule. This table shows that we have classified codes 038.12 (Methicillin-resistant *Staphylococcus aureus* septicemia) and 482.42 (Methicillin-resistant pneumonia due to *Staphylococcus aureus*) as MCCs. We agree that, based on the predecessor code and our clinical evaluation, this MCC classification is warranted.

We disagree with classifying code 041.12 (Methicillin-resistant *Staphylococcus aureus* in conditions classified elsewhere and of unspecified site) as a CC. As is shown in Table 6A, we have classified this code as a non-CC. We agree with the commenter that the predecessor code was a non-CC. However, we also point out that all codes in the 041.00–041.9 category of bacterial infection in conditions classified elsewhere and of unspecified site are non-CCs. All of the codes in this category are used as an additional code to identify a bacterial agent in diseases that are classified by another more precise code. For instance, if a patient has a MRSA urinary tract infection or infected toenail, one would assign a code for the specific type and location of the infection (for example, urinary tract infection or infected toenail bed) and an additional code to fully describe the bacterial agent, such as MRSA. The CC/MCC classification would be determined by the more precise infection code (for example, urinary tract infection or infected toenail bed).

We do not believe it is appropriate to change the CC/MCC classification of one of the codes in the category of bacterial infection in conditions classified elsewhere and of unspecified site to a CC while leaving all of the others as non-CCs. Further, we believe it is more appropriate to assign a CC/MCC classification based on the more precise description of the patient's infection such as pneumonia, septicemia, or nail bed infection. Therefore, we have made code 041.12 a non-CC, as shown in Table 6A of the Addendum to this final rule.

c. POA

Comment: Commenters raised issues regarding the timing of laboratory testing (receiving results in 48–72 hours) and the effect this may have on the POA indicator reported for the HAC candidates proposed, such as *Staphylococcus aureus* septicemia and CDAD. The commenters expressed concern that when a lab test including cultures is performed upon admission, the results may not be available until 48–72 hours later. The commenters were not clear on how the POA indicator would be applied in this scenario.

Response: We acknowledge the commenter's concerns regarding correct assignment of the POA indicator when lab tests are involved. We refer the reader to the ICD–9–CM Official Guidelines for Coding and Reporting, Appendix I, Present on Admission Reporting Guidelines. These guidelines have been updated to address the issue of timeframe for POA identification and documentation. The updated guidelines recognize that in some clinical situations it may take a period of time after admission before a definitive diagnosis can be made. Determination of whether the condition was present on admission will be based on the applicable POA guidelines or on the physician's best clinical judgment. The guidelines address several scenarios, including those with infections and organisms, and how to assign the POA indicator. We also note that in this final rule we decided not to select at this time the proposed HAC cited by the commenter, *Staphylococcus aureus* septicemia, as an HAC.

11. HACs Selected for Implementation on October 1, 2008

The following table sets out a complete list of the HACs selected for implementation on October 1, 2008 in this final rule and in the FY 2008 IPPS final rule with comment period:

HAC	CC/MCC (ICD–9–CM codes)
Foreign Object Retained After Surgery	998.4 (CC)
	998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC)
	707.24 (MCC)
Falls and Trauma:	Codes within these ranges on the CC/MCC list:
—Fracture	800–829
—Dislocation	830–839
—Intracranial Injury	850–854
—Crushing Injury	925–929
—Burn	940–949

HAC	CC/MCC (ICD–9–CM codes)
—Electric Shock	991–994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10–250.13 (MCC) 250.20–250.23 (MCC) 251.0 (CC) 249.10–249.11 (MCC) 249.20–249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG).	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01–81.08, 81.23–81.24, 81.31–81.83, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis*—278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures.	415.11 (MCC) 415.19 (MCC) 453.40–453.42 (MCC) And one of the following procedure codes: 00.85–00.87, 81.51–81.52, or 81.54

G. Changes to Specific MS–DRG Classifications

1. Pre-MDCs: Artificial Heart Devices

Heart failure affects more than 5 million patients in the United States with 550,000 new cases each year, and causes more than 55,000 deaths annually. It is a progressive disease that is medically managed at all stages, but over time leads to continued deterioration of the heart's ability to pump sufficient amounts of adequately oxygenated blood throughout the body. When medical management becomes inadequate to continue to support the patient, the patient's heart failure would be considered to be the end stage of the disease. At this point, the only remaining treatment options are a heart transplant or mechanical circulatory support. A device termed an artificial heart has been used only for severe failure of both the right and left ventricles, also known as biventricular failure. Relatively small numbers of patients suffer from biventricular failure, but the exact numbers are unknown. There are about 4,000 patients approved and waiting to receive heart transplants in the United States at any given time, but only about 2,000 hearts per year are transplanted due to a scarcity of donated organs. There are a number of mechanical devices that may be used to support the ventricles of a failing heart on either a temporary or permanent basis. When it is apparent that a patient will require long-term support, a ventricular support device is generally implanted and may be considered either as a bridge to recovery or a bridge to transplantation. Sometimes a patient's prognosis is uncertain, and with device support the native heart may recover its function. However, when recovery is not likely, the patient may qualify as a transplant candidate and require mechanical circulatory support until a donor heart becomes available. This type of support is commonly supplied by ventricular assist devices (VADs), which are surgically attached to the native ventricles but do not replace them.

Devices commonly called artificial hearts are biventricular heart replacement systems that differ from VADs in that a substantial part of the native heart, including both ventricles, is removed. When the heart remains intact, it remains possible for the native heart to recover its function after being assisted by a VAD. However, because the artificial heart device requires the resection of the ventricles, the native heart is no longer intact and such recovery is not possible. The designation ''artificial heart'' is somewhat of a misnomer because some portion of the native heart remains and there is no current mechanical device that fully replaces all four chambers of the heart. Over time, better descriptive language for these devices may be adopted.

In 1986, CMS made a determination that the use of artificial hearts was not covered under the Medicare program. To conform to that decision, we placed ICD–9–CM procedure code 37.52 (Implantation of total replacement heart system) on the GROUPER program's MCE in the noncovered procedure list.

On August 1, 2007, CMS began a national coverage determination process for artificial hearts. SynCardia Systems, Inc. submitted a request for reconsideration of the longstanding noncoverage policy when its device, the CardioWest™ Temporary Total Artificial Heart (TAH–t) System, is used for ''bridge to transplantation'' in accordance with the FDA-labeled indication for the device. ''Bridge to transplantation'' is a phrase meaning

that a patient in end-stage heart failure may qualify as a heart transplant candidate, but will require mechanical circulatory support until a donor heart becomes available. The CardioWest™ TAH–t System is indicated for use as a bridge to transplantation in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The system is intended for use inside the hospital as the patient awaits a donor heart. The ultimate desired outcome for insertion of the TAH–t is a successful heart transplant, along with the potential that offers for cure from heart failure.

CMS determined that a broader analysis of artificial heart coverage was deemed appropriate, as another manufacturer, Abiomed, Inc., has developed an artificial heart device, AbioCor® Implantable Replacement Heart Device, with different indications. SynCardia Systems, Inc. has received approval of its device from the FDA for humanitarian use as destination therapy for patients in end-stage biventricular failure who cannot qualify as transplant candidates. The AbioCor® Implantable Replacement Heart Device is indicated for use in severe biventricular end-stage heart disease patients who are not cardiac transplant candidates and who are less than 75 years old, who require multiple inotropic support, who are not treatable by VAD destination therapy, and who cannot be weaned from biventricular support if they are on such support. The desired outcome for this device is prolongation of life and discharge to home.

On February 1, 2008, CMS published a proposed coverage decision memorandum for artificial hearts which stated, in part, that while the evidence is inadequate to conclude that the use of an artificial heart is reasonable and necessary for Medicare beneficiaries, the evidence is promising for the uses of artificial heart devices as described above. CMS supports additional research for these devices, and therefore proposed that the artificial heart will be covered by Medicare when performed under the auspices of a clinical study. The study must meet all of the criteria listed in the proposed decision memorandum. This proposed coverage decision memorandum may be found on the CMS Web site at: *http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=211*.

Following consideration of the public comments received, CMS made a final decision to cover artificial heart devices for Medicare beneficiaries under ''Coverage with Evidence Development'' when beneficiaries are enrolled in a clinical study that meets all of the criteria set forth by CMS. These criteria can be found in the final decision memorandum on the CMS Web site at: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=211*. The effective date of this decision was May 1, 2008.

The topic of coding of artificial heart devices was discussed at the September 27–28, 2007 ICD–9–CM Coordination and Maintenance Committee meeting held at CMS in Baltimore, MD. We note that this topic was placed on the Committee's agenda because any proposed changes to the ICD–9–CM coding system must be discussed at a Committee meeting, with opportunity for comment from the public. At the September 2007 Committee meeting, the Committee accepted oral comments from participants and encouraged attendees or anyone with an interest in the topic to comment on proposed changes to the code, inclusion terms, or exclusion terms. We accepted written comments until October 12, 2007. As a result of discussion and comment from the Committee meeting, the Committee revised the title of procedure code 37.52 for artificial hearts to read ''Implantation of internal biventricular heart replacement system'' with an inclusion note specifying that this is the code for an artificial heart. This code can be found in Table 6F, Revised Procedure Code Titles, in the Addendum to this final rule. In addition, the Committee created new code 37.55 (Removal of internal biventricular heart replacement system) to identify explantation of the artificial heart prior to heart transplantation. This code can be found in Table 6B, New Procedure Codes, in the Addendum to this final rule.

To make conforming changes to the IPPS system with regard to the proposed revision to the coverage decision for artificial hearts, in the FY 2009 IPPS proposed rule (73 FR 23563), we proposed to remove procedure code 37.52 from MS–DRG 215 (Other Heart Assist System Implant) and assign it to MS–DRG 001 (Heart Transplant or Implant of Heart Assist System with Major Comorbidity or Complication (MCC)) and MS–DRG 002 (Heart Transplant or Implant of Heart Assist System without Major Comorbidity or Complication (MCC)). In addition, we proposed to remove procedure code 37.52 from the MCE ''Non-Covered Procedure'' edit and assign it to the ''Limited Coverage'' edit. In addition, we proposed to include in this edit the requirement that ICD–9–CM diagnosis code V70.7 (Examination of participant in clinical trial) also be present on the claim. We proposed that claims submitted without both procedure code 37.52 and diagnosis code V70.7 would be denied because they would not be in compliance with the proposed coverage policy.

Comment: Commenters supported CMS' proposal to remove procedure code 37.52 from MS–DRG 215 and reassign it to MS–DRGs 001 and 002. We did not receive any public comments regarding the corresponding change to the MCE.

Response: We appreciate the commenters' support.

Comment: One commenter suggested that CMS create a new MS–DRG combining all implantable heart assist devices to ensure that the proposed changes to cost centers reflect both LVAD device costs and implantable artificial hearts. The commenter suggested that if CMS were unwilling to create an MS–DRG combining all the implantable heart assist devices, an acceptable alternative would be to assign all ventricular assist devices identified by ICD–9–CM procedure code 37.66 (Insertion of implantable heart assist system) into MS–DRG 001, irrespective of the absence of a secondary diagnosis code determined to be an MCC.

Response: We believe that we have already appropriately created MS–DRGs combining heart transplantation, heart assist devices, and other VAD device insertion in MS–DRGs 001 and 002. As the coverage decision for artificial hearts has only become effective May 1, 2008, CMS has no data to suggest that the cost centers will not adequately reflect the cost of all implantable heart devices. We also point out that change to the structure of the MS–DRGs is most appropriately discussed in the proposed rule, so that the public has a chance to review the proposal and comment on it as it affects a facility or medical practice.

With regard to the alternative suggestion of assigning all VADs to MS–DRG 001, irrespective of the presence of an MCC, we point out that when the MS–DRGs were originally created for use beginning FY 2008, the data suggested the appropriateness of separating the patients based on their severity as determined by the presence of an MCC or a CC. We do not have convincing evidence that hospitals are not being adequately reimbursed for the VAD procedures. Therefore, we are not adopting this suggestion.

After consideration of the public comments received, in this final rule, we are assigning code 37.52 (now titled ''Implantation of total internal biventricular heart replacement system'') to MS–DRGs 001 and 002, as

proposed. In addition, we are removing code 37.52 from the ''Non-Covered Procedure'' edit and assign it to the ''Limited Coverage'' edit. This means that implantation of an artificial heart in a Medicare beneficiary will be covered when the implanting facility has met the criteria as set forth by CMS. In addition, both procedure code 37.52 and diagnosis code V07.7 must be present on the claim in order for the claim to be considered a covered Medicare service.

To reiterate, during FY 2008, we made mid-year changes to portions of the GROUPER program not affecting MS–DRG assignment or ICD–9–CM coding. However, as the final coverage decision memorandum for artificial hearts was published after the CMS contractor's testing and release of the mid-year product, changes to the MCE included in the proposed rule were not included in that revision of the GROUPER Version 25.0. GROUPER Version 26.0, which will be in use for FY 2009, contains the final changes that we are adopting in this final rule. The edits in the MCE Version 25.0 will be effective retroactive to May 1, 2008. (To reduce confusion, we note that the version number of the MCE is one digit lower than the current GROUPER version number; that is, Version 26.0 of the GROUPER uses Version 25.0 of the MCE.)

2. MDC 1 (Diseases and Disorders of the Nervous System)

a. Transferred Stroke Patients Receiving Tissue Plasminogen Activator (tPA)

In 1996, the FDA approved the use of tissue plasminogen activator (tPA), one type of thrombolytic agent that dissolves blood clots. In 1998, the ICD–9–CM Coordination and Maintenance Committee created code 99.10 (Injection or infusion of thrombolytic agent) in order to be able to uniquely identify the administration of these agents. Studies have shown that tPA can be effective in reducing the amount of damage the brain sustains during an ischemic stroke, which is caused by blood clots that block blood flow to the brain. tPA is approved for patients who have blood clots in the brain, but not for patients who have a bleeding or hemorrhagic stroke. Thrombolytic therapy has been shown to be most effective when used within the first 3 hours after the onset of an embolic stroke, but it is contraindicated in hemorrhagic strokes.

For FY 2006, we modified the structure of CMS DRGs 14 (Intracranial Hemorrhage or Cerebral Infarction) and 15 (Nonspecific CVA and Precerebral Occlusion without Infarction) by removing the diagnostic ischemic (embolic) stroke codes. We created a new CMS DRG 559 (Acute Ischemic Stroke with Use of Thrombolytic Agent) which increased reimbursement for patients who sustained an ischemic or embolic stroke and who also had administration of tPA. The intent of this DRG was not to award higher payment for a specific drug, but to recognize the need for better overall care for this group of patients. Even though tPA is indicated only for a small proportion of stroke patients, that is, those patients experiencing ischemic strokes treated within 3 hours of the onset of symptoms, our data suggested that there was a sufficient quantity of patients to support the DRG change. While our goal is to make payment relate more closely to resource use, we also note that use of tPA in a carefully selected patient population may lead to better outcomes and overall care and may lessen the need for postacute care.

For FY 2008, with the adoption of MS–DRGs, CMS DRG 559 became MS–DRGs 061 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC), 062 (Acute Ischemic Stroke with Use of Thrombolytic Agent with CC), and 063 (Acute Ischemic Stroke with Use of Thrombolytic Agent without CC/MCC). Stroke cases in which no thrombolytic agent was administered were grouped to MS–DRGs 064 (Intracranial Hemorrhage or Cerebral Infarction with MCC), 065 (Intracranial Hemorrhage or Cerebral Infarction with CC), or 066 (Intracranial Hemorrhage or Cerebral Infarction without CC/MCC). The MS–DRGs that reflect use of a thrombolytic agent, that is, MS–DRGs 061, 062, and 063, have higher relative weights than the hemorrhagic or cerebral infarction MS–DRGs 064, 065, and 066.

The American Society of Interventional and Therapeutic Neuroradiology (ASITN) (now the Society of NeuroInterventional Surgery (SNIS)) and the American Academy of Neurology Professional Association (AANPA) have made us aware of a treatment issue that is of concern to the stroke provider's community. In some instances, patients suffering an embolytic or thrombolytic stroke are evaluated and given tPA in a community hospital's emergency department, and then are transferred to a larger facility's stroke center that is able to provide the level of services required by the increased severity of these cases. The facility providing the administration of tPA in its emergency department does not realize increased reimbursement, as the patient is often transferred as soon a possible to a stroke center. The facility to which the patient is transferred does not realize increased reimbursement, as the tPA was not administered there. The ASITN/SNIS requested that CMS give permission to code the administration of tPA as if it had been given in the receiving facility. This would result in the receiving facility being paid the higher weighted MS–DRGs 061, 062, or 063 instead of MS–DRGs 064, 065, or 066. The ASITN/SNIS's rationale was that the patients who received tPA in another facility (even though administration of tPA may have alleviated some of the worst consequences of their strokes) are still extremely compromised and require increased health care services that are much more resource consumptive than patients with less severe types of stroke. We have advised the ASITN/SNIS that hospitals may not report services that were not performed in their facility.

We recognize that the ASITN/SNIS's concerns potentially have merit but the quantification of the increased resource consumption of these patients is not currently possible in the existing ICD–9–CM coding system. Without specific length of stay and average charges data, we are unable to determine an appropriate MS–DRG for these cases. Therefore, we advised the ASITN/SNIS and AANAP to present a request at the diagnostic portion of the ICD–9–CM Coordination and Maintenance Committee meeting on March 20, 2008, for creation of a code that would recognize the fact that the patient had received a thrombolytic agent for treatment of the current stroke. In the proposed rule, we indicated that if this request was presented at the March 20, 2008 meeting, it could not be approved in time to be published as a new code in Table 6A in the proposed rule. However, we indicated that if a diagnosis code was created by the National Centers for Health Statistics as a result of that meeting, it would be added to the list of codes published in the FY 2009 IPPS final rule effective on October 1, 2008. With such information appearing on subsequent claims, we will have a better idea of how to classify these cases within the MS–DRGs. Therefore, because we did not have data to identify these patients at the time we issued the FY 2009 IPPS proposed rule, we did not propose an MS–DRG modification for the stroke patients receiving tPA in one facility prior to being transferred to another facility.

The AANPA did make such a request at the Coordination and Maintenance Committee Meeting on March 20, 2008, which resulted in the creation of code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility). This code can be found

on Table 6A in the Addendum to this final rule.

Comment: All of the commenters approved the creation of a V-code to identify patients who had tPA administered at another hospital but were then transferred to a tertiary facility with the specialized stroke center resources to provide optimal patient care throughout the patient's entire hospital stay. According to two of the commenters, the description of patients who receive intravenous tPA administration at one facility but are then transferred to a tertiary hospital's stroke center are commonly referred to in the health care industry as ''drip and ship''.

The commenters agreed with CMS' suggestion to recognize these patients by specific diagnostic coding, and suggested that CMS gather data in order to appropriately categorize these patients in the MS–DRG system. One commenter specifically suggested that data be collected via the new diagnostic code in FY 2009 with a view toward establishing a new MS–DRG or set of MS–DRGs in FY 2010.

Response: We appreciate the support from the industry regarding creation of a unique code and subsequent data gathering. We believe that the transferred patients who have received tPA are a unique category of patients, but without precise and evidentiary data, we are not able yet to evaluate whether a modification of the structure of the MS–DRG system concerning these stroke patients is warranted. We will continue to examine these cases and the broad category of stroke DRGs in our upcoming reviews of revisions to the MS–DRG classifications that may be warranted.

Comment: One commenter disagreed with CMS' suggestion that a new diagnostic code be approved and used to identify ''drip and ship'' cases. The commenter believed that CMS may not be able to identify this patient population based on the restriction of the CMS claims processing system. The commenter encouraged CMS to update the claims processing systems to accept the reporting of more than eight secondary diagnosis codes per claim.

Response: We believe that the commenter has misunderstood our statement in the proposed rule (73 FR 23563 and 23564). We stated: ''* * * the quantification of the increased resource consumption of these patients is not currently possible in the existing ICD–9–CM coding system. Without specific length of stay and average charge data, we are unable to determine an appropriate MS–DRG for these cases.'' This statement was made in the context of describing the need for a specific code describing patients to whom tPA had been administered in another setting and who then were transferred to a tertiary care hospital. We did not intend to open the CMS claims processing system for discussion of possible changes.

There are currently six stroke MS–DRGs as described above, with MS–DRGs 061, 062, and 063 identifying cases of acute ischemic stroke with use of thrombolytic agents, by severity, and MS–DRGs 064, 065, and 066 identifying cases of intracranial hemorrhage or cerebral infarction, again divided by severity as determined by the presence of an MCC, a CC, or neither a CC or an MCC. We believe to arbitrarily assign the ''drip and ship'' cases to any one of these six DRGs is capricious and lacks objectivity. Further, in the interest of longitudinal data, we point out that epidemiologists will be able to gather their statistics more logically if we ultimately assign the cases to the most appropriate MS–DRG(s) after it has been proven that the patients consume a certain level of resources during their inpatient hospital course of treatment.

Comment: One commenter encouraged CMS to assign all patients receiving tPA in a transferring hospital to the categorization of those patients in MS–DRGs 061, 062, and 063 at the receiving hospital as ''the payment rate for these transferred patients should be the same as for patients treated with tPA in the admitting hospital because the remainder of the care is the same. The commenter believed that establishment of a separate code should not be a prerequisite to including these cases in MS–DRGs 061, 062, and 063 if CMS would allow hospitals to code the administration of tPA as if it had occurred at the receiving hospital until such time as a new code is established.

Response: The new diagnostic code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) has been established, and will be implemented for FY 2009 for those patients who are discharged on or after October 1, 2008. This will allow CMS sufficient time to collect accurate data on the most appropriate assignment of these patients in the MS–DRG system. We point out that other commenters have supported this position by urging CMS to gather data in order to create a new DRG for these patients. As we do not yet have comprehensive information on this category of patients regarding frequency, distribution, length of stay, or charge data, we do not believe it is appropriate to assign these cases to a potentially inappropriate MS–DRG. We point out the MS–DRGs system is a system of averages. If we assign cases to an MS–DRG based on what the industry believes to be warranted, but if later data for the cases reflect that the cases are less costly than assumed, the result would be that, in subsequent annual recalibrations, the relative weight(s) for those MS–DRGs would decrease. This would ultimately result in a lower payment for precisely those cases that should be receiving higher payment due to their complexity.

In addition, we reiterate our position regarding the submission of an ICD–9–CM code for a service that was not specifically performed at a facility receiving the transferred patient. Hospitals are not permitted to report services that were not performed in their facilities.

Comment: Two commenters suggested that, if a new code describing the administration of tPA at another facility is created, the new code be assigned to the list of major comorbidities and complications. The commenter suggested that this action would allow cases to be assigned to MS–DRG 064 (Intracranial Hemorrhage or Cerebral Infarction with MCC) or MS–DRG 067 (Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction with MCC).

The commenters also suggested that, if a new code describing the administration of tPA at another facility was not created, a proxy code that is already in the list of MCCs could be assigned to the ''drip and ship'' cases that would then allow hospitals to be compensated for this category of more severe patients. The commenters suggested code 286.5 (Hemorrhagic disorder due to intrinsic circulating anticoagulants) as a proxy code.

Response: We believe the types of action suggested by the commenters would result in a dilution of the principles upon which the MS–DRGs are structured. When we created the MS–DRGs for implementation beginning with FY 2008, we did so based on data and statistics. As we stated in the FY 2008 IPPS final rule: ''The purpose of the MS–DRGs is to more accurately stratify groups of Medicare patients with varying levels of severity'' (72 FR 47155). Therefore, we would not assign the new diagnostic code V45.88 that we have created (discussed earlier) to the list of MCCs or CCs without understanding the ramifications of such an action on the rest of the MS–DRGs and thus compromise our own need for accuracy. We refer the readers to the FY 2008 IPPS final rule that identifies the criteria we used to create the lists of MCCs and CCs (72 FR 47153). In the

same vein, we would not randomly choose a code that is already assigned to the list of MCCs and suggest that hospitals include this code on their claims submission to insure placement of the case in a higher-weighted MS–DRG. We believe that this violate the intent of the construction of the CCs and MCCs. We also believe that the hospital personnel responsible for entering these codes on the claim would be reluctant to do so, given that the patient may not actually have this condition.

After consideration of the public comments received, we are specifying that, for FY 2009 and absent any other conditions or procedures that would result in an alternative MS–DRG assignment, stroke cases involving patients who receive intravenous tPA administration at one facility but are then transferred to a tertiary hospital's stroke center will continue to be assigned to MS–DRGs 064, 065, and 066. We will continue to monitor the cases of patients suffering an embolytic or thrombolytic stroke who are evaluated and given tPA in a community hospital's emergency department and then are transferred to another facility. In the future, we will evaluate our data for potential MS–DRG reassignment based on the use of the new diagnostic code V45.88, and we are strongly encouraging receiving hospitals to include this code on appropriate claims.

b. Intractable Epilepsy With Video Electroencephalogram (EEG)

As we did for FY 2008, we received a request from an individual representing the National Association of Epilepsy Centers to consider further refinements to the MS–DRGs describing seizures. Specifically, the representative recommended that a new MS–DRG be established for patients with intractable epilepsy who receive an electroencephalogram with video monitoring (vEEG) during their hospital stay. Similar to the initial recommendation, the representative stated that patients who suffer from uncontrolled seizures or intractable epilepsy are admitted to an epilepsy center for a comprehensive evaluation to identify the epilepsy seizure type, the cause of the seizure, and the location of the seizure. These patients are admitted to the hospital for 4 to 6 days with 24-hour monitoring that includes the use of EEG video monitoring along with cognitive testing and brain imaging procedures.

Effective October 1, 2007, MS–DRG 100 (Seizures with MCC) and MS–DRG 101 (Seizures without MCC) were implemented as a result of refinements to the DRG system to better recognize severity of illness and resource utilization. Once again, the representative applauded CMS for making changes in the DRG structure to better recognize differences in patient severity. However, the representative stated that a subset of patients in MS–DRG 101 who have a primary diagnosis of intractable epilepsy and are treated with vEEG are substantially more costly to treat than other patients in this MS–DRG and represent the majority of patients being evaluated by specialized epilepsy centers. Alternatively, the representative stated that he was not requesting any change in the structure of MS–DRG 100. According to the representative, the number of cases that would fall into this category is not significant. The representative further noted that this is a change from last year's request.

Epilepsy is currently identified by ICD–9–CM diagnosis codes 345.0x through 345.9x. There are two fifth digits that may be assigned to a subset of the epilepsy codes depending on the physician documentation:

- ''0'' for without mention of intractable epilepsy
- ''1'' for with intractable epilepsy

With the assistance of an outside reviewer, the representative analyzed cost data for MS–DRGs 100 and 101, which focused on three subsets of patients identified with a primary diagnosis of epilepsy or convulsions who also received vEEG (procedure code 89.19):

- Patients with a primary diagnosis of epilepsy with intractability specified (codes 345.01 through 345.91)
- Patients with a primary diagnosis of epilepsy without intractability specified (codes 345.00 through 345.90)
- Patients with a primary diagnosis of convulsions (codes 780.39)

The representative acknowledged that the association did not include any secondary diagnoses in its analyses. Based on its results, the representative recommended that CMS further refine MS–DRG 101 by subdividing cases with a primary diagnosis of intractable epilepsy (codes 345.01 through 345.91) when vEEG (code 89.19) is also performed into a separate MS–DRG that would be defined as ''MS–DRG XXX'' (Epilepsy Evaluation without MCC).

According to the representative, these cases are substantially more costly than the other cases within MS–DRG 101 and are consistent with the criteria for dividing MS–DRGs on the basis of CCs and MCCs. In addition, the representative stated that the request would have a minimal impact on most hospitals but would substantially improve the accuracy of payment to hospitals specializing in epilepsy care.

In the FY 2009 IPPS proposed rule, we discussed our performance of an analysis using FY 2007 MedPAR data. As shown in the table below, we found a total of 54,060 cases in MS–DRG 101 with average charges of $14,508 and an average length of stay of 3.69 days. There were 879 cases with intractable epilepsy and vEEG with average charges of $19,227 and an average length of stay of 5 days.

MS–DRG	Number of cases	Average length of stay	Average charges
MS–DRG 100—All Cases	16,142	6.34	$27,623
MS–DRG 100—Cases with Intractable Epilepsy with vEEG (Codes 345.01, 345.11, 345.41, 345.51, 345.61, 345.71, 345.81, 345.91)	69	6.6	26,990
MS–DRG 100—Cases with Intractable Epilepsy without vEEG	328	7.81	32,539
MS–DRG 101—All cases	54,060	3.69	14,508
MS–DRG 101—Cases with Intractable Epilepsy with vEEG (Codes 345.01, 345.11, 345.41, 345.51, 345.61, 345.71, 345.81, 345.91)	879	5.0	19,227
MS–DRG 101—Cases with Intractable Epilepsy without vEEG	1,351	4.25	14,913

In applying the criteria to establish subgroups, the data do not support the creation of a new subdivision for MS–DRG 101 for cases with intractable epilepsy and vEEG, nor does the data support moving the 879 cases from MS–DRG 101 to MS–DRG 100. Moving the 879 cases to MS–DRG 100 would mean moving cases with average charges of approximately $19,000 into an MS–DRG with average charges of $28,000. Therefore, we did not propose to refine

MS–DRG 101 by subdividing cases with a primary diagnosis of intractable epilepsy (codes 345.01 through 345.91) when vEEG (code 89.19) is also performed into a separate MS–DRG.

Comment: One commenter supported the National Association of Epilepsy Centers in recommending that MS–DRG 101 be subdivided for a subset of patients with a primary diagnosis of intractable epilepsy (codes 345.01 through 345.91) when EEG with video monitoring is reported. Similar to the Association's comments, the commenter stated that this subgroup of patients is most often admitted to hospitals with specialized epilepsy centers for a comprehensive evaluation to determine epilepsy seizure type, cause and location for consideration of surgery or to alter medications, and that the hospitalization is longer than the other cases in MS–DRG 101, resulting in higher costs (due to continuous 24-hour EEG with video monitoring (vEEG) and additional expensive diagnostic tests such as MRI, ictal SPECT, PET, and neuropsychological testing).

The commenter acknowledged that CMS has set specific criteria for the establishment of a new MS–DRG. According to the commenter, the FY 2007 data analyzed by the Association reported that the intractable epilepsy with vEEG cases exceed the average charge criteria as well as the minimum number of cases needed to establish a separate DRG. However, the total number of cases in the subgroup represents less than 2 percent of the cases in MS–DRG 101, while the criterion calls for a threshold of 5 percent. The commenter stated that the number of cases is small because most patients with intractable epilepsy admitted to the hospital for vEEG are younger than 65 years of age and are eligible for Medicare due to their disability. In addition, the commenter indicated that the population is typically covered by private insurance or Medicaid. The commenter asserted that the Medicare intractable epilepsy with vEEG cases will remain small, but asked that CMS establish the separate MS–DRG as it has done for pediatric and other small subgroups of patients.

Lastly, like the Association, the commenter noted that most of the admissions of the epilepsy subgroup occur in a relatively small number of hospitals with specialized epilepsy centers. The commenter believed that the establishment of a separate MS–DRG for the epilepsy subgroup would have a minimal impact on most hospitals, but would substantially improve the accuracy of payment to hospitals that specialize in epilepsy care.

Response: We appreciate the commenter's comments. As we indicated in the proposed rule and in this final rule, we performed an analysis of the FY 2007 MedPAR data. In applying the criteria to establish subgroups, the data did not support the creation of a new subdivision for MS–DRG 101 for cases with intractable epilepsy and vEEG.

As mentioned elsewhere in this final rule, we received several comments acknowledging CMS' discussion of the FY 2008 implementation of MS–DRGs and lack of data to support major MS–DRG changes for FY 2009. The commenters accepted CMS' proposal of not making significant revisions to the MS–DRGs until claims data under the new MS–DRG system are available. Therefore, as final policy for FY 2009, we are not modifying MS–DRG 101.

3. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Automatic Implantable Cardioverter-Defibrillators (AICD) Lead and Generator Procedures

In the FY 2008 IPPS final rule with comment period (72 FR 47257), we created a separate, stand alone DRG for automatic implantable cardioverter-defibrillator (AICD) generator replacements and defibrillator lead replacements. The new MS–DRG 245 (AICD lead and generator procedures) contains the following codes:

- 00.52, Implantation or replacement of transvenous lead [electrode] into left ventricular coronary venous system
- 00.54, Implantation or replacement of cardiac resynchronization defibrillator pulse generator device only [CRT–D]
- 37.95, Implantation of automatic cardioverter/defibrillator lead(s) only
- 37.96, Implantation of automatic cardioverter/defibrillator pulse generator only
- 37.97, Replacement of automatic cardioverter/defibrillator lead(s) only
- 37.98, Replacement of automatic cardioverter/defibrillator pulse generator only

Commenters on the FY 2008 IPPS proposed rule supported this MS–DRG, which recognizes the distinct differences in resource utilization between pacemaker and defibrillator generators and leads. One commenter suggested that CMS consider additional refinements for the defibrillator generator and leads. In reviewing the standardized charges for the AICD leads, the commenter believed that the leads may be more appropriately assigned to another DRG such as MS–DRG 243 (Permanent Cardiac Pacemaker Implant with CC) or MS–DRG 258 (Cardiac Pacemaker Device Replacement with MCC). The commenter recommended that CMS consider moving the defibrillator leads back into a pacemaker DRG, either MS–DRG 243 or MS–DRG 258.

In response to the commenter, we indicated that the data supported separate MS–DRGs for these very different devices (72 FR 47257). We indicated that moving the defibrillator leads back into a pacemaker MS–DRG defeated the purpose of creating separate MS–DRGs for defibrillators and pacemakers. Therefore, we finalized MS–DRG 245 as proposed with the leads and generator codes listed above.

After publication of the FY 2008 IPPS final rule with comment period, we received a request from a manufacturer that recommended a subdivision for MS–DRG 245 (AICD Lead and Generator Procedures). The requestor suggested creating a new MS–DRG to separate the implantation or replacement of the AICD leads from the implantation or replacement of the AICD pulse generators to better recognize the differences in resource utilization for these distinct procedures.

The requestor applauded CMS' decision to create separate MS–DRGs for the pacemaker device procedures from the AICD procedures in the FY 2008 IPPS final rule (72 FR 47257). The requestor further acknowledged its support of the clinically distinct MS–DRGs for pacemaker devices. Currently, MS–DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with MCC and without MCC, respectively) describe the implantation or replacement of pacemaker generators, while MS–DRGs 260, 261, and 262 (Cardiac Pacemaker Revision Except Device Replacement with MCC, with CC, without CC/MCC, respectively) describe the insertion or replacement of pacemaker leads.

The requestor believed that the IPPS ''needs to continue to evolve to accurately reflect clinical differences and costs of services.'' As such, the requestor recommended that CMS follow the same structure as it did with the pacemaker MS–DRGs for MS–DRG 245 to separately identify the implantation or replacement of the defibrillator leads (codes 37.95, 37.97, and 00.52) from the implantation or replacement of the pulse generators (codes 37.96, 37.98 and 00.54).

In the FY 2009 IPPS proposed rule, we discussed our analysis of the FY 2007 MedPAR data, in which we found a total of 5,546 cases in MS–DRG 245 with average charges of $62,631 and an average length of stay of 3.3 days. We

found 1,894 cases with implantation or replacement of the defibrillator leads (codes 37.95, 37.97, and 00.52) with average charges of $42,896 and an average length of stay of 3.4 days. We also found a total of 3,652 cases with implantation or replacement of the pulse generator (codes 37.96, 37.98, 00.54) with average charges of $72,866 and an average length of stay of 3.2 days.

We agree with the requestor that the IPPS should accurately recognize differences in resource utilization for clinically distinct procedures. As the data demonstrate, average charges for the implantation or replacement of the AICD pulse generators are significantly higher than for the implantation or replacement of the AICD leads. Therefore, we proposed to create a new MS–DRG 265 to separately identify these distinct procedures.

Comment: Several commenters expressed their appreciation and applauded CMS for acting on the proposal to subdivide MS–DRG 245 and create a new MS–DRG to recognize the differences in resource utilization for the implantation or replacement of leads from the implantation or replacement of pulse generators. The commenters supported these refinements to the MS–DRG classification system and stated that this proposed modification would ''reflect appropriate allocation and use of resources.''

Response: We appreciate the commenters' support. We proposed that the title for this new MS–DRG 265 would be ''AICD Lead Procedures'' and would include procedure codes that identify the AICD leads (codes 37.95, 37.97 and 00.52). We also proposed that the title for MS–DRG 245 would be revised to ''AICD Generator Procedures'' and include procedure codes 37.96, 37.98, and 00.54. We believe these changes will better reflect the clinical differences and resources utilized for these distinct procedures.

Therefore, in this final rule, we are finalizing our proposals to revise the title of MS–DRG 245 to read ''AICD Generator Procedures'', which includes procedure codes 37.96, 37.98, 00.54 and to create a new MS–DRG 265 (AICD Lead Procedures) to include procedure codes 37.95, 37.97 and 00.52, effective October 1, 2009.

b. Left Atrial Appendage Device

Atrial fibrillation (AF) is the primary cardiac abnormality associated with ischemic or embolytic stroke. Most ischemic strokes associated with AF are possibly due to an embolism or thrombus that has formed in the left atrial appendage. Evidence from studies such as transesophageal echocardiography shows left atrial thrombi to be more frequent in AF patients with ischemic stroke as compared to AF patients without stroke. While anticoagulation medication can be efficient in ischemic stroke prevention, there can be problems of safety and tolerability in many patients, especially those older than 75 years. Chronic warfarin therapy has been proven to reduce the risk of embolism but there can be difficulties concerning its administration. Frequent blood tests to monitor warfarin INR are required at some cost and patient inconvenience. In addition, because warfarin INR is affected by a large number of drug and dietary interactions, it can be unpredictable in some patients and difficult to manage. The efficacy of aspirin for stroke prevention in AF patients is less clear and remains controversial. With the known disutility of warfarin and the questionable effectiveness of aspirin, a device-based solution may provide added protection against thromboembolism in certain patients with AF.

At the April 1, 2004 ICD–9–CM Coordination and Maintenance Committee meeting, a proposal was presented for the creation of a unique procedure code describing insertion of the left atrial appendage filter system. Subsequently, ICD–9–CM code 37.90 (Insertion of left atrial appendage device) was created for use beginning October 1, 2004. This code was designated as a non-operating room (non-O.R.) procedure, and had an effect only on cases in MDC 5, CMS DRG 518 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or Acute Myocardial Infarction). With the adoption of MS–DRGs in FY 2008, CMS DRG 518 was divided into MS–DRGs 250 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI with MCC) and 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI without MCC).

We have reviewed the data concerning this procedure code annually. Using FY 2005 MedPAR data for the FY 2007 IPPS final rule, 24 cases were reported, and the average charges ($27,620) closely mimicked the average charges of the other 22,479 cases in CMS DRG 518 ($28,444). As the charges were comparable, we made no recommendations to change the CMS DRG assignment for FY 2007.

Using FY 2006 MedPAR data for the FY 2008 IPPS final rule, we divided CMS DRG 518 into the cases that would be reflected in the MS–DRG configuration; that is, we divided the cases based on the presence or absence of an MCC. There were 35 cases without an MCC with average charges of $24,436, again mimicking the 38,002 cases with average charges of $32,546. There were 3 cases with an MCC with average charges of $62,337, compared to the 5,458 cases also with an MCC with average charges of $53,864. Again, it was deemed that cases with code 37.90 were comparable to the rest of the cases in CMS DRG 518, and the decision was made not to make any changes in the DRG assignment for this procedure code. As noted above, CMS DRG 518 became MS–DRGs 250 and 251 in FY 2008.

We have received a request regarding code 37.90 and its placement within the MS–DRG system for FY 2009. The requestor, a manufacturer's representative, asked for either the reassignment of code 37.90 to an MS–DRG that would adequately cover the costs associated with the complete procedure or the creation of a new MS–DRG that would reimburse hospitals adequately for the cost of the device. The requestor reported that the device's IDE clinical trial is nearing completion, with the conclusion of study enrollment in May 2008. The requestor will continue to enroll patients in a Continued Use Registry following completion of the trial. The requestor reported that it did not charge hospitals for the atrial appendage device, estimated to cost $6,000, during the trial period, but it will begin to charge hospitals upon the completion of the trial in May. The requestor provided us with its data showing what it believed to be a differential of $107 more per case than the payment average for MS–DRG 250, and a shortfall of $3,808 per case than the payment average for MS–DRG 251.

The requestor pointed out that code 37.90 is assigned to both MS–DRGs 250 and 251, but stated that the final MS–DRG assignment would be MS–DRG 251 when the patient has a principal diagnosis of atrial fibrillation (code 427.31) because AF is not presently listed as a CC or an MCC. We note that it is the principal diagnosis that is used to determine assignment of a case to the correct MDC and subsequently the MS–DRG. Secondary or additional diagnosis codes are the only codes that can be used to determine the presence of a CC or an MCC.

With regard to the request to create a specific MS–DRG for the insertion of this device titled ''Percutaneous Cardiovascular Procedures with Implantation of a Left Atrial Appendage Device without CC/MCC'', we point out that the payments under a prospective

payment system are predicated on averages. The device is already assigned to MS–DRGs containing other percutaneous cardiovascular devices; to create a new MS–DRG specific to this device would be to remove all other percutaneously inserted devices and base the MS–DRG assignment solely on the presence of code 37.90. This approach negates our longstanding method of grouping like procedures, and removes the concept of averaging. Further, to ignore the structure of the MS–DRG system solely for the purpose of increasing payment for one device would set an unwelcome precedent for defining all of the other MS–DRGs in the system. We also point out that the final rule establishing the MS–DRGs set forth five criteria, all five of which are required to be met, in order to warrant creation of a CC or an MCC subgroup within a base MS–DRG. The criteria can be found in the FY 2008 IPPS final rule with comment period (72 FR 47169). One of the criteria specifies that there will be at least 500 cases in the CC or MCC subgroup. To date, there are not enough cases assigned to code 37.90 that are reported within the MedPAR data.

Using FY 2007 MedPAR data, for the FY 2009 IPPS proposed rule, we reviewed MS–DRGs 250 and 251 for the presence of the left atrial appendage device. The following table displays our results:

MS–DRG	Number of cases	Average length of stay	Average charges
250—All Cases	6,424	7.72	$60,597.58
250—Cases with code 37.90	4	6.50	65,829.51
250—Cases without code 37.90	6,420	7.72	60,594.32
251—All Cases	39,456	2.84	35,719.81
251—Cases with code 37.90	101	1.30	20,846.09
251—Cases without code 37.90	39,335	2.85	35,757.98

There were a total of 105 cases assigned code 37.90 that were reported for Medicare beneficiaries in the 2007 MedPAR data. There are 4 cases with an atrial appendage device in MS–DRG 250 that have higher average charges than the other 6,420 cases in the MS–DRG, and that have slightly shorter lengths of stay by 1.25 days. However, the more telling data are located in MS–DRG 251, which shows that the 101 cases in which an atrial appendage device was implanted have much lower average charges ($20,846.09) than the other 39,355 cases in the MS–DRG with average charges of $35,758.98. The difference in the average charges is approximately $14,912, so even when the manufacturer begins charging the hospitals the estimated $6,000 for the device, there is still a difference of approximately $8,912 in average charges based on the comparison within the total MS–DRG 251. Interestingly, the 101 cases also have an average length of stay of less than half of the average length of stay compared to the other cases assigned to that MS–DRG.

Because the data did not support either the creation of a unique MS–DRG or the assignment of procedure code 37.90 to another higher-weighted MS–DRG, we did not propose any change to MS–DRGs 250 and 251, or to code 37.90 for FY 2009. We believe, based on the past 3 years' comparisons, that this code is appropriately located within the MS–DRG structure.

We did not receive any comments on our proposal to make no changes to MS–DRGs 250 or 251, or on the assignment of code 37.90 (Insertion of left atrial appendage device) within the MS–DRG structure. Therefore, in the absence of comment to the contrary, and in the presence of what we believe to be compelling evidence concerning the accuracy of the placement of code 37.90 in the current MS–DRG structure, we are not modifying MS–DRG 250 or 251 or procedure code 37.90 for FY 2009.

As an additional note, we point out that the titles of MS–DRGs 250 and 251 have been changed for FY 2009. We have removed the reference to AMI, as that portion of the title was a holdover from the CMS DRGs last used in FY 2007. The correct titles are: MS–DRG 250 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC) and MS–DRG 251 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC). The entire list of MS–DRGs can be found in Table 5 of the Addendum to this final rule.

4. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Hip and Knee Replacements and Revisions

For FY 2009, we again received a request from the American Association of Hip and Knee Surgeons (AAHKS), a specialty group within the American Academy of Orthopedic Surgeons (AAOS), concerning modifications of the lower joint procedure MS–DRGs. The request is similar, in some respects, to the AAHKS' request in FY 2008, particularly as it relates to separating routine and complex procedures. For the benefit of the reader, we are republishing a history of the development of DRGs for hip and knee replacements and a summary of the AAHKS FY 2008 request that were included in the FY 2008 IPPS final rule with comment period (72 FR 47222 through 47224) before we discuss the AAHKA's more recent request.

a. Brief History of Development of Hip and Knee Replacement Codes

In the FY 2006 IPPS final rule (70 FR 47303), we deleted CMS DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created two new CMS DRGs: 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement). The two new CMS DRGs were created because revisions of joint replacement procedures are significantly more resource intensive than original hip and knee replacements procedures. CMS DRG 544 included the following procedure code assignments:

- 81.51, Total hip replacement
- 81.52, Partial hip replacement
- 81.54, Total knee replacement
- 81.56, Total ankle replacement
- 84.26, Foot reattachment
- 84.27, Lower leg or ankle reattachment
- 84.28, Thigh reattachment

CMS DRG 545 included the following procedure code assignments:

- 00.70, Revision of hip replacement, both acetabular and femoral components
- 00.71, Revision of hip replacement, acetabular component
- 00.72, Revision of hip replacement, femoral component
- 00.73, Revision of hip replacement, acetabular liner and/or femoral head only
- 00.80, Revision of knee replacement, total (all components)
- 00.81, Revision of knee replacement, tibial component

• 00.82, Revision of knee replacement, femoral component
• 00.83, Revision of knee replacement, patellar component
• 00.84, Revision of knee replacement, tibial insert (liner)
• 81.53, Revision of hip replacement, not otherwise specified
• 81.55, Revision of knee replacement, not otherwise specified

Further, we created a number of new ICD–9–CM procedure codes effective October 1, 2005, that better distinguish the many different types of joint replacement procedures that are being performed. In the FY 2006 IPPS final rule (70 FR 47305), we indicated a commenter had requested that, once we receive claims data using the new procedure codes, we closely examine data from the use of the codes under the two new CMS DRGs to determine if future additional DRG modifications are needed.

b. Prior Recommendations of the AAHKS

Prior to this year, the AAHKS had recommended that we make further refinements to the CMS DRGs for knee and hip arthroplasty procedures. The AAHKS previously presented data to CMS on the important differences in clinical characteristics and resource utilization between primary and revision total joint arthroplasty procedures. The AAHKS stated that CMS' decision to create a separate DRG for revision of total joint arthroplasty (TJA) in October 2005 resulted in more equitable reimbursement for hospitals that perform a disproportionate share of complex revision of TJA procedures, recognizing the higher resource utilization associated with these cases. The AAHKS stated that this important payment policy change led to increased access to care for patients with failed total joint arthroplasties, and ensured that high volume TJA centers could continue to provide a high standard of care for these challenging patients.

The AAHKS further stated that the addition of new, more descriptive ICD–9–CM diagnosis and procedure codes for TJA in October 2005 gave it the opportunity to further analyze differences in clinical characteristics and resource intensity among TJA patients and procedures. Inclusive of the preparatory work to submit its recommendations, the AAHKS compiled, analyzed, and reviewed detailed clinical and resource utilization data from over 6,000 primary and revision TJA procedure codes from 4 high volume joint arthroplasty centers located within different geographic regions of the United States: University of California, San Francisco, CA; Mayo Clinic, Rochester, MN; Massachusetts General Hospital, Boston, MA; and the Hospital for Special Surgery, New York, NY. Based on its analysis, the AAHKS recommended that CMS examine Medicare claims data and consider the creation of separate DRGs for total hip and total knee arthroplasty procedures. The AAHKS stated that based on the differences between patient characteristics, procedure characteristics, resource utilization, and procedure code payment rates between total hip and total knee replacements, separate DRGs were warranted. Furthermore, the AAHKS recommended that CMS create separate base DRGs for routine versus complex joint revision or replacement procedures as shown below.

Routine Hip Replacements

• 00.73, Revision of hip replacement, acetabular liner and/or femoral head only
• 00.85, Resurfacing hip, total, acetabulum and femoral head
• 00.86, Resurfacing hip, partial, femoral head
• 00.87, Resurfacing hip, partial, acetabulum
• 81.51, Total hip replacement
• 81.52, Partial hip replacement
• 81.53, Revision of hip replacement, not otherwise specified

Complex Hip Replacements

• 00.70, Revision of hip replacement, both acetabular and femoral components
• 00.71, Revision of hip replacement, acetabular component
• 00.72, Revision of hip replacement, femoral component

Routine Knee Replacements and Ankle Procedures

• 00.83, Revision of knee replacement, patellar component
• 00.84, Revision of knee replacement, tibial insert (liner)
• 81.54, Revision of knee replacement, not otherwise specified
• 81.55, Revision of knee replacement, not otherwise specified
• 81.56, Total ankle replacement

Complex Knee Replacements and Other Reattachments

• 00.80, Revision of knee replacement, total (all components)
• 00.81, Revision of knee replacement, tibial component
• 00.82, Revision of knee replacement, femoral component
• 84.26, Foot reattachment
• 84.27, Lower leg or ankle reattachment
• 84.28, Thigh reattachment

The AAHKS also recommended the continuation of CMS DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) without modifications. CMS DRG 471 included any combination of two or more of the following procedure codes:

• 00.70, Revision of hip replacement, both acetabular and femoral components
• 00.80, Revision of knee replacement, total (all components)
• 00.85, Resurfacing hip, total, acetabulum and femoral head
• 00.86, Resurfacing hip, partial, femoral head
• 00.87, Resurfacing hip, partial, acetabulum
• 81.51, Total hip replacement
• 81.52, Partial hip replacement
• 81.54, Total knee replacement
• 81.56, Total ankle replacement

c. Adoption of MS–DRGs for Hip and Knee Replacements for FY 2008 and AAHKS' Recommendations

In the FY 2008 IPPS final rule with comment period (72 FR 47222 through 47226), we adopted MS–DRGs to better recognize severity of illness for FY 2008. The MS–DRGs include two new severity of illness levels under the then current base DRG 544. We also added three new severity of illness levels to the base DRG for Revision of Hip or Knee Replacement. The new MS–DRGs are as follows:

• MS–DRG 466 (Revision of Hip or Knee Replacement with MCC)
• MS–DRG 467 (Revision of Hip or Knee Replacement with CC)
• MS–DRG 468 (Revision of Hip or Knee Replacement without CC/MCC)
• MS–DRG 469 (Major Joint Replacement or Reattachment of Lower Extremity with MCC)
• MS–DRG 470 (Major Joint Replacement or Reattachment of Lower Extremity without MCC)

We found that the MS–DRGs greatly improved our ability to identify joint procedures with higher resource costs. In the final rule, we presented data indicating the average charges for each new MS–DRG for the joint procedures.

In the FY 2008 IPPS final rule with comment period, we acknowledged the valuable assistance the AAHKS had provided to CMS in creating the new joint replacement procedure codes and modifying the joint replacement DRGs beginning in FY 2006. These efforts greatly improved our ability to categorize significantly different groups of patients according to severity of illness. Commenters on the FY 2008 proposed rule had encouraged CMS to continue working with the orthopedic

community, including the AAHKS, to monitor the need for additional new DRGs. The commenters stated that MS–DRGs 466 through 470 are a good first step. However, they stated that CMS should continue to evaluate the data for these procedures and consider additional refinements to the MS–DRGs, including the need for additional severity levels. AAHKS stated that its data suggest that all three base DRGs (primary replacement, revision of major joint replacement, and bilateral joint replacement) should be separated into three severity levels (that is, MCC, CC, and non-CC). (We had proposed three severity levels for revision of hip and knee replacement (MS–DRGs 466, 467, and 468), and AAHKS agreed with this 3-level subdivision.)

The AAHKS recommended that the base DRG for the proposed two severity subdivision MS–DRGs for major joint replacement or reattachment of lower extremity with and without CC/MCC (MS–DRGs 483 and 484) be subdivided into three severity levels, as was the case for the revision of hip and knee replacement MS–DRGs. AAHKS also recommended that the two severity subdivision MS–DRGs for bilateral or multiple major joint procedures of lower extremity with and without MCC (MS–DRGs 461 and 462) be subdivided three ways for this base DRG. AAHKS acknowledged that the three way split would not meet all five of the criteria for establishing a subgroup, and stated that these criteria were too restrictive, lack face validity, and create perverse admission selection incentives for hospitals by significantly overpaying for cases without a CC and underpaying for cases with a CC. It recommended that the existing five criteria be modified for low volume subgroups to assure materiality. For higher volume MS–DRG subgroups, the AAHKS recommended that two other criteria be considered, particularly for nonemergency, elective admissions:

- Is the per-case underpayment amount significant enough to affect admission vs. referral decisions on a case-by-case basis?
- Is the total level of underpayments sufficient to encourage systematic admission vs. referral policies, procedures, and marketing strategies?

The AAHKS also recommended refining the five existing criteria for MCC/CC/without subgroups as follows:

- Create subgroups if they meet the five existing criteria, with cost difference between subgroups ($1,350) substituted for charge difference between subgroups ($4,000);
- If a proposed subgroup meets criteria number 2 and 3 (at least 5 percent and at least 500 cases) but fails one of the others, then create the subgroup if either of the following criteria are met:
- At least $1,000 cost difference per case between subgroups; or
- At least $1 million overall cost should be shifted to cases with a CC (or MCC) within the base DRG for payment weight calculations.

In response, we indicated that we did not believe it was appropriate to modify our five criteria for creating severity subgroups. Our data did not support creating additional subdivisions based on the criteria. At that time, we believed the criteria we established to create subdivisions within a base DRG were reasonable and establish the appropriate balance between better recognition of severity of illness, sufficient differences between the groups, and a reasonable number of cases in each subgroup. However, we indicated that we may consider further modifications to the criteria at a later date once we have had some experience with MS–DRGs created using the proposed criteria.

The AAHKS indicated in its response to the FY 2008 proposed rule that it continued to support the separation of routine and complex joint procedures. It believed that certain joint replacement procedures have significantly lower average charges than do other joint replacements. The AAKHS' data suggest that more routine joint replacements are associated with substantially less resource utilization than other more complex revision procedures. The AAHKS stated that leaving these procedures in the revision MS–DRGs results in substantial overpayment for these relatively simple, less costly revision procedures, which in turn results in a relative underpayment for the more complex revision procedures.

In response, we examined data on this issue and identified two procedure codes for partial knee revisions that had significantly lower average charges than did other joint revisions. The two codes are as follows:

- 00.83 Revision of knee replacement, patellar component
- 00.84 Revision of total knee replacement, tibial insert (liner)

The data suggest that these less complex partial knee revisions are less resource intensive than other cases assigned to MS–DRGs 466, 467, or 468. We examined other orthopedic DRGs to which these two codes could be assigned. We found that these cases have very similar average charges to those in MS–DRG 485 (Knee Procedures with Principal Diagnosis of Infection with MCC), MS–DRG 486 (Knee Procedures with Principal Diagnosis of Infection with CC), MS–DRG 487 (Knee Procedures with Principal Diagnosis of Infection without CC), MS–DRG 488 (Knee Procedures without Principal Diagnosis of Infection with CC or MCC), and MS–DRG 489 (Knee Procedures without Principal Diagnosis of Infection without CC).

Given the very similar resource requirements of MS–DRG 485 and the fact that these DRGs also contain knee procedures, we moved codes 00.83 and 00.84 out of MS–DRGs 466, 467, and 468 and into MS–DRGs 485, 486, 487, 488, and 489. We also indicated that we would continue to monitor the revision MS–DRGs to determine if additional modifications are needed.

d. AAHKS' Recommendations for FY 2009

The AAHKS' current request involves the following recommendations:

- That CMS consolidate and reassign certain joint procedures that have a diagnosis of an infection or malignancy into MS–DRGs that are similar in terms of clinical characteristics and resource utilization. The AAKHS further identifies groups called Stage 1 and 2 procedures that it believes require significant differences in resource utilization.
- That CMS reclassify certain specific joint procedures, which AAHKS refers to as ''routine,'' out of their current MS–DRG assignments. The three joint procedures that AAHKS classifies as ''routine'' are codes 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only), 00.83 (Revision of knee replacement, patellar component), and 00.84 (Revision of total knee replacement, tibial insert (liner)). The AAHKS advocated removing these three ''routine'' procedures from the following DRGs: MS–DRGs 466, 467, and 468, MS–DRGs 485, 486, and 487, and MS–DRGs 488 and 489. The AAHKS refers to MS–DRGs 466, 467, and 468 as ''complex'' revision MS–DRGs, and recommended that the three ''routine'' procedures be moved out of MS–DRGs 466, 467, and 468 and MS–DRGs 485, 486, and 489 and into MS–DRGs 469 and 470 (Major Joint Replacement or Reattachment of Lower Extremity with and without MCC, respectively). The AAHKS contended that the three ''routine'' procedures have similar clinical characteristics and resource utilization to those in MS–DRGs 469.

The recommendations suggested by AAHKS are quite complex and involve a number of specific code lists and MS–DRG assignment changes. We discuss each of these requests in detail below.

(1) AAHKS Recommendation 1: Consolidate and reassign patients with

hip and knee prosthesis related infections or malignancies.

The AAHKS pointed out that deep infection is one of the most devastating complications associated with hip and knee replacements. These infections have been reported to occur in approximately 0.5 percent to 3 percent of primary and 4 percent to 6 percent of revision total joint replacement procedures. These infections often result in the need for multiple reoperations, prolonged use of intravenous and oral antibiotics, extended inpatient and outpatient rehabilitation, and frequent followup visits. Furthermore, clinical outcomes following single- and two-stage revision total joint arthroplasty procedures have been less favorable than revision for other causes of failure not associated with infection.

In addition to the clinical impact, the AAHKS stated that infected total joint replacement procedures also have substantial economic implications for patients, payers, hospitals, physicians, and society in terms of direct medical costs, resource utilization, and the indirect costs associated with lost wages and productivity. The AAHKS stated that the considerable resources required to care for these patients have resulted in a strong financial disincentive for physicians and hospitals to provide care for patients with infected total joint replacements, an increased economic burden on the high volume tertiary care referral centers where patients with infected hip replacement procedures are frequently referred for definitive management. The AAHKS further stated that, in some cases, there are compromised patient outcomes due to treatment delays as patients with infected joint replacements seek providers who are willing to care for them.

Once a deep infection of a total joint prosthesis is identified, the first stage of treatment involves a hospital admission for removal of the infected prosthesis and debridement of the involved bone and surrounding tissue. During the same procedure, an antibiotic-impregnated cement spacer is typically inserted to maintain alignment of the limb during the course of antibiotic therapy. The patient is then discharged to a rehabilitation facility/nursing home (or to home if intravenous therapy can be safely arranged for the patient) for a 6-week course of IV antibiotic treatment until the infection has cleared.

After the completion of antibiotic therapy, the hip or knee may be reaspirated to look for evidence of persistent infection or eradication of infection. A second stage procedure is then undertaken, where the patient is readmitted, the hip or knee is reexplored, and the cement spacer removed. If there are no signs of persistent infection, a hip or knee prosthesis is reimplanted, often using bone graft and costly revision implants in order to address extensive bone loss and distorted anatomy. Thus, the entire course of treatment for patients with infected joint replacements is 4 to 6 months, with an additional 6 to 12 months of rehabilitation. Furthermore, clinical outcomes following revision for infection are poor relative to outcomes following revision for other aseptic causes. The AAHKS noted that patients with bone malignancy have a similar treatment focus—surgery to remove diseased tissue, chemotherapy to treat the malignancy, and implantation of the new prosthesis. They also have similar resource use. For simplicity, the AAHKS' discussion focused on infected joint prostheses, but it suggested that the issues it raises would apply to patients with a malignancy as well.

The AAHKS stated that these patients are currently grouped in multiple MS–DRGs, and the cases are often ''outliers'' in each one. AAHKS proposed to consolidate these patients with similar clinical characteristics and treatment into MS–DRGs reflective of their resource utilization.

The AAHKS states that these more severe patients are currently classified into the following MS–DRGs:

- MS–DRGs 463, 463, and 465 (Wound Debridement and Skin Graft Excluding Hand, for Musculoskeletal-Connective Tissue Disease with MCC, with CC, without CC/MCC, respectively)
- MS–DRGs 480, 481, and 482 (Hip and Femur Procedures Except Major Joint with MCC, with CC, without CC/MCC, respectively)
- MS–DRGs 485, 486, and 487 (Knee Procedures with Principal Diagnosis of Infection and with MCC, with CC, and without CC/MCC, respectively)
- MS–DRGs 488 and 489 (Knee Procedures without Principal Diagnosis of Infection and with CC/MCC and without CC/MCC, respectively)
- MS–DRGs 495, 496, and 497 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with MCC, with CC, and without CC/MCC, respectively)
- Other MS–DRGs (The AAHKS did not specify what these other MS–DRGs were.)

The AAHKS indicated that cases with the severe diagnoses of infections, neoplasms, and structural defects have similarities. These similarities are due to an overlap of a severe diagnosis (including a principal diagnosis of code 996.66 (Infected joint prosthesis) and the resulting need for more extensive surgical procedures. The AAHKS stated that currently these patients are grouped into MS–DRGs by major procedure alone. AAHKS recommended that these cases be grouped into what it refers to as Stages 1 and 2 as follows:

- Stage 1 would include the removal of an infected prosthesis and includes cases in MS–DRGs 463, 464, and 465, 480, 481, and 482, 485 through 489, and 495, 496, and 497. Stage 1 joint procedure codes would include codes 80.05 (Arthrotomy for removal of prosthesis, hip), 80.06 (Arthrotomy for removal of prosthesis, knee), 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only), and 00.84 (Revision of knee replacement, tibial insert (liner)).
- Stage 2 would include the implant of a new prosthesis and includes cases in MS–DRGs 461 and 462, 463, 464, and 465, 466, 467, and 468, and 469 and 470. Stage 2 joint procedure codes would include codes 00.70 (Revision of hip replacement, both acetabular and femoral components), 00.71 (Revision of hip replacement, acetabular component), 00.72 (Revision of hip replacement, femoral component), 00.80 (Revision of knee replacement, total (all components)), 00.81 (Revision of knee replacement, tibial component), 00.82 (Revision of knee replacement, femoral component), 00.85 (Resurfacing hip, total, acetabulum and femoral head), 00.86 (Resurfacing hip, partial, femoral head), 00.87 (Resurfacing hip, partial, acetabulum), 81.51 (Total hip replacement), 81.52 (Partial hip replacement), 81.53 (Revise hip replacement), 81.54 (Total knee replacement), 81.55 (Revise knee replacement), and 81.56 (Total ankle replacement).

As stated earlier, the AAHKS recommended patients with certain more severe diagnoses be grouped into a higher severity level. While most of AAHKS' comments focused on joint replacement patients with infections, the AAHKS also believed that patients with certain neoplasms require greater resources. To this group of infections and neoplasms, the AAHKS recommended the addition of four codes that capture acquired deformities. The AAHKS believed that these codes would capture admissions for the second stage of the treatment for an infected joint. The AAHKS stated that the significance of these diagnoses when they are reported as the principal code position was significant in predicting resource utilization. However, the impact was not as significant when the diagnosis was reported as a secondary diagnosis.

The AAHKS recommended that patients with one of the following infection/neoplasm/defect principal diagnosis codes be segregated into a higher severity level.

Stage 1 Infection/Neoplasm/Defect Principal Diagnosis Codes

- 170.7 (Malignant neoplasm of long bones of lower limb)
- 171.3 (Malignant neoplasm of soft tissue, lower limb, including hip)
- 711.05 (Pyogenic arthritis, pelvic region and thigh)
- 711.06 (Pyogenic arthritis, lower leg)
- 730.05 (Acute osteomyelitis, pelvic region and thigh)
- 730.06 (Acute osteomyelitis, lower leg)
- 730.15 (Chronic osteomyelitis, pelvic region and thigh)
- 730.16 (Chronic osteomyelitis, lower leg)
- 730.25 (Unspecified osteomyelitis, pelvic region and thigh)
- 730.26 (Unspecified osteomyelitis, lower leg)
- 996.66 (Infection and inflammatory reaction due to internal joint prosthesis)
- 996.67 (Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft)

*Stage 2 Infection/Neoplasm/Defect Principal Diagnosis Codes (an Asterisk * Shows the Diagnoses Included in Stage 2 That Were Not Listed in Stage 1)*

- 170.7 (Malignant neoplasm of long bones of lower limb)
- 171.3 (Malignant neoplasm of soft tissue, lower limb, including hip)
- 198.5 (Secondary malignant neoplasm of bone and bone marrow) *
- 711.05 (Pyogenic arthritis, pelvic region and thigh)
- 711.06 (Pyogenic arthritis, lower leg)
- 730.05 (Acute osteomyelitis, pelvic region and thigh)
- 730.06 (Acute osteomyelitis, lower leg)
- 730.15 (Chronic osteomyelitis, pelvic region and thigh)
- 730.16 (Chronic osteomyelitis, lower leg)
- 730.25 (Unspecified osteomyelitis, pelvic region and thigh)
- 730.26 (Unspecified osteomyelitis, lower leg)
- 736.30 (Acquired deformities of hip, unspecified deformity)
- 736.39 (Other acquired deformities of hip) *
- 736.6 (Other acquired deformities of knee) *
- 736.89 (Other acquired deformities of other parts of limbs) *
- 996.66 (Infection and inflammatory reaction due to internal joint prosthesis) *
- 996.67 (Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft) *

For the Stage 2 procedures, AAHKS also suggested the use of the following secondary diagnosis codes to assign the cases to a higher severity level. These conditions would not be the reason the patient was admitted to the hospital. They would instead represent secondary conditions that were also present on admission or conditions that were diagnosed after admission.

Stage 2 Infection/Neoplasm/Defect Secondary Diagnosis Codes

- 170.7 (Malignant neoplasm of long bones of lower limb)
- 171.3 (Malignant neoplasm of soft tissue, lower limb, including hip)
- 711.05 (Pyogenic arthritis, pelvic region and thigh)
- 711.06 (Pyogenic arthritis, lower leg)
- 730.05 (Acute osteomyelitis, pelvic region and thigh)
- 730.06 (Acute osteomyelitis, lower leg)
- 730.15 (Chronic osteomyelitis, pelvic region and thigh)
- 730.16 (Chronic osteomyelitis, lower leg)
- 730.25 (Unspecified osteomyelitis, pelvic region and thigh)
- 730.26 (Unspecified osteomyelitis, lower leg)
- 996.66 (Infection and inflammatory reaction due to internal joint prosthesis)
- 996.67 (Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft)

(2) AAHKS Recommendation 2: Reclassify certain specific joint procedures.

The AAHKS suggested that cases with the infection/neoplasm/defect diagnoses listed above be segregated according to the Stage 1 and 2 groups listed above. The AAHKS made one final recommendation concerning joint procedure cases with infections. It identified a subset of patients who had a principal diagnosis of code 996.66 (Infection and inflammatory reaction due to internal joint prosthesis) and who also had a secondary diagnosis of sepsis or septicemia. The AAHKS believed that these patients are for the most part admitted with both the joint infection and sepsis/septicemia present at the time of admission. The codes for sepsis/septicemia are classified as MCCs under MS–DRGs. The AAHKS believed it is inappropriate to count the secondary diagnosis of sepsis/septicemia as an MCC when it is reported with code 996.66. The AAHKS believed that counting sepsis and septicemia as an MCC results in double counting the infections. It believed that the joint infection and septicemia are the same infection. The AAHKS recommended that the following sepsis and septicemia codes not count as an MCC when reported with code 996.66:

- 038.0 (Streptococcal septicemia)
- 038.10 (Staphylococcal septicemia, unspecified)
- 038.11 (Staphylococcal aureus septicemia)
- 038.19 (Other staphylococcal septicemia)
- 038.2 (Pneumococcal septicemia [streptococcus pneumonia septicemia])
- 038.3 (Septicemia due anaerobes)
- 038.40 (Septicemia due to gram-negative organisms)
- 038.41 (Hemophilus influenzae [H. Influenzae])
- 038.42 (Escherichia coli [E. Coli])
- 038.43 (Pseudomonas)
- 038.44 (Serratia)
- 038.49 (Other septicemia due to gram-negative organisms)
- 038.8 (Other specified septicemias)
- 038.9 (Unspecified septicemia)
- 995.91 (Sepsis)
- 995.92 (Severe sepsis)

e. CMS' Response to AAHKS' Recommendations

The MS–DRG modifications proposed by the AAHKS are quite complex and have many separate parts. We made changes to the MS–DRGs in FY 2008 as a result of a request by the AAHKS as discussed above, to recognize two types of partial knee replacements as less complex procedures. We have no data on how effective the new MS–DRGs for joint procedures are in differentiating patients with varying degrees of severity. Therefore, as we indicated in the proposed rule, we analyzed data reported prior to the adoption of MS–DRGs to analyze each of the recommendations made. We begin our analysis by focusing first on the more simple aspects of the recommendations made by the AAHKS.

(1) Changing the MS–DRG assignment for codes 00.73, 00.83, and 00.84.

As discussed previously, in FY 2008, the AAHKS recommended that CMS classify certain joint procedures as either routine or complex. We examined the data for these cases and found that the following two codes had significantly lower charges than the other joint revisions: 00.83 (Revision of knee replacement, patellar component) and 00.84 (Revision of knee replacement, tibial insert (liner)). Therefore, we moved these two codes to MS–DRGs 485, 486, and 487, and MS–DRGs 488 and 489.

As a result of AAHKS' most recent recommendations, we once again

examined claims data for these two knee procedures (codes 00.83 and 00.84) as well as its request that we move code 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only). Code 00.73 is assigned to MS–DRGs 466, 467, and 468. The following tables show our findings.

MS–DRG	Number of cases	Average length of stay	Average charges
485—All Cases	1,122	12.20	$64,672.47
485—Cases with Code 00.83 or 00.84	179	11.83	64,446.68
485—Cases without Code 00.83 or 00.84	943	12.27	64,715.33
486—All Cases	2,061	8.03	40,758.55
486—Cases with Code 00.83 or 00.84	464	7.34	39,864.39
486—Cases without Code 00.83 or 00.84	1,597	8.23	41,018.34
487—All Cases	1,236	5.67	29,180.88
487—Cases with Code 00.83 or 00.84	284	5.61	31,231.79
487—Cases without Code 00.83 or 00.84	952	5.68	28,569.06
488—All Cases	2,374	5.17	30,180.80
488—Cases with Code 00.83 or 00.84	754	4.09	28,432.06
488—Cases without Code 00.83 or 00.84	1,620	5.67	30,994.73
489—All Cases	5,493	3.04	21,385.67
489—Cases with Code 00.83 or 00.84	2,154	3.07	23,122.18
489—Cases without Code 00.83 or 00.84	3,339	3.03	20,265.44
469—All Cases	29,030	8.17	56,681.64
470—All Cases	385,123	3.93	36,126.23
466—All Cases	3,888	9.18	76,015.66
466—Cases with Code 00.73	273	10.02	71,293.33
466—Cases without Code 00.73	3,616	9.12	76,372.06
467—All Cases	13,551	5.50	53,431.63
467—Cases with Code 00.73	1,078	5.94	43,635.63
467—Cases without Code 00.73	12,484	5.47	54,284.13
468—All Cases	19,917	3.94	44,055.62
468—Cases with Code 00.73	1,688	3.93	33,449.22
468—Cases without Code 00.73	18,232	3.94	45,037.09
469—All Cases	29,030	8.17	56,681.64
470—All Cases	385,123	3.93	36,126.23

The tables show that codes 00.73, 00.83, and 00.84 are appropriately assigned to their current MS–DRGs. The data do not support moving these three codes to MS–DRGs 469 and 470. Therefore, we did not propose a change of MS–DRG assignment for codes 00.73, 00.83, and 00.84 for FY 2009.

(2) Excluding sepsis and septicemia from being an MCC with code 996.66.

There are cases where a patient may be admitted with an infection of a joint prosthesis (code 996.66) and also have sepsis. In these cases, it may be possible to perform joint procedures as suggested by AAHKS. However, in other cases, a patient may be admitted with an infection of a joint prosthesis and then develop sepsis during the stay. Because our current data do not indicate whether a condition is present on admission, we could not determine whether or not the sepsis occurred after admission. Our data have consistently shown that cases of sepsis and septicemia require significant resources. Therefore, we classified the sepsis and septicemia codes as MCCs. Our clinical advisors do not believe it is appropriate to exclude all cases of sepsis and septicemia that are reported as a secondary diagnosis with code 996.66 from being classified as a MCC. We discuss septicemia as part of the HAC provision under section II.F. of the preamble of the proposed rule and this final rule. For the purposes of classifying sepsis and septicemia as non-CCs when reported with code 996.66, we do not support this recommendation. Therefore, in the proposed rule, we did not propose that the sepsis and septicemia codes be added to the CC exclusion list for code 996.66.

(3) Differences between Stage 1 and 2 cases with severe diagnoses.

As indicated in the proposed rule, we next examined data on AAHKS' suggestion that there are significant differences in resource utilization for cases they refer to as Stage 1 and 2. AAHKS stated that this is particularly true for those with infections, neoplasms, or structural defects. We used the list of procedure codes listed above that AAHKS describes as Stage 1 and 2 procedures. We also used AAHKS' designated lists of Stage 1 and 2 principal diagnosis codes to examine this proposal. This proposal entails moving cases with a Stage 1 or 2 principal diagnosis and procedure out of their current MS–DRG assignment in the following 19 MS–DRGs and into a newly consolidated set of MS–DRGs: MS–DRGs 463, 464, and 465, 480, 481, and 482, 485 through 489, and 495, 496, and 497.

As can be seen from the information below, there was not a significant difference in average charges between these Stage 1 and Stage 2 cases that have an MCC.

Stage 1	Total cases	Average length of stay	Average charges
Stage 1 Cases With Infection, Neoplasm, or Structural Defect			
With MCC	1,306	14.1	$79,232
Without MCC	4,115	7.6	$44,716

Stage 1	Total cases	Average length of stay	Average charges
Stage 2 Cases With Infection, Neoplasm, or Structural Defect			
With MCC	1,072	10.9	$80,781
Without MCC	5,413	6.0	$57,355

Average charges for Stage 1 cases with an MCC was $79,232 compared to $80,781 for Stage 2. Stage 1 cases without an MCC had average charges of $44,716 compared to $57,355. These data do not support reconfiguring the current MS–DRGs based on this new subdivision.

(4) Moving joint procedure cases to new MS–DRGs based on secondary diagnoses of infection.

We examined AAHKS' recommendation that Stage 2 joint cases with specific secondary diagnoses of infection or neoplasm be moved out of their current MS–DRG assignments and into a newly constructed MS–DRG. We indicated in the proposed rule that we are reluctant to make this type of significant DRG change to the joint MS–DRGs based on the presence of a secondary diagnosis. This results in the movement of cases out of MS–DRGs which were configured based on the reason for the admission (for example, principal diagnosis) and surgery. The cases would instead be assigned based on conditions that are reported as secondary diagnoses. In some cases, the infection may have developed or be diagnosed during the admission. This would be a significant logic change to the MS–DRGs for joint procedures. This logic change would involve setting a new precedent of reassigning cases to a different MS–DRG if an infection is reported as a secondary diagnosis. The secondary diagnosis of infection could be present on admission or develop after the admission. Currently, secondary diagnoses are evaluated to determine if they are an MCC or CC, and then they can lead to the case being assigned to a higher severity level. The secondary diagnoses do not currently lead to the removal of the case from the MS–DRG and reassignment to a new MS–DRG. We have not had an opportunity to examine claims data based on hospital discharges under the MS–DRGs which began October 1, 2008. Our clinical advisors believe it would be more appropriate to wait for data under the new MS–DRG system to determine how well the new severity levels are addressing accurate payment for these cases before considering this approach to assigning cases to a MS–DRG.

(5) Moving cases with infection, neoplasms, or structural defects out of 19 MS–DRGs and into two newly developed MS–DRGs.

The last recommended by AAHKS that we considered was moving cases with a principal diagnosis of infection, neoplasm, or structural defect from their list of Stage 1 and 2 diagnoses and consolidating them into newly constructed and modified MS–DRGs. AAHKS could not identify an existing set of MS–DRGs with similar resource utilizations into which the Stage 1 cases could be assigned. Therefore, the AAHKS recommended that CMS create three new MS–DRGs for Stage 1 cases with infections, neoplasms and structural defects which would be titled ''Arthrotomy/Removal/Component exchange of Infected Hip or Knee Prosthesis with MCC, with CC, and without CC/MCC'', respectively.

The AAHKS recommended moving Stage 2 cases out of MS–DRGs 466, 467, and 468, and 469 and 470 and into MS–DRGs 461 and 462. AAHKS recommended that MS–DRGs 461 and 462 be renamed ''Major Joint Procedures of Lower Extremity—Bilateral/Multiple/Infection/Malignancy''.

As we indicated in the proposed rule, in reviewing these proposed changes, we had a number of concerns. The first concern was that these proposed changes would result in the removal of cases with varying average charges from 19 current MS–DRGs and consolidating them into two separate sets of MS–DRGs. As the data below indicate, the average charges vary from as low as $29,181 in MS–DRG 487 to $81,089 in MS–DRG 463. Furthermore, the average charges for these infection/neoplasm/structural defect cases are very similar to other cases in their respective MS–DRG assignments for many of these MS–DRGs. There are cases where the average charges are higher. In MS–DRG 469 and 470, the infection/neoplasm/structural defect cases are significantly higher. However, there are only 136 cases in MS–DRG 469 out of a total of 29,030 cases with these diagnoses. There are only 673 cases in MS–DRG 470 out of a total of 385,123 cases with one of these diagnoses. The table below clearly demonstrates the wide variety of charges for cases with these diagnoses.

MS–DRGs	Number of cases	Average length of stay	Average charges
463—All Cases	4,747	16.25	$73,405.46
463—Cases with PDX of Infection/Malignancy/React	1,009	17.79	81,089.07
464—All Cases	5,499	10.21	44,387.73
464—Cases with PDX of Infection/Malignancy/React	1,420	10.59	46,800.60
465—All Cases	2,271	5.95	26,631.57
465—Cases with PDX of Infection/Malignancy/React	557	10.59	29,816.40
466—All Cases	3,888	9.18	76,015.66
466—Cases with PDX of Infection/Malignancy/React	890	10.67	79,334.69
467—All Cases	13,551	5.50	53,431.63
467—Cases with PDX of Infection/Malignancy/React	2,401	6.71	58,506.86
468—All Cases	19,917	3.94	44,055.62
468—Cases with PDX of Infection/Malignancy/React	1,994	4.76	54,322.03
469—All Cases	29,030	8.17	56,681.64
469—Cases with PDX of Infection/Malignancy/React	136	11.74	85,256.07
470—All Cases	385,123	3.93	36,126.23
470—Cases with PDX of Infection/Malignancy/React	673	6.44	59,676.31
480—All Cases	25,391	9.32	52,281.65
480—Cases with PDX of Infection/Malignancy/React	880	14.53	76,355.15
481—All Cases	68,655	5.94	32,963.64

MS–DRGs	Number of cases	Average length of stay	Average charges
481—Cases with PDX of Infection/Malignancy/React	878	8.78	48,655.30
482—All Cases	45,832	4.86	27,266.20
482—Cases with PDX of Infection/Malignancy/React	577	6.19	37,572.38
485—All Cases	1,122	12.20	64,672.47
485—Cases with PDX of Infection/Malignancy/React	1,122	12.20	64,672.47
486—All Cases	2,061	8.03	40,758.55
486—Cases with PDX of Infection/Malignancy/React	2,061	8.03	40,758.55
487—All Cases	1,236	5.67	29,180.88
487—Cases with PDX of Infection/Malignancy/React	1,236	5.67	29,180.88
488—All Cases	2,374	5.17	30,180.80
488—Cases with PDX of Infection/Malignancy/React	31	7.13	50,155.42
489—All Cases	5,493	3.04	21,385.67
489—Cases with PDX of Infection/Malignancy/React	36	3.72	35,313.84
495—All Cases	1,860	10.94	55,103.91
495—Cases with PDX of Infection/Malignancy/React	1,025	11.74	59,453.69
496—All Cases	5,203	5.95	32,177.29
496—Cases with PDX of Infection/Malignancy/React	2,759	6.98	36,940.99
497—All Cases	6,259	3.01	21,445.60
497—Cases with PDX of Infection/Malignancy/React	1,500	5.18	29,966.98

Given the wide variety of charges and the small number of cases where there are differences in charges, we do not believe the data support the AAKHS' recommendations. The data do not support removing these cases from the 19 MS–DRGs above and consolidating them into a new set of MS–DRGs, either newly created, or by adding them to MS–DRG 461 or 462, which have average charges of $80,718 and $57,355, respectively.

A second major concern involves redefining MS–DRGs 461 and 462 is that these MS–DRGs currently capture bilateral and multiple joint procedures. These MS–DRGs were specifically created to capture a unique set of patients who undergo procedures on more than one lower joint. Redefining these MS–DRGs to include both single and multiple joints undermines the clinical coherence of this MS–DRG. It would create a widely diverse group of patients based on either a list of specific diagnoses or the fact that the patient had multiple lower joint procedures.

Comment: While we did not receive any public comments specifically supporting the reassignment of codes 00.73, 00.83, and 00.84 to MS–DRGs 469 and 470, several commenters acknowledged CMS' discussion of the FY 2008 implementation of MS–DRGs and lack of data to support major MS–DRG changes for FY 2009. The commenters accepted CMS' proposal of not making significant revisions to the MS–DRGs until claims data under the new MS–DRG system are available.

Several commenters suggested an alternative way of capturing the more resource intensive joint procedure cases, particularly those involving an infected joint. The commenters recommended moving codes 80.05 (Arthrotomy for removal of hip prosthesis) and 80.06 (Arthrotomy for removal of knee prosthesis) into MS–DRGs 463 through 465 (Wound Debridement and Skin Graft Except Hand, for Musculoskeletal-Connective Tissue Disease with MCC, with CC, and without CC/MCC, respectively). (We note that code 80.05 is currently assigned to MS–DRGs 480 through 482 (Hip and Femur Procedures Except Major Joint with MCC, with CC, and without CC/MCC, respectively). Code 80.06 is currently assigned to MS–DRGs 495 through 497 (Local Excision and Removal Internal Fixation Devices Except Hip and Femur with MCC, with CC, and without CC/MCC, respectively).)

The commenters stated that a deep infection is one of the most devastating complications associated with hip and knee joint replacements, and that these cases require increased costs and resource utilization. The commenters believed that there is a strong financial disincentive for physicians and hospitals to provide care for patients with infected joint replacements. They indicated that this leads to an increased economic burden on tertiary care referral centers where patients with infected joint replacements are frequently referred for definitive management.

The commenters believed that codes 80.05 and 80.06 were a good proxy for cases of infected joints containing a previously implanted joint prosthesis. The commenters suggested that moving these two codes was considerably less complex than the previously discussed revisions to the joint DRGs. They also believed these two codes clearly captured cases with infected joint prostheses. The commenters believed that these codes would only be reported in cases of an infected joint where the previous infected prosthesis was removed and no new prosthesis was inserted. The commenters stated that when a previously implanted joint prosthesis is removed and replaced with a new prosthesis, coders assign only the code for the insertion of the new prosthesis. They added that they do not routinely assign an additional code for the removal of the joint prosthesis (code 80.05 or 80.06). The commenters also stated that when there is an infected joint, the joint prosthesis may be removed and extensive debridement may be provided involving bone and surrounding tissue. The commenters further stated that an antibiotic-impregnated cement spacer may be inserted to maintain alignment of the limb during the course of antibiotic therapy. According to the commenters, the new prosthesis will not be inserted until such time as the infection is fully resolved. In this case, the commenter stated that code 80.05 or 80.06 would be reported.

The commenters believed that when codes 80.05 or 80.06 are reported to capture the removal of a joint prosthesis, one can assume that the patient had a joint infection. Therefore, the commenters requested that codes 80.05 and 80.06 be reassigned to MS–DRGs 463, 464, and 465 because wound debridement is a treatment for infected joints.

Response: We agree with the commenters that we should not move codes 00.73, 00.83, and 00.84 to MS–DRGs 469 and 470. Our data do not support this change. Therefore, in this final rule for FY 2009, we are not moving codes 00.73, 00.83, and 00.84 to MS–DRGs 469 and 470.

We evaluated the alternative suggestion of moving codes 80.05 and 80.06 into MS–DRGs 463, 464, and 465. We disagree with the suggestion that the use of codes 80.05 and 80.06 serves as a good proxy for cases of infected joint prostheses. These two codes are used to capture the fact that a previously inserted joint prosthesis is now being removed. These prostheses can be removed for a variety of reason including wearing, breakage, and infection. Assuming that these cases are infections and then moving the cases to the debridement DRGs, MS–DRGs 463, 464, and 465, is inappropriate. We acknowledge that when a patient has an infected joint prosthesis, the prosthesis may be removed and treatment for the infection instituted, such as debridement. However, the most specific way of identifying these cases would be to examine the diagnosis code for the presence of an infection and to look for a debridement procedure code.

Furthermore, the current codes for removal of joint prostheses do not have specific instructions indicating that a coder must not report codes 80.05 and 80.06 when also reporting one of the joint revision codes. While the coding index implies that one does not need to report a code for the removal of the prosthesis when it is being replaced, it is not precluded under the codes. If a code is reported for the removal of the previous joint prosthesis along with a code for the joint revision, the proposed logic change would result in the case being assigned to MS–DRGs 463, 464, and 465 even though the patient did not have an infection or a debridement performed. This DRG assignment would be a result of the surgical hierarchy which places the debridement DRGs (MS–DRGs 463, 464, and 465) higher than the joint revision DRGs (MS–DRGs 466, 467, and 468). The proposed MS–DRG logic change could lead to the misclassification of many joint revision cases that did not have an infection or a debridement into the debridement DRGs.

We plan to discuss the need to provide more definitive coding notes under codes 80.05 and 80.06 at the September 24–25, 2008 ICD–9–CM Coordination and Maintenance Committee meeting to better clarify that one would not assign a code for the removal of a joint prosthesis if a new prosthesis is inserted. This clarification may be useful when considering future refinements to the joint procedure DRGs. However, at this time, we believe that codes 80.05 and 80.06 cannot be used as a definitive means of capturing cases of an infected joint prosthesis. We believe it is more appropriate to utilize diagnosis codes to clearly identify joint infections and debridement codes to indicate debridement. We will continue to examine means to better classify joint infections under the MS–DRGs. However, we are not moving codes 80.05 and 80.06 into MS–DRGs 463, 464, and 465 at this time. In addition, as stated previously, we also are not moving codes 00.73, 00.83, and 00.84 to MS–DRGs 469 and 470. We are making no changes to the joint procedure MS–DRGs for FY 2009.

Comment: One commenter provided additional recommendations to those discussed in the previous comment. The commenter stated that, after submission of his first comment, he had discovered a technical anomaly in the treatment of patients with hip and knee revision who also have a debridement that relates to the surgical hierarchy in MDC 8. The commenter pointed out that the wound debridement and skin graft MS–DRGs (MS–DRGs 463, 464, and 465) are currently sequenced before the revision of hip or knee replacement MS–DRGs (MS–DRGs 466, 467, and 468). Therefore, the commenter added, if codes are reported for revision of hip or knee replacement as well as for debridement of an infection, the case will be assigned to MS–DRGs 463, 467, or 465. The commenter believed that cases with both a debridement and a total revision prosthesis are more clinically similar to the revision cases than the debridement cases. Therefore, the commenter requested that the order of the wound debridement and skin graft MS–DRGs and the revision of the hip and knee MS–DRGs be reversed.

Response: We agree that the current logic for wound debridement of infections results in cases being assigned to MS–DRGs 463, 467, and 465. We also agree that joint revisions without debridements of infections are currently assigned to MS–DRGs 466, 467, and 468. We point out that this logic results in patients with infections being assigned to the exact MS–DRGs requested by the commenters in the prior discussion. We believe this current logic results in the appropriate assignment of joint revisions with and without debridements.

MS–DRGs 466, 467, and 468 contain revisions for both total and partial joint revisions. For instance, MS–DRGs 466, 467, and 468 includes revisions of the total hip joint as well as a partial hip revision of only the femoral component. The commenter believed that a subset of the revision cases, those with a total revision, are more clinically similar to the revision cases than to the debridement cases. For this reason, the commenter recommended that the surgical hierarchy be changed so that revision of a hip and knee prosthesis in MS–DRGs 466, 467, and 468 should be placed above the debridement MS–DRGs (MS–DRGs 463, 464, and 465). We point out that the surgical hierarchy is based on all cases within each DRG, not a subset. Furthermore, we have no MS–DRG claims data on which to evaluate the need to change the surgical hierarchy based on this recommendation. We note that this discussion reinforces the point that the current codes for debridement of an infection and joint revisions seem to correctly assign cases to the most appropriate MS–DRG. Therefore, in this final rule, we are not making any changes to the joint procedure MS–DRGs for FY 2009. We are deferring the examination of infections of joint replacements until such time as we have MS–DRG claims data.

Comment: Several commenters expressed their concern about the joint procedure MS–DRGs. The commenters supported CMS' efforts in the FY 2008 IPPS final rule to better reflect the clinical needs of patients and the resources used by hospitals. The commenters particularly appreciated CMS' adoption of the FY 2008 refined joint replacement MS–DRGs that better recognize patient acuity. However, the commenters believed that further refinements and additional MS–DRGs are needed for joint procedures. The commenters stated that the joint procedure MS–DRGs could be improved by making changes in FY 2009 to the MCC/CC classifications of specific codes that represent conditions impacting joint procedure patients. In particular, the commenters recommended the following changes:

- Changing the following codes from non-CCs to CCs: 731.3 (Major osseous defects); 278.0 (Overweight and obesity); V85.35 (Body Mass index 35.0–35.9, adult); V85.36 (Body Mass index 36.0–36.9, adult); and V85.37 (Body Mass index 37.0–37.9, adult).
- Changing the following codes from non-CCs to MCCs: 278.01 (Morbid obesity); V85.38 (Body Mass index 38.0–38.9, adult); and V85.39 (Body Mass index 39.0–39.9, adult).
- Changing code V85.40 (Body Mass index 40 and over, adult) from a CC to an MCC.

The commenters also recommended that CMS continue to evaluate the MS–DRG assignments for codes 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only) and 00.84 (Revision of total knee replacement, tibial insert (liner)). The commenters stated that once CMS receives MS–DRG data, these data may

support reassigning these codes to other MS–DRGs.

Response: While we acknowledge that the commenters were concerned about the effect that the obesity may have on joint patients, we point out that specific codes are classified as CCs or MCCs based on how they affect a wide range of patients. In the creation of the MS–DRGs, clinical evaluation and claims data did support the current MCC/CC classifications for these codes. However, as we gain experience and data under the MS–DRG system, we will continue to examine ways to improve the joint procedure MS–DRGs. We do not have MS–DRG data to evaluate these MCC/CC reclassifications or the possible reassignment of codes 00.73 or 00.84 at this time.

Therefore, in this final rule, we are not changing the MCC/CC classifications or the MS–DRG reassignments for codes 00.73, 00.83, or 00.84 for FY 2009. We also are not making changes to the joint procedure MS–DRGs for FY 2009.

f. Conclusion

The AAHKS recommended a number of complicated, interrelated MS–DRG changes to the joint procedure MS–DRGs. We have not yet had the opportunity to review data for these cases under the new MS–DRGs. We did analyze the impact of these recommendations using cases prior to the implementation of MS–DRGs. The recommendations were difficult to analyze because there were so many separate logic changes that impacted a number of MS–DRGs. We did examine each major suggestion separately, and found that our data and clinical analysis did not support making these changes. Therefore, in the FY 2009 IPPS proposed rule, we did not propose any revisions to the joint procedure MS–DRGs for FY 2009, nor are we making any revisions in this final rule. We look forward to examining these issues once we receive data under the MS–DRG system. As we indicated in the proposed rule, we also welcome additional recommendations from the AAHKS and others on a more incremental approach to resolving its concerns about the ability of the current MS–DRGs to adequately capture differences in severity levels for joint procedure patients.

5. MDC 18 (Infections and Parasitic Diseases (Systemic or Unspecified Sites): Severe Sepsis

We received a request from a manufacturer to modify the titles for three MS–DRGs with the most significant concentration of severe sepsis patients. The manufacturer stated that modification of the titles will assist in quality improvement efforts and provide a better reflection on the types of patients included in these MS–DRGs. Specifically, the manufacturer urged CMS to incorporate the term ''severe sepsis'' into the titles of the following MS–DRGs that became effective October 1, 2007 (FY 2008)

- MS–DRG 870 (Septicemia with Mechanical Ventilation 96+ Hours)
- MS–DRG 871 (Septicemia without Mechanical Ventilation 96+ Hours with MCC)
- MS–DRG 872 (Septicemia without Mechanical Ventilation 96+ Hours without MCC)

These MS–DRGs were created to better recognize severity of illness among patients diagnosed with conditions including septicemia, severe sepsis, septic shock, and systemic inflammatory response syndrome (SIRS) who are also treated with mechanical ventilation for a specified duration of time.

According to the manufacturer, ''severe sepsis is a common, deadly and costly disease, yet the number of patients impacted and the outcomes associated with their care remain largely hidden within the administrative data set.'' The manufacturer further noted that, although improvements have been made in the ICD–9–CM coding of severe sepsis (diagnosis code 995.92) and septic shock (diagnosis code 785.52), results of an analysis demonstrated an unacceptably high mortality rate for patients reported to have those conditions. The manufacturer believed that revising the titles to incorporate ''severe sepsis'' will provide various clinicians and researchers the opportunity to improve outcomes for these patients. Therefore, the manufacturer recommended revising the current MS–DRG titles as follows:

- Proposed Revised MS–DRG 870 (Septicemia or Severe Sepsis with Mechanical Ventilation 96+ Hours)
- Proposed Revised MS–DRG 871 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC)
- Proposed Revised MS–DRG 872 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC)

Comment: Many commenters applauded CMS for helping to promote quality improvement efforts for patients with severe sepsis. The commenters expressed their support for revising the titles of MS–DRGs 870, 871, and 872 to include the term ''Severe Sepsis''. The commenters agreed that MS–DRGs 870, 871, and 872 already include a significant concentration of patients with severe sepsis and the change would increase awareness as well as facilitate research to improve care and patient outcomes.

Response: As we indicated in the proposed rule, we agree that revising the current MS–DRG titles to include the term ''Severe Sepsis'' would better assist in the recognition and identification of this disease, which could lead to better clinical outcomes and quality improvement efforts. In addition, both severe sepsis (diagnosis code 995.92) and septic shock (diagnosis code 785.52) are currently already assigned to these three MS–DRGs. Therefore, as we proposed, in this final rule we are revising the titles of MS–DRGs 870, 871, and 872 to reflect severe sepsis in the titles for FY 2009, as suggested and listed above.

Comment: One commenter thanked CMS for the proposal to modify the titles for MS–DRGs 870, 871, and 872 by including the term ''severe sepsis'' and suggested that the title for MS–DRG 853 (Infectious and Parasitic Diseases with O.R. Procedure with MCC) be modified to include the term ''severe sepsis and other'' as well. The commenter stated that, based on an analysis the commenter conducted using Medicare discharge data, the concentration of patients with severe sepsis (code 995.92) and septic shock (code 785.52) in surgical MS–DRG 853 is comparable to the concentration of patients in medical MS–DRGs 870, 871, and 872.

According to the commenter's study, 43.1 percent of cases in MS–DRG 853 represent patients with severe sepsis. As a result of these findings, the commenter stated that revising the title for MS–DRG 853 to include the term ''severe sepsis and other'' would be consistent with the rationale for proposing to modify the titles to MS–DRGs 870, 871, and 872. The commenter asserted that this additional MS–DRG modification would also better assist in the recognition and identification of severe sepsis, leading to better clinical outcomes and quality improvement efforts.

Response: We appreciate the commenter's support for the proposal to modify the titles to MS–DRGs 870, 871, and 872 to include the term ''Severe Sepsis''. As stated above, we agree and are finalizing the proposed revisions to the titles for MS–DRGs 870, 871, and 872 for FY 2009.

With regard to modifying the title to MS–DRG 853, we point out that the MS–DRG titles generally do not reflect all of the diagnoses or conditions that may have a significant concentration of patients within that particular MS–DRG.

In other words, the foundation of the MS–DRG titles represents ''*Diagnostic-Related Groups*'' [emphasis added].

We have also received several comments acknowledging CMS' discussion of the FY 2008 implementation of MS–DRGs and the lack of data to support major MS–DRG changes at this time. Overall, the commenters accepted CMS' proposal of not making significant revisions to the MS–DRGs until claims data under this new system are available. Therefore, as final policy for FY 2009, we are not making any change to the title for MS–DRG 853.

Comment: One commenter agreed with CMS' proposal to revise the descriptions for MS–DRGs 870, 871, and 872 by including the term ''Severe Sepsis'' in the titles. However, the commenter also suggested that CMS continue to study technological advances that may provide earlier identification of sepsis and clinical findings that indicate endotoxemia as a ''driver of morbidity and mortality in sepsis.''

The commenter believed that it would be essential to continue making modifications to the MS–DRG classification system to recognize newer technologies and treatments. Specifically, this commenter asked that CMS consider endotoxemia as an MCC, stating this would be consistent with the current MS–DRG system's designation of sepsis and septicemia as MCCs.

Response: We acknowledge the commenter's suggestion and appreciate the support for modifying the titles for MS–DRGs 870, 871, and 872 to include the term ''Severe Sepsis''. As mentioned earlier, we are finalizing the proposed revisions to the titles for these MS–DRGs for FY 2009.

In response to the commenter's recommendation that the MS–DRG classification system continue to be modified for purposes of recognizing new technologies or treatments, we do have a process in place under which we annually evaluate data and specific issues brought to our attention to determine if revisions are warranted. We refer the reader to section II.B.2 of the preamble in this final rule for a discussion on this process, as well as section II.J. of the preamble of this final rule for a discussion on the new technology add-on payment policy.

The term ''endotoxemia'' is defined as the presence of endotoxins in the blood. This condition (or finding) is established on the basis of a laboratory test. The ICD–9–CM coding system currently indexes the term ''endotoxemia'' with the instructional note to ''*code to condition*''. This instruction refers the coder to seek the underlying, definitive condition that is established and documented as a result of the laboratory finding of endotoxemia. Therefore, an ICD–9–CM code for endotoxemia does not exist and consideration cannot be given as to a severity level assignment such as MCC, as the commenter requested. However, as the commenter pointed out, the diagnoses of sepsis and septicemia are currently designated as MCCs and, as such; patients with these diagnoses are already appropriately identified in the classification system, despite the presence or absence of endotoxemia.

6. MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs): Traumatic Compartment Syndrome

Traumatic compartment syndrome is a condition in which increased pressure within a confined anatomical space that contains blood vessels, muscles, nerves, and bones causes a decrease in blood flow and may lead to tissue necrosis.

There are five ICD–9–CM diagnosis codes that were created effective October 1, 2006, to identify traumatic compartment syndrome of various sites.

- 958.90 (Compartment syndrome, unspecified)
- 958.91 (Traumatic compartment syndrome of upper extremity)
- 958.92 (Traumatic compartment syndrome of lower extremity)
- 958.93 (Traumatic compartment syndrome of abdomen)
- 958.99 (Traumatic compartment syndrome of other sites)

Cases with one of the diagnosis codes listed above reported as the principal diagnosis and no operating room procedure are assigned to either MS–DRG 922 (Other Injury, Poisoning and Toxic Effect Diagnosis with MCC) or MS–DRG 923 (Other Injury, Poisoning and Toxic Effect Diagnosis without MCC) in MDC 21.

In the FY 2008 IPPS final rule with comment period when we adopted the MS–DRGs, we inadvertently omitted the addition of these traumatic compartment syndrome codes 958.90 through 958.99 to the multiple trauma MS–DRGs 963 (Other Multiple Significant Trauma with MCC), MS–DRG 964 (Other Multiple Significant Trauma with CC), and MS–DRG 965 (Other Multiple Significant Trauma without CC/MCC) in MDC 24 (Multiple Significant Trauma). Cases are assigned to MDC 24 based on the principal diagnosis of trauma and at least two significant trauma diagnosis codes (either as principal or secondary diagnoses) from different body site categories. There are eight different body site categories as follows:

- Significant head trauma
- Significant chest trauma
- Significant abdominal trauma
- Significant kidney trauma
- Significant trauma of the urinary system
- Significant trauma of the pelvis or spine
- Significant trauma of the upper limb
- Significant trauma of the lower limb

Therefore, in the FY 2009 IPPS proposed rule, we proposed to add traumatic compartment syndrome codes 958.90 through 958.99 to MS–DRGs 963 and MS–DRG 965 in MDC 24. Under this proposal, codes 958.90 through 958.99 would be added to the list of principal diagnosis of significant trauma. In addition, code 958.91 would be added to the list of significant trauma of upper limb, code 958.92 would be added to the list of significant trauma of lower limb, and code 958.93 would be added to the list of significant abdominal trauma.

We did not address the consolidation of heart transplant MS–DRGs or liver transplant MS–DRGs in the FY 2009 IPPS proposed rule. However, we received a comment on these issues.

Comment: One commenter representing a national association of health information professionals expressed appreciation to CMS for proposing to add the traumatic compartment syndrome codes to the multiple trauma MS–DRGs in order to correct a previous omission.

Response: We appreciate the commenter's support.

In this final rule, we are adopting as final our proposal to add traumatic compartment syndrome codes 958.90 through 958.99 to MS–DRGs 963 and MS–DRG 965 in MDC 24. Codes 958.90 through 958.99 are added to the list of principal diagnosis of significant trauma. In addition, code 958.91 is added to the list of significant trauma of upper limb, code 958.92 is added to the list of significant trauma of lower limb, and code 958.93 is added to the list of significant abdominal trauma.

7. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this final rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a DRG.

For FY 2009, we proposed to make the following changes to the MCE edits:

a. List of Unacceptable Principal Diagnoses in MCE

Diagnosis code V62.84 (Suicidal ideation) was created for use beginning October 1, 2005. At the time the diagnosis code was created, it was not clear that the creation of this code was requested in order to describe the principal reason for admission to a facility or the principal reason for treatment. The NCHS Official ICD–9–CM Coding Guidelines therefore categorized the group of codes in V62.X for use only as additional or secondary diagnoses. It has been brought to the government's attention that the use of this code is hampered by its designation as an additional-only diagnosis. NCHS has therefore modified the Official Coding Guidelines for FY 2009 by making this code acceptable as a principal diagnosis as well as an additional diagnosis. In order to conform to this change by NCHS, we proposed to remove code V62.84 from the MCE list of ''Unacceptable Principal Diagnoses'' for FY 2009.

We did not receive any public comments on this proposal. Therefore, in this final rule, we are adopting as final our proposal to remove code V62.84 from the MCE list of ''Unacceptable Principal Diagnoses'' for FY 2009.

b. Diagnoses Allowed for Males Only Edit

There are four diagnosis codes that were inadvertently left off of the MCE edit titled ''Diagnoses Allowed for Males Only.'' These codes are located in the chapter of the ICD–9–CM diagnosis codes entitled ''Diseases of Male Genital Organs.'' We are proposing to add the following four codes to this MCE edit: 603.0 (Encysted hydrocele), 603.1 (Infected hydrocele), 603.8 (Other specified types of hydrocele), and 603.9 (Hydrocele, unspecified). We have had no reported problems or confusion with the omission of these codes from this section of the MCE, but in order to have an accurate product, we proposed that these codes be added for FY 2009.

We did not receive any public comments on these proposed MCE revisions. Therefore, for FY 2009, we are implementing the proposed changes as final by adding codes 603.0, 603.1, 603.8, and 603.9 to the MCE edit of diagnosis allowed for males only.

c. Limited Coverage Edit

As explained in section II.G.1. of the preamble of the proposed rule, we proposed to remove procedure code 37.52 (Implantation of internal biventricular heart replacement system) from the MCE ''Non-Covered Procedure'' edit and to assign it to the ''Limited Coverage'' edit. We proposed to include in this proposed edit the requirement that ICD–9–CM diagnosis code V70.7 (Examination of participant in clinical trial) also be present on the claim. We proposed that claims submitted without both procedure code 37.52 and diagnosis code V70.7 would be denied because they would not be in compliance with the coverage policy explained in section II.G.1. of this preamble.

We did not receive any public comments on this proposed MCE revision. Therefore, for FY 2009, we are implementing the proposed changes as final by removing code 37.52 from the ''Non-Covered Procedures'' edit and assigning it to the ''Limited Coverage'' edit. In addition, included in this edit is the requirement that ICD–9–CM diagnosis code V70.7 also be present on the claim. Claims submitted on behalf of Medicare beneficiaries that do not have both procedure code 37.52 and diagnosis code V70.7 will be denied, retroactive to May 1, 2008 (the date of the coverage decision memorandum described in section II.G.1. of the preamble of this final rule).

8. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different MS–DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single MS–DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. Application of this hierarchy ensures that cases involving multiple surgical procedures are assigned to the MS–DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of MS–DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more MS–DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single MS–DRG (MS–DRG 652) and the class ''kidney, ureter and major bladder procedures'' consists of three MS–DRGs (MS–DRGs 653, 654, and 655). Consequently, in many cases, the surgical hierarchy has an impact on more than one MS–DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each MS–DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes MS–DRGs 1 and 2 and surgical class B includes MS–DRGs 3, 4, and 5. Assume also that the average charge of MS–DRG 1 is higher than that of MS–DRG 3, but the average charges of MS–DRGs 4 and 5 are higher than the average charge of MS–DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each MS–DRG in the class by frequency (that is, by the number of cases in the MS–DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other O.R. procedures'' as discussed below.

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted MS–DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER search for the procedure in the most resource-intensive surgical class, in cases involving multiple procedures, this result is sometimes unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the MS–DRG or MS–DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average charges for two surgical classes is very small.

We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

For FY 2009, we proposed to revise the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System) by reordering MS–DRG 245 (AICD Generator Procedures) above new MS–DRG 265 (AICD Lead Procedures).

We did not receive any public comments on the proposed change to the surgical hierarchy described above. Based on the test of the proposed revision using the March 2008 update of the FY 2007 MedPAR file and the revised GROUPER software, we found that the revision is still supported by the data. Therefore, we are incorporating the proposed revision to the surgical hierarchy as final for FY 2009.

9. CC Exclusions List

a. Background

As indicated earlier in the preamble of this final rule, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered CCs. Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2. and 3. of the preamble of the FY 2008 IPPS final rule with comment period for a discussion of the refinement of CCs in relation to the MS–DRGs we adopted for FY 2008 (72 FR 47152 through 47121).

b. CC Exclusions List for FY 2009

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. As we indicated above, we developed a list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list.

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another.
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[19]

For FY 2009, as we proposed, in this final rule we are making limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2008. (See section II.G.11. of the preamble of this final rule for a discussion of ICD–9–CM changes.) We are making these changes in accordance with the principles established when we created the CC Exclusions List in 1987. In addition, as discussed in section II.D.3. of the preamble of this final rule, we are indicating on the CC exclusion list some updates to reflect the exclusion of a few codes from being an MCC under the MS–DRG system that we adopted for FY 2008.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which will be effective for discharges occurring on or after October 1, 2008, are not being published in this final rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H with an asterisk, and the conditions that will not count as a CC, are provided in an indented column immediately following the affected principal diagnosis.

A complete updated MCC, CC, and Non-CC Exclusions List is also available through the Internet on the CMS Web site at: *http:/www.cms.hhs.gov/AcuteInpatientPPS*. Beginning with discharges on or after October 1, 2008, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

To assist readers in the review of changes to the MCC and CC lists that occurred as a result of updates to the ICD–9–CM codes, as described in Tables 6A, 6C, and 6E, we are providing the following summaries of those MCC and CC changes.

In the summary tables, the diagnosis codes with an asterisk (*) were discussed at the March 19–20, 2008 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. Code 998.33 in Table 6J1, marked with two asterisks (**), had a change in code title subsequent to the

[19] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; the FY 2007 final rule (71 FR 47870) for the FY 2007 revisions; and the FY 2008 final rule (72 FR 47130) for the FY 2008 revisions. In the FY 2000 final rule (64 FR 41490, July 30, 1999, we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

proposed rule. The new codes will be implemented on October 1, 2008.

SUMMARY OF ADDITIONS TO THE MS–DRG MCC LIST—TABLE 6I.1

Code	Description
038.12*	Methicillin resistant Staphylococcus aureus septicemia.
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified.
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled.
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified.
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled.
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified.
249.31	Secondary diabetes mellitus with other coma, uncontrolled.
482.42*	Methicillin resistant pneumonia due to Staphylococcus aureus.
535.71*	Eosinophilic gastritis, with hemorrhage.
707.23	Pressure ulcer, stage III.
707.24	Pressure ulcer, stage IV.
777.50	Necrotizing enterocolitis in newborn, unspecified.
777.51	Stage I necrotizing enterocolitis in newborn.
777.52	Stage II necrotizing enterocolitis in newborn.
777.53	Stage III necrotizing enterocolitis in newborn.
780.72	Functional quadriplegia.

SUMMARY OF DELETIONS FROM THE MS–DRG MCC LIST—TABLE 6I.2

Code	Description
136.2	Specific infections by free-living amebae.
511.8	Other specified forms of pleural effusion, except tuberculous.
707.02	Pressure ulcer, upper back.
707.03	Pressure ulcer, lower back.
707.04	Pressure ulcer, hip.
707.05	Pressure ulcer, buttock.
707.06	Pressure ulcer, ankle.
707.07	Pressure ulcer, heel.
777.5	Necrotizing enterocolitis in fetus or newborn.

SUMMARY OF ADDITIONS TO THE MS–DRG CC LIST—TABLE 6J.1

Code	Description
046.11	Variant Creutzfeldt-Jakob disease.
046.19	Other and unspecified Creutzfeldt-Jakob disease.
046.71	Gerstmann-Sträussler-Scheinker syndrome.
046.72	Fatal familial insomnia.
046.79	Other and unspecified prion disease of central nervous system.
059.01	Monkeypox.
059.21	Tanapox.
136.29	Other specific infections by free-living amebae.
199.2	Malignant neoplasm associated with transplant organ.
203.02	Multiple myeloma, in relapse.
203.12	Plasma cell leukemia, in relapse.
203.82	Other immunoproliferative neoplasms, in relapse.
204.02	Acute lymphoid leukemia, in relapse.
204.12	Chronic lymphoid leukemia, in relapse.
204.22	Subacute lymphoid leukemia, in relapse.
204.82	Other lymphoid leukemia, in relapse.
204.92	Unspecified lymphoid leukemia, in relapse.
205.02	Acute myeloid leukemia, in relapse.
205.12	Chronic myeloid leukemia, in relapse.
205.22	Subacute myeloid leukemia, in relapse.
205.32	Myeloid sarcoma, in relapse.
205.82	Other myeloid leukemia, in relapse.
205.92	Unspecified myeloid leukemia, in relapse.
206.02	Acute monocytic leukemia, in relapse.
206.12	Chronic monocytic leukemia, in relapse.
206.22	Subacute monocytic leukemia, in relapse.
206.82	Other monocytic leukemia, in relapse.
206.92	Unspecified monocytic leukemia, in relapse.
207.02	Acute erythremia and erythroleukemia, in relapse.
207.12	Chronic erythremia, in relapse.
207.22	Megakaryocytic leukemia, in relapse.
207.82	Other specified leukemia, in relapse.

SUMMARY OF ADDITIONS TO THE MS–DRG CC LIST—TABLE 6J.1—Continued

Code	Description
208.02	Acute leukemia of unspecified cell type, in relapse.
208.12	Chronic leukemia of unspecified cell type, in relapse.
208.22	Subacute leukemia of unspecified cell type, in relapse.
208.82	Other leukemia of unspecified cell type, in relapse.
208.92	Unspecified leukemia, in relapse.
209.00	Malignant carcinoid tumor of the small intestine, unspecified portion.
209.01	Malignant carcinoid tumor of the duodenum.
209.02	Malignant carcinoid tumor of the jejunum.
209.03	Malignant carcinoid tumor of the ileum.
209.10	Malignant carcinoid tumor of the large intestine, unspecified portion.
209.11	Malignant carcinoid tumor of the appendix.
209.12	Malignant carcinoid tumor of the cecum.
209.13	Malignant carcinoid tumor of the ascending colon.
209.14	Malignant carcinoid tumor of the transverse colon.
209.15	Malignant carcinoid tumor of the descending colon.
209.16	Malignant carcinoid tumor of the sigmoid colon.
209.17	Malignant carcinoid tumor of the rectum.
209.20	Malignant carcinoid tumor of unknown primary site.
209.21	Malignant carcinoid tumor of the bronchus and lung.
209.22	Malignant carcinoid tumor of the thymus.
209.23	Malignant carcinoid tumor of the stomach.
209.24	Malignant carcinoid tumor of the kidney.
209.25	Malignant carcinoid tumor of foregut, not otherwise specified.
209.26	Malignant carcinoid tumor of midgut, not otherwise specified.
209.27	Malignant carcinoid tumor of hindgut, not otherwise specified.
209.29	Malignant carcinoid tumor of other sites.
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site.
238.77	Post-transplant lymphoproliferative disorder (PTLD).
279.50	Graft-versus-host disease, unspecified.
279.51	Acute graft-versus-host disease.
279.52	Chronic graft-versus-host disease.
279.53	Acute on chronic graft-versus-host disease.
346.60	Persistent migraine aura with cerebral infarction, without mention of intractable migraine without mention of status migrainosus.
346.61	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus.
346.62	Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus.
346.63	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, with status migrainosus.
349.31*	Accidental puncture or laceration of dura during a procedure.
349.39*	Other dural tear.
511.81	Malignant pleural effusion.
511.89	Other specified forms of effusion, except tuberculous.
649.70	Cervical shortening, unspecified as to episode of care or not applicable.
649.71	Cervical shortening, delivered, with or without mention of antepartum condition.
649.73	Cervical shortening, antepartum condition or complication.
695.12	Erythema multiforme major.
695.13	Stevens-Johnson syndrome.
695.14	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome.
695.15	Toxic epidermal necrolysis.
695.53	Exfoliation due to erythematous condition involving 30–39 percent of body surface.
695.54	Exfoliation due to erythematous condition involving 40–49 percent of body surface.
695.55	Exfoliation due to erythematous condition involving 50–59 percent of body surface.
695.56	Exfoliation due to erythematous condition involving 60–69 percent of body surface.
695.57	Exfoliation due to erythematous condition involving 70–79 percent of body surface.
695.58	Exfoliation due to erythematous condition involving 80–89 percent of body surface.
695.59	Exfoliation due to erythematous condition involving 90 percent or more of body surface.
997.31	Ventilator associated pneumonia.
997.39	Other respiratory complications.
998.30	Disruption of wound, unspecified.
998.33**	Disruption of traumatic injury wound repair.
999.81	Extravasation of vesicant chemotherapy.
999.82	Extravasation of other vesicant agent

SUMMARY OF DELETIONS TO THE MS–DRG CC LIST—TABLE 6J.2

Code	Description
046.1	Jakob-Creutzfeldt disease.
337.0	Idiopathic peripheral autonomic neuropathy.
695.1	Erythema multiforme.
707.00	Pressure ulcer, unspecified site.
707.01	Pressure ulcer, elbow.

SUMMARY OF DELETIONS TO THE MS–DRG CC LIST—TABLE 6J.2—Continued

Code	Description
707.09	Pressure ulcer, other site.
997.3	Respiratory complications.
999.8	Other transfusion reaction.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 25.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 26.0 of this manual, which includes the final FY 2009 DRG changes, is available in hard copy for $250.00. Version 26.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

10. Review of Procedure Codes in MS DRGs 981, 982, and 983; 984, 985, and 986; and 987, 988, and 989.

Each year, we review cases assigned to former CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these CMS DRGs. Under the MS–DRGs that we adopted for FY 2008, CMS DRG 468 was split three ways and became MS–DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 476 became MS–DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 477 became MS–DRGs 987, 988, and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC).

MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. MS–DRGs 984 through 986 (previously CMS DRG 476) are assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0, Incision of prostate
- 60.12, Open biopsy of prostate
- 60.15, Biopsy of periprostatic tissue
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue
- 60.21, Transurethral prostatectomy
- 60.29, Other transurethral prostatectomy
- 60.61, Local excision of lesion of prostate
- 60.69, Prostatectomy, not elsewhere classified
- 60.81, Incision of periprostatic tissue
- 60.82, Excision of periprostatic tissue
- 60.93, Repair of prostate
- 60.94, Control of (postoperative) hemorrhage of prostate
- 60.95, Transurethral balloon dilation of the prostatic urethra
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy
- 60.99, Other operations on prostate

All remaining O.R. procedures are assigned to MS–DRGs 981 through 983 and 987 through 989, with MS–DRGs 987 through 989 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[20]

For FY 2009, we did not propose to change the procedures assigned among these DRGs. We did not receive any public comments on our proposal and, therefore, are adopting it as final for FY 2009 in this final rule.

a. Moving Procedure Codes From MS–DRGs 981 Through 983 or MS–DRGs 987 Through 989 to MDCs

We annually conduct a review of procedures producing assignment to MS–DRGs 981 through 983 (formerly CMS DRG 468) or MS–DRGs 987 through 989 (formerly CMS DRG 477) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. For FY 2009, we did not propose to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989. We did not receive any public comments on our proposal and, therefore, we are adopting it as final for FY 2009 in this final rule.

b. Reassignment of Procedures Among MS–DRGs 981 Through 983, 984 Through 986, and 987 Through 989

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal

[20] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554. In FY 2008, no procedures were moved, as noted in the final rule with comment period (72 FR 46241).

diagnosis code, result in assignment to MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly, CMS DRGs 468, 476, and 477, respectively), to ascertain whether any of those procedures should be reassigned from one of these three DRGs to another of the three DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

For FY 2009, we did not propose to move any procedure codes among these DRGs. We did not receive any public comments on our proposal and, therefore, we are adopting it as final for FY 2009 in this final rule.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, as we proposed, we are not adding any diagnosis codes to MDCs for FY 2009. We did not receive any public comments on this subject.

11. Changes to the ICD–9–CM Coding System

As described in section II.B.1. of the preamble of this final rule, the ICD–9–CM is a coding system used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention, and CMS, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $27.00 by calling (202) 512–1800.) Complete information on ordering the CD–ROM is also available at: *http://www.cdc.gov/nchs/products/_prods/subject/icd96ed.htm*. The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures*.

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as individual physicians, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2009 at a public meeting held on September 27–28, 2007 and finalized the coding changes after consideration of comments received at the meetings and in writing by December 3, 2007. Those coding changes are announced in Tables 6A through 6F in the Addendum to this final rule. The Committee held its 2008 meeting on March 19–20, 2008. New codes for which there was a consensus of public support and for which complete tabular and indexing changes were made by May 2008 will be included in the October 1, 2008 update to ICD–9–CM. Code revisions that were discussed at the March 19–20, 2008 Committee meeting but that could not be finalized in time to include them in the Addendum to the proposed rule are included in Tables 6A through 6F of this final rule and are marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 27–28, 2007 meeting and March 19–20, 2008 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. The minutes of the diagnosis codes discussions at the September 27–28, 2007 meeting and March 19–20, 2008 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm*. Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS, Room 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov*.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *patricia.brooks2@cms.hhs.gov*.

The ICD–9–CM code changes that have been approved will become effective October 1, 2008. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the FY 2009 IPPS proposed rule, we only solicited comments on the proposed classification of these new codes.

For codes that have been replaced by new or expanded codes, and the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2008. Table 6D contains invalid procedure codes. These

invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2008. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the MS–DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2009.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 19–20, 2008 Committee meeting that received consensus and that were finalized by May 2008, are included in Tables 6A through 6F of the Addendum to this final rule.

Comment: One commenter was encouraged that CMS and the CDC have acted favorably on the commenter's proposal to create a new ICD–9–CM diagnosis code for heparin-induced thrombocytopenia (HIT).

According to the commenter, a specific code dedicated to this disease will provide more information regarding the prevalence of the condition and the cost associated with treating the disease. The increased focus on this condition can in turn promote proper screening to avoid its occurrence and improve patient safety. Accurate diagnosis and coding will also ensure that proper protocols are put in place and HIT specific treatment is rendered, thereby reducing adverse events when HIT does arise.

Response: We appreciate the comment. Effective October 1, 2008, an ICD–9–CM diagnosis code 289.84 (Heparin-induced thrombocytopenia (HIT)) is created.

Section 503(a) of Public Law 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the ''Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to identify the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to identify and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the spring and fall in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, is published on the CMS and NCHS Web sites in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April l, 2008 implementation of an ICD–9–CM code at the September 27–28, 2007 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2008.

We believe that this process captures the intent of section 1886(d)(5)(K)(vii) of the Act. This requirement was included in the provision revising the standards and process for recognizing new technology under the IPPS. In addition, the need for approval of new codes outside the existing cycle (October 1) arises most frequently and most acutely where the new codes will identify new technologies that are (or will be) under consideration for new technology add-on payments. Thus, we believe this provision was intended to expedite data collection through the assignment of new ICD–9–CM codes for new technologies seeking higher payments.

Current addendum and code title information is published on the CMS Web site at: *http://www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01_overview.asp#TopofPage*. Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Web site at: *http://www.cdc.gov/*

nchs/icd9.htm. Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM.* AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its contractors for use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. Thus, although we publish the code titles in the IPPS proposed and final rules, they are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same DRG in which its predecessor code was assigned so there will be no DRG impact as far as DRG assignment. Any midyear coding updates will be available through the Web sites indicated above and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. We will strive to have the April 1 updates available through these Web sites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates.

12. Other MS–DRG Issues

a. Heart Transplants or Implants of Heart Assist System and Liver Transplants

Comment: One commenter representing transplant surgeons was concerned about the proposed reductions in the MS–DRG relative weights for MS–DRG 002 (Heart Transplant or Implant of Heart Assist System without MCC) and MS–DRG 006 (Liver Transplant without MCC). According to the commenter, the relative weight for MS–DRG 006 would decrease by approximately 33 percent and the relative weight for MS–DRG 002 would be reduced by 20 percent. The commenter also reported that only 30 percent of the heart transplant cases were assigned to MS–DRG 002 and 26 percent of the liver transplant cases were assigned to MS–DRG 006. The commenter questioned the statistical reliability of the data and recommended that CMS establish a single MS–DRG for heart transplants and a single MS–DRG for liver transplants.

The commenter stated that one factor that influences hospital costs and lengths of stay is the characteristics of the donor organ. The commenter stated that the donor risk index (DRI) and the model for end-stage liver disease (MELD) system which prioritizes patients waiting for liver transplants by severity of illness are two important factors for any severity index for transplant DRGs. This information is not identified in the MedPAR data. The commenter acknowledged that it is in the process of developing a proposal for NCHS to incorporate this information into potential ICD–9–CM diagnosis codes. The commenter stated that, until these factors can be incorporated into the data, it is not appropriate to have severity-based DRGs for heart and liver transplant procedures based on CC or MCC that have not been validated as predictors in the transplant population.

The commenter also requested that CMS create a new MS–DRG for combined liver/kidney transplants. These cases are currently assigned to the liver transplant DRGs 005–006 (Liver Transplant with MCC or Intestinal Transplant and Liver Transplant without MCC). While the commenter acknowledged that most of these cases would be assigned to MS–DRG 005, the MCC group, the commenter contended that a separate DRG is needed to address the significantly higher costs and length of stay associated with combined liver/kidney transplants.

Response: As we stated in the FY 2008 IPPS final rule (72 FR 47251), clinical evaluation and claims data supported the current MCC split for heart and liver transplants. Several commenters accepted CMS's proposal of not making significant revisions to the MS–DRGs until claims data under the new MS–DRG system are available. At this time, we do not have MS–DRG data to evaluate these significant changes. Therefore, we are not implementing any changes to the transplant MS–DRGs for FY 2009.

b. New Codes for Pressure Ulcers

As discussed in the FY 2008 IPPS final rule with comment period (72 FR 47205–47206), we referred the need for more detailed ICD–9–CM pressure ulcer codes to the CDC. The topic of expanding pressure ulcer codes to capture the stage of the ulcer was addressed at the September 27–28, 2007, meeting of the ICD–9–CM Coordination and Maintenance Committee. A summary report of that meeting is available on the Web site at: *http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm*.

At the September 2007 meeting of the ICD–9–CM Coordination and Maintenance Committee, numerous wound care professionals supported modifying the pressure ulcer codes to capture staging information. The stage of the pressure ulcer is a powerful predictor of severity and resource utilization. At the meeting, the ICD–9–CM Coordination and Maintenance Committee discussed the creation of pressure ulcer codes to capture staging information. The new codes, along with their CC/MCC classifications, are shown in Table 6A of the Addendum to the proposed rule and this final rule. The new codes are as follows:

- 707.20 (Pressure ulcer, unspecified stage)
- 707.21 (Pressure ulcer stage I)
- 707.22 (Pressure ulcer stage II)
- 707.23 (Pressure ulcer stage III)
- 707.24 (Pressure ulcer stage IV)
- 707.25 (Pressure ulcer unstageable)

Comment: Several commenters supported the ICD–9–CM diagnosis codes for pressure ulcer stages. The commenters also supported the revised terminology for the existing decubitus ulcer codes (707.00 through 707.09), stating that changing these code titles from decubitus ulcer to pressure ulcer is a more accurate and appropriate nomenclature. Further, the commenters asked for additional pressure ulcer stage codes beyond what was created for FY 2009, as shown in Table 6A of the Addendum to this final rule (codes 707.20 through 707.25). Instead of a single code for pressure ulcer, unstageable (707.25), the commenters requested the following:

- Recommended new code: 707.25 (Deep tissue injury)
- Recommended new code: 707.26 (Unstageable pressure ulcers)

The commenters asked that both of these proposed new codes be classified as MCCs because either condition can progress to a stage III or stage IV pressure ulcer. In addition, the commenters stated that unstageable pressure ulcers will be a stage III or stage IV if debridement takes place. However, the commenters added, debridement is not always indicated in unstageable pressure ulcers, so the wound may remain unstageable throughout the entire stay. The commenters further stated that deep tissue injury can deteriorate rapidly into a stage III or stage IV pressure ulcer, even with optimal treatment.

Response: As stated earlier, the creation of new codes for pressure

ulcers was discussed at the ICD–9–CM Coordination and Maintenance Committee on September 28, 2007. CDC received formal comments on the proposed new codes through December 3, 2007. CDC considered a wide range of comments, including those mentioned above. CDC finalized the pressure ulcer stage codes, which included new codes 707.20 through 707.25. As mentioned above, CDC created a new ICD–9–CM code, 707.25 (Pressure ulcer, unstageable) to include pressure ulcers described as unstageable as well as pressure ulcers documented as deep tissue injury. The ICD–9–CM index specifically assigns pressure ulcers that are described as deep tissue injuries to code 707.25. These new codes will go into effect on October 1, 2008. After experience is gained using these new codes, the public can request that the ICD–9–CM Coordination and Maintenance Committee reconsider the issue of pressure ulcer coding.

We do not support the request to make ICD–9–CM code 707.25 (Pressure ulcer, unstageable) an MCC. Unstageable indicates that the stage of the pressure ulcer cannot be determined because it is covered by a dressing or because it is covered by a black eschar. If the ulcer does deteriorate and is determined to be a stage III or stage IV pressure ulcer, then stage III or IV codes will be reported. To classify an unstageable pressure ulcer as the same severity as a stage III or stage IV because it may become a stage III or stage IV is inappropriate. Therefore, we are not changing the MCC/CC classification of code 707.25 (Pressure ulcer, unstageable), and it will remain a non-CC.

The CDC has recently updated the ICD–9–CM coding guidance for pressure ulcers. Code assignments for pressure ulcer stages may be based on medical record documentation from clinicians who are not the patient's provider. The coding guidelines are available at: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpICD9/ftpICD9.htm.*

c. Coronary Artery Stents

This topic was not raised by CMS in the proposed rule. However, four commenters have taken this opportunity to comment on the content of MS–DRG 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ Vessels/Stents), and 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC or 4+ Vessels/Stents) in MDC 5 (Diseases and Disorders of the Circulatory System).

For a comprehensive review of the most recent discussion concerning coronary stents, both drug-eluting and non-drug-eluting, we refer readers to FY 2006 IPPS final rule (70 FR 47929 through 47295). In Table 6B of that rule, we published the new ICD–9–CM procedure codes describing newly created adjunct codes 00.40 through 00.43 (codes describing the number of blood vessels upon which a procedure had been performed) and 00.45 through 00.48 (codes describing the number of vascular stents which had been inserted). These codes were available for use beginning October 1, 2006, for FY 2007. We note that under the former CMS DRG structure, the DRGs containing either drug-eluting or non-drug-eluting stents were located in CMS DRG 556 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without Major Cardiovascular Diagnosis), CMS DRG 557 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with Major Cardiovascular Diagnosis), or CMS DRG 558 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without Major Cardiovascular Diagnosis).

In response to a late comment during the last update cycle regarding insertion of four or more stents, CMS had reviewed, but did not publish, FY 2007 MedPAR data containing some statistics included in MS–DRGs 246 and 248. The ICD–9–CM procedure codes we reviewed were:

- 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy)
- 00.40 (Procedure on single vessel)
- 00.41 (Procedure on two vessels)
- 00.42 (Procedure on three vessels)
- 00.43 (Procedure on four or more vessels)
- 00.44 (Procedure on vessel bifurcation)
- 00.45 (Insertion of one vascular stent)
- 00.46 (Insertion of two vascular stents)
- 00.47 (Insertion of three vascular stents)
- 00.48 (Insertion of four or more vascular stents)

We arrayed the data several ways, looking at PTCA cases with 4+ vessels without 4+ stents (codes 00.66 with 00.43), with 4+ stents without 4+ vessels (codes 00.66 with 00.48), and the balance of the contents of MS–DRGs 246 and 248 eliminating PTCA plus 4+ vessels and 4+ stents (codes 00.66 plus 00.43) and (codes 00.66 plus 00.48). In addition, we reviewed the data on cases involving 1–3 vessels with 4+ stents (codes 00.40 through 00.42 with 00.48) and 1–3 stents with 4+ vessels (codes 00.45 through 00.47 with 00.43). We also reviewed MS–DRGs 246, 247, 248, and 249 containing the code for vessel bifurcation (code 00.44). The data we reviewed are represented in the tables below.

MS–DRGs	Number of cases	Average length of stay	Average charges
246—All Cases	27,591	5.36	$65,423.34
246—Cases with PTCA with 4+ vessels without 4+ stents (Codes 00.66 with 00.43)	311	2.56	50,986.31
246—Cases with PTCA with 4+ stents without 4+ vessels (Codes 00.66 with 00.48)	5,697	2.73	66,275.14
246—Cases without Codes 00.66 with 00.43 or 00.66 with 00.48	21,289	6.13	65,329.96
247—All Cases	180,307	2.17	42,084.09
248—All Cases	12,979	6.03	59,016.01
248—Cases with PTCA with 4+ vessels without 4+ stents (Codes 00.66 with 00.48)	59	2.44	44,454.05
248—Cases with PTCA with 4+ stents withouth 4+ vessels (Codes 00.66 with 00.48)	1,474	3.57	57,210.58
248—Cases without Codes 00.66 with 00.43 or 00.66 with 00.48	11,396	6.38	59,318.54
249—All Cases	65,858	2.50	36,958.18
246—All Cases	27,591	5.36	65,423.34
246—Cases with 1–3 vessels with 4+ stents (Codes 00.40–00.42 with 00.48)	3,901	2.67	64,363.82
246—Cases with 1–3 stents with 4+ vessels (Codes 00.45–00.47 with 00.43)	214	2.45	50,425.73
246—Cases with procedure on vessel bifurcation (Code 00.44)	387	3.56	62,338.01
247—All Cases	180,307	2.17	42,084.09
247—Cases with procedure on vessel bifurcation (Code 00.44)	1,742	1.97	42,212.23
248—All Cases	12,979	6.03	59,016.01
248—Cases with 1–3 vessels with 4+ stents (Codes 00.40–00.42 with 00.48)	961	3.60	55,721.11
248—Cases with 1–3 stents with 4+ vessels (Codes 00.45–00.47 with 00.43)	45	2.36	45,491.68

MS–DRGs	Number of cases	Average length of stay	Average charges
248—Cases with procedure on vessel bifurcation (Code 00.44)	92	5.22	65,756.27
249—All Cases	65,858	2.50	36,958.18
249—Cases with procedure on vessels bifurcation (Code 00.44)	422	2.31	38,507.05

The results of our review do not suggest to us that there should be any proposal for change to MS–DRGs 246 or 248 for FY 2009 because there was no compelling evidence that the cases involving either 4+ vessels or 4+ stents were inappropriately placed in the MS–DRGs.

Comment: Three commenters urged CMS to revise the GROUPER logic to include ICD–9–CM procedure codes 00.42 and 00.47 in MS–DRG 246. In addition, the commenters suggested the CMS revise the GROUPER logic for the bare metal stents in MS–DRG 248 by assigning codes 00.42 and 00.47 there as well. One commenter stated that assigning these codes to the ''with MCC'' MS–DRGs increases payment accuracy.

Response: We agree that reassigning these codes to MS–DRG 246 and 248 would increase payment. However, at this time we are not convinced that a change of this nature would increase payment accuracy. As previously stated, we reviewed the data for cases involving 4+ vessels and 4+ stents as shown above in the tables, but did not specifically review the data for cases involving 3 vessels and/or 3 stents inserted at one operative episode. However, we note that while all three commenters submitted data based on the MedPAR files of FY 2007, their conclusions regarding the numbers of cases and the charges were not consistent among themselves, nor did their data match our figures, even to the number of cases under review.

We note that evaluation of CMS's data comparing insertion of 1–3 stents with 4+ vessels shows an average length of stay almost 3 days lower than the average length of stay for the entire MS–DRG 246, as well as average charges $15,000 lower than the average for the entire DRG. Another evaluation of CMS's data comparing insertion in 1–3 vessels with 4+ stents shows an average length of stay of 2.7 days lower than the average length of stay for the entire MS–DRG 246, as well as average charges more than $1,000 lower than the average for the entire DRG. We believe that these data do not support an MS–DRG change.

Comment: One commenter, a device manufacturer, believed that MS–DRGs 246 through 251 (percutaneous cardiovascular procedures with and without drug-eluting and non-drug-eluting stents and with and without MCCs) contain appropriate procedure code assignments. The commenter indicated its intent to continue to monitoring the data in these MS–DRGs in an effort to improve coding accuracy and appropriate hospital resource allocation, but, at this time, recommended no changes to this group of MS–DRGs.

Response: We appreciate the commenter's feedback and look forward to working with the industry to assure appropriate payment to hospitals under all MS–DRGs.

As stated above, the topic of reassigning certain procedure codes for numbers of cardiac stents in cardiac vessels was not discussed in the FY 2009 IPPS proposed rule; therefore, no proposals had been made by CMS. We believe it is inappropriate to make these MS–DRG modifications without claims data under the MS–DRG system. Therefore, we will continue to monitor MDC 5 and the stent MS–DRGs. Should there be evidence-based justification for reassignment of codes within these MS–DRGs, we will be open to proposing to make changes to the structure of the MS–DRG in the future.

d. TherOx (Downstream® System)

This topic was not discussed in the FY 2009 IPPS proposed rule. However, one commenter addressed this subject.

TherOx, manufacturer of the Downstream® System, also known as SuperSaturated Oxygen Therapy (SSO_2) or Aqueous Oxygen (AO) System, is a new technology involving the creation and delivery of superoxygenated arterial blood directly to reperfused areas of myocardial tissue. The concept is that this will reduce infarct size by minimizing microvascular damage in heart attack patients following percutaneous coronary intervention. The Downstream® System is the console portion of a disposable cartridge-based system that withdraws a small amount of the patient's arterial blood, mixes it with a small amount of saline, and supersaturates it with oxygen to create highly oxygen-enriched blood, which is delivered directly to the infarct-related artery via the TherOx infusion catheter. An additional 100 minutes of catheterization laboratory time is required for this procedure. According to the proposed package insert, the Downstream® System will be used for patients undergoing a percutaneous cardiovascular procedure in which a stent is implanted. According to the manufacturer, factoring in the average charges for supplies ($2,333), procedure time ($8,727) and device cost ($10,560), the additional charges unique to the Downstream® System are estimated to be $21,620.

At the September 27, 2007, a request was made before the ICD–9–CM Coordination and Maintenance Committee to consider establishing a new code to describe this intervention. A new code, 00.49 (SuperSaturated oxygen therapy) was created for use beginning October 1, 2008, for FY 2009. This code can be found in Table 6B of the Addendum to this final rule.

Comment: One commenter, the manufacturer of the Downstream® System, expressed concern about the assignment of code 00.49 as a non-O.R. procedure in the proposed rule. This is indicated by an ''N'' in the O.R. column of Table 6B, and indicates that the GROUPER program will not take this code into account when reviewing Medicare claims data for MS–DRG assignment. The manufacturer encouraged CMS to assign code 00.49 to MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Vessels/Stents), irrespective of the actual presence of a drug-eluting stent or an MCC.

The manufacturer also encouraged CMS to help ensure that hospitals adopt this unique and beneficial treatment option in a timely manner after its FDA approval by assigning cases using the technology to MS–DRG 246, stating that: ''This action will provide appropriate reimbursement [to hospitals] for its use''. The manufacturer further noted that in 2002, CMS established DRG assignments for drug-eluting stents, a technology that had not yet been approved by the FDA. The manufacturer requested that CMS take similar action [to the precedent set for drug-eluting stents] for cases involving patients that have had an anterior ST-elevated myocardial infarction (STEMI) and have received a stent and the Downstream® System.

The manufacturer further noted that assigning all cases using the Downstream® System to MS–DRG 246 is

consistent with CMS' past MS–DRG reclassifications, pointing out that, in the FY 2008 final rule, CMS reorganized several MS–DRGs to better recognize the costs of particular technologies. The example was given concerning the reassignment of all cases utilizing the Gliadel® Wafer to MS–DRG 023 after CMS found that the average charges for Gliadel® cases in MS–DRG 024 were 27 percent greater than the average charges for non-Gliadel® cases. The manufacturer encourages CMS to follow this example ''by assigning all cases using the Downstream® System to MS–DRG 246 where the average charges of these cases will be more closely aligned with the overall average of charges in the MS–DRG.''

Response: We note that procedure code 00.49 is so new that it has not yet had a chance to be reflected in the MedPAR database. Therefore, we do not have data on the impact of the Downstream® System procedure, which is an adjunct therapy to PTCA. Without claims data, we cannot evaluate the commenter's suggestion that the use of the Downstream® System is equivalent to cases in MS–DRG 246 which include the insertion of drug-eluting stents with MCC or 4+ vessels/stent. We also believe that the Downstream® System is not a stand-alone procedure (that is, it is only performed after a PTCA has been done, and while the patient is still in the catheterization laboratory). Therefore, it is most appropriately described as non-O.R. in its GROUPER designation. This would continue to allow the MS–DRG assignment to be based on the definitive procedures performed such as a PTCA or the insertions of stents, and not on adjunctive procedures.

When we created the severity-based MS–DRGs for use beginning in FY 2008, we thoroughly reviewed over 13,000 diagnosis codes in order to establish realistic severity measures. We had two major goals: To create DRGs that would more accurately reflect the severity of the cases assigned to them; and to create groups that would have sufficient volume so that meaningful and stable payment weights could be developed. We developed a set of five criteria to determine whether an MS–DRG should be subdivided into subgroups based on the presence of a CC or an MCC, and determined that a subgroup had to meet all five criteria in order to be so subdivided. These criteria can be reviewed in the FY 2008 final rule with comment period (72 FR 47169). There was no criteria suggesting that device-based procedures be assigned to the MS–DRG with an MCC designation in order for additional reimbursement to be made available to hospitals.

The commenter used the example of our review of the Gliadel® Wafer and subsequent MS–DRG reassignment to bolster the argument that these Downstream® System cases should be assigned to MS–DRG 246. We point out that the commenter himself noted that this reassignment took place after CMS had reviewed the MedPAR data and was able to determine that the average charges for Gliadel® cases in MS–DRG 024 were 27 percent greater than the average charges for non-Gliadel® cases, thereby warranting such a change.

Without evidence-based data, we are reluctant to subjectively assign a technology to an MS–DRG based on assumption. Further, to ignore the structure of the MS–DRG system solely for the purpose of increasing payment for one device would set an unwelcome precedent for defining all of the other MS–DRGs in the system, as previously stated in the FY 2007 IPPS final rule (71 FR 47943). We believe that the MS–DRG structure for the percutaneous procedures with stent insertion (MS–DRGs 246, 247, 248, and 249, with and without volume of vessels and/or stents, and with or without CC/MCC) are appropriate MS–DRG assignments for the Downstream® System, and the cases will be assigned based on the presence of either a drug-eluting or a non-drug eluting stent, and the presence or absence of an MCC. Therefore, for FY 2009, because there is no data to support the assignment of procedure code 00.49 to MS–DRG 246, we are not making the change requested by the commenter. Should there be evidence-based justification for assignment of code 00.49 in the future, we will be open to making a proposal to change the structure of these MS–DRGs.

e. Spinal Disc Devices

This topic was not discussed in the FY 2009 IPPS proposed rule. However, one commenter addressed this subject.

Comment: One commenter representing a manufacturer of artificial disc devices recommended that CMS create a new MS–DRG for disc device procedures in MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue). Specifically, the commenter suggested that ICD–9–CM codes 84.58 (Implantation of interspinous process decompression device), 84.59 (Insertion of other spinal devices), 84.62 (Insertion of total spinal disc prosthesis, cervical), and 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) be moved into a separate MS–DRG that combines procedures that utilize expensive implantable devices. According to the commenter, by creating this new MS–DRG, CMS would avoid classifying these procedures with procedures that do not utilize devices.

Response: We point out that ICD–9–CM code 84.58 was deleted effective October 1, 2007 (FY 2008). The procedure previously assigned to that code was reassigned to new ICD–9–CM code 84.80 (Insertion or replacement of interspinous process device(s)).

With regards to the creation of a new MS–DRG for the procedure codes 84.59, 84.62, and 84.65, we refer the reader to the FY 2008 IPPS proposed rule (72 FR 24733 through 24735) and the FY 2008 IPPS final rule with comment period (72 FR 47226 through 47232) for a discussion on the comprehensive evaluation of all the spinal DRGs in the development of the MS–DRG classification system. Effective October 1, 2007, all the aforementioned procedures were grouped together in MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator). The modifications made to the spinal DRGs for FY 2008 recognized the similar utilization of resources, differences in levels of severity and the complexity of the services being performed on patients undergoing those types of procedures.

In response to the suggested creation of a new, separate MS–DRG to combine spinal procedures that utilize expensive implantable devices, we note that the MS–DRG classification system (and more importantly, the IPPS), is not based solely on the cost of devices; it is not a device classification system. We refer the reader to section II.B.2. of the preamble to this final rule for a summary of the process and criteria utilized in determining whether specific MS–DRG modifications are warranted in a given year.

We note that several commenters acknowledged CMS' discussion of the FY 2008 implementation of the MS–DRGs and the lack of data to support major MS–DRG changes for FY 2009. In addition, several commenters accepted CMS' proposal of not making significant revisions to the MS–DRGs until claims data under the new MS–DRG system are available. Therefore, because we do not have claims data at this time to evaluate the need for revisions to MS–DRGs, we are not making any revisions to the MS–DRGs involving implantable spinal devices for FY 2009.

f. Spinal Fusion

This topic was not discussed in the FY 2009 IPPS proposed rule. However, one commenter addressed this subject.

Comment: Similar to last year, a manufacturer again requested that CMS reassign procedure code 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), which was effective October 1, 2007, from MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator) to MS–DRG 460 (Spinal Fusion Except Cervical without MCC).

As a result of CMS' final policy for FY 2008 that assigned procedure code 84.82 to MS–DRG 490, the commenter reported that it conducted a number of analyses that included: (1) A clinical comparison of the implant procedure of dynamic stabilization and instrumented spinal fusion; (2) a comparison of average charge data in MS–DRGs 460 and 490 utilizing FY 2007 MedPAR data; and (3) a cost comparison of claims including the implant of the Dynesys® system compared to those of spinal fusion.

Due to the fact that claims data on procedure code 84.82 was unavailable in the MedPAR file, the commenter stated it utilized procedure code 84.59 (Insertion of other spinal devices) and conducted the same analysis CMS had done for FY 2008. Results of the commenter's analysis showed a large increase in the volume of cases with procedure code 84.59 assigned, which, according to the commenter, provided a more reliable number of cases to compare average charges.

Response: We appreciate the commenter's analysis and acknowledge the commenter's request. In response to the commenter's analyses of the charge data for procedure code 84.59, the Dynesys® system is not the only technology that was assigned to code 84.59 in the years that the commenter examined. During that time, there were a number of other spinal technologies that were under development or in clinical trials that were also assigned procedure code 84.59 because a unique code for their specific technology did not yet exist.

As stated in the FY 2008 final rule with comment period (72 FR 47228), we conducted a comprehensive review of the entire group of spine DRGs in the development of the MS–DRG system. In the analysis that we conducted, the data demonstrated that procedures assigned to MS–DRG 490 were not the same in terms of resource utilization, severity of illness, and complexity of care, as those assigned to MS–DRG 460 (Spinal Fusion Except Cervical without MCC). As we stated earlier, we received several comments acknowledging CMS' discussion of the recent implementation of MS–DRGs and lack of data to support major MS–DRG changes for FY 2009. The commenters accepted CMS' proposal of not making significant revisions to the MS–DRGs until claims data under the new MS–DRG system are available. Therefore, as final policy for FY 2009, we are not reassigning procedure code 84.82 from MS–DRG 490 to MS–DRG 460.

g. Special Treatment for Hospitals With High Percentages of ESRD Discharges

In our existing regulations under 42 CFR 412.104, we provide that CMS will make an additional payment to a hospital for inpatient services furnished to a beneficiary with end-stage renal disease (ESRD) who is discharged and who receives a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges constitute 10 percent or more of its total Medicare discharges. However, as specified in the regulations, in determining a hospital's eligibility for this additional payment, we excluded from the hospital's ESRD beneficiary discharge count discharges classified into the following CMS DRGs: DRG 302 (Kidney Transplant); DRG 316 (Renal Failure); or DRG 317 (Admit for Renal Dialysis). As discussed in section II.C. of the preamble of this final rule, we adopted the MS–DRG classification system for FY 2008 to better recognize severity of illness. Under the MS–DRG system, these three DRGs have been changed. Therefore, we are revising § 412.104 to make the three DRG numbers and titles consistent with their replacement MS–DRGs. DRG 302 (Kidney Transplant) became MS–DRG 652; DRG 316 (Renal Failure) became MS–DRG 682 (Renal Failure with MCC), MS–DRG 683 (Renal Failure with CC), and MS–DRG 684 (Renal Failure without CC/MCC); and DRG 317 (Admit for Renal Dialysis) became MS–DRG 685 (Admit for Renal Dialysis).

H. Recalibration of MS–DRG Weights

In section II.E. of the preamble of this final rule, we state that we are fully implementing the cost-based DRG relative weights for FY 2009, which is the third year in the 3-year transition period to calculate the relative weights at 100 percent based on costs. In the FY 2008 IPPS final rule with comment period (72 FR 47267), as recommended by RTI, for FY 2008, we added two new CCRs for a total of 15 CCRs: One for ''Emergency Room'' and one for ''Blood and Blood Products,'' both of which can be derived directly from the Medicare cost report.

As we proposed, in developing the FY 2009 system of weights, we used two data sources: Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2007 MedPAR data used in this final rule include discharges occurring on October 1, 2006, through September 30, 2007, based on bills received by CMS through March 2008, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2007 MedPAR file used in calculating the relative weights includes data for approximately 11,554,993 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2006 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2005, and before October 1, 2006), which represents the most recent full set of cost report data available. We used the March 31, 2008 update of the HCRIS cost report files for FY 2006 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2007 MedPAR claims data and FY 2006 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the FY 2009 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this final rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2007 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition

charges before computing the average cost for each DRG and before eliminating statistical outliers.

• Claims with total charges or total length of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.

• At least 95.9 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.

• Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each DRG.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 15 cost groups for each claim were standardized to remove the effects of differences in area wage levels, IME and DSH payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Because hospital charges include charges for both operating and capital costs, we standardized total charges to remove the effects of differences in geographic adjustment factors, cost-of-living adjustments, DSH payments, and IME adjustments under the capital IPPS as well. Charges were then summed by DRG for each of the 15 cost groups so that each DRG had 15 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2006 cost report data.

The 15 cost centers that we used in the relative weight calculation are shown in the following table. The table shows the lines on the cost report and the corresponding revenue codes that we used to create the 15 national cost center CCRs.

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Routine Days	Private Room Charges	011X and 014X	Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X			C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X				
Intensive Days	Intensive Care Charges	020X	Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
					C_1_C7_26	
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
					C_1_C7_27	
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
						C_1_C7_28	
				Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
						C_1_C7_29	
				Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
						C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X		Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48
						C_1_C7_48	
				Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
						C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X		Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
						C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299		DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66
						C_1_C7_66	
	Used Durable Medical Charges	0293		DME-Sold	C_1_C5_67	C_1_C6_67	D4_HOS_C2_67

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Therapy Services	Physical Therapy Charges	042X	Physical Therapy	C_1_C5_50	C_1_C6_50 C_1_C7_50	D4_HOS_C2_50
	Occupational Therapy Charges	043X	Occupational Therapy	C_1_C5_51	C_1_C6_51 C_1_C7_51	D4_HOS_C2_51
	Speech Pathology Charges	044X and 047X	Speech Pathology	C_1_C5_52	C_1_C6_52 C_1_C7_52	D4_HOS_C2_52
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X	Respiratory Therapy	C_1_C5_49	C_1_C6_49 C_1_C7_49	D4_HOS_C2_49
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X	Operating Room	C_1_C5_37	C_1_C6_37 C_1_C7_37	D4_HOS_C2_37
			Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_38

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs** **370, 371, 372, 373, 374, 375**	Operating Room Charges	036X, 071X and 072X	Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X	Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X	Anesthesi-ology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44 C_1_C7_44	D4_HOS_C2_44
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45 C_1_C7_45	D4_HOS_C2_45
			Electro-encep halography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
					C_1_C7_54	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43
					C_1_C7_43	
Emergency Room	Emergency Room Charges	045x	Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
					C_1_C7_61	
Blood and Blood Products	Blood Charges	038x	Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
					C_1_C7_46	
	Blood Storage / Processing	039x	Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
					C_1_C7_47	
Other Services	Lithotripsy Charge	079X				

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X	ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
					C_1_C7_58	
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
					C_1_C7_59	
			Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
					C_1_C7_60	
	Ambulance Charges	054X				
	ESRD Revenue Setting Charges	080X and 082X-088X	Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
					C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X	Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_6201
					C_1_C7_6201	
			Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X			C_1_C7_6350	

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
				FQHC	C_1_C5_6360	C_1_C6_6360 C_1_C7_6360	D4_HOS_C2_6360
				Home Program Dialysis	C_1_C5_64	C_1_C6_64 C_1_C7_64	D4_HOS_C2_64
				Ambulance	C_1_C5_65	C_1_C6_65 C_1_C7_65	D4_HOS_C2_65
				Other Reimbursable	C_1_C5_68	C_1_C6_68 C_1_C7_68	D4_HOS_C2_68

We developed the national average CCRs as follows:

Taking the FY 2006 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D–4 and deriving the Medicare-specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D–4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

After we multiplied the total charges for each DRG in each of the 15 cost centers by the corresponding national average CCR, we summed the 15 ''costs'' across each DRG to produce a total standardized cost for the DRG. The average standardized cost for each DRG was then computed as the total standardized cost for the DRG divided by the transfer-adjusted case count for the DRG. The average cost for each DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based relative weights were then normalized by an adjustment factor of 1.50598 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

The 15 national average CCRs for FY 2009 are as follows:

Group	CCR
Routine Days	0.546
Intensive Days	0.486
Drugs	0.205
Supplies & Equipment	0.345
Therapy Services	0.423
Laboratory	0.169
Operating Room	0.295
Cardiology	0.190
Radiology	0.171
Emergency Room	0.292
Blood and Blood Products	0.444
Other Services	0.432
Labor & Delivery	0.476
Inhalation Therapy	0.199
Anesthesia	0.149

As we explained in section II.E. of the preamble of this final rule, we are completing our 2-year transition to the MS–DRGs. For FY 2008, the first year of the transition, 50 percent of the relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR data grouped to the Version 24.0 (FY 2007) DRGs. The remaining 50 percent of the FY 2008 relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR grouped to the Version 25.0 (FY 2008) MS–DRGs. In FY 2009, the relative weights are based on 100 percent cost

weights computed using the Version 26.0 (FY 2009) MS–DRGs.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We are using that same case threshold in recalibrating the MS–DRG weights for FY 2009. Using the FY 2007 MedPAR data set, there are 8 MS–DRGs that contain fewer than 10 cases. Under the MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. All of the low-volume MS–DRGs listed below are for newborns. Newborns are unique and require separate DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate DRGs for newborns. In FY 2009, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume MS–DRGs, we are computing weights for the low-volume MS–DRGs by adjusting their FY 2008 weights by the percentage change in the average weight of the cases in other MS–DRGs. The crosswalk table is shown below:

Low-volume MS–DRG	MS–DRG title	Crosswalk to MS–DRG
768	Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C.	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
789	Neonates, Died or Transferred to Another Acute Care Facility.	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
791	Prematurity with Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
792	Prematurity without Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
793	Full-Term Neonate with Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
794	Neonate with Other Significant Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
795	Normal Newborn	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).

We did not receive any public comments on this section. Therefore, we are adopting the national average CCRs as proposed, with the MS–DRG weights recalibrated based on these CCRs.

I. Medicare Severity Long-Term Care (MS–LTC–DRG) Reclassifications and Relative Weights for LTCHs for FY 2009

1. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a diagnosis-related group (DRG)-based patient classification system reflecting the differences in patient resources and costs). Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the long-term care hospital (LTCH) PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data.''

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to the patient classification system as the ''long-term care diagnosis-related groups (LTC–DRGs).'' As discussed in greater detail below, although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in LTC–DRG relative weights that reflect ''the differences in patient resource use * * *'' of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113). As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted for the IPPS and the LTCH PPS, respectively, effective October 1, 2007 (FY 2008). For a full description of the development and implementation of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR Part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification system unless specifically referring to the previous LTC–DRG patient classification system that was in effect before October 1, 2007.) We believe the MS–DRGs (and by extension, the MS–LTC–DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS–DRGs represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In addition to improving the DRG system's recognition of severity of illness, we believe the MS–DRGs are responsive to the public comments that were made on the FY 2007 IPPS proposed rule with respect to how we should undertake further DRG reform. The MS–DRGs use the CMS DRGs as the starting point for revising the DRG system to better recognize resource complexity and severity of illness. We have generally retained all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice.

Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge; and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis.
- Up to eight additional diagnoses.
- Up to six procedures performed.
- Age.
- Sex.
- Discharge status of the patient.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM*, a product of the American Hospital Association.

Medicare contractors (that is, fiscal intermediaries or MACs) enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, the following types of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.69 (Other and unspecified radical abdominal hysterectomy) would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a nonapproved transplant center.)
- Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262 (Other severe protein-calorie malnutrition) contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software. The Medicare GROUPER software, which is used under the LTCH PPS, is specialized computer software, and is the same GROUPER software program used under the IPPS. The GROUPER software was developed as a means of classifying each case into a MS–LTC–DRG on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for the LTCH to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as provided in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the MS–LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG and MS–LTC–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS uses the same DRGs as those used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the LTC–DRG classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the DRGs used under the IPPS. Therefore, we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. We further stated that we will publish the annual proposed and final update of the LTC–DRGs in the same notice as the proposed and final update for the IPPS (69 FR 34125).

In the RY 2009 LTCH PPS final rule (73 FR 26798), due to administrative considerations as well as in response to numerous comments urging CMS to establish one rulemaking cycle that would encompass the update of the LTCH PPS payment rates, which has been updated on a rate year basis, effective July 1 as well as the development of the MS–LTC–DRG weights, which are updated on a fiscal year basis, effective October 1, we amended the regulations at § 412.503 and § 412.535 in order to consolidate the rate year and fiscal year rulemaking cycles. Specifically, the annual update of the LTCH PPS payment rates (and description of the methodology and data used to calculate these payment rates) and the annual update of the MS–LTC–

DRG classifications and associated weighting factors for LTCHs will be effective on October 1 of each Federal fiscal year beginning October 1, 2009. In order to revise the payment rate update from July 1 through June 30 to an October 1 through September 30 cycle, we extended the 2009 rate period to September 30, 2009, so that RY 2009 is 15 months. This 15-month rate year period is July 1, 2008, through September 30, 2009. We believe that extending RY 2009 by 3 months (to include July, August, and September) provides for a smooth transition to a consolidated annual update for both the LTCH PPS payment rates and the LTCH PPS MS–LTC–DRG classifications and weighting factors. Consequently, under the extension of RY 2009 to a 15-month rate period, after September 30, 2009, when the RY 2009 cycle ends, the LTCH PPS payment rates and other policy changes will subsequently be updated on an October 1 through September 30 cycle in conjunction with the annual update to the MS–LTC–DRG classifications and relative weights. Accordingly, the next update to the LTCH PPS payment rates, after the 15-month RY 2009, will begin October 1, 2009, coinciding with the 2010 Federal fiscal year.

In the past, the annual update to the DRGs used under the IPPS has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the FY 2009 IPPS proposed rule (73 FR 23591 through 23592), with the implementation of section 503(a) of Public Law 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS. Section 503(a) of Public Law 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data earlier than the agency had accounted for new technology in the past. In implementing the statutory change, the agency has provided that ICD–9–CM diagnosis and procedure codes for new medical technology may be created and assigned to existing DRGs in the middle of the Federal fiscal year, on April 1. However, this policy change does not impact the DRG relative weights in effect for that year, which will continue to be updated only once a year (October 1). The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162, promulgated in accordance with HIPAA.

As noted above, the patient classification system used under the LTCH PPS is the same patient classification system that is used under the IPPS. Therefore, the ICD–9–CM codes currently used under both the IPPS and the LTCH PPS have the potential of being updated twice a year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS.

Because we do not publish a midyear IPPS rule, any April 1 ICD–9–CM coding update will not be published in the **Federal Register**. Rather, we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.G.11. of the preamble of this final rule). Any coding updates will be available through the Web sites provided in section II.G.11. of the preamble of this final rule and through the *Coding Clinic for ICD–9–CM*. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because the most current ICD–9–CM codes must be reported. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case under the correct LTCH PPS, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Public Law 108–173, there will only be an April 1 update if new technology diagnosis and procedure code revisions are requested and approved. We note that any new codes created for April 1 implementation will be limited to those primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM is an open process through the ICD–9–CM Coordination and Maintenance Committee. Requestors will be given the opportunity to present the merits for a new code and to make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.G.11. of the preamble of this final rule).

At the September 27, 2007 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2008 implementation of ICD–9–CM codes. Therefore, the next update to the ICD–9–CM coding system will occur on October 1, 2008 (FY 2009). Because there were no coding changes suggested for an April 1, 2008 update, the ICD–9–CM coding set implemented on October 1, 2008, will continue through September 30, 2009 (FY 2009). The update to the ICD–9–CM coding system for FY 2009 is discussed in section II.G.11. of the preamble of this final rule.

Accordingly, in this final rule, as discussed in greater detail below and as we proposed, we are modifying and revising the MS–LTC–DRG classifications and relative weights to be effective October 1, 2008 through September 30, 2009 (FY 2009). As discussed in greater detail below, the MS–LTC–DRGs for FY 2009 in this final rule are the same as the MS–DRGs for the IPPS for FY 2009 (GROUPER Version 26.0) discussed in section II.B. of the preamble to this final rule.

2. Changes in the MS–LTC–DRG Classifications

a. Background

As discussed earlier, section 123 of Public Law 106–113 specifically requires that the agency implement a PPS for LTCHs that is a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs. Section 307(b)(1) of Public Law 106–554 modified the requirements of section 123 of Public Law 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.''

Consistent with section 123 of Public Law 106–113 as amended by section 307(b)(1) of Public Law 106–554 and § 412.515 of our existing regulations, the

LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. As described in section II.D. of the preamble of this final rule, for FY 2008, we adopted MS–DRGs under the IPPS because we believe that this system results in a significant improvement in the DRG system's recognition of severity of illness and resource usage. We stated that we believe these improvements in the DRG system are equally applicable to the LTCH PPS. The changes we are making in this FY 2009 IPPS final rule are reflected in the FY 2009 GROUPER, Version 26.0, that will be effective for discharges occurring on or after October 1, 2008, through September 30, 2009.

Consistent with our historical practice of having LTC–DRGs correspond to the DRGs applicable under the IPPS, under the broad authority of section 123(a) of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, under the LTCH PPS for FY 2008, we adopted the use of MS–LTC–DRGs, which correspond to the MS–DRGs we adopted under the IPPS. In addition, as stated above, we are using the final FY 2009 GROUPER Version 26.0, established in section II.B. of this final rule, to classify cases effective for LTCH discharges occurring on or after October 1, 2008, and through September 30, 2009. The changes to the MS–DRG classification system that we are using under the IPPS for FY 2009 (GROUPER Version 26.0) are discussed in section II.B. of the preamble to this final rule.

Under the LTCH PPS, as described in greater detail below, we determine relative weights for each of the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. (Unless otherwise noted in this final rule, our MS–LTC–DRG analysis is based on LTCH data from the March 2008 update of the FY 2007 MedPAR file, which contains hospital bills received through March 31, 2008, for discharges occurring in FY 2007.)

LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Therefore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2008 IPPS final rule with comment period (72 FR 47283), we use low-volume quintiles in determining the DRG relative weights for DRGs with less than 25 LTCH cases (low-volume MS–LTC–DRGs). Specifically, we group those low-volume DRGs into 5 quintiles based on average charges per discharge. (A listing of the composition of low-volume quintiles for the FY 2008 MS–LTC–DRGs (based on FY 2006 MedPAR data) appears in section II.I.3. of the FY 2008 IPPS final rule with comment period (72 FR 47281 through 47288).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier (SSO) cases, as discussed below in section II.I.4. of the preamble of this final rule.

b. Patient Classifications Into MS–LTC–DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the DRG to which a beneficiary's stay is assigned. Just as cases have been classified into the MS–DRGs for acute care hospitals under the IPPS (discussed in section II.B. of the preamble of this final rule), cases have been classified into MS–LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as demographic information about the patient. The diagnosis and procedure information is reported by the hospital using the ICD–9–CM coding system. Under the MS–DRGs for the IPPS and the MS–LTC–DRGs for the LTCH PPS, these factors will not change.

Section II.B. of the preamble of this final rule discusses the organization of the existing MS–DRGs, which we are maintaining under the MS–LTC–DRG system. As noted above, the patient classification system for the LTCH PPS is derived from the IPPS DRGs and is similarly organized into 25 major diagnostic categories (MDCs). Most of these MDCs are based on a particular organ system of the body and the remainder involves multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Under the MS–DRGs, some surgical and medical DRGs are further defined for severity purposes based on the presence or absence of MCCs or CCs. The existing MS–LTC–DRGs are similarly categorized. (We refer readers to section II.B. of the preamble of this final rule for further discussion of surgical DRGs and medical DRGs.)

Therefore, consistent with the MS–DRGs, a base MS–LTC–DRG may be subdivided according to three alternatives. The first alternative includes division of the DRG into one, two, or three severity levels. The most severe level has cases with at least one code that is a major CC, referred to as ''with MCC''. The next lower severity level contains cases with at least one CC, referred to as ''with CC''. Those DRGs without an MCC or a CC are referred to as ''without CC/MCC''. When data do not support the creation of three severity levels, the base DRG is divided into either two levels or the base is not subdivided.

The two-level subdivisions consist of one of the following subdivisions: ''with CC/MCC'' or ''without CC/MCC.'' In this type of subdivision, cases with at least one code that is on the CC or MCC list are assigned to the ''with CC/MCC'' DRG. Cases without a CC or an MCC are assigned to the ''without CC/MCC'' DRG.

The other type of two-level subdivision is as follows: ''with MCC'' and without MCC.'' In this type of subdivision, cases with at least one code that is on the MCC list are assigned to the ''with MCC'' DRG. Cases that do not have an MCC are assigned to the ''without MCC' DRG. This type of subdivision could include cases with a CC code, but no MCC.

3. Development of the FY 2009 MS–LTC–DRG Relative Weights

a. General Overview of Development of the MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case. (As we have noted above, we adopted the MS–LTC–DRGs for the LTCH PPS beginning in FY 2008. However, this change in the patient classification system does not affect the basic principles of the development of relative weights under a DRG–based prospective payment system.)

Although the adoption of the MS–LTC–DRGs resulted in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, as discussed in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and the FY 2009 IPPS

proposed rule and as detailed in the following sections, the basic methodology for developing the FY 2009 MS–LTC–DRG relative weights in this final rule continue to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Data

In the FY 2009 IPPS proposed rule (73 FR 23593), to calculate the proposed MS–LTC–DRG relative weights for FY 2009, we obtained total Medicare allowable charges from FY 2007 Medicare LTCH bill data from the December 2007 update of the MedPAR file, which were the best available data at that time, and we used the proposed Version 26.0 of the CMS GROUPER that was also proposed for use under the IPPS to classify LTCH cases for FY 2009. We also proposed that if more recent data became available, we would use those data and the finalized Version 26.0 of the CMS GROUPER in establishing the FY 2009 MS–LTC–DRG relative weights in the final rule. Consistent with that proposal, to calculate the MS–LTC–DRG relative weights for FY 2009, in this final rule, we obtained total Medicare allowable charges from FY 2007 Medicare LTCH bill data from the March 2008 update of the FY 2007 MedPAR file, which are the best available data at this time, and we used the Version 26.0 of the CMS GROUPER that will be used under the IPPS (as discussed in section III.B. of the preamble of this final rule).

Consistent with our historical methodology, as proposed, we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 or section 222(a) of Public Law 92–603. (We refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47282).) Therefore, in the development of the FY 2009 MS–LTC–DRG relative weights in this final rule, we have excluded the data of the 17 all-inclusive rate providers and the 2 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2007 MedPAR file.

c. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonarbitrary distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, as we proposed, in this final rule, we used a hospital-specific relative value (HSRV) methodology to calculate the MS–LTC–DRG relative weights instead of the methodology used to determine the MS–DRG relative weights under the IPPS described in section II.H. of the preamble of this final rule. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we are reducing the impact of the variation in charges across providers on any particular MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV methodology, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for SSOs under § 412.529 as described in section II.I.4. (step 3) of the preamble of this final rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Treatment of Severity Levels in Developing Relative Weights

Under the MS–LTC–DRGs, for purposes of the setting of the relative weights, as we discussed in the FY 2009 IPPS proposed rule (73 FR 23594), there would be three different categories of DRGs based on volume of cases within specific MS–LTC–DRGs. MS–LTC–DRGs with at least 25 cases are each assigned a unique relative weight; low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs that contain between one and 24 cases annually) are grouped into quintiles (described below) and assigned the weight of the quintile. No-volume MS–LTC–DRGs (that is, no cases in the database were assigned to those MS–LTC–DRGs) are crosswalked to other MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG. (We provide in-depth discussions of our policy regarding weight setting for low-volume MS–LTC–

DRGs in section II.I.3.e. of the preamble of this final rule and for no-volume MS–LTC–DRGs, under Step 5 in section II.I.4. of the preamble of this final rule.)

As described above, in response to the need to account for severity and pay appropriately for cases, we developed a severity-adjusted patient classification system which we adopted for both the IPPS and the LTCH PPS in FY 2008. As described in greater detail above, the MS–LTC–DRG system can accommodate three severity levels: ''with MCC'' (most severe); ''with CC,'' and ''without CC/MCC'' (the least severe) with each level assigned an individual MS–LTC–DRG number. In cases with two subdivisions, the levels are either ''with CC/MCC'' and ''without CC/MCC'' or ''with MCC'' and ''without MCC''. For example, under the MS–LTC–DRG system, multiple sclerosis and cerebellar ataxia with MCC is MS–LTC–DRG 58; multiple sclerosis and cerebellar ataxia with CC is MS–LTC–DRG 59; and multiple sclerosis and cerebellar ataxia without CC/MCC is MS–LTC–DRG 60. For purposes of discussion in this section, the term ''base DRG'' is used to refer to the DRG category that encompasses all levels of severity for that DRG. For example, when referring to the entire DRG category for multiple sclerosis and cerebellar ataxia, which includes the above three severity levels, we would use the term ''base-DRG.''

As noted above, while the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. As a general rule, consistent with the methodology we used when we adopted the MS–LTC–DRGs in the FY 2008 IPPS final rule with comment period (72 FR 47278 through 47281), as we proposed, we determined the FY 2009 relative weights for the MS–LTC–DRGs using the following steps: (1) If an MS–LTC–DRG has at least 25 cases, it is assigned its own relative weight; (2) if an MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we compute a relative weight for all of the MS–LTC–DRGS assigned to that quintile; and (3) if an MS–LTC–DRG has no cases, it is crosswalked to another MS–LTC–DRG based upon clinical similarities to assign an appropriate relative weight (as described below in detail in Step 5 of the Steps for Determining the FY 2009 MS–LTC–DRG Relative Weights). Furthermore, in determining the FY 2009 MS–LTC–DRG relative weights, when necessary, as we proposed, we are making adjustments to account for nonmonotonicity, as explained below.

Theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, weights should increase with severity, from lowest to highest. If the weights do not increase (that is, if based on the relative weight methodology outlined above, the MS–LTC–DRG with MCC would have a lower relative weight than one with CC, or the MS–LTC–DRG without CC/MCC would have a higher relative weight than either of the others), there is a problem with monotonicity. Since the start of the LTCH PPS for FY 2003 (67 FR 55990), in determining the LTC–DRG relative weights, we have made adjustments in order to maintain monotonicity by grouping both sets of cases together and establishing a new relative weight for both LTC–DRGs. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because, in a nonmonotonic system, cases that are more severe and require greater expenditure of medical care resources would be paid based on a lower relative weight than cases that are less severe and require lower resource use. The procedure for dealing with nonmonotonicity under the MS–LTC–DRG classification system is discussed in greater detail below in section II.I.4. (Step 6) of the preamble of this final rule.

e. Low-Volume MS–LTC–DRGs

In order to account for MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with the methodology we established when we implemented the LTCH PPS (August 30, 2002; 67 FR 55984 through 55995), we group those ''low-volume MS–LTC–DRGs'' (that is, MS–LTC–DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights (72 FR 47283 through 47288). In determining the FY 2009 MS–LTC–DRG relative weights in this final rule, as we proposed, we continue to employ this quintile methodology for low-volume MS–LTC–DRGs. In addition, in cases where the initial assignment of a low-volume MS–LTC–DRG to quintiles results in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we are making adjustments to the treatment of low-volume MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section II.I.4 (Step 6 of the methodology for determining the FY 2009 MS–LTC–DRG relative weights). In this final rule, using LTCH cases from the March 2008 update of the FY 2007 MedPAR file, we identified 290 MS–LTC–DRGs that contained between 1 and 24 cases. This list of MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing 58 MS–LTC–DRGs (290/5 = 58). As proposed, we assigned a low-volume MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Specifically, for this final rule, the 290 low-volume MS–LTC–DRGs were sorted by ascending order by average charge and assigned to a specific low-volume quintile (as described below). After sorting the 290 low-volume MS–LTC–DRGs by average charge in ascending order, we grouped the first fifth (1st through 58th) of low-volume MS–LTC–DRGs (with the lowest average charge) into Quintile 1. This process was repeated through the remaining low-volume MS–LTC–DRGs so that each of the 5 low-volume quintiles contains 58 MS–LTC–DRGs. The highest average charge cases are grouped into Quintile 5. (We note that, consistent with our historical methodology, if the number of low-volume MS–LTC–DRGs had not been evenly divisible by 5, we would have used the average charge of the low-volume MS–LTC–DRG to determine which low-volume quintile would have received the additional low-volume MS–LTC–DRG.)

Accordingly, in order to determine the relative weights for the MS–LTC–DRGs with low-volume for FY 2009, as proposed, we used the five low-volume quintiles described above. The composition of each of the five low-volume quintiles shown in the chart below was used in determining the MS–LTC–DRG relative weights for FY 2009 (Table 11 of the Addendum to this final rule). We determined a relative weight and (geometric) average length of stay for each of the five low-volume quintiles using the methodology that we applied to the regular MS–LTC–DRGs (25 or more cases), as described in section II.I.4. of the preamble of this final rule. As we proposed, we assigned the same relative weight and average length of stay to each of the low-volume MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of

MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the relative weights based on our methodology.

Composition of Low-Volume Quintiles for FY 2009

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)
QUINTILE 1	
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC
67	Nonspecific cva & precerebral occlusion w/o infarct w MCC
69	Transient ischemia
72	Nonspecific cerebrovascular disorders w/o CC/MCC
79	Hypertensive encephalopathy w/o CC/MCC
87	Traumatic stupor & coma, coma <1 hr w/o CC/MCC
89	Concussion w CC
125	Other disorders of the eye w/o MCC
135	Sinus & mastoid procedures w CC/MCC
136	Sinus & mastoid procedures w/o CC/MCC**
148	Ear, nose, mouth & throat malignancy w/o CC/MCC
149	Dysequilibrium
159	Dental & Oral Diseases w/o CC/MCC
185	Major chest trauma w/o CC/MCC
184	Major chest trauma w CC
183	Major chest trauma w MCC
201	Pneumothorax w/o CC/MCC
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC
261	Cardiac pacemaker revision except device replacement w CC***
263	Vein ligation & stripping
304	Hypertension w MCC
305	Hypertension w/o MCC
311	Angina pectoris
313	Chest pain

382	Complicated peptic ulcer w/o CC/MCC
387	Inflammatory bowel disease w/o CC/MCC
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC
468	Revision of hip or knee replacement w/o CC/MCC
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC***
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
547	Connective tissue disorders w/o CC/MCC
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
601	Non-malignant breast disorders w/o CC/MCC
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC
642	Inborn errors of metabolism
645	Endocrine disorders w/o CC/MCC
694	Urinary stones w/ot esw lithotripsy w/o MCC
723	Malignancy, male reproductive system w CC
726	Benign prostatic hypertrophy w/o MCC
730	Other male reproductive system diagnoses w/o CC/MCC
756	Malignancy, female reproductive system w/o CC/MCC
781	Other antepartum diagnoses w medical complications
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC
816	Reticuloendothelial & immunity disorders w/o CC/MCC
864	Fever of unknown origin
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC
880	Acute adjustment reaction & psychosocial dysfunction
882	Neuroses except depressive
886	Behavioral & developmental disorders
895	Alcohol/drug abuse or dependence w rehabilitation therapy
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
917	Poisoning & toxic effects of drugs w MCC
918	Poisoning & toxic effects of drugs w/o MCC
958	Other O.R. procedures for multiple significant trauma w CC
965	Other multiple significant trauma w/o CC/MCC
QUINTILE 2	
59	Multiple sclerosis & cerebellar ataxia w CC
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC
75	Viral meningitis w CC/MCC
78	Hypertensive encephalopathy w CC
83	Traumatic stupor & coma, coma >1 hr w CC
84	Traumatic stupor & coma, coma >1 hr w/o CC/MCC
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC
102	Headaches w MCC
103	Headaches w/o MCC
121	Acute major eye infections w CC/MCC
122	Acute major eye infections w/o CC/MCC
124	Other disorders of the eye w MCC
153	Otitis media & URI w/o MCC
156	Nasal trauma & deformity w/o CC/MCC
158	Dental & Oral Diseases w CC
157	Dental & Oral Diseases w MCC

182	Respiratory neoplasms w/o CC/MCC*
188	Pleural effusion w/o CC/MCC*
203	Bronchitis & asthma w/o CC/MCC
254	Other vascular procedures w/o CC/MCC
284	Circulatory disorders w AMI, expired w CC*
294	Deep vein thrombophlebitis w CC/MCC
354	Hernia procedures except inguinal & femoral w CC
376	Digestive malignancy w/o CC/MCC
379	G.I. hemorrhage w/o CC/MCC
381	Complicated peptic ulcer w CC
390	G.I. obstruction w/o CC/MCC
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC
433	Cirrhosis & alcoholic hepatitis w CC
440	Disorders of pancreas except malignancy w/o CC/MCC
446	Disorders of the biliary tract w/o CC/MCC*
489	Knee procedures w/o pdx of infection w/o CC/MCC
534	Fractures of femur w/o MCC
533	Fractures of femur w MCC
553	Bone diseases & arthropathies w MCC
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC
663	Minor bladder procedures w CC
665	Prostatectomy w MCC***
669	Transurethral procedures w CC
671	Urethral procedures w CC/MCC
688	Kidney & urinary tract neoplasms w/o CC/MCC
696	Kidney & urinary tract signs & symptoms w/o MCC
722	Malignancy, male reproductive system w MCC
759	Infections, female reproductive system w/o CC/MCC*
815	Reticuloendothelial & immunity disorders w CC
835	Acute leukemia w/o major O.R. procedure w CC***
842	Lymphoma & non-acute leukemia w/o CC/MCC
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC
844	Other myeloprolif dis or poorly diff neopl diag w CC
866	Viral illness w/o MCC
876	O.R. procedure w principal diagnoses of mental illness
881	Depressive neuroses
923	Other injury, poisoning & toxic effect diag w/o MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
964	Other multiple significant trauma w CC
976	HIV w major related condition w/o CC/MCC
QUINTILE 3	
23	Craniotomy w major device implant or acute complex CNS PDX w MCC***
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC
53	Spinal disorders & injuries w/o CC/MCC
58	Multiple sclerosis & cerebellar ataxia w MCC
82	Traumatic stupor & coma, coma >1 hr w MCC
98	Non-bacterial infect of nervous sys exc viral meningitis w CC
113	Orbital procedures w CC/MCC

116	Intraocular procedures w CC/MCC
136	Sinus & mastoid procedures w/o CC/MCC***
152	Otitis media & URI w MCC
165	Major chest procedures w/o CC/MCC
168	Other resp system O.R. procedures w/o CC/MCC
238	Major cardiovascular procedures w/o MCC
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC
261	Cardiac pacemaker revision except device replacement w CC**
262	Cardiac pacemaker revision except device replacement w/o CC/MCC**
287	Circulatory disorders except AMI, w card cath w/o MCC
369	Major esophageal disorders w CC
370	Major esophageal disorders w/o CC/MCC
380	Complicated peptic ulcer w MCC
384	Uncomplicated peptic ulcer w/o MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC
471	Cervical spinal fusion w MCC
472	Cervical spinal fusion w CC
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC
482	Hip & femur procedures except major joint w/o CC/MCC
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC*
502	Soft tissue procedures w/o CC/MCC
504	Foot procedures w CC
505	Foot procedures w/o CC/MCC
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC**
511	Shoulder,elbow or forearm proc,exc major joint proc w CC**
535	Fractures of hip & pelvis w MCC
542	Pathological fractures & musculoskelet & conn tiss malig w MCC
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC
598	Malignant breast disorders w CC
599	Malignant breast disorders w/o CC/MCC**
600	Non-malignant breast disorders w CC/MCC
626	Thyroid, parathyroid & thyroglossal procedures w CC
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC
665	Prostatectomy w MCC**
666	Prostatectomy w CC**
668	Transurethral procedures w MCC
686	Kidney & urinary tract neoplasms w MCC
687	Kidney & urinary tract neoplasms w CC
693	Urinary stones w/o esw lithotripsy w MCC
725	Benign prostatic hypertrophy w MCC
744	D&C, conization, laparascopy & tubal interruption w CC/MCC
755	Malignancy, female reproductive system w CC
800	Splenectomy w CC
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC
814	Reticuloendothelial & immunity disorders w MCC
824	Lymphoma & non-acute leukemia w other O.R. proc w CC
835	Acute leukemia w/o major O.R. procedure w CC**
834	Acute leukemia w/o major O.R. procedure w MCC
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC**

843	Other myeloprolif dis or poorly diff neopl diag w MCC
883	Disorders of personality & impulse control
903	Wound debridements for injuries w/o CC/MCC
905	Skin grafts for injuries w/o CC/MCC
922	Other injury, poisoning & toxic effect diag w MCC
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC
963	Other multiple significant trauma w MCC
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC
QUINTILE 4	
23	Craniotomy w major device implant or acute complex CNS PDX w MCC**
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC**
30	Spinal procedures w/o CC/MCC
29	Spinal procedures w CC
28	Spinal procedures w MCC
37	Extracranial procedures w MCC
38	Extracranial procedures w CC
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC*
77	Hypertensive encephalopathy w MCC
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC
164	Major chest procedures w CC
237	Major cardiovascular procedures w MCC
242	Permanent cardiac pacemaker implant w MCC***
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC**
259	Cardiac pacemaker device replacement w/o MCC
260	Cardiac pacemaker revision except device replacement w MCC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC***
286	Circulatory disorders except AMI, w card cath w MCC
327	Stomach, esophageal & duodenal proc w CC
328	Stomach, esophageal & duodenal proc w/o CC/MCC
348	Anal & stomal procedures w CC
358	Other digestive system O.R. procedures w/o CC/MCC*
405	Pancreas, liver & shunt procedures w MCC
406	Pancreas, liver & shunt procedures w CC**
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC***
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC***
466	Revision of hip or knee replacement w MCC
467	Revision of hip or knee replacement w CC
469	Major joint replacement or reattachment of lower extremity w MCC***
478	Biopsies of musculoskeletal system & connective tissue w CC
481	Hip & femur procedures except major joint w CC
486	Knee procedures w pdx of infection w CC
485	Knee procedures w pdx of infection w MCC
487	Knee procedures w pdx of infection w/o CC/MCC**
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices
492	Lower extrem & humer proc except hip,foot,femur w MCC
493	Lower extrem & humer proc except hip,foot,femur w CC
503	Foot procedures w MCC
511	Shoulder,elbow or forearm proc,exc major joint proc w CC***

513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
597	Malignant breast disorders w MCC
599	Malignant breast disorders w/o CC/MCC***
625	Thyroid, parathyroid & thyroglossal procedures w MCC
660	Kidney & ureter procedures for non-neoplasm w CC
659	Kidney & ureter procedures for non-neoplasm w MCC
666	Prostatectomy w CC***
695	Kidney & urinary tract signs & symptoms w MCC
711	Testes procedures w CC/MCC
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC
739	Uterine,adnexa proc for non-ovarian/adnexal malign w MCC
749	Other female reproductive system O.R. procedures w CC/MCC
754	Malignancy, female reproductive system w MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
909	Other O.R. procedures for injuries w/o CC/MCC*
928	Full thickness burn w skin graft or inhal inj w CC/MCC
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft
957	Other O.R. procedures for multiple significant trauma w MCC
969	HIV w extensive O.R. procedure w MCC
970	HIV w extensive O.R. procedure w/o MCC**
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC
QUINTILE 5	
12	Tracheostomy for face,mouth & neck diagnoses w CC
11	Tracheostomy for face,mouth & neck diagnoses w MCC
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC***
26	Craniotomy & endovascular intracranial procedures w CC
25	Craniotomy & endovascular intracranial procedures w MCC
31	Ventricular shunt procedures w MCC
32	Ventricular shunt procedures w CC
132	Cranial/facial procedures w/o CC/MCC
137	Mouth procedures w CC/MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
242	Permanent cardiac pacemaker implant w MCC**
244	Permanent cardiac pacemaker implant w/o CC/MCC
243	Permanent cardiac pacemaker implant w CC
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC***
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC
326	Stomach, esophageal & duodenal proc w MCC
331	Major small & large bowel procedures w/o CC/MCC
330	Major small & large bowel procedures w CC
335	Peritoneal adhesiolysis w MCC
344	Minor small & large bowel procedures w MCC
347	Anal & stomal procedures w MCC
353	Hernia procedures except inguinal & femoral w MCC
406	Pancreas, liver & shunt procedures w CC***

411	Cholecystectomy w c.d.e. w MCC
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC**
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC**
418	Laparoscopic cholecystectomy w/o c.d.e. w CC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC
459	Spinal fusion except cervical w MCC
469	Major joint replacement or reattachment of lower extremity w MCC**
470	Major joint replacement or reattachment of lower extremity w/o MCC
477	Biopsies of musculoskeletal system & connective tissue w MCC
480	Hip & femur procedures except major joint w MCC
487	Knee procedures w pdx of infection w/o CC/MCC***
488	Knee procedures w/o pdx of infection w CC/MCC
496	Local excision & removal int fix devices exc hip & femur w CC*
498	Local excision & removal int fix devices of hip & femur w CC/MCC
507	Major shoulder or elbow joint procedures w CC/MCC
582	Mastectomy for malignancy w CC/MCC
619	O.R. procedures for obesity w MCC
653	Major bladder procedures w MCC
656	Kidney & ureter procedures for neoplasm w MCC
662	Minor bladder procedures w MCC
709	Penis procedures w CC/MCC
713	Transurethral prostatectomy w CC/MCC
746	Vagina, cervix & vulva procedures w CC/MCC
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC***
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC*
906	Hand procedures for injuries
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft
970	HIV w extensive O.R. procedure w/o MCC***

*One of the original 290 low-volume MS-LTC-DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4.of the preamble of this final rule).
**One of the original 290 low-volume MS-LTC-DRGs initially assigned to a different low-volume quintile but moved to this low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4. of the preamble of this final rule).
***One of the original 290 low-volume MS-LTC-DRGs initially assigned to this low-volume quintile but moved to a different low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4. of the preamble of this final rule).

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in the low-volume quintiles to ensure that our quintile assignments result in appropriate payment for such cases and do not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

4. Steps for Determining the FY 2009 MS–LTC–DRG Relative Weights

In general, as we proposed, the FY 2009 MS–LTC–DRG relative weights in this final rule were determined based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, for FY 2009, we grouped LTCH cases to the appropriate MS–LTC–DRG, while taking into account the low-volume MS–LTC–DRGs (as described above), before the FY 2009 MS–LTC–DRG relative weights were determined. After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculated the relative weights for FY 2009 by first removing statistical outliers and cases with a length of stay of 7 days or less (as discussed in greater detail below). Next, we adjusted the number of cases in each MS–LTC–DRG (or low-volume quintile) for the effect of SSO cases (as also discussed in greater detail below). The SSO adjusted discharges and corresponding charges were used to calculate ''relative adjusted weights'' in each MS–LTC–DRG (or low-volume quintile) using the HSRV method (described above). In general, to determine the FY 2009 MS–LTC–DRG relative weights in this final rule, as we proposed, we used the same methodology we used in determining the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment period (72 FR 47281 through 47299). However, as we proposed, we made a modification to our methodology for determining relative weights for MS–LTC–DRGs with no LTCH cases (as discussed in greater detail in Step 5 below). Also, we note that, although we are generally using the same methodology in this final rule (with the exception noted above) as the

methodology used in the FY 2008 IPPS final rule with comment, the discussion presented below of the steps for determining the FY 2009 MS–LTC–DRG relative weights varies slightly from the discussion of the steps for determining the FY 2008 MS–LTC–DRG relative weights (presented in the FY 2008 IPPS final rule with comment) because we took this opportunity to refine our description to more precisely explain our methodology for determining the MS–LTC–DRG relative weights.

As discussed in the FY 2008 IPPS final rule with comment when we adopted the MS–LTC–DRGs, the adoption of the MS–LTC–DRGs with either two or three severity levels resulted in some slight modifications of procedures for assigning relative weights in cases of zero volume and/or nonmonotonicity (described in detail below) from the methodology we established when we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule. As also discussed in the FY 2008 IPPS final rule with comment when we adopted the MS–LTC–DRGs, we implemented the MS–LTC–DRGs with a 2-year transition beginning in FY 2008. For FY 2008, the first year of the transition, 50 percent of the relative weight for a MS–LTC–DRG was based on the average LTC–DRG relative weight under Version 24.0 of the LTC–DRG GROUPER. The remaining 50 percent of the relative weight was based on the MS–LTC–DRG relative weight under Version 25.0 of the MS–LTC–DRG GROUPER. In FY 2009, the MS–LTC–DRG relative weights are based on 100 percent of the MS–LTC–DRG relative weights. Accordingly, in determining the FY 2009 MS–LTC–DRG relative weights in this final rule, there was no longer a need to include a step to calculate MS–LTC–DRG transition blended relative weights (see Step 7 in the FY 2008 IPPS final rule with comment period (72 FR 47295). Therefore, as we proposed, in this final rule, we determined the FY 2009 MS–LTC–DRG relative weights based solely on the MS–LTC–DRG relative weight under Version 26.0 of the MS–LTC–DRG GROUPER, which is discussed in section II.B. of the preamble of this final rule. Furthermore, as we proposed, we determined the final FY 2009 MS–LTC–DRG relative weights in this final rule based on the final Version 26.0 of the MS–LTC–DRG GROUPER that is presented in this final rule.

Below we discuss in detail the steps for calculating the FY 2009 MS–LTC–DRG relative weights. We note that, as we stated above in section II.I.3.b. of the preamble of this final rule, we have excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2007 MedPAR file.

Step 1—Remove statistical outliers.

As we proposed, the first step in the calculation of the FY 2009 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the MS–LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the FY 2009 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the FY 2009 MS–LTC–DRG relative weights, as we proposed, we removed LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of SSOs.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. As we proposed, as the next step in the calculation of the FY 2009 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we adjusted each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503 for LTCH discharges occurring on or after October 1, 2008). (We note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as an SSO if its length of stay was less than or equal to five-sixths of the average length of stay of the MS–LTC–DRG.)

We made this adjustment by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the MS–LTC–DRG for non-SSO cases. This has the effect of proportionately reducing the impact of the lower charges for the SSO cases in calculating the average charge for the MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of an SSO case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the MS–LTC–DRG.

Counting SSO cases as full discharges with no adjustment in determining the FY 2009 MS–LTC–DRG relative weights would lower the FY 2009 MS–LTC–DRG relative weight for affected MS–LTC–DRGs because the relatively lower charges of the SSO cases would bring down the average charge for all cases within an MS–LTC–DRG. This would result in an ''underpayment'' for non-SSO cases and an ''overpayment'' for SSO cases. Therefore, as we proposed, we adjusted for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the FY 2009 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, as we proposed, we calculated the MS–LTC–DRG relative weights using the HSRV methodology, which is an iterative process. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the SSO adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio was then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each MS–LTC–DRG, the FY 2009 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the MS–LTC–DRG by

the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) were calculated by dividing the sum of all the LTCH's MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above were multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values were then used to calculate a new set of MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there was convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Determine an FY 2009 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, we determined the FY 2009 relative weight for each MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the March 2008 update of the FY 2007 MedPAR file for this final rule). Of the FY 2009 MS–LTC–DRGs, we identified a number of MS–LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2007 MedPAR file used for this final rule, no patients who would have been classified to those MS–LTC–DRGs were treated in LTCHs during FY 2007 and, therefore, no charge data were available for those MS–LTC–DRGs. Thus, in the process of determining the MS–LTC–DRG relative weights, we were unable to calculate relative weights for these MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, as we proposed, we assigned relative weights to each of the no-volume MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of ''transplant'' MS–LTC–DRGs and ''error'' MS–LTC–DRGs as discussed below). In general, we determined FY 2009 relative weights for the MS–LTC–DRGs with no LTCH cases in the FY 2007 MedPAR file used in this final rule (that is, ''no-volume MS–LTC–DRGs) by crosswalking each no-volume MS–LTC–DRG to another MS–LTC–DRG with a calculated relative weight (determined in accordance with the methodology described above). Then, the ''no-volume'' MS–LTC–DRG was assigned the same relative weight of the MS–LTC–DRG to which it was crosswalked (as described in greater detail below). As noted above, as proposed, we made a modification to our methodology for determining relative weights for MS–LTC–DRGs with no LTCH cases in this final rule, which is discussed in greater detail below. As also noted above, even where we are not changing our existing methodology, as we did in the FY 2009 IPPS proposed rule, we took this opportunity to refine our description to more precisely explain our proposed methodology for determining the MS–LTC–DRG relative weights in this final rule.

Specifically, in this final rule, as we proposed, we determined the relative weight for each MS–LTC–DRG using total Medicare allowable charges reported in the March 2008 update of the FY 2007 MedPAR file. Of the 746 MS–LTC–DRGs for FY 2009, we identified 203 MS–LTC–DRGs for which there were no LTCH cases in the database (including the 8 ''transplant'' MS–LTC–DRGs and 2 ''error'' MS–LTC–DRGs). For this final rule, as noted above and as we proposed, we assigned relative weights for each of the 203 no-volume MS–LTC–DRGs (with the exception of the 8 ''transplant'' MS–LTC–DRGs and the 2 ''error'' MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 543 (746 − 203= 543) MS–LTC–DRGs for which we were able to determine relative weights, based on FY 2007 LTCH claims data. (For the remainder of this discussion, we refer to one of the 543 MS–LTC–DRGs for which we were able to determine relative weight as the ''crosswalked'' MS–LTC–DRG.) Then, as we proposed, we assigned the no-volume MS–LTC–DRG the relative weight of the crosswalked MS–LTC–DRG. As discussed in the FY 2009 IPPS proposed rule (73 FR 23602), this approach differs from the one we used to determine the FY 2008 MS–LTC–DRG relative weights when there were no LTCH cases (72 FR 47290). Specifically, in determining the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment period, if the no volume MS–LTC–DRG was crosswalked to a MS–LTC–DRG that had 25 or more cases and, therefore, was not in a low-volume quintile, we assigned the relative weight of a quintile to a no-volume MS–LTC–DRG (rather than assigning the relative weight of the crosswalked MS–LTC–DRG). While we believe this approach would result in appropriate LTCH PPS payments (because it is consistent with our methodology for determining relative weights for MS–LTC–DRGs that have a low volume of LTCH cases (which is discussed above in section II.I.3.e. of this preamble)), upon further review during the development of the FY 2009 MS–LTC–DRG relative weights in this final rule, we now believe that assigning the relative weight of the crosswalked MS–LTC–DRG to the no-volume MS–LTC–DRG would result in more appropriate LTCH PPS payments because those cases generally require equivalent relative resource (and therefore should generally have the same LTCH PPS payment). The relative weight of each MS–LTC–DRG should reflect relative resource of the LTCH cases grouped to that MS–LTC–DRG. Because the no-volume MS–LTC–DRGs are crosswalked to other MS–LTC–DRGs based on clinical similarity and relative costliness, which usually require equivalent relative resource use, we believe that assigning the no-volume MS–LTC–DRG the relative weight of the crosswalked MS–LTC–DRG would result in appropriate LTCH PPS payments. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

Comment: Although we did not receive any comments on any of the specific proposed MS–LTC–DRG no-volume crosswalks presented in the table in the proposed rule, we received one general comment on our description of the proposed methodology to determine the proposed no-volume MS–LTC–DRGs crosswalks for FY 2009. Specifically, the commenter stated that, although it generally supported the proposed methodology for determining relative weights for the no-volume MS–LTC–DRGs, it was not clear how CMS was able to compare the ''relative costliness'' of the no-volume MS–LTC–DRGs to other MS–LTC–DRGs because, by definition, the no-volume MS–LTC–DRGs do not have costs associated with them (since there are no LTCH cases in the data). The commenter questioned whether CMS may have evaluated the relative costliness of the proposed no-volume FY 2009 MS–LTC–DRGs using prior years' LTCH data or if relative costliness was assessed based on the cost experience of those MS–DRGs under the IPPS. The commenter requested that, in the final rule, CMS provide additional detail on the ''relative costliness'' aspect of the proposed no-volume crosswalk methodology.

Response: We appreciate the commenter's support of our proposed methodology for determining relative weight for the no-volume MS–LTC–DRGs for FY 2009. As requested by the commenter, we are taking this

opportunity to provide additional information on how we evaluated the relative costliness in determining the applicable MS–LTC–DRG to which a no-volume MS–LTC–DRG was cross-walked in order to assign an appropriate relative weight for the no-volume MS–LTC–DRGs in FY 2009. In general, most of the no-volume MS–LTC–DRGs historically have not had any cases in the LTCH data. Therefore, we typically are unable to evaluate relative costliness based on prior years' LTCH claims data. In evaluating the relative costliness for most of the no-volume MS–LTC–DRGs, a group of CMS Medical Officers, who have extensive knowledge and familiarity with both the IPPS and LTCH DRG-based payment systems, used their DRG experience to evaluate the relative costliness of the no-volume MS–LTC–DRGs. Specifically, the relative costliness of each of the no-volume MS–LTC–DRGs was assessed by taking into consideration factors such as relative resource use, clinical cohesiveness, and the comparableness of services provided, based on the collective IPPS and LTCH PPS experience of those Medical Officers. We also note, as discussed above, the no-volume MS–LTC–DRG crosswalks are based on both clinical similarity and relative costliness, including such factors as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We believe in the rare event that there would be a few LTCH cases grouped to one of the no-volume MS–LTC–DRGs in the future, the relative weights assigned based on the crosswalked MS–LTC–DRGs will result in an appropriate LTCH PPS payment because the crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use.

In this final rule, we are adopting the methodology we proposed for determining the relative weights for the no-volume MS–LTC–DRGs. Our methodology for determining the relative weights for the no-volume MS–LTC–DRGs is as follows: We crosswalk the no-volume MS–LTC–DRG to an MS–LTC–DRG for which there are LTCH cases in the FY 2007 MedPAR file and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We then assign the relative weight of the crosswalked MS–LTC–DRG as the relative weight for the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the crosswalked MS–LTC–DRG) would have the same relative weight. We note that if the crosswalked MS–LTC–DRG has 25 cases or more, its relative weight, which is calculated using the methodology described in steps 1 through 4 above, is assigned to the no-volume MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume MS–LTC–DRG is crosswalked has 24 or less cases, and therefore is designated to one of the low-volume quintiles for purposes of determining the relative weights, we assign the relative weight of the applicable low-volume quintile to the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the crosswalked MS–LTC–DRG) have the same relative weight. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing relative weights.)

For this final rule, a list of the no-volume FY 2009 MS–LTC–DRGs and the FY 2009 MS–LTC–DRG to which it is crosswalked (that is, the crosswalked MS–LTC–DRG) is shown in the chart below.

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No-Volume MS-LTC-DRG Crosswalk for FY 2009

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)	Crosswalked MS-LTC-DRG
9	Bone marrow transplant	823
13	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	12
20	Intracranial vascular procedures w PDX hemorrhage w MCC	31
21	Intracranial vascular procedures w PDX hemorrhage w CC	32
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	32
33	Ventricular shunt procedures w/o CC/MCC	32
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedure w CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
76	Viral meningitis w/o CC/MCC	75
88	Concussion w MCC	89
90	Concussion w/o CC/MCC	89
114	Orbital procedures w/o CC/MCC	113
115	Extraocular procedures except orbit	125
117	Intraocular procedures w/o CC/MCC	125
123	Neurological eye disorders	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
131	Cranial/facial procedures w CC/MCC	132
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	133
138	Mouth procedures w/o CC/MCC	137
139	Salivary gland procedures	137
150	Epistaxis w MCC	152
151	Epistaxis w/o MCC	153
215	Other heart assist system implant	238
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	238
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	238
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	238
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	238
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	243

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)	Crosswalked MS-LTC-DRG
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	238
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	238
235	Coronary bypass w/o cardiac cath w MCC	237
236	Coronary bypass w/o cardiac cath w/o MCC	238
245	AICD generator procedures	244
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
258	Cardiac pacemaker device replacement w MCC	259
265	AICD lead procedures	259
285	Circulatory disorders w AMI, expired w/o CC/MCC	284
295	Deep vein thrombophlebitis w/o CC/MCC	294
296	Cardiac arrest, unexplained w MCC	283
297	Cardiac arrest, unexplained w CC	284
298	Cardiac arrest, unexplained w/o CC/MCC	284
332	Rectal resection w MCC	356
333	Rectal resection w CC	357
334	Rectal resection w/o CC/MCC	358
336	Peritoneal adhesiolysis w CC	335
337	Peritoneal adhesiolysis w/o CC/MCC	335
338	Appendectomy w complicated principal diag w MCC	371
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
345	Minor small & large bowel procedures w CC	344
346	Minor small & large bowel procedures w/o CC/MCC	344
349	Anal & stomal procedures w/o CC/MCC	348
350	Inguinal & femoral hernia procedures w MCC	348
351	Inguinal & femoral hernia procedures w CC	348
352	Inguinal & femoral hernia procedures w/o CC/MCC	348
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
383	Uncomplicated peptic ulcer w MCC	384
407	Pancreas, liver & shunt procedures w/o CC/MCC	406
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	409
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	409
412	Cholecystectomy w c.d.e. w CC	411
413	Cholecystectomy w c.d.e. w/o CC/MCC	411
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	415
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	418
420	Hepatobiliary diagnostic procedures w MCC	424
421	Hepatobiliary diagnostic procedures w CC	424
422	Hepatobiliary diagnostic procedures w/o CC/MCC	424
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)	Crosswalked MS-LTC-DRG
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	433
453	Combined anterior/posterior spinal fusion w MCC	457
454	Combined anterior/posterior spinal fusion w CC	457
455	Combined anterior/posterior spinal fusion w/o CC/MCC	457
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	457
460	Spinal fusion except cervical w/o MCC	459
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
473	Cervical spinal fusion w/o CC/MCC	472
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	478
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
491	Back & neck procedures except spinal fusion w/o CC/MCC	490
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC	498
506	Major thumb or joint procedures	514
508	Major shoulder or elbow joint procedures w/o CC/MCC	507
509	Arthroscopy	505
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	511
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	516
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	537
583	Mastectomy for malignancy w/o CC/MCC	582
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	584
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
620	O.R. procedures for obesity w CC	619
621	O.R. procedures for obesity w/o CC/MCC	619
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	626
654	Major bladder procedures w CC	653
655	Major bladder procedures w/o CC/MCC	653
657	Kidney & ureter procedures forneoplasm w CC	656
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	656
664	Minor bladder procedures w/o CC/MCC	663
667	Prostatectomy w/o CC/MCC	666
670	Transurethral procedures w/o CC/MCC	669
672	Urethral procedures w/o CC/MCC	671
675	Other kidney & urinary tract procedures w/o CC/MCC	674
691	Urinary stones w esw lithotripsy w CC/MCC	694
692	Urinary stones w esw lithotripsy w/o CC/MCC	694
697	Urethral stricture	688
707	Major male pelvic procedures w CC/MCC	660
708	Major male pelvic procedures w/o CC/MCC	661
710	Penis procedures w/o CC/MCC	709

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)	Crosswalked MS-LTC-DRG
712	Testes procedures w/o CC/MCC	711
714	Transurethral prostatectomy w/o CC/MCC	713
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	717
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	717
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	717
724	Malignancy, male reproductive system w/o CC/MCC	723
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	717
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	717
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	754
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	756
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	739
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	739
742	Uterine & adnexa proc for non-malignancy w CC/MCC	755
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	756
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	744
747	Vagina, cervix & vulva procedures w/o CC/MCC	746
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
760	Menstrual & other female reproductive system disorders w CC/MCC	744
761	Menstrual & other female reproductive system disorders w/o CC/MCC	744
765	Cesarean section w CC/MCC	744
766	Cesarean section w/o CC/MCC	744
767	Vaginal delivery w sterilization &/or D&C	744
768	Vaginal delivery w O.R. proc except steril &/or D&C	744
769	Postpartum & post abortion diagnoses w O.R. procedure	744
770	Abortion w D&C, aspiration curettage or hysterotomy	744
774	Vaginal delivery w complicating diagnoses	744
775	Vaginal delivery w/o complicating diagnoses	744
776	Postpartum & post abortion diagnoses w/o O.R. procedure	744
777	Ectopic pregnancy	744
778	Threatened abortion	759
779	Abortion w/o D&C	759
780	False labor	759
782	Other antepartum diagnoses w/o medical complications	781
789	Neonates, died or transferred to another acute care facility	781
790	Extreme immaturity or respiratory distress syndrome, neonate	781
791	Prematurity w major problems	781
792	Prematurity w/o major problems	781

MS-LTC-DRG (Version 26.0)	MS-LTC-DRG Description (Version 26.0)	Crosswalked MS-LTC-DRG
793	Full term neonate w major problems	781
794	Neonate w other significant problems	781
795	Normal newborn	781
799	Splenectomy w MCC	800
801	Splenectomy w/o CC/MCC	800
803	Other O.R. proc of the blood & blood forming organs w CC	802
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	802
820	Lymphoma & leukemia w major O.R. procedure w MCC	823
821	Lymphoma & leukemia w major O.R. procedure w CC	824
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	824
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	824
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	827
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	829
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	829
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	829
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	847
887	Other mental disorder diagnoses	881
894	Alcohol/drug abuse or dependence, left ama	881
915	Allergic reactions w MCC	918
916	Allergic reactions w/o MCC	918
955	Craniotomy for multiple significant trauma	26
956	Limb reattachment, hip & femur proc for multiple significant trauma	482
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	958
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	985

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To illustrate this methodology for determining the relative weights for the MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume MS–LTC–DRGs crosswalk information for FY 2009 provided in the chart above.

Example: There were no cases in the FY 2007 MedPAR file used for this final rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that MS–LTC–DRG 70 (Nonspecific Cerebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same relative weight of MS–LTC–DRG 70 of 0.8718 for FY 2009 to MS–LTC–DRG 61 (Table 11 of the Addendum to this final rule).

Furthermore, for FY 2009, consistent with our historical relative weight methodology, as we proposed, we are establishing MS–LTC–DRG relative weights of 0.0000 for the following transplant MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (MS–LTC–DRG 5); Liver Transplant without MCC (MS–LTC–DRG 6); Lung Transplant (MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (MS–LTC–DRG 8); Pancreas Transplant (MS–LTC–DRG 10); and Kidney Transplant (MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs will become certified as a transplant center. In fact, in the more than 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

If in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the

MS–LTC–DRGs affected. At the present time, we only include these eight transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these MS–LTC–DRGs would be administratively burdensome.

Again, we note that, as this system is dynamic, it is entirely possible that the number of MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no-volume MS–LTC–DRGs and to determine the relative weights in this final rule.

Step 6—Adjust the FY 2009 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed in section II.B. of the preamble of this final rule, the MS–DRGs (used under the IPPS) on which the MS–LTC–DRGs are based provide a significant improvement in the DRG system's recognition of severity of illness and resource usage. The MS–DRGs contain base DRGs that have been subdivided into one, two, or three severity levels. Where there are three severity levels, the most severe level has at least one code that is referred to as an MCC. The next lower severity level contains cases with at least one code that is a CC. Those cases without an MCC or a CC are referred to as without CC/MCC. When data did not support the creation of three severity levels, the base was divided into either two levels or the base was not subdivided. The two-level subdivisions could consist of the CC/MCC and the without CC/MCC. Alternatively, the other type of two level subdivision could consist of the MCC and without MCC.

In those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the ''without CC/MCC'' MS–LTC–DRG are expected to have a lower resource use (and lower costs) than the ''with CC/MCC'' MS–LTC–DRG (in the case of a two-level split) or the ''with CC'' and ''with MCC'' MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights do not increase (that is, if within a base MS–LTC–DRG, an MS–LTC–DRG with MCC has a lower relative weight than one with CC, or the MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others, they are nonmonotonic). We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments. Consequently, in general, as we proposed, we combined MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. In determining the FY 2009 MS–LTC–DRG relative weights in this final rule, in general, we are using the same methodology to adjust for nonmonotonicity that we used to determine the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment (72 FR 47293 through 47295). However, as noted above and as we did in the proposed rule, we are taking this opportunity to refine our description to more precisely explain our methodology for determining the MS–LTC–DRG relative weights in this final rule. We note that we did not receive any comments on our refinement to the description of our methodology for adjusting for nonmonotonicity in determining the relative weights for FY 2009 that was presented in the FY 2009 IPPS proposed rule. In determining the FY 2009 MS–LTC–DRG relative weights in this final rule, under each of the example scenarios provided below, we combined severity levels within a base MS–LTC–DRG as follows:

The first example of nonmonotonically increasing relative weights for a MS–LTC–DRG pertains to a base MS–LTC–DRG with a three-level split and each of the three levels has 25 or more LTCH cases and, therefore, none of those MS–LTC–DRGs is assigned to one of the five low-volume quintiles. In this final rule, if nonmonotonicity was detected in the relative weights of the MS–LTC–DRGs in adjacent severity levels (for example, the relative weight of the ''with MCC'' (the highest severity level) is less than the ''with CC'' (the middle level), or the ''with CC'' is less than the ''without CC/MCC''), we combined the nonmonotonic adjacent MS–LTC–DRGs and redetermined a relative weight based on the case-weighted average of the combined LTCH cases of the nonmonotonic MS–LTC–DRGs. The case-weighted average charge is calculated by dividing the total charges for all LTCH cases in both severity levels by the total number of LTCH cases for both MS–LTC–DRGs. The same relative weight is assigned to both affected levels of the base MS–LTC–DRG. If nonmonotonicity remains an issue because the above process resulted in a relative weight that was still nonmonotonic to the remaining MS–LTC–DRG relative weight within the base MS–LTC–DRG, we combined all three of the severity levels to redetermine the relative weights based on the case-weighted average charge of the combined severity levels. This same relative weight was then assigned to each of the MS–LTC–DRGs in that base MS–LTC–DRG.

A second example of nonmonotonically increasing relative weights for a base MS–LTC–DRG pertains to the situation where there are three severity levels and one or more of the severity levels within a base MS–LTC–DRG has less than 25 LTCH cases (that is, low volume). In this final rule, if nonmonotonicity occurs in the case where either the highest or lowest severity level (''with MCC'' or ''without CC/MCC'') has 25 LTCH cases or more and the other two severity levels are low volume (and therefore the other two severity levels are otherwise assigned the relative weight of the applicable low-volume quintile(s)), we combined the data for the cases in the two adjacent low-volume MS–LTC–DRGs for the purpose of determining a relative weight. If the combination resulted in at least 25 cases, we redetermined one relative weight based on the case-weighted average charge of the combined severity levels and assigned this same relative weight to each of the severity levels. If the combination resulted in less than 25 cases, based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs, both MS–LTC–DRGs were assigned to the appropriate low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile). If nonmonotonicity persisted, we combined all three severity levels and redetermined one relative weight based on the case-weighted average charge of the combined severity levels and this same relative weight was assigned to each of the three levels.

Similarly, in nonmonotonic cases where the middle level has 25 cases or more but either or both of the lowest or highest severity level has less than 25 cases (that is, low volume), we combined the nonmonotonic low-volume MS–LTC–DRG with the middle level MS–LTC–DRG of the base MS–

LTC–DRG. We redetermined one relative weight based on the case-weighted average charge of the combined severity levels and assigned this same relative weight to each of the affected MS–LTC–DRGs. If nonmonotonicity persisted, we combined all three levels for the purpose of redetermining a relative weight based on the case-weighted average charge of the combined severity levels, and assigned that relative weight to each of the three severity levels.

In the case where all three severity levels in the base MS–LTC–DRGs were low-volume MS–LTC–DRGs and two of the severity levels were nonmonotonic in relation to each other, we combined the two adjacent nonmonotonic severity levels. If that combination resulted in less than 25 cases, both low-volume MS–LTC–DRGs were assigned to the appropriate low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile). If the nonmonotonicity persisted, we combined all three levels of that base MS–LTC–DRG for the purpose of redetermining a relative weight based on the case-weighted average charge of the combined severity levels, and assigned that relative weight to each of the three severity levels. If that combination of all three severity levels resulted in less than 25 cases, we assigned that ''combined'' base MS–LTC–DRG to the appropriate low-volume quintile based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile).

Another example of nonmonotonicity involves a base MS–LTC–DRG with three severity levels where at least one of the severity levels has no cases. As discussed above in greater detail in Step 5, based on resource use intensity and clinical similarity, as we proposed, we crosswalked a no-volume MS–LTC–DRG to an MS–LTC–DRG that had at least one case. Under our methodology for the treatment of no-volume MS–LTC–DRGs, the no-volume MS–LTC–DRG was assigned the same relative weight as the MS–LTC–DRG to which the no-volume MS–LTC–DRG was crosswalked. For many no-volume MS–LTC–DRGs, as shown in the chart above in Step 5, the application of our methodology resulted in a crosswalked MS–LTC–DRG that is the adjacent severity level in the same base MS–LTC–DRG. Consequently, in most instances, the no-volume MS–LTC–DRG and the adjacent MS–LTC–DRG to which it was crosswalked did not result in nonmonotonicity because both of these severity levels would have the same relative weight. (In this final rule, under our methodology for the treatment of no-volume MS–LTC–DRGs, in the case where the no-volume MS–LTC–DRG was either the highest or lowest severity level, the crosswalked MS–LTC–DRG would be the middle level (''with CC'') within the same base MS–LTC–DRG, and therefore the no-volume MS–LTC–DRG (either the ''with MCC'' or the ''without CC/MCC'') and the crosswalked MS–LTC–DRG (the ''with CC'') would have the same relative weight. Consequently, no adjustment for monotonicity was necessary.) However, if our methodology for determining relative weights for no-volume MS–LTC–DRGs resulted in nonmonotonicity with the third severity level in the base MS–LTC–DRG, all three severity levels were combined for the purpose of redetermining one relative weight based on the case-weighted average charge of the combined severity levels. This same relative weight was assigned to each of the three severity levels in the base MS–LTC–DRG.

Thus far in the discussion, we have presented examples of nonmonotonicity in a base MS–LTC–DRG that has three severity levels. We apply the same process where the base MS–LTC–DRG contains only two severity levels. For example, if nonmonotonicity occurs in a base MS–LTC–DRG with two severity levels (that is, the relative weight of the higher severity level is less than the lower severity level), where both of the MS–LTC–DRGs have at least 25 cases or where one or both of the MS–LTC–DRGs is low volume (that is, less than 25 cases), we combine the two MS–LTC–DRGs of that base MS–LTC–DRG for the purpose of redetermining a relative weight based on the combined case-weighted average charge for both severity levels. This same relative weight is assigned to each of the two severity levels in the base MS–LTC–DRG. Specifically, if the combination of the two severity levels results in at least 25 cases, we redetermine one relative weight based on the case-weighted average charge and assign that relative weight to each of the two MS–LTC–DRGs. If the combination results in less than 25 cases, we assign both MS–LTC–DRGs to the appropriate low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on their combined case-weighted average charge. Then the relative weight of the affected low-volume quintile is redetermined and that relative weight is assigned to each of the affected severity levels.

Step 7— Calculate the FY 2009 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary under section 123 of Public Law 106–113 as amended by section 307(b) of Public Law 106–554 to develop the LTCH PPS, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the MS–LTC–DRG classifications and relative weights is done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes. Specifically, in that same final rule, we established under § 412.517(b) that the annual update to the MS–LTC–DRG classifications and relative weights be done in a budget neutral manner. For a detailed discussion on the establishment of the requirement to update the MS–LTC–DRG classifications and relative weights in a budget neutral manner, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884). Updating the MS–LTC–DRGs in a budget neutral manner results in an annual update to the individual MS–LTC–DRG classifications and relative weights based on the most recent available data to reflect changes in relative LTCH resource use. To accomplish this, for each annual update, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, as we proposed, we updated the MS–LTC–DRG classifications and relative weights for FY 2009 based on the most recent available data and included a budget neutrality adjustment that was applied in determining the MS–LTC–DRG relative weights.

To ensure budget neutrality in updating the MS–LTC–DRG classifications and relative weights under § 412.517(b), consistent with the budget neutrality methodology we established in the FY 2008 IPPS final rule with comment period (72 FR 47295

through 47296), in determining the budget neutrality adjustment for FY 2009 in this final rule, as we proposed, we used a method that is similar to the methodology used under the IPPS. Specifically, for FY 2009, after recalibrating the MS–LTC–DRG relative weights as we do under the methodology as described in detail in Steps 1 through 6 above, we calculated and applied a normalization factor to those relative weights to ensure that estimated payments were not influenced by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases total estimated payments.

To calculate the normalization factor for FY 2009, as we proposed, we used the following steps: (1) We use the most recent available claims data (FY 2007) and the MS–LTC–DRG relative weights (determined above in Steps 1 through 6 above) to calculate the average CMI; (2) we group the same claims data (FY 2007) using the FY 2008 GROUPER (Version 25.0) and FY 2008 relative weights (established in the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296)) and calculate the average CMI: and (3), we compute the ratio of these average CMIs by dividing the average CMI determined in step (2) by the average CMI determined in step (1). In determining the MS–LTC–DRG relative weights for FY 2009, based on the latest available LTCH claims data, the normalization factor is estimated as 1.03887, which is applied in determining each MS–LTC–DRG relative weight. That is, each MS–LTC–DRG relative weight is multiplied by 1.03887 in the first step of the budget neutrality process. Accordingly, the relative weights in Table 11 in the Addendum of this final rule reflect this normalization factor. We also ensured that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (the new FY 2009 MS–LTC–DRG classifications and relative weights) are equal to estimated aggregate LTCH PPS payments (for the same most recent available LTCH claims data) before reclassification and recalibration (the existing FY 2008 MS–LTC–DRG classifications and relative weights). Therefore, we calculated the budget neutrality adjustment factor by simulating estimated total payments under both sets of GROUPERs and relative weights using current LTCH PPS payment policies (RY 2009) and the most recent available LTCH claims data (FY 2007). As we discussed in the FY 2009 IPPS proposed rule (73 FR 23608), we have established payments rates and policies for RY 2009 prior to the development of the FY 2009 IPPS final rule (73 FR 26788 through 26874). Therefore, for purposes of determining the FY 2009 budget neutrality factor in this final rule, as we proposed, we simulated estimated total payments using the most recent LTCH PPS payment policies and LTCH claims data that are available at this time. As noted above, the most recent available LTCH claims data are from the March 2008 update of the FY 2007 MedPAR file.

Accordingly, we used RY 2009 LTCH PPS rates and policies in determining the FY 2009 budget neutrality adjustment in this final rule, using the following steps: (1) We simulated estimated total payments using the normalized relative weights under GROUPER Version 26.0 (as described above); (2) we simulated estimated total payments using the FY 2008 GROUPER (Version 25.0) and FY 2008 MS–LTC–DRG relative weights (as established in the FY 2008 IPPS final rule (72 FR 47295 through 47296)); and (3) we calculated the ratio of these estimated total payments by dividing the estimated total payments determined in step (2) by the estimated total payments determined in step (1). Then, each of the normalized relative weights was multiplied by the budget neutrality factor to determine the budget neutral relative weight for each MS–LTC–DRG.

Accordingly, in determining the MS–LTC–DRG relative weights for FY 2009 in this final rule, based on the most recent available LTCH claims data, we are establishing a budget neutrality factor of 1.04186, which was applied to the normalized relative weights (described above). The FY 2009 MS–LTC–DRG relative weights in Table 11 in the Addendum of this final rule reflect this budget neutrality factor.

Table 11 in the Addendum to this final rule lists the MS–LTC–DRGs and their respective budget neutral relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in the determination of SSO payments under § 412.529) for FY 2009.

5. Other Comments

Comment: While CMS did not propose for FY 2009 an adjustment for improved coding practices resulting from the transition to the MS–LTC–DRG system, one commenter urged CMS to wait until sufficient claims data under the MS–LTC–DRG system are available to provide CMS with a solid benchmark on coding behavior for the comparison between the previous LTC–DRG and current MS–LTC–DRG systems. The commenter believed that any evaluation of the need for an adjustment for improved coding practices should take into account all of the previous case-mix adjustments to the market basket and the self-correcting nature of the current policy of the budget neutral reweighting of the MS–LTC–DRG relative weights. Furthermore, the commenter believed that it would not be appropriate to apply a coding adjustment to the MS–LTC–DRGs where coding changes would not be expected to change as a result of the transitioning from LTC–DRGs to MS–LTC–DRGs (for example, in ventilator DRGs where there have been no changes from the LTC–DRG system to the MS–LTC–DRG system).

Response: At this time, we have not proposed any adjustment for FY 2009 to account for improved coding practices resulting from the transition to the MS–LTC–DRG system. In the FY 2008 IPPS final rule with comment period (72 FR 47297 through 47299), we indicated that we believe that the adoption of the MS–LTC–DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. However, we acknowledged, at the time, that because we had not been able to determine an appropriate adjustment factor for LTCHs and because we have an established mechanism to adjust LTCH PPS payments to account for the effects of changes in documentation and coding practices, we believed that it was appropriate to continue to use this established process. We note that, in the FY 2008 IPPS final rule with comment period, we responded to comments similar to the one summarized above. In section II.D.4. of this final rule, we discuss the intended future evaluation of claims data and resulting case-mix growth from the implementation of the MS–DRG system. A similar retrospective evaluation will be conducted for MS–LTC–DRGs. The analysis, findings, and any resulting proposals to adjust payments to offset the estimated amount of increase or decrease in aggregate payments that occurred in FY 2008 and FY 2009 for LTCHs as a result of coding improvements, will be discussed in future years' proposed rules, which would be open for public comment.

Comment: One commenter addressed our discussion in the RY 2009 LTCH final rule on the possible application to LTCHs of the broad principle articulated in the HACs payment provision that

goes into effect for acute care hospitals paid under the IPPS for FY 2009.

Response: We appreciate the commenter's support and remarks concerning the possible application of a HACs payment provision to LTCHs. Although we did not propose a HAC provision under the LTCH PPS nor did we discuss the possible application of one in the FY 2009 IPPS proposed rule, we will take into account the commenter's concerns and recommendations in our ongoing consideration of the applicability of a possible HACs policy for LTCHs.

J. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.''

The regulations implementing this provision establish three criteria for new medical services and technologies to receive an additional payment. First, 42 CFR 412.87(b)(2) states that a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments until such time as Medicare data are available to fully reflect the cost of the technology in the DRG weights through recalibration. Typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2007 are used to calculate the FY 2009 DRG weights in this final rule. Section 412.87(b)(2) of our existing regulations provides that ''a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin on the date on which the medical service or technology received FDA approval or clearance. (We note that, for purposes of this section of the final rule, we refer to both FDA approval and FDA clearance as FDA ''approval.'') However, in some cases, initially there may be no Medicare data available for the new service or technology following FDA approval. For example, the newness period could extend beyond the 2-year to 3-year period after FDA approval is received in cases where the product initially was generally unavailable to Medicare patients following FDA approval, such as in cases of a national noncoverage determination or a documented delay in bringing the product onto the market after that approval (for instance, component production or drug production has been postponed following FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the medical service or technology is no longer eligible for special add-on payment for new medical services or technologies (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2007 and entered the market at that time may be eligible to receive add-on payments as a new technology for discharges occurring before October 1, 2010 (the start of FY 2011). Because the FY 2011 DRG weights would be calculated using FY 2009 MedPAR data, the costs of such a new technology would be fully reflected in the FY 2011 DRG weights. Therefore, the new technology would no longer be eligible to receive add-on payments as a new technology for discharges occurring in FY 2011 and thereafter.

Section 412.87(b)(3) further provides that, to be eligible for the add-on payment for new medical services or technologies, the DRG prospective payment rate otherwise applicable to the discharge involving the new medical services or technologies must be assessed for adequacy. Under the cost criterion, to assess the adequacy of payment for a new technology paid under the applicable DRG-prospective payment rate, we evaluate whether the charges for cases involving the new technology exceed certain threshold amounts. In the FY 2004 IPPS final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and converted back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in more than one DRG).

However, section 503(b)(1) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide that, beginning in FY 2005, CMS will apply ''a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved.'' (We refer readers to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 in section XIX. of the interim final rule with comment period published in the **Federal Register** on November 27, 2007, contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2009 (72 FR 66888 through 66892). An applicant must demonstrate that the cost threshold is met using information from inpatient hospital claims.

We note that section 124 of Public Law 110–275 extends, through FY 2009, wage index reclassifications under section 508 of Public Law 108–173 (the MMA) and special exceptions contained in the final rule promulgated in the **Federal Register** on August 11, 2004 (69 FR 49105, 49107) and extended under section 117 of the MMSEA of 2007 (Pub. L. 110–173). The wage data affects the standardized amounts (as well as the outlier offset and budget neutrality factors that are applied to the standardized amounts), which we use to compute the cost criterion thresholds in Table 10 of this final rule. Therefore, the thresholds reflected in Table 10 of this final rule are tentative. A new Table 10 with revised thresholds will be published when section 124 of Public Law 110–275 is implemented and the

wage index rates for FY 2009 are finalized. Subsequent to the publication of this final rule, we will publish a **Federal Register** document listing the final version of Table 10 that will be used to determine if an applicant for new technology add-on payments in FY 2010 meets the cost threshold for new technology add-on payments for FY 2010. The final thresholds also will be published on the CMS Web site.

In the September 7, 2001 final rule that established the new technology add-on payment regulations (66 FR 46917), we discussed the issue of whether the HIPAA Privacy Rule at 45 CFR parts 160 and 164 applies to claims information that providers submit with applications for new technology add-on payments. Specifically, we explained that health plans, including Medicare, and providers that conduct certain transactions electronically, including the hospitals that would be receiving payment under the FY 2001 IPPS final rule, are required to comply with the HIPAA Privacy Rule. We further explained how such entities could meet the applicable HIPAA requirements by discussing how the HIPAA Privacy Rule permitted providers to share with health plans information needed to ensure correct payment, if they had obtained consent from the patient to use that patient's data for treatment, payment, or health care operations. We also explained that, because the information to be provided within applications for new technology add-on payment would be needed to ensure correct payment, no additional consent would be required. The HHS Office of Civil Rights has since amended the HIPAA Privacy Rule, but the results remain. The HIPAA Privacy Rule no longer requires covered entities to obtain consent from patients to use or disclose protected health information for treatment, payment, or health care operations, and expressly permits such entities to use or to disclose protected health information for any of these purposes. (We refer readers to 45 CFR 164.502(a)(1)(ii), and 164.506(c)(1) and (c)(3), and the Standards for Privacy of Individually Identifiable Health Information published in the **Federal Register** on August 14, 2002, for a full discussion of changes in consent requirements.)

Section 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents ''an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.'' For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (We refer readers to the September 7, 2001 final rule for a complete discussion of this criterion (66 FR 46902).)

The new medical service or technology add-on payment policy under the IPPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies while preserving some of the incentives inherent under an average-based prospective payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, if the costs of the discharge (determined by applying CCRs as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 50 percent of the estimated costs of the new technology (if the estimated costs for the case including the new technology exceed Medicare's payment) or (2) 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case. Unless the discharge qualifies for an outlier payment, Medicare payment is limited to the full DRG payment plus 50 percent of the estimated costs of the new technology.

Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year, while at the same time estimating the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts. However, section 503(d)(2) of Public Law 108–173 provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, following section 503(d)(2) of Public Law 108–173, add-on payments for new medical services or technologies for FY 2005 and later years have not been subjected to budget neutrality.

Applicants for add-on payments for new medical services or technologies for FY 2010 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be posted as it becomes available on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp#TopOfPage*. To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2010, the Web site will also list the tracking forms completed by each applicant.

The Council on Technology and Innovation (CTI) at CMS oversees the agency's cross-cutting priority on coordinating coverage, coding and payment processes for Medicare with respect to new technologies and procedures, including new drug therapies, as well as promoting the exchange of information on new technologies between CMS and other entities. The CTI, composed of senior CMS staff and clinicians, was established under section 942(a) of Public Law 108–173. The Council is co-chaired by the Director of the Office of Clinical Standards and Quality (OCSQ) and the Director of the Center for Medicare Management (CMM), who is also designated as the CTI's Executive Coordinator.

The specific processes for coverage, coding, and payment are implemented by CMM, OCSQ, and the local claims-payment contractors (in the case of local coverage and payment decisions). The CTI supplements rather than replaces these processes by working to assure that all of these activities reflect the agency-wide priority to promote high-quality, innovative care, and at the same time to streamline, accelerate, and improve coordination of these processes to ensure that they remain up to date as new issues arise. To achieve its goals, the CTI works to streamline and create a more transparent coding and payment process, improve the quality of medical decisions, and speed patient access to effective new treatments. It is also dedicated to supporting better decisions by patients and doctors in using Medicare-covered services through the promotion of better evidence development, which is critical for

improving the quality of care for Medicare beneficiaries.

CMS plans to continue its Open Door forums with stakeholders who are interested in CTI's initiatives. In addition, to improve the understanding of CMS' processes for coverage, coding, and payment and how to access them, the CTI is developing an ''innovator's guide'' to these processes. This guide will, for example, outline regulation cycles and application deadlines. The intent is to consolidate this information, much of which is already available in a variety of CMS documents and in various places on the CMS Web site, in a user-friendly format.

In the meantime, we invite any product developers with specific issues involving the agency to contact us early in the process of product development if they have questions or concerns about the evidence that would be needed later in the development process for the agency's coverage decisions for Medicare.

The CTI aims to provide useful information on its activities and initiatives to stakeholders, including Medicare beneficiaries, advocates, medical product manufacturers, providers, and health policy experts. Stakeholders with further questions about Medicare's coverage, coding, and payment processes, or who want further guidance about how they can navigate these processes, can contact the CTI at *CTI@cms.hhs.gov* or from the ''Contact Us'' section of the CTI home page (*http://www.cms.hhs.gov/CouncilonTechInnov/*).

Comment: One commenter supported CMS' emphasis on the role of the CTI. The commenter also urged CMS to remain vigilant in ensuring that CTI's activities do not inadvertently layer new processes and requirements onto those already applicable to innovative medical technology.

Response: We appreciate the support from the commenter. As discussed in the proposed rule, we intend to continue to use the CTI to promote high quality, innovative care while working to streamline, accelerate and improve coordination of the coverage, coding, and payment processes.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Public Law 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries;
- Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending;
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement; and
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new medical service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2009 prior to publication of the FY 2009 IPPS proposed rule, we published a notice in the **Federal Register** on December 28, 2007 (72 FR 73845 through 73847), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 21, 2008. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2009 new medical service and technology add-on payment applications before the publication of the FY 2009 IPPS proposed rule.

Approximately 70 individuals attended the town hall meeting in person, while approximately 20 additional participants listened over an open telephone line. Each of the four FY 2009 applicants presented information on its technology, including a focused discussion of data reflecting the substantial clinical improvement aspect of the technology. We considered each applicant's presentation made at the town hall meeting, as well as written comments submitted on each applicant's application, in our evaluation of the new technology add-on applications for FY 2009 in the FY 2009 proposed rule and in this final rule. We received two comments during the town hall meeting. In the proposed rule, we summarized the comments we received at the town hall meeting or, if applicable, indicated at the end of the discussion of each application that no comments were received on that new technology. We refer readers to the FY 2009 IPPS proposed rule at 73 FR 23611 for those comments and responses.

In addition to the comment summaries and our responses presented in the proposed rule, we received additional comments as summarized below.

Comment: A number of commenters addressed topics relating to the marginal cost factor for the new technology add-on payment, the potential implementation of ICD–10–CM, the use of external data in determining the cost threshold, and the use of the date that a ICD–9–CM code is assigned to a technology or the FDA approval date (whichever is later) as the start of the newness period.

Response: We did not request public comments nor propose to make any changes to any of the issues addressed above. Because these comments are out of the scope of the provisions in the proposed rule, we are not providing a complete summary of the comments or responding to them in this final rule.

3. FY 2009 Status of Technologies Approved for FY 2008 Add-On Payments

We did not approve any applications for new technology add-on payments for FY 2008. For additional information, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47305 through 47307).

4. FY 2009 Applications for New Technology Add-On Payments

We received four applications to be considered for new technology add-on payment for FY 2009. A discussion of each of these applications is presented below. We note that, in the past, we have considered applications during the rulemaking process that had not yet received FDA approval, but were anticipating FDA approval prior to publication of the IPPS final rule. In such cases, we generally provide a more limited discussion of those technologies in the proposed rule because it is not known if these technologies will meet the newness criterion in time for us to conduct a complete analysis in the final rule. This year, three out of four applicants had not yet received FDA approval of their technologies (Emphasys Medical Zephyr® Endobronchial Valve, Oxiplex®, and the TherOx Downstream® System) prior to

issuance of the proposed rule. Consequently, we presented a limited analysis of them in the proposed rule. At the time of the development of this final rule, FDA approval was still pending for all three of the applicants. Therefore, those three applications are not eligible for consideration for FY 2009 new technology add-on payments because they do not meet the newness criterion (because, by definition, a technology that has not received FDA approval cannot be considered ''new'' for purposes of new technology add-on payments). Because those applications do not meet the newness criterion, the cost threshold criterion and the substantial clinical improvement criterion applicable to those applications are not discussed in this final rule. If FDA approval is received in time for consideration for the FY 2010 new technology add-on payment application process, we encourage those applicants to submit new technology add-on payments applications for consideration during the FY 2010 IPPS rulemaking process.

a. CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t)

SynCardia Systems, Inc. submitted an application for approval of the CardioWest™ temporary Total Artificial Heart system (TAH–t) for new technology add-on payments for FY 2009. The TAH–t is a technology that is used as a bridge to heart transplant device for heart transplant-eligible patients with end-stage biventricular failure. The TAH–t pumps up to 9.5 liters of blood per minute. This high level of perfusion helps improve hemodynamic function in patients, thus making them better heart transplant candidates.

The TAH–t was approved by the FDA on October 15, 2004, for use as a bridge to transplant device in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The TAH–t is intended to be used in hospital inpatients. One of the FDA's post-approval requirements is that the manufacturer agrees to provide a post-approval study demonstrating success of the device at one center can be reproduced at other centers. The study was to include at least 50 patients who would be followed up to 1 year, including (but not limited to) the following endpoints; survival to transplant, adverse events, and device malfunction.

In the past, Medicare did not cover artificial heart devices, including the TAH–t. However, on February 1, 2008, CMS proposed to reverse a national noncoverage determination that would extend coverage to this technology within the confines of an approved clinical study. (To view the proposed national coverage determination (NCD), we refer readers to the CMS Web site at *http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?from2=viewdraftdecisionmemo.asp&id=211&*). On May 1, 2008, CMS issued a final NCD expanding Medicare coverage of artificial hearts when they are implanted as part of a study that is approved by the FDA and is determined by CMS to meet CMS' Coverage with Evidence Development (CED) clinical research criteria. (The final NCD is available on the CMS Web site at: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=211*.)

Because Medicare's previous coverage policy with respect to this device has precluded payment from Medicare, we do not expect the costs associated with this technology to be currently reflected in the data used to determine MS–DRGs relative weights. As we have indicated in the past, and as we discussed in the proposed rule, although we generally believe that the newness period would begin on the date that FDA approval was granted, in cases where the applicant can demonstrate a documented delay in market availability subsequent to FDA approval, we would consider delaying the start of the newness period. This technology's situation represents such a case. We also note that section 1886(d)(5)(K)(ii)(II) of the Act requires that we provide for the collection of cost data for a new medical service or technology for a period of at least 2 years and no more than 3 years ''beginning on the date on which an inpatient hospital code is issued with respect to the service or technology.'' Furthermore, the statute specifies that the term ''inpatient hospital code'' means any code that is used with respect to inpatient hospital services for which payment may be made under the IPPS and includes ICD–9–CM codes and any subsequent revisions. Although the TAH–t has been described by the ICD–9–CM code(s) (described below in the cost threshold discussion) since the time of its FDA approval, because the TAH–t has not been covered under the Medicare program (and, therefore, no Medicare payment has been made for this technology), this code is not ''used with respect to inpatient hospital services for which payment'' is made under the IPPS, and thus we assume that none of the costs associated with this technology would be reflected in the Medicare claims data used to recalibrate the MS–DRG weights for FY 2009. For this reason, as discussed in the proposed rule, despite its FDA approval date, it appeared that this technology would still be eligible to be considered ''new'' for purposes of the new technology add-on payment if and when the proposal to reverse the national noncoverage determination concerning this technology was finalized. Therefore, based on this information, we stated that we believed that the TAH–t would meet the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD. Because the final NCD was issued and became effective on May 1, 2008, we believe that the TAH–t meets the newness criterion as of May 1, 2008.

Comment: One commenter, the manufacturer, agreed with CMS' statement in the proposed rule that the TAH–t appeared to meet the newness criterion even though it received FDA approval more than 3 years ago. The commenter stated that because the TAH–t had not been covered by Medicare in any setting until the coverage decision issued on May 1, 2008, the costs associated with the TAH–t are not yet reflected in the Medicare claims data used to recalibrate the FY 2009 MS–DRG relative weights.

Response: We agree with the commenter and, as we discussed in the proposed rule, we continue to believe that the TAH–t meets the newness criterion despite having received FDA approval more than 3 years ago because it was not covered by Medicare until May 1, 2008. Therefore, as stated above, we believe that the TAH–t meets the newness criterion as of May 1, 2008.

In an effort to demonstrate that TAH–t would meet the cost criterion, as presented in the proposed rule, the applicant submitted data based on 28 actual cases of the TAH–t. The data included 6 cases (or 21.4 percent of cases) from 2005, 13 cases (or 46.5 percent of cases) from 2006, 7 cases (or 25 percent of cases) from 2007, and 2 cases (or 7.1 percent of cases) from 2008. Currently, cases involving the TAH–t are assigned to MS–DRG 215 (Other Heart Assist System Implant). As discussed below in this section, we are proposing to remove the TAH–t from MS–DRG 215 and reassign the TAH–t to MS–DRGs 001 (Heart Transplant or Implant of Heart Assist System with MCC) and 002 (Heart Transplant or Implant of Heart Assist System without MCC). Therefore, to determine if the technology meets the cost criterion, it is appropriate to compare the average standardized charge per case to the thresholds for MS–DRGs 001, 002, and 215 included in Table 10 of the

November 27, 2007 interim final rule (72 FR 66888 through 66889). The thresholds for MS–DRGs 001, 002, and 215 included in Table 10 are $345,031, $178,142, and $151,824, respectively. Based on the 28 cases the applicant submitted, the average standardized charge per case was $731,632. Because the average standardized charge per case is much greater than the thresholds cited above for MS–DRG 215 (and MS–DRGs 001 and 002, should the proposal to reassign the TAH–t be finalized), the applicant asserted that the TAH–t meets the cost criterion whether or not the costs were analyzed by using either a case-weighted threshold or case-weighted standardized charge per case.

In addition to analyzing the costs of actual cases involving the TAH–t, the applicant searched the FY 2006 MedPAR file to identify cases involving patients who would have potentially been eligible to receive the TAH–t. The applicant submitted three different MedPAR analyses. The first MedPAR analysis involved a search for cases using ICD–9–CM diagnosis code 428.0 (Congestive heart failure) in combination with ICD–9–CM procedure code 37.66 (Insertion of implantable heart assist system), and an inpatient hospital length of stay greater than or equal to 60 days. The applicant found two cases that met this criterion, which had an average standardized charge per case of $821,522. The second MedPAR analysis searched for cases with ICD–9–CM diagnosis code 428.0 (Congestive heart failure) and one or more of the following ICD–9–CM procedure codes: 37.51 (Heart transplant), 37.52 (Implantation of total heart replacement system), 37.64 (Removal of heart assist system), 37.66 (Insertion of implantable heart assist system), or 37.68 (Insertion of percutaneous external heart assist device), and a length of stay greater than or equal to 60 days. The applicant found 144 cases that met this criterion, which had an average standardized charge per case of $841,827. The final MedPAR analysis searched for cases with ICD–9–CM procedure code 37.51 (Heart transplant) in combination with one of the following ICD–9–CM procedure codes: 37.52 (Implantation of total heart replacement system), 37.65 (Implantation of external heart system), or 37.66 (Insertion of implantable heart assist system). The applicant found 37 cases that met this criterion, which had an average standardized charge per case of $896,601. Because only two cases met the criterion for the first analysis, consistent with historical practice, we would not consider it to be of statistical significance and, therefore, would not rely upon it to demonstrate whether the TAH–t would meet the cost threshold. However, both of the additional analyses seem to provide an adequate number of cases to demonstrate whether the TAH–t would meet the cost threshold. We assume that none of the costs associated with this technology would be reflected in the MedPAR analyses that the applicant used to demonstrate that the technology would meet the cost criterion. We note that, under all three of the analyses the applicant performed, it identified cases that would have been eligible for the TAH–t, but did not remove charges that were unrelated to the TAH–t, nor did the applicant insert a proxy of charges related to the TAH–t. However, as stated above, the average standardized charge per case is much greater than any of the thresholds for MS–DRGs 001, 002, and 215. Therefore, even if the applicant were to approximate what the costs of cases eligible to receive the TAH–t would have been by removing non-TAH–t associated charges and inserting charges related to the TAH–t, it appears that the average standardized charges per case for cases eligible for the TAH–t would exceed the relevant thresholds included in Table 10 (as discussed above) and would therefore appear to meet the cost criterion. In the FY 2009 IPPS proposed rule, we invited public comment on whether TAH–t met the cost criterion.

Comment: One commenter, the manufacturer, asserted that it believed that the TAH–t satisfied the cost criterion by exceeding the cost threshold and agreed with CMS' discussion in the proposed rule that the TAH–t appeared to meet the cost threshold.

Response: Based on data submitted by the applicant and discussed in the proposed rule, we noted that the TAH–t appeared to meet the cost threshold criterion. Using the March update of the FY 2007 MedPAR file, we searched for cases that matched the manufacturer's second and third MedPAR analyses described above. (As previously noted, because the first analysis only returned two cases, we did not simulate it for the final rule.) When we simulated the second and third analyses, we found a total of 75 cases and 79 cases, respectively (that mapped to CMS DRG 103 (Heart Transplant or Implant of Heart Assist System) which crosswalks to MS–DRGs 001 and 002), with an average standardized charge per case of $883,301 and $830,200, respectively. Therefore, because the average standardized charge exceeds the thresholds of MS–DRGs 001 and 002 ($345,031 and $178,142, respectively) based on data submitted by the applicant and on our analyses of MedPAR data, we believe that the TAH–t meets the cost threshold criterion.

As noted in section II.G.1. of the preamble to the FY 2009 IPPS proposed rule, we proposed to remove the TAH–t from MS–DRG 215 and reassign the TAH–t to MS–DRGs 001 and 002. As stated earlier, on May 1, 2008, CMS issued an NCD that extends coverage to artificial heart devices within the confines of an FDA-approved clinical study. Therefore, as of May 1, 2008, the MCE will require both procedure code 37.52 (Implantation of total replacement heart system) and diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). As we stated in the proposed rule, the TAH–t appeared to meet the cost thresholds for MS–DRGs 001, 002, and 215. Therefore, we noted, its proposed reassignment from MS–DRG 215 to MS–DRGs 001 and 002 would not appear to have a material effect on meeting the cost thresholds in MS–DRGs 001 and 002 should the reassignment proposal be finalized. In section II.G.1. of the preamble of this final rule, we finalized the proposal to reassign cases involving the TAH–t from MS–DRG 215 to MS–DRGs 001 and 002. We refer readers to that section for additional information.

The manufacturer stated that the TAH–t is the only mechanical circulatory support device intended as a bridge-to-transplant for patients with irreversible biventricular failure. It also asserted that the TAH–t improves clinical outcomes because it has been shown to reduce mortality in patients who are otherwise in end-stage heart failure. In addition, the manufacturer claimed that the TAH–t provides greater hemodynamic stability and end-organ perfusion, thus making patients who receive it better candidates for eventual heart transplant.

We did not receive any written comments or public comments at the town hall meeting regarding whether this technology represents a substantial clinical improvement in the treatment of inpatients with end-stage biventricular heart failure relative to previous technology available to the Medicare population. However, in the FY 2009 IPPS proposed rule, we welcomed comments from the public regarding whether the TAH–t represents a substantial clinical improvement.

Comment: One commenter, the manufacturer, stated that, with regard to whether the TAH–t meet the substantial clinical improvement criterion, the TAH–t ''fulfills a role that no other mechanical circulatory support device can for patients in irreversible

biventricular failure * * *'' With respect to the coverage decision that was issued on May 1, 2008, the commenter stated that ''the agency's reversal of such a longstanding noncoverage policy alone demonstrates that the TAH–t is a substantial clinical improvement.''

Response: We disagree with the commenter's assertion that CMS' recent change to the coverage decision alone demonstrates that the TAH–t is a substantial clinical improvement. Rather the coverage decision signifies that the TAH–t device is ''reasonable and necessary'' within the parameters of approved clinical trial studies. In our view, demonstration of substantial clinical improvement requires that a higher threshold be met. That is, not only is the device safe and effective (as indicated by FDA approval) and reasonable and necessary (as indicated by CMS coverage), but the device offers such clinical improvement over previously available technologies to the Medicare population that Medicare will lessen barriers inhibiting physicians and hospitals from utilizing the costly new technology so as not to hinder Medicare beneficiaries' access to the technology before its costs are adequately reflected in the MS–DRG payment system.

However, we agree with the commenter's assertion that the TAH–t ''fulfills a role that no other mechanical circulatory support device can for patients in irreversible biventricular failure.'' We note that the TAH–t is the only available FDA-approved temporary total artificial heart device. Clinical evidence submitted by the applicant supports the manufacturer's assertion that the TAH–t provides a treatment option for patients suffering from biventricular failure who may be unresponsive to, or ineligible for, currently available treatments (including other mechanical circulatory devices). Specifically, the applicant referred to the FDA approved multicenter IDE clinical trial in which 81 patients at risk of imminent death from biventricular heart failure received the device. At 30 days, 69.1 percent of those patients met the treatment success criteria for the study, which included: Having an improvement in heart failure from New York Heart Association Class IV to Class I or II, not being bedridden, not being ventilator dependent and not being on dialysis. Therefore, the TAH–t appears to provide a viable treatment option to patients who might otherwise be at risk for imminent death, and who, by virtue of successful bridge to transplant, may ultimately benefit from the extended survival that is possible with heart transplant. We acknowledge that there were some patients who did not survive despite receiving the TAH–t, but we believe at this time that the benefit provided by the device to patients who might otherwise be at risk for imminent death outweighs the risks associated with the device. Therefore, we believe that this device has demonstrated that it is a substantial clinical improvement over existing technology for those patients who meet the specific criteria for inclusion in an approved clinical trial for purposes of FY 2009 new technology add-on payments.

After evaluation of the three new technology add-on criteria (newness, costs, and substantial clinical improvement) and consideration of the public comments received, we are approving the TAH–t for FY 2009 new technology add-on payment. As discussed above, we believe that the TAH–t offers a new treatment option that previously did not exist for patients with end-stage biventricular failure. However, we recognize that the TAH–t's Medicare coverage is limited to approved clinical trial settings. The new technology add-on payment status does not negate the restrictions under the NCD nor does it obviate the need for continued monitoring of clinical evidence for the TAH–t, and we remain interested in seeing whether the clinical evidence from the CED parameters demonstrates that the TAH–t continues to be effective. If evidence is found that the TAH–t may no longer offer a substantial clinical improvement, we reserve the right to discontinue new technology add-on payments, even within the 2 to 3 year period that the device may still be considered to be new. The new technology add-on payment for FY 2009 will be triggered by the presence of ICD–9–CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). As noted in the proposed rule, the manufacturer submitted data to support its estimated operating cost per case involving the TAH–t procedure of $106,000. Accordingly, we are finalizing a maximum add-on payment of $53,000 (that is, 50 percent of the estimated operating costs of the device) for cases that involve this technology.

b. Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV)

Emphasys Medical submitted an application for new technology add-on payments for FY 2009 for the Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV). The Zephyr® EBV is intended to treat patients with emphysema by reducing volume in the diseased, hyperinflated portion of the emphysematous lung with fewer risks and complications than with more invasive surgical alternatives. Zephyr® EBV therapy involves placing small, one-way valves in the patients' airways to allow air to flow out of, but not into, the diseased portions of the lung thus reducing the hyperinflation. A typical procedure involves placing three to four valves in the target lobe using a bronchoscope, and the procedure takes approximately 20 to 40 minutes to complete. The Zephyr® EBVs are designed to be relatively easy to place, and are intended to be removable so that, unlike more risky surgical alternatives such as Lung Volume Reduction Surgery (LVRS) or Lung Transplant, the procedure has the potential to be fully reversible.

In the proposed rule, we noted that the Zephyr® EBV had yet to receive approval from the FDA, but the manufacturer indicated to CMS that it expected to receive its FDA approval in the second or third quarter of 2008. Because the technology had not yet been approved by the FDA, we limited our discussion of this technology in the proposed rule to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on criteria.

In an effort to demonstrate that the Zephyr® EBV would meet the cost criterion, as discussed in the proposed rule, the applicant searched the FY 2006 MedPAR file for cases with one of the following ICD–9–CM diagnosis codes: 492.0 (Emphysematous bleb), 492.8 (Other emphysema, NEC), or 496 (Chronic airway obstruction, NEC). Based on the diagnosis codes searched by the applicant, cases of the Zephyr® EBV would be most prevalent in MS–DRGs 190 (Chronic Obstructive Pulmonary Disease with MCC), 191 (Chronic Obstructive Pulmonary Disease with CC), and 192 (Chronic Obstructive Pulmonary Disease without CC/MCC). The applicant found 1,869 cases (or 12.8 percent of cases) in MS–DRG 190, 5,789 cases (or 39.5 percent of cases) in MS–DRG 191, and 6,995 cases (or 47.7 percent of cases) in MS–DRG 192 (which equals a total of 14,653 cases). The average standardized charge per case was $21,567 for MS–DRG 190, $15,494 for MS–DRG 191, and $11,826 for MS–DRG 192. The average standardized charge per case does not include charges related to the Zephyr® EBV; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in

evaluating the cost threshold criteria. Although the applicant submitted data related to the estimated cost of the Zephyr® EBV per case, the applicant noted that the cost of the device was proprietary information because the device is not yet available on the open market. The applicant estimated $23,920 in charges related to the Zephyr® EBV (based on a 100 percent charge markup of the cost of the device). In addition to case-weighting the data based on the amount of cases that the applicant found in the FY 2006 MedPAR file, the applicant case-weighted the data based on its own projections of how many Medicare cases it would expect to map to MS–DRGs 190, 191, and 192 in FY 2009. The applicant projected that, 5 percent of the cases would map to MS–DRG 190, 15 percent of the cases would map to MS–DRG 191, and 80 percent of the cases would map to MS–DRG 192. Adding the charges related to the device to the average standardized charge per case (based on the applicant's projected case distribution) resulted in a case-weighted average standardized charge per case of $36,782 ($12,862 plus $23,920). Using the thresholds published in Table 10 (72 FR 66889), the case-weighted threshold for MS–DRGs 190, 191, and 192 was $18,394. Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintained that the Zephyr® EBV would meet the cost criterion. As noted above, the applicant also performed a case-weighted analysis of the data based on the 14,653 cases the applicant found in the FY 2006 MedPAR file. Based on this analysis, the applicant found that the case-weighted average standardized charge per case ($38,441 based on the 14,653 cases) exceeded the case-weighted threshold ($20,606 based on the 14,653 cases). Based on both analyses described above, we stated in the proposed rule that it appeared that the applicant would meet the cost criterion.

In the FY 2009 IPPS proposed rule, we invited public comment on whether Zephyr® EBV met the cost criterion.

Comment: One commenter, the manufacturer, addressed issues regarding whether the Zephyr® EBV met the cost criterion.

Response: Because the Zephyr® EBV has not yet received FDA approval, and therefore, does not meet the newness criterion, as discussed above, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are not summarizing the details of this comment nor responding to them in this final rule.

As discussed in the proposed rule, the applicant also asserted that the Zephyr® EBV is a substantial clinical improvement because it provides a new therapy along the continuum of care for patients with emphysema that offers improvement in lung function over standard medical therapy while incurring significantly less risk than more invasive treatments such as LVRS and lung transplant. Specifically, the applicant submitted data from the ongoing pivotal Endobronchial Valve for Emphysema Palliation (VENT) trial,[21] which compared 220 patients who received EBV treatment to 101 patients who received standard medical therapy, including bronchodilators, steroids, mucolytics, and supplemental oxygen. At 6 months, patients who received the Zephyr® EBV had an average of 7.2 percent and 5.8 percent improvement (compared to standard medical therapy) in the primary effectiveness endpoints of the Forced Expiratory Volume in 1 second test (FEV1), and the 6 Minute Walk Test (6MWT), respectively. Both results were determined by the applicant to be statistically significant. The FEV1 results were determined using the t-test parametric confidence intervals (the p value determined using the one-side t-test adjusted for unequal variance) and the 6MWT results were determined using the Mann-Whitney nonparametric confidence intervals (the p value was calculated using the one-sided Wilcoxon rank sum test). However, the data also showed that patients who received the Zephyr® EBV experienced a number of adverse events, including hemoptyis, pneumonia, respiratory failure, pneumothorax, and COPD exacerbations, as well as valve migrations and expectorations that, in some cases, required repeat bronchoscopy. The manufacturer also submitted the VENT pivotal trial 1-year followup data, but requested that the data not be disclosed in the proposed rule because it had not yet been presented publicly nor published in a peer-reviewed journal.

While CMS recognizes that the Zephyr® EBV therapy is significantly less risky than LVRS and lung transplant, we are concerned that the benefits as shown in the VENT pivotal trial may not outweigh the risks when compared with medical therapy alone. Further, we note that, according to the applicant, the Zephyr® EBV is intended for use in many patients who are ineligible for LVRS and/or lung transplant (including those too sick to undergo more invasive surgery and those with lower lobe predominant disease distribution), but that certain patients (that is, those with upper lobe predominant disease distribution) could be eligible for either surgery or the Zephyr® EBV.

In the FY 2009 IPPS proposed rule, we welcomed comments from the public on both the patient population who would be eligible for the technology, and whether the Zephyr® EBV represented a substantial clinical improvement in the treatment of patients with emphysema.

Comment: Commenters representing the manufacturer and physicians, outlined various reasons why they believed that the Zephyr® EBV represented a substantial clinical improvement over technologies currently available to Medicare beneficiaries.

Response: Because the Zephyr® EBV has not yet received FDA approval, and therefore does not meet the newness criterion, as discussed above, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are not summarizing the details of these comments received nor responding to them in this final rule.

As noted in the proposed rule, we also received written comments from the manufacturer and its presenters at the town hall meeting clarifying some questions that were raised at the town hall meeting. Specifically, these commenters explained that, in general, the target population for the Zephyr® EBV device was the same population that could benefit from LVRS, and also includes some patients who were too sick to undergo surgery. The commenters also explained that patients with emphysema with more heterogeneous lung damage were more likely to benefit from the device.

In the FY 2009 IPPS proposed rule, we welcomed public comments regarding where exactly this technology falls in the continuum of care of patients with emphysema, and for whom the risk/benefit ratio is most favorable.

Comment: Commenters representing the manufacturer and individual physicians addressed issues regarding where the Zephyr® EBV fell in the continuum of care of patients with emphysema and for whom the risk/benefit ratio was most favorable.

Response: Because the Zephyr® EBV has not yet received FDA approval, and therefore does not meet the newness criterion, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are not summarizing the details of these public

[21] Strange, Charlie., *et al.*, Design of the Endobronchial Valve for Emphysema Palliation trial (VENT): A Nonsurgical Method of Lung Volume Reduction, *BMC Pulmonary Medicine.* 2007; 7:10.

comments nor responding to them in this final rule.

As we previously stated, because the Zephyr® EBV has not yet received FDA approval, it does not meet the newness criterion. Therefore, it cannot be approved for FY 2009 IPPS new technology add-on payments.

c. Oxiplex®

FzioMed, Inc. submitted an application for new technology add-on payments for FY 2009 for Oxiplex®. Oxiplex® is an absorbable, viscoelastic gel made of carboxymethylcellulose (CMC) and polyethylene oxide (PEO) that is intended to be surgically implanted during a posterior discectomy, laminotomy, or laminectomy. The manufacturer asserted that the gel reduces the potential for inflammatory mediators that injure, tether, or antagonize the nerve root in the epidural space by creating an acquiescent, semi-permeable environment to protect against localized debris. These proinflammatory mediators (phospholipase A and nitric oxide), induced or extruded by intervertebral discs, may be responsible for increased pain during these procedures. The manufacturer also asserted that Oxiplex® is a unique material in that it coats tissue, such as the nerve root in the epidural space, to protect the nerve root from the effects of inflammatory mediators originating from either the nucleus pulposus, from blood derived inflammatory cells, or cytokines during the healing process.

Oxiplex® indicated to CMS that it was expecting to receive premarket approval from the FDA by June 2008. As discussed earlier in this section, Oxiplex® had not received FDA approval prior to the development of this final rule. Because the technology had not yet received FDA approval at the time the proposed rule was developed, we indicated in the proposed rule that we were limiting our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on payment criteria.

In the proposed rule, we noted that we were concerned that Oxiplex® may be substantially similar to adhesion barriers that have been on the market for several years. We also noted that Oxiplex® has been marketed as an adhesion barrier in other countries outside of the United States. The manufacturer maintained that Oxiplex® is different from adhesion barriers in several ways, including chemical composition, method of action, surgical application (that is, it is applied liberally to the nerve root and surrounding neural tissues as opposed to minimally only to nerve elements), and tissue response (noninflammatory as opposed to inflammatory).

In the FY 2009 IPPS proposed rule, we welcomed comments from the public on this issue.

Comment: One commenter, the manufacturer, addressed the issue of whether Oxiplex® met the newness criterion. The commenter explained that there are no products approved for this indication in the spine in the United States. The commenter further explained that the indication for use for Oxiplex® outside the United States includes the descriptor ''for the reduction of pain, radiculopathy, lower extreme weakness'' and the United State IDE study was designed to show that Oxiplex® reduces back and leg pain and associated neurological symptoms following discectomy or laminectomy, in a controlled, randomized study. The commenter asserted that this is a new and different indication for use in the United States, designated by the FDA as a product that fulfills an ''Unmet Medical Need.'' The commenter submitted clinical studies to demonstrate that Oxiplex® is substantially different than other adhesion barriers in the mode of action, dural healing, wound healing, and local tissue response.

Response: We thank the commenter for its comments on the newness criteria. However, because Oxiplex® has not yet received FDA approval, and therefore does not meet the newness criterion, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are responding to these comments in this final rule.

In an effort to demonstrate that the technology meets the cost criterion, as discussed in the proposed rule, the applicant searched the FY 2006 MedPAR file for cases with ICD–9–CM procedure codes 03.09 (Other exploration and decompression of spinal canal) or 80.51 (Excision of interveterbral disc) that mapped to CMS DRGs 499 and 500 (CMS DRGs 499 and 500 are crosswalked to MS–DRGs 490 and 491 (Back and Neck Procedures except Spinal Fusion with or without CC)). Because these cases do not include charges associated with the technology, the applicant determined it was necessary to add an additional $7,143 in charges to the average standardized charge per case of cases that map to MS–DRGs 490 and 491. (To do this, the applicant used a methodology of inflating the costs of the technology by the average CCR computed by using the average costs and charges for supplies for cases with ICD–9–CM procedure codes 03.09 and 80.51 that map to MS–DRGs 490 and 491). Of the 221,505 cases the applicant found, 95,340 cases (or 43 percent of cases) would map to MS–DRG 490, which has an average standardized charge of $60,301, and 126,165 cases (or 57 percent of cases) would map to MS–DRG 491, which has an average standardized charge per case of $43,888. This resulted in a case-weighted average standardized charge per case of $50,952. The case-weighted threshold for MS–DRGs 490 and 491 was $27,481. Because the case-weighted average standardized charge per case exceeds the case-weighted threshold in MS–DRGs 490 and 491, the applicant maintained that Oxiplex® would meet the cost criterion.

In the FY 2009 IPPS proposed rule, we invited public comment on whether Oxiplex® met the cost criterion.

Comment: One commenter, the manufacturer, addressed the issue of whether Oxiplex® met the cost criterion.

Response: Because Oxiplex® has not yet received FDA approval, and therefore does not meet the newness criterion, we are not summarizing this public comment nor responding to it in this final rule.

As discussed in the proposed rule, the manufacturer maintained that Oxiplex® is a substantial clinical improvement because it ''creates a protective environment around the neural tissue that limits nerve root exposure to post-surgical irritants and damage and thus reduces adverse outcomes associated with Failed Back Surgery Syndrome (FBSS) following surgery.'' The manufacturer also claimed that the Oxiplex® gel reduces leg and back pain after discetomy, laminectomy, and laminotomy. The manufacturer also asserted that the use of Oxiplex® is consistent with fewer revision surgeries. (During the FDA Investigational Device Exemption (IDE) trial, one Oxiplex® patient required revision surgery compared to six control patients.) However, as we noted in the proposed rule, we had concerns that Oxiplex® may be substantially similar to adhesion barriers that have been on the market for several years. We also stated that we were concerned that even if we were to determine that Oxiplex® is not substantially similar to existing adhesion barriers, there may still be insufficient evidence to support the manufacturer's claims that Oxiplex® reduces pain associated with spinal surgery. In addition, as discussed in the proposed rule, we have found no evidence to support the manufacturer's claims regarding mode of action, degree of dural healing, degree of wound

healing, and local tissue response such as might be shown in animal studies.

We did not receive any written comments or public comments at the town hall meeting regarding the substantial clinical improvement aspects of this technology. However, in the FY 2009 IPPS proposed rule, we welcomed comments from the public regarding whether Oxiplex® represented a substantial clinical improvement.

Comment: One commenter, the manufacturer, claimed that Oxiplex® represents a substantial clinical improvement over technology currently available to Medicare beneficiaries. Other commenters representing trade associations and physicians, stated that there was not enough evidence to determine whether Oxiplex® represented a substantial clinical improvement because it had not yet received FDA approval and there was insufficient peer-reviewed published literature to make such a determination.

Response: Because Oxiplex® has not yet received FDA approval, and therefore does not meet the newness criterion, we are not summarizing these public comments nor responding to them in this final rule.

As we previously stated, Oxiplex® does not meet the newness criterion and, therefore, cannot be approved for FY 2009 IPPS new technology add-on payments.

d. TherOx Downstream® System

TherOx, Inc. submitted an application for new technology add-on payments for FY 2009 for the TherOx Downstream® System (Downstream® System). The TherOx Downstream® System uses SuperSaturatedOxygen Therapy (SSO2) that is designed to limit myocardial necrosis by minimizing microvascular damage in acute myocardial infarction (AMI) patients following intervention with Percutaneous Transluminal Coronary Angioplasty (PTCA), and coronary stent placement by perfusing the affected myocardium with blood that has been supersaturated with oxygen. SSO2 therapy refers to the delivery of superoxygenated arterial blood directly to areas of myocardial tissue that have been reperfused using PTCA and stent placement, but which may still be at risk. The desired effect of SSO2 therapy is to reduce infarct size and thus preserve heart muscle and function. The TherOx DownStream® System is the console portion of a disposable cartridge-based system that withdraws a small amount of the patient's arterial blood, mixes it with a small amount of saline, and supersaturates it with oxygen to create highly oxygen-enriched blood. The superoxygenated blood is delivered directly to the infarct-related artery via the TherOx infusion catheter. SSO2 therapy is a catheter laboratory-based procedure. Additional time in the catheter lab area is an average of 100 minutes. The manufacturer claimed that the SSO2 therapy duration lasts 90 minutes and requires an additional 10 minutes post-procedure preparation for transfer time. The TherOx Downstream® System was not FDA approved at the time that the proposed rule was published; however, the manufacturer indicated to CMS that it expected to receive FDA approval in the second quarter of 2008. Because the technology was not approved by the FDA during the development of the proposed rule, we limited our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on criteria in the proposed rule. At the time of the development of this final rule, the TherOx Downstream® System had not yet received FDA approval.

In an effort to demonstrate that it would meet the cost criterion as we discussed in the proposed rule, the applicant submitted two analyses. The applicant stated that it believed that cases that would be eligible for the Downstream® System would most frequently group to MS–DRGs 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ Vessels/Stents), 247 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without MCC), 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC or 4+ Vessels/Stents), and 249 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without MCC). The first analysis used data based on 83 clinical trial patients from 10 clinical sites. Of the 83 cases, 78 were assigned to MS–DRGs 246, 247, 248, or 249. The data showed that 32 of these patients were 65 years old or older. There were 12 cases (or 15.4 percent of cases) in MS–DRG 246, 56 cases (or 71.8 percent cases) in MS–DRG 247, 2 cases (or 2.6 percent of cases) in MS–DRG 248, and 8 cases (or 10.3 percent of cases) in MS–DRG 249. (The remaining five cases grouped to MS–DRGs that the technology would not frequently group to and therefore are not included in this analysis.) The average standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $66,730, $53,963, $54,977, and $41,594, respectively. The case-weighted average standardized charge per case for the four MS–DRGs listed above is $54,665. Based on the threshold from Table 10 (72 FR 66890), the case-weighted threshold for the four MS–DRGs listed above was $49,303. The applicant also searched the FY 2006 MedPAR file to identify cases that would be eligible for the Downstream® System. The applicant specifically searched for cases with primary ICD–9–CM diagnosis code 410.00 (Acute myocardial infarction of anterolateral wall with episode of care unspecified), 410.01 (Acute myocardial infarction of anterolateral wall with initial episode of care), 410.10 (Acute myocardial infarction of other anterior wall with episode of care unspecified), or 410.11 (Acute myocardial infarction of other anterior wall with initial episode of care) in combination with ICD–9–CM procedure code of 36.06 (Insertion of non-drug-eluting coronary artery stent(s)) or 36.07 (Insertion of drug-eluting coronary artery stent(s)). The applicant's search found 13,527 cases within MS–DRGs 246, 247, 248, and 249 distributed as follows: 2,287 cases (or 16.9 percent of cases) in MS–DRG 246; 9,691 cases (or 71.6 percent of cases) in MS–DRG 247; 402 cases (or 3 percent of cases) in MS–DRG 248; and 1,147 cases (or 8.5 percent of cases) in MS–DRG 249. Not including the charges associated with the technology, the geometric mean standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $59,631, $42,357, $49,718 and $37,446, respectively. Therefore, based on this analysis, the total case-weighted geometric mean standardized charge per case across these MS–DRGs was $45,080. The applicant estimated that it was necessary to add an additional $21,620 in charges to the total case-weighted geometric mean standardized charge per case. In the additional charge amount, the applicant included charges for supplies and tests related to the technology, charges for 100 minutes of additional procedure time in the catheter laboratory and charges for the technology itself. The inclusion of these charges would result in a total case-weighted geometric mean standardized charge per case of $66,700. The case-weighted threshold for MS–DRGs 246, 247, 248, and 249 (from Table 10 (72 FR 66889)) was $49,714. Because the total case-weighted average standardized charge per case from the first analysis and the case-weighted geometric mean standardized charge per case from the second analysis exceeds the applicable case-weighted threshold, the applicant maintained the Downstream® System would meet the cost criterion.

In the FY 2009 IPPS proposed rule, we invited public comment on whether

Downstream® System met the cost criterion.

Comment: One commenter, the manufacturer, addressed the issue of whether the TherOx Downstream® System met the cost criterion. Another comment addressed the 100 minutes of additional catheter lab time that is required for the therapy and the preparation for transfer time.

Response: Because the TherOx Downstream® System has not yet received FDA approval, and therefore does not meet the newness criterion, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are not summarizing the details of these comments nor responding to them in this final rule.

As discussed in the proposed rule, the applicant asserted that the Downstream® System is a substantial clinical improvement because it reduces infarct size in acute AMI where PTCA and stent placement have also been performed. Data was submitted from the Acute Myocardial Infarction Hyperbaric Oxygen Treatment (AMIHOT) II trial which was presented at the October 2007 Transcatheter Cardiovascular Therapeutics conference, but has not been published in peer reviewed literature, that showed an average of 6.5 percent reduction in infarct size as measured with Tc-99m Sestamibi imaging in patients who received supersaturated oxygen therapy. We note that those patients also showed a significantly higher incidence of bleeding complications. While we recognize that a reduction of infarct size may correlate with improved clinical outcomes, we question whether the degree of infarct size reduction found in the trial represents a substantial clinical improvement, particularly in light of the apparent increase in bleeding complications.

As noted in the proposed rule, we received one written comment from the manufacturer clarifying questions that were raised at the town hall meeting. Specifically, the commenter explained the methodology of Tc-99m sestamibi scanning and interpretation in the AMIHOT II trial. In addition, the commenter explained that the AMIHOT [22] and AMIHOT II trials did not attempt to measure differences in heart failure outcomes nor mortality outcomes.

In the FY 2009 IPPS proposed rule, we welcomed comments from the public on this matter.

Comment: Commenters representing the manufacturer and physicians addressed the issue of whether the TherOx Downstream® System meets the substantial clinical improvement criterion.

Response: Because the TherOx Downstream® System has not yet received FDA approval, and therefore does not meet the newness criterion, it is not eligible for the IPPS new technology add-on payments for FY 2009. Therefore, we are not summarizing the details of this comment nor responding to it in this final rule.

As we previously stated, because the Downstream® System does not meet the newness criterion, it cannot be approved for FY 2009 IPPS new technology add-on payments.

5. Regulatory Changes

Section 1886(d)(5)(K)(i) of the Act directs us to establish a mechanism to recognize the cost of new medical services and technologies under the IPPS, with such mechanism established after notice and opportunity for public comment. In accordance with this authority, we established at § 412.87(b) of our regulations criteria that a medical service or technology must meet in order to qualify for the additional payment for new medical services and technologies. Specifically, we evaluate applications for new medical service or technology add-on payment by determining whether they meet the criteria of newness, adequacy of payment, and substantial clinical improvement.

As stated in section III.J.1. of the preamble of this final rule, § 412.87(b)(2) of our existing regulations provides that a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new service or technology. The point at which these data become available typically begins when the new medical service or technology is first introduced on the market, generally on the date that the medical service or technology receives FDA approval. Accordingly, for purposes of the new medical service or technology add-on payment, a medical service or technology cannot be considered new prior to the date on which FDA approval is granted.

In addition, as stated in section III.J.1. of the preamble of this final rule, § 412.87(b)(3) of our existing regulations provides that, to be eligible for the add-on payment for new medical services or technologies, the DRG prospective payment rate otherwise applicable to the discharge involving the new medical service or technology must be assessed for adequacy. Under the cost criterion, to assess the adequacy of payment for a new medical service or technology paid under the applicable DRG prospective payment rate, we evaluate whether the charges for cases involving the new medical service or technology exceed certain threshold amounts.

Section 412.87(b)(1) of our existing regulations provides that, to be eligible for the add-on payment for new medical services or technologies, the new medical service or technology must represent an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. In addition, § 412.87(b)(1) states that CMS will announce its determination as to whether a new medical service or technology meets the substantial clinical improvement criteria in the **Federal Register** as part of the annual updates and changes to the IPPS.

Since the implementation of the policy on add-on payments for new medical services and technologies, we accept applications for add-on payments for new medical services and technologies on an annual basis by a specified deadline. For example, applications for FY 2009 were submitted in November 2007. After accepting applications, CMS then evaluates them in the annual IPPS proposed and final rules to determine whether the medical service or technology is eligible for the new medical service or technology add-on payment. If an application meets each of the eligibility criteria, the medical service or technology is eligible for new medical service or technology add-on payments beginning on the first day of the new fiscal year (that is, October 1).

We have advised prior and potential applicants that we evaluate whether a medical service or technology is eligible for the new medical service or technology add-on payments prior to publication of the final rule setting forth the annual updates and changes to the IPPS, with the results of our determination announced in the final rule. We announce our results in the final rule for each fiscal year because we believe predictability is an important aspect of the IPPS and that it is important to apply a consistent payment methodology for new medical services

[22] Oneill, W.W., *et al.:* Acute Myocardial Infarction with Hyperoxemic Therapy (AMIHOT): A Prospective Randomized Trial of Intracoronary Hyperoxemic Reperfusion after Percutaneous Coronary Intervention. *Journal of the American College of Cardiology*, Vol. 50, No. 5, 2007, pp. 397–405.

or technologies throughout the entire fiscal year. For example, hospitals must train their billing and other staff after publication of the final rule to properly implement the coding and payment changes for the upcoming fiscal year set forth in the final rule. In addition, hospitals' budgetary process and clinical decisions regarding whether to utilize new technologies are based in part on the applicable payment rates under the IPPS for the upcoming fiscal year, including whether the new medical services or technologies qualify for the new medical service or technology add-on payment. If CMS were to make multiple payment changes under the IPPS during a fiscal year, these changes could adversely affect the decisions hospitals implement at the beginning of the fiscal year. As we stated in the proposed rule, for these reasons, we believe applications for new medical service or technology add-on payments should be evaluated prior to publication of the final IPPS rule for each fiscal year. Therefore, if an application does not meet the new medical service or technology add-on payment criteria prior to publication of the final rule, it will not be eligible for the new medical service or technology add-on payments for the fiscal year for which it applied for the add-on payments.

Because we make our determination regarding whether a medical service or technology meets the eligibility criteria for the new medical service or technology add-on payments prior to publication of the final rule, we have advised both past and potential applicants that their medical service or technology must receive FDA approval early enough in the IPPS rulemaking cycle to allow CMS enough time to fully evaluate the application prior to the publication of the IPPS final rule. Moreover, because new medical services or technologies that have not received FDA approval do not meet the newness criterion, it would not be necessary or prudent for us to make a final determination regarding whether a new medical service or technology meets the cost threshold and substantial clinical improvement criteria prior to the medical service or technology receiving FDA approval. In addition, we do not believe it is appropriate for CMS to determine whether a medical service or technology represents a substantial clinical improvement over existing technologies before the FDA makes a determination as to whether the medical service or technology is safe and effective. For these reasons, we first determine whether a medical service or technology meets the newness criteria, and only if so, do we then make a determination as to whether the technology meets the cost threshold and represents a substantial clinical improvement over existing medical services or technologies. For example, even if an application has FDA approval, if the medical service or technology is beyond the timeline of 2–3 years to be considered new, in the past we have not made a determination on the cost threshold and substantial clinical improvement. Further, as we have discussed in prior final rules (69 FR 49018–49019 and 70 FR 47344), it is our past and present practice to analyze the new medical service or technology add-on payment criteria in the following sequence: Newness, cost threshold, and finally substantial clinical improvement.

In the FY 2009 IPPS proposed rule (73 FR 23616) we proposed to continue this practice of analyzing the eligibility criteria in this sequence and announce in the annual **Federal Register** as part of the annual updates and changes to the IPPS our determination on whether a medical service or technology meets the eligibility criteria in § 412.87(b). However, in the interest of more clearly defining the parameters under which CMS can fully and completely evaluate new medical service or technology add-on payment applications, we proposed to amend the regulations at § 412.87 by adding a new paragraph (c) to codify our current policy and specify that CMS will consider whether a new medical service or technology meets the eligibility criteria in § 412.87(b) and announce the results in the **Federal Register** as part of the annual updates and changes to the IPPS. As a result, we proposed to remove the duplicative text in § 412.87(b)(1) that specifies that CMS will determine whether a new medical service or technology meets the substantial clinical improvement criteria and announce the results of its determination in the **Federal Register** as part of the annual updates and changes to the IPPS. We noted that this proposal was not a change to our current policy, as we have always given consideration to whether an application meets the new medical service or technology eligibility criteria in the annual IPPS proposed and final rules. Rather, the proposal was to simply codify our current practice of fully evaluating new medical service or technology add-on payment applications prior to publication of the final rule in order to maintain predictability within the IPPS for the upcoming fiscal year.

We did not receive any public comments on this proposal. Therefore, in this final rule, we are adopting as final our proposal to § 412.87(b)(1) to remove the duplicative text.

We also proposed in new paragraph (c) of § 412.87 to set July 1 of each year as the deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval. This deadline would provide us with enough time to fully consider all of the new medical service or technology add-on payment criteria for each application and maintain predictability in the IPPS for the coming fiscal year.

Finally, under our proposal, applications that have not received FDA approval by July 1 would not be considered in the final rule, even if they were summarized in the corresponding IPPS proposed rule. However, applications that receive FDA approval of the medical service or technology after July 1 would be able to reapply for the new medical service or technology add-on payment the following year (at which time they would be given full consideration in both the IPPS proposed and final rules).

Comment: A few commenters opposed the proposed policy. Specifically, the commenters expressed concern that the imposition of such a deadline would decrease flexibility in the new technology add-on payment approval process because applicants who received FDA approval shortly after the deadline would not be able to be considered for new technology add-on payments for the corresponding fiscal year and would instead have to wait until a subsequent year to apply. One commenter suggested that CMS use July 1 as a general guideline for when FDA approval would have to be received, but that technologies that received FDA approval a day or two after the deadline should also be considered. One commenter suggested that the deadline be announced at the annual new technology town hall meeting instead of through regulation.

Response: While we acknowledge that the deadline may decrease flexibility in the new technology add-on payment approval process by a very marginal degree, we remind the commenters that we have been committed to working with applicants very closely throughout the new technology application review process and that we have afforded applicants an opportunity to supplement their original applications with information that we believed might better support their ability to demonstrate that they meet the eligibility criteria for the new technology add-on payments. Furthermore, we have provided

flexibility in the new technology add-on application process by accepting applications for technologies prior to their approval by the FDA, despite the fact that we are unable to approve a technology that has not been proven to be ''safe and effective'' for marketing in the United States as FDA approval signifies. We note that it is difficult to determine whether a technology is a substantial clinical improvement over existing (FDA-approved) technologies because there is usually only limited clinical data available and because it requires subjective judgment, but we have made efforts to analyze data available to us even prior to FDA approval. While we prefer that technologies have FDA approval at the time that an application for new technology add-on payment is submitted, we acknowledge that it is not always feasible for a new technology to receive FDA approval prior to the submission deadline for new technology add-on payment applications. We believe that July 1 of each year provides an appropriate balance between the necessity for adequate time to fully evaluate the applications, the requirement to publish the IPPS final rule by August 1 of each year, and the commenters' concerns that potential new technology applicants have some flexibility with respect to when their technology receives FDA approval. Finally, we believe that announcing the deadline at the annual new technology town hall meeting does not provide a standard as predictable as a regulatory standard. In addition, not all interested parties are able to attend the town hall meeting and, therefore, may not be aware of a deadline that is announced at that meeting.

Comment: Two commenters supported the proposal. The commenters stated that setting a deadline would increase transparency and predictability in the IPPS new technology add-on application process. One of the commenters noted that setting such a deadline would save manufacturers the cost and effort of submitting an application for technologies that were not likely to make the deadline and that the deadline would also save CMS time from reviewing these applications. The commenter also stated that the deadline would bring clarity to the new technology application process by helping applicants coordinate the timing of their applications with FDA approval.

Response: We appreciate the commenters' support and agree that both transparency and predictability in the new technology add-on payment application process will be improved as a result of this regulatory change. We also continue to believe that this policy will provide us with enough time to fully consider all of the new medical service or technology add-on payment criteria for each application without imposing additional burden on future applicants that are unable to meet this deadline.

After consideration of the public comments received, we are adopting as final our proposal to revise § 412.87 to remove the second sentence of (b)(1), thereby codifying our current practice of how CMS evaluates new medical service or technology add-on payment applications. We are also finalizing our proposal in paragraph (c) of § 412.87 which establishes a date of July 1 of each year as the deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval in order to be fully evaluated in the applicable IPPS final rule each year.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the FY 2009 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.C. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The adjustment for FY 2009 is discussed in section II.B. of the Addendum to this final rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The budget neutrality adjustment for FY 2009 is discussed in section II.A.4.b. of the Addendum to this final rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are applying beginning October 1, 2008 (the FY 2009 wage index) appears under section III.D. of this preamble.

After the issuance of the FY 2009 IPPS proposed rule, a new law, the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) was enacted on July 15, 2008. Section 124 of Public Law 110–275 extended certain hospital wage index reclassifications originally provided for under section 508 of Public Law 108–173, as well as certain special exceptions, through September 30, 2009 (FY 2009). A discussion of the provisions of section 124 and its implementation in a separate **Federal Register** notice to be published subsequent to this final rule are discussed in section III.I.7. of this preamble.

B. Requirements of Section 106 of the MIEA–TRHCA

1. Wage Index Study Required Under the MIEA–TRHCA

a. Legislative Requirement

Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare IPPS. Section 106(b) of MIEA–TRHCA required the report to include any alternatives that MedPAC recommends to the method to compute the wage

index under section 1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The Secretary was also to consider each of the following:

- Problems associated with the definition of labor markets for the wage index adjustment.
- The modification or elimination of geographic reclassifications and other adjustments.
- The use of Bureau of Labor of Statistics (BLS) data or other data or methodologies to calculate relative wages for each geographic area.
- Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.
- The feasibility of applying all components of CMS' proposal to other settings.
- Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.
- The effect that the implementation of the proposal would have on health care providers on each region of the country.
- Methods for implementing the proposal(s), including methods to phase in such implementations.
- Issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

b. MedPAC's Recommendations

In its June 2007 Report to Congress, ''Report to the Congress: Promoting Greater Efficiency in Medicare'' (Chapter 6 with Appendix), MedPAC made three broad recommendations regarding the wage index:

(1) Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish a new wage index system;

(2) The Secretary should establish a hospital compensation index that—

- Uses wage data from all employers and industry-specific occupational weights;
- Is adjusted for geographic differences in the ratio of benefits to wages;
- Is adjusted at the county level and smoothes large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period; and

(3) The Secretary should use the hospital compensation index for the home health and skilled nursing facility prospective payment systems and evaluate its use in the other Medicare fee-for-service prospective payment systems.

The full June 2007 Report to Congress is available at the Web site: *http://www.medpac.gov/documents/Jun07_EntireReport.pdf*).

In the presentation and analysis of its alternative wage index system, MedPAC addressed almost all of the nine points for consideration under section 106(b)(2) of Public Law 109–432. Following are the highlights of the alternative wage index system recommended by MedPAC:

- Although the MedPAC recommended wage index generally retains the current labor market definitions, it supplements the metropolitan areas with county-level adjustments and eliminates single wage index values for rural areas.
- In the MedPAC recommended wage index, the county-level adjustments, together with a smoothing process that constrains the magnitude of differences between and within contiguous wage areas, serve as a replacement for geographical reclassifications.
- The MedPAC recommended wage index uses BLS data instead of the CMS hospital wage data collected on the Medicare cost report. MedPAC adjusts the BLS data for geographic differences in the ratio of benefits to wages using Medicare cost report data.
- The BLS data are collected from a sample of all types of employers, not just hospitals. The MedPAC recommended wage index could be adapted to other providers such as HHAs and SNFs by replacing hospital occupational weights with occupational weights appropriate for other types of providers.
- In the MedPAC recommended wage index, volatility over time is addressed by the use of BLS data, which is based on a 3-year rolling sample design.
- MedPAC recommended a phased implementation for its recommended wage index in order to cushion the effect of large wage index changes on individual hospitals.
- MedPAC suggested that using BLS data automatically addresses occupational mix differences, because the BLS data are specific to health care occupations, and national industry-wide occupational weights are applied to all geographic areas.
- The MedPAC report does not provide any evidence of the impact of its wage index on staffing practices or the quality of care and patient safety.

c. CMS Contract for Impact Analysis and Study of Wage Index Reform

To assist CMS in meeting the requirements of section 106(b)(2) of Public Law 109–432, in February 2008, CMS awarded a Task Order to Acumen, LLC. The two general responsibilities of the Task Order are to (1) conduct a detailed impact analysis that compares the effects of MedPAC's recommended wage and hospital compensation indices with the CMS wage index and (2) provide analysis and research that assist CMS in developing a proposal (or proposals) that addresses the nine points for consideration under section 106(b)(2) of Public Law 109–432. Specifically, the tasks under the Task Order include, but are not limited to, an evaluation of whether differences between the two types of wage data (that is, CMS cost report and occupational mix data and BLS data) produce significant differences in wage index values among labor market areas, a consideration of alternative methods of incorporating benefit costs into the construction of the wage index, a review of past and current research on alternative labor market area definitions, and a consideration of how aspects of the MedPAC recommended wage index can be applied to the CMS wage data in constructing a new methodology for the wage index. Acumen has completed the first phase of its study (that is, a comparative and impact analysis of the CMS wage index and the MedPAC recommended wage indices). A summary of Acumen's findings is included in section III.B.1.e. of the preamble to this final rule. Acumen will post on its Web site, subsequent to the publication of this final rule, an interim report that includes the full set of findings from this analysis. Acumen's Web site is: *http://www.acumenllc.com/reports/cms*.

d. Public Comments Received on the MedPAC Recommendations and the CMS/Acumen Wage Index Study and Analysis

We received many public comments regarding the MedPAC's recommendations for reforming the wage index, as well as on CMS' and Acumen's study and analysis. The public comments vary greatly, and at this time, we are not proposing or finalizing the specific recommendations made by MedPAC discussed above. For

this reason, we are briefly highlighting the public comments according to the issues they address. A complete set of the public comments on the FY 2009 IPPS proposed rule (CMS–1390–P) is available on the Internet at: *www.regulations.gov*. In developing proposals for additional wage index reform (anticipated to be included in the FY 2010 IPPS proposed rule), we plan to consider all of the public comments on the MedPAC recommendations that we received in this rulemaking cycle, along with the interim and final reports to be submitted to us by Acumen.

MedPAC Recommendation: Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions.

Public Comment Summaries:

• Wage index reclassifications and exceptions process should not be eliminated. Exceptions are necessary for hospitals with labor costs that are atypical for their local area but comparable to other areas.

• Reclassifications and other wage index exceptions should be modified or eliminated. As the MedPAC noted, 40 percent of hospitals receive a wage index exception, thereby indicating that the current system is broken.

MedPAC Recommendation: Use BLS data instead of the CMS hospital wage data collected on the Medicare cost report to calculate the wage index.

Public Comment Summaries:

• CMS should adopt the MedPAC's recommendations to use BLS data. A wage index based on a 3-year average, instead of a single year of 4-year-old data, would better reflect hospitals' average hourly wages.

• BLS data may be inappropriate to use for the hospital wage index because it includes data from all employers, not just short term acute hospitals.

• Wages for contract or temporary employees are included in BLS data, but they reflect the lower salary paid by the agency to the employee and not the higher salary of what the hospital paid the agency.

• Unlike CMS's public process for reviewing and correcting wage index data at the hospital level, BLS has a strict confidentiality policy. Hospitals would be unable to verify any inaccuracies in the BLS data. Complete transparency is needed for the entire wage index process.

• Every 6 months, BLS surveys 200,000 establishments and builds the database to include 1.2 million unique establishments over a 3-year period. The data are then inflated to a certain month and year using a ''single national estimate'' of wage growth for broad occupational divisions. This approach fails to account for any differences in wage growth between markets over the 3-year period.

• To determine average hourly wages, CMS collects data over a 12-month period, while the BLS collects data from 2 payroll periods, with each period capturing data from one-sixth of the total number of sampled establishments. Integrity in the wage index may be compromised using data from only two payroll periods rather than from 12 months of data.

• BLS data exclude overtime pay, jury duty pay, and shift differentials. Excluding these costs, which are often associated with tight labor market areas, could understate areas that have higher utilization of these items.

• BLS data do not include employee fringe benefits costs. The MedPAC relied on benefit data from the CMS hospital, home health agency, and SNF cost reports, which negates the potential benefit of eliminating the collection of hospital-specific wage data. There are also concerns about mixing data from two sources.

• Full-time and part-time employees are equally weighted in the BLS data.

• Estimates from using a sampling methodology like the BLS uses are subject to sampling errors and will be less reliable than CMS' current methodology of using data from all PPS hospitals.

• CMS data are mandatory while BLS data are voluntary. Data that are voluntarily submitted may have less integrity than mandatory data.

• BLS imputes data for nonresponsive employers. The use of imputed data is inappropriate.

• BLS data do not reflect premiums that hospitals must pay for certain workers; for example, premiums for registered nurses with additional training and certification in specialties such as critical care. Payment premiums for these workers would not be adequately reflected in the BLS data because the BLS survey does not capture information on nurse specialty areas.

• On the BLS survey, hospitals simply report data for occupational categories by average hourly wage ranges. Hospitals do not report actual hours worked. BLS' method for weighting the data in computing hourly rates is confusing because it does not have hours as a basis for the weighting.

MedPAC Recommendation: Use county-level adjustments, together with a smoothing process, to constrain the magnitude of differences between and within contiguous wage areas.

Public Comment Summaries:

• The MedPAC used 2000 census data to establish the relationship between counties within a MSA. Using old data may create differences in wage indices that are inconsistent with actual geographic differences in wages.

• Using counties as the units of analysis may not be optimal. Some counties tend to be quite large and topographically diverse, while other counties are small and relatively homogeneous.

• CMS' current methodology, with the exception of commuting pattern adjustments, assumes there is no interrelationship between areas. More refined areas, such as resulting from the MedPAC's smoothing methodology, may be more realistic and less arbitrary.

• Smoothing may mask actual variation between labor market areas.

• The 10-percent cliffs used in the MedPAC's smoothing process are set subjectively and, as the MedPAC noted, a percentage of 8 or 12 percent could alternatively be used. Depending on the area, changing the percentage could cause swings of millions of dollars.

MedPAC Recommendation: Adopt methods (such as a 3-year rolling average) to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.

Public Comment Summaries:

• Volatility in hospital wage indices from one year to the next makes it difficult for hospitals to estimate Medicare payments for budgeting purposes. While the 3-year rolling average used by BLS may reduce volatility, alternative approaches should be examined, including those that do not rely on BLS data.

• While a rolling average may make the wage data look better from a statistical point, it may not result in a fair wage distribution tool. As hospitals make adjustments for current market conditions, an average will mask the change.

CMS/Acumen Study and Analysis Plan: As stated earlier, CMS contracted with Acumen to conduct an impact analysis and compare the effects of MedPAC's recommended wage and hospital compensation indexes with the CMS wage index and to provide analysis that assists CMS in developing a proposal(s) that address the nine points under section 106(b)(2) of the MIEA–TRHCA.

Public Comment Summaries:

• Comments were favorable and supportive of CMS' contract with Acumen. One commenter found Acumen's analysis plan ''very thorough'' and was pleased with the ''wide variety of options and issues

relating to the wage index'' that were included in the analysis plan. (Acumen discussed the plan at CMS' May 20, 2008 special open door forum on wage index reform. The full transcript of the forum discussions is available at the Web site: *http://www.cms.hhs.gov/OpendoorForums/05_ODF_SpecialODF.asp*. Acumen's analysis plan will be posted on Acumen's Web site subsequent to the publication of this final rule at: *http://www.acumenllc.com/reports/cms*.) Another commenter expressed appreciation for the breadth and complexity of fulfilling CMS' statutory obligation under MIEA–TRHCA as well as the ''political challenges of this task,'' and commended CMS' engagement of an outside, independent contractor to assist CMS in this endeavor.

• The majority of commenters suggested that comprehensive wage index reform was necessary as opposed to incremental, interim changes. To that end, the commenters strongly urged that CMS make no changes to the wage index system until the Acumen study has been completed. The commenters also stated that the process to consider changes to the existing wage index should be very thorough and include a wide range of options beyond MedPAC's recommendations. In addition, the commenters recommended that CMS' review include the reasons that CMS replaced the BLS data with cost report data in the 1980s.

• Commenters commended CMS for the open door forum on the wage index held in May 2008 and believed that, given the importance the wage index has on hospital payment and the need for reform, the industry and interested stakeholders be given every opportunity for input through such open door forums. The commenters recommended transparency in the process and that CMS provide ample time for public review and comment on the study and any proposals stemming from CMS' and Acumen's study results.

• Several commenters suggested alternatives to the MedPAC recommendations and CMS proposals. For example, some commenters recommended that CMS implement a stop-loss to reduce wage index decreases from one year to the next. The commenters explained that a stop-loss would reduce volatility and increase predictability within the hospital wage index. In addition, many commenters expressed the need for a transition period for any changes to the wage index to ensure less volatility in the wage index and prevent significant reallocation of Medicare funds.

Response: We appreciate the many comments we received regarding MedPAC's recommendations and the CMS/Acumen study and analysis of reforming the wage index. At this time, because Acumen has not yet completed all of its research and analysis and because we have not fully analyzed the MedPAC recommendations, we are neither proposing nor finalizing any changes in response to the specific MedPAC recommendations. As stated above, as we study wage index reform in further depth, we plan to consider all of the public comments on the recommendations received during the rulemaking cycle. We plan to include our assessment of the MedPAC recommendations, along with any additional recommendations for further reforming the wage index, in the FY 2010 IPPS proposed rule.

e. Impact Analysis of Using MedPAC's Recommended Wage Index

Acumen conducted an analysis comparing use of the MedPAC recommended wage indices to the current CMS wage index. In the following discussion, we use a variety of terminology to refer to the wage indices recommended by MedPAC, as well as the wage indices currently used by CMS.

• When we refer to MedPAC's ''hospital compensation index'' or ''compensation index'', we are discussing the wage index that MedPAC developed that includes an adjustment to account for differences in the ratio of benefits to wages in different labor market areas. MedPAC developed this ratio of benefits using Medicare cost report data.

• When we refer to MedPAC's recommended ''wage index'', we are discussing the MedPAC-developed index without any adjustment for nonwage benefits. This wage index was developed using BLS data.

• When we refer to CMS' ''pre-reclassification wage index'' or ''pre-reclassification, pre-floor wage index'', we are discussing the wage index developed by CMS but without any adjustments for geographic reclassifications or the rural floor. This wage index also does not include any adjustments for outmigration, section 508 reclassifications, Lugar redesignations, section 401 urban-to-rural reclassifications, or for any special exceptions.

• When we refer to CMS' ''final wage index'', we are discussing the wage index developed by CMS that is the final wage index received by or to be received by a hospital. Thus, this wage index does account for all geographic reclassifications as well as the rural floor. This final wage index also includes any adjustments as a result of outmigration, section 508 reclassifications, Lugar redesignations, section 401 urban-to-rural reclassifications, or any other special exceptions.

Acumen analyzed and compared all four of the wage indices discussed above. In other words, Acumen compared (A) CMS' pre-reclassification, pre-floor wage index for FY 2008 (which was provided by CMS and is based on hospital cost reports from FY 2004) and CMS' final wage index for FY 2008 with (B) both the MedPAC recommended hospital compensation index and wage index for FY 2007. Acumen's comparisons of the CMS wage index to the MedPAC recommended indices indicate the effects of various components of the alternative wage indices. All of the comparisons reflect differences between the CMS and BLS wage data. The comparison of the CMS pre-reclassification index to the MedPAC compensation index reflects the additional impact of MedPAC's method of using county level adjustors to smooth differences in index values among the CMS wage areas. The comparison of the CMS pre-reclassification index to the MedPAC recommended wage index includes the effect of county-level smoothing and indicates the incremental effect of removing the MedPAC adjustment for benefits. The comparison of the CMS final wage index to the MedPAC recommended wage index adds the incremental effect of geographic reclassifications and other wage index exceptions (for example, the rural and imputed floors) to the preceding comparison. Finally, the comparison of the CMS final wage index to the MedPAC recommended compensation index yields the combined effects of all the differences between the two indices.

First, Acumen analyzed the overall impacts of the MedPAC recommended indices. Acumen conducted the analysis at two levels: the hospital level and the county level. At the hospital level, Acumen analyzed all four comparisons described above. However, at the county level, Acumen did not include comparisons using the CMS final wage index because it includes reclassifications and other changes which are granted to hospitals, not counties. As a result, hospitals in the same county or wage area can have different final index values. Acumen's analysis was based on 3,426 hospitals, for which all four wage index values were available (the CMS pre-reclassification wage index, the CMS

final wage index, the MedPAC recommended hospital wage index, and the MedPAC recommended hospital compensation index), and on the 1,595 counties in which these hospitals are located.

Second, Acumen estimated the impact for several subgroups of hospitals and counties. At the hospital level, Acumen assessed the impact by geographic area (for example, urban hospitals and rural hospitals), hospital size (number of beds), geographic region, teaching status, DSH status, SCH status, RRC status, MDH status, type of ownership (government, proprietary, voluntary), and reclassification status. At the county level, Acumen presented results for metropolitan area counties and rural counties.

Third, Acumen calculated the change in the wage index that each hospital (or county) could expect to experience from adopting the MedPAC recommendations and reported statistics on these expected differences (mean, median, standard deviation, minimum and maximum). Acumen did not model changes in Medicare payments that would result from using different wage indices. Instead, Acumen normalized all four wage indices by setting their discharge weighted means equal to 1.00. Normalization puts all four wage indices on the same scale so that differences in wage index values between one index and another index are directly comparable. As a result, the wage index differences reported by Acumen imply payment differences, but do not precisely measure the magnitude of those payment differences.

The main findings of Acumen's impact analysis are summarized as follows:

- Adopting the MedPAC recommendations would reduce the differentials between wage index values across geographic areas. Both the MedPAC wage and compensation indices are less dispersed than either the CMS pre-reclassification wage index or the final wage index.
- Under either of the MedPAC recommended indices, differences between the highest and lowest wage index hospitals would be reduced. For example, the range or difference that exists from the highest wage index hospital to the lowest wage index hospital (the ''high-low range'') under the MedPAC compensation index (0.752 versus 1.499, or a difference of 0.747) is roughly 11 percent smaller than the high-low range in the CMS final wage index (0.732 versus 1.569, or a difference of 0.837). Using the CMS pre-reclassification wage index as a comparison (with a high-low range of 0.716 versus 1.600), the MedPAC recommended compensation index is roughly 16 percent smaller. The minimum value of the MedPAC recommended compensation index (0.752) is roughly 5 percent larger than the minimum value of the CMS pre-reclassification wage index (0.716), and the maximum value of the MedPAC recommended compensation index (1.499) is roughly 6 percent less than the maximum value of the CMS pre-reclassification index (1.600).
- Adopting the MedPAC recommendations would also lower the wage dispersion among both rural and urban hospitals (whether classified by geography or payment), among hospitals of all sizes, and among all hospitals categorized by teaching status, DSH status, ownership status, and Medicare utilization status. These findings are generally consistent, regardless of whether the MedPAC recommended compensation index is compared to the CMS final wage index or to the CMS pre-reclassification wage index.
- Adopting the MedPAC recommendations would have a differential impact on urban hospitals across geographic regions of the country. In moving from the CMS final wage index to the MedPAC compensation index, the largest reduction in standard deviations would occur for urban hospitals in the New England region (−19.0 percent), the Middle Atlantic region (−27.8 percent), and the Pacific region (−19.0 percent). However, for urban hospitals in the West North Central region, the standard deviation of wage index values would increase by 11.7 percent.
- Adopting the MedPAC recommendations would decrease the standard deviation among hospitals with most types of reclassifications. For example, compared to the CMS final wage index, the MedPAC compensation index would reduce the standard deviation by 11.6 percent.
- The adoption of the MedPAC recommended indices would lead a substantial number of hospitals to experience a large change in their index values in the transition. If the MedPAC compensation index is compared to the CMS final wage index, 37 percent of all hospitals would see either increases or decreases of more than 5 percent. For approximately 34 percent of the reclassified hospitals (or 278 hospitals), wage index values would decrease by more than 5 percent. Reclassified hospitals comprise more than one-half of all hospitals that would likely experience wage index decreases greater than 5 percent in moving from the CMS final wage index to the MedPAC compensation index.
- Under a move from the CMS pre-reclassification wage index to the MedPAC recommended compensation index, counties in rural areas would experience fewer decreases and more increases in their wage index compared to counties in urban areas. (As noted above, county level comparisons were not performed using the CMS final wage index.)

The above findings are discussed in more detail in Acumen's interim report, which will be available after the publication of this final rule, at the Web site: *http://www.acumenllc.com/reports/cms*.

2. CMS Proposals and Final Policy Changes in Response to Requirements Under Section 106(b) of the MIEA–TRHCA

As discussed in section III.A. of this preamble, the purpose of the hospital wage index is to adjust the IPPS standardized payment to reflect labor market area differences in wage levels. The geographic reclassification system exists in order to assist ''hospitals which are disadvantaged by their current geographic classification because they compete with hospitals that are located in the geographic area to which they seek to be reclassified'' (56 FR 25469). Geographic reclassification is established under section 1886(d)(10) of the Act and is implemented through 42 CFR part 412, subpart L. (We refer readers to section III.I. of this preamble for a detailed discussion of the geographic reclassification system and other area wage index exceptions.)

In its June 2007 Report to Congress, MedPAC discussed its findings that geographic reclassification, and numerous other area wage index exceptions added to the system over the years, have created major complexities and ''troubling anomalies'' in the hospital wage index. A review of the IPPS final rules reveals a long history of legislative changes that have permitted certain hospitals, that otherwise would not be able to reclassify under section 1886(d)(10) of the Act, to receive a higher wage index than calculated for their geographic area. MedPAC reports that more than one-third of hospitals now receive a higher wage index due to geographic reclassification or other wage index exceptions. We are concerned about the integrity of the current system, and agree with MedPAC that the process has become burdensome.

As noted above, MedPAC recommended the elimination of geographic reclassification and other

wage index exceptions. In addition, the President's FY 2009 Budget included a proposal to apply the geographic reclassification budget neutrality requirement at the State level rather than by adjusting the standardized rate for hospitals nationwide. Given the language in section 1886(d)(10) of the Act establishing the MGCRB, we believe a statutory change would be required to make these changes. However, we do have the authority to make some regulatory changes to the reclassification system. These regulatory changes are discussed below. We note that these changes do not preclude future consideration of the MedPAC recommendations discussed in section III.B.1. of this preamble, when the recommendations could be implemented administratively.

a. Proposed and Final Revision of the Reclassification Average Hourly Wage Comparison Criteria

Regulations at 42 CFR 413.230(d)(1) set forth the average hourly wage comparison criteria that an individual hospital must meet in order for the MGCRB to approve a geographic reclassification application. Our current criteria (requiring an urban hospital to demonstrate that its average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located and at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation) were adopted in the FY 1993 IPPS final rule (57 FR 39825). In that final rule, we explained that the 108 percent threshold ''is based on the national average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (12 percent).'' We also explained that we would use the 84-percent threshold to reflect the average hospital wage of the hospital as a percentage of its area wage less one standard deviation. We stated that ''to qualify for a wage index reclassification, a hospital must have an average hourly wage that is more than one national standard deviation above its original labor market area and not less than one national standard deviation below its new labor market area'' (57 FR 39770). In response to numerous public comments we received, we expressed our policy and legal justifications for adopting the specific thresholds. Among other things, we stated that geographic reclassifications must be viewed not just in terms of those hospitals that are reclassifying, but also in terms of the nonreclassifying hospitals that, through a budget neutrality adjustment, are required to bear a financial burden associated with the higher wage indices received by those hospitals that reclassify. We also indicated that the Secretary has ample legal authority under section 1886(d)(10) of the Act to set the wage comparison thresholds and to revise such thresholds upon further review. We refer readers to that final rule for a full discussion of our justifications for the standards.

In the FY 2000 IPPS final rule (65 FR 47089 through 47090), the wage comparison criteria for rural hospitals seeking individual hospital reclassifications were reduced to 82 percent and 106 percent to compensate for the historic economic underperformance of rural hospitals. The 2-percent drop in both thresholds was determined to allow a significant benefit to some hospitals that were close to meeting the existing criteria but would not make the reclassification standards overly liberal for rural hospitals.

CMS had not evaluated or recalibrated the average hourly wage criteria for geographic reclassification since they were established in FY 1993. In consideration of the MIEA–TRHCA requirements and MedPAC's finding that over one-third of hospitals are receiving a reclassified wage index or other wage index adjustment, we decided to reevaluate the average hourly wage criteria for geographic reclassification. We ran simulations with more recent wage data to determine what would be the appropriate average hourly wage criteria. We found that the average hospital average hourly wage as a percentage of its area's wage has increased from approximately 96 percent in FY 1993 to closer to 98 percent over FYs 2006, 2007, and 2008 (97.8, 98.1, and 98.1 percent, respectively). We also determined that the standard deviation has been reduced from approximately 12 percent in FY 1993 to closer to 10 percent over the same 3-year period (10.7, 10.3, and 10.1 percent, respectively); that is, assuming normal distributions, approximately 68 percent of all hospitals would have an average hourly wage that deviates less than 10 percentage points above or below the mean. This assessment indicates that the new baseline criteria for reclassification should be set to 88/108 percent. While the 108 criterion does not require adjustment, the current 84 percent standard is too low a threshold to serve the purpose of establishing wage comparability with a proximate labor market area.

To assess the impact that these changes would have had on hospitals that reclassified in FY 2008, we ran models that set urban individual reclassification standards to 88/108 percent and the county group reclassification standard to 88 percent. We retained the 2-percent benefit for rural hospitals by setting an 86/106 percent standard. We used 3-year average hourly wage figures from the 2005, 2006, and 2007 wage surveys and compared them to 3-year average hourly wage figures for CBSAs over the same 3-year period.

Of the 295 hospitals that applied for and received individual reclassifications in FY 2008, 45 of them (15.3 percent) would not meet the proposed 88/86 percent threshold. Of the 66 hospitals that applied for and received county group reclassification in FY 2008, 6 hospitals (9.1 percent) in 3 groups would not have qualified with the new standards. We also ran comparisons for hospitals that reclassified in FY 2006 and FY 2007 to determine if they would have been able to reclassify in FY 2008, using 3-year averages available in FY 2008. We found that, of all hospitals that were reclassified in FY 2008 (that is, applications approved for FYs 2006 through 2008), 14.7 percent of individual reclassifications and 8.5 percent of county group reclassification would not have qualified to reclassify in FY 2008.

Section 106 of MIEA–TRHCA requires us to propose revisions to the hospital wage index system after considering the recommendations of MedPAC. To address this requirement, in the FY 2009 IPPS proposed rule (73 FR 23620), we proposed that the 84/108 criteria for urban hospital reclassifications and the 82/106 criteria for rural hospital reclassifications be recalibrated using the methodology published in the FY 1993 final rule and more recent wage data (that is, data used in computing the FYs 2006, 2007, 2008 wage indices). As we stated in the proposed rule, we believe that hospitals that are seeking to reclassify to another area should be required to demonstrate more similarity to the area than the current criteria permit, and our recent analysis demonstrates that those criteria are no longer appropriate. Therefore, we proposed to change the criterion for the comparison of a hospital's average hourly wage to that of the area to which the hospital seeks reclassification to 88 percent for urban hospitals and 86 percent for rural hospitals for new reclassifications beginning with the FY 2010 wage index and, accordingly, revise our regulations at 42 CFR 412.230 to reflect these changes. The criterion for the comparison of a hospital's average hourly wage to that of its geographic area would be unchanged

(108 percent for urban hospitals and 106 percent for rural hospitals). We also proposed that, when there are significant changes in labor market area definitions, such as CMS' adoption of new OMB CBSA definitions based upon the decennial census (69 FR 49027), we would again reevaluate and, if warranted, recalibrate these criteria. This would allow CMS to consider the effects of periodic changes in labor market boundaries and provide a regular timeline for updating and validating the reclassification criteria. Finally, we proposed to adjust the 85 percent criterion for both urban and rural county group reclassifications to be equal to the proposed 88 percent standard for urban reclassifications, and to revise the regulations at 42 CFR 412.232 and 412.234 to reflect the change. The urban and rural county group average hourly wage standard has always been equivalent for both urban and rural county groups and has always been 1 percent higher than the 84 percent urban area individual reclassification standard. We proposed to continue the policy of having an equivalent wage comparison criterion for both urban and rural county groups, as these groups have always used the same wage comparison criteria. We also proposed to use the individual urban hospital reclassification standard of 88 percent because this threshold would ensure that the hospitals in the county group are at least as comparable to the proximate area as are individual hospitals within their own areas. In addition, we indicated that we do not believe it would be appropriate to have a group reclassification standard lower than the individual reclassification standards, thus potentially creating a situation where all of the hospitals in a county could reclassify, even though no single hospital within such county would be able to meet any average hourly wage-related comparisons for an individual reclassification.

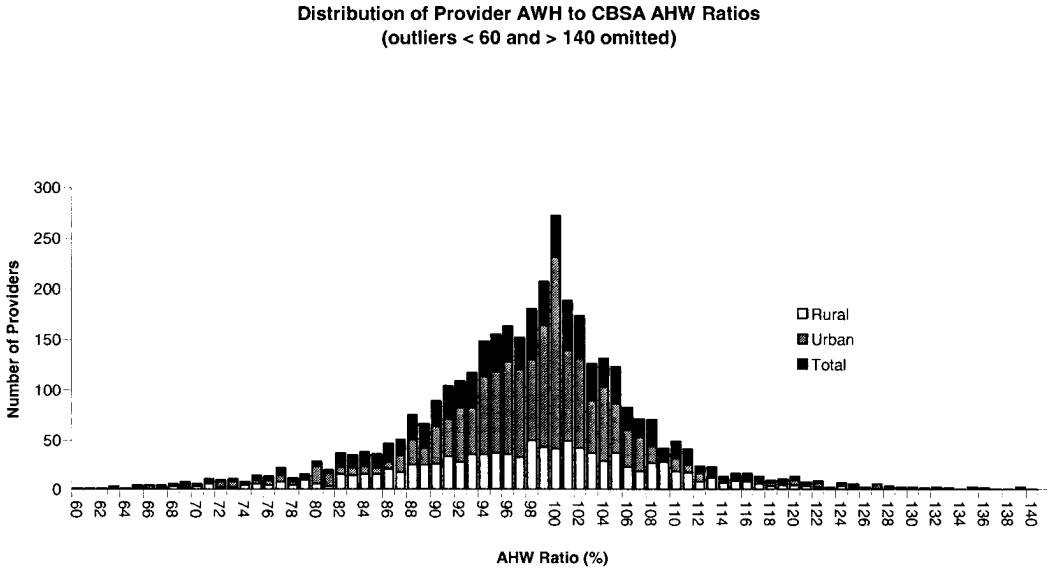
We considered raising the group reclassification criterion to 89 percent in order to preserve the historical policy of the standard being set at 1 percent higher than the individual reclassification standard. However, we determined that making the group standard equal to the individual standard would adequately address our stated concerns.

The proposed changes in the reclassification criteria would apply only to new reclassifications beginning with the FY 2010 wage index. Any hospital or county group that is in the midst of a 3-year reclassification in FY 2010 would not be affected by the proposed criteria change until they reapply for a geographic reclassification. Therefore, we proposed that the effective date for these changes would be September 1, 2008, the deadline for hospitals to submit applications for reclassification for the FY 2010 wage index.

Comment: The majority of commenters did not support CMS' proposal to revise the average hourly wage criteria because of concern that the policy would make achieving geographic reclassification more difficult for some providers. Most commenters stated that such proposals should be delayed and incorporated into a more comprehensive reform framework. The commenters also expressed concerns that such a proposal would further destabilize an already highly variable wage index system, and would make provider operations and planning more onerous and result in detrimental impacts on quality of care. Although some commenters supported CMS using more recent data to analyze the reclassification criteria, they questioned whether CMS performed appropriate statistical analysis. The commenters requested additional study and impact analyses to assure that provider-to-CBSA average hourly wage ratios (the basis for the reclassification average hourly wage criteria) were indeed normally distributed, as was assumed by the original methodology.

Response: We do not believe that our commitment to examine further broad-based reform requires us to postpone specific reclassification criteria changes that would enhance labor market integrity under the current system. It is not our intention to destabilize the wage index system, but to instead implement consistent and meaningful criteria to standardize a reclassification process that analysis proves no longer accomplishes its stated purpose. The MedPAC report on the Medicare hospital wage index reform specifically cited the fact that a large percentage of the wage index variation between its proposed methodologies and the current system occurred relative to reclassifications and other wage index exceptions. This suggests that the current reclassification system has a strong causal connection to the large variations and inconsistencies that are often observed in the Medicare hospital wage index system. Although some hospitals will likely no longer be able to reclassify with the new standards, revising the reclassification average hourly wage comparison criteria is not only well within the authority of CMS under section 1886(d)(10)(D) of the Act, but it also reflects what we believe to be a more reasonable reclassification threshold based on the most recent data.

In response to concerns expressed about the assumptions and validity of our methodology, we refer to the chart at the end of this response. We agree that, in using standard deviations from the mean to establish threshold criteria, it is important for the data to be normally distributed (for example, a bell-shaped curve). While some commenters stated that a mean of 98 percent (versus a mean of 100 percent or 1.00) shows that the distribution was necessarily skewed, using FY 2008 data, we found that the analyzed ratios formed a consistent bell-curve and demonstrated only a minor negative skew which tested well within the bounds of statistical significance of a normal distribution. Rural hospitals show a greater variability and less central tendency than urban providers. However, even if the original methodology was applied to urban and rural providers separately, the mean and standard deviation would support a comparison criterion still more restrictive than the proposed 86-percent standard for rural providers. Furthermore, additional statistical analysis would suggest that the 106-percent standard is not restrictive enough for rural providers. Certain outliers are removed from the chart at the end of this response to provide a clearer visual representation. Inclusion or exclusion of these outliers did not greatly affect the statistical significance of the analysis. With the nearly perfectly distributed nature of the comparison data, and the additional 2 percent benefit that rural providers receive, we are not convinced that an alternative methodology would yield a truer representation of typical variations in any given labor market area.



Comment: Some commenters requested CMS to specifically address the impact on rural providers and RRCs.

Response: Rural providers would be more likely to fail to meet reclassification standards. More than half of the hospitals currently receiving geographic reclassification are located in rural areas, while less than one-third of all IPPS hospitals are located in rural CBSAs. Therefore, it is to be expected that the proposed criteria change would affect a higher proportion of rural providers. However, we cannot fully analyze such a specific impact on rural providers because the 35-mile reclassification proximity requirement makes it quite possible that many rural providers would have additional reclassification opportunities, perhaps to more wage appropriate CBSAs. We also note that our proposal did not affect benefits currently afforded to RRCs, such as waiver of the 106/108 percent standards and limited waiver of normal proximity requirements.

Comment: Other comments cited specific circumstances where providers would encounter significant negative impacts not considered by CMS when the average hourly wage criteria proposal is implemented in conjunction with other wage index proposals. One commenter requested that any criteria changes be phased in over the course of multiple fiscal years.

Response: We believe that the overall benefits of maintaining appropriate reclassification standards will improve the overall wage index payment system. If some hospitals have been benefiting from reclassifying to labor market areas which are not statistically appropriate on the basis of their average hourly wage data, such reclassifications have been at the expense of all other providers because of the geographic reclassification budget neutrality adjustment.

After consideration of the public comments we received, we are adopting in this final rule the policy to adjust the reclassification average hourly wage standard, comparing a reclassifying hospital's (or county hospital group's) average hourly wage relative to the average hourly wage of the area to which it seeks reclassification. However, we will be phasing in the adjustment over two years. For the first transitional year, FY 2010, the average hourly wage standards will be changed to 86 percent for urban and group reclassifications and to 84 percent for rural hospitals. In the second year, FY 2011, the average hourly wage standards will be changed to 88 percent for urban and group reclassifications and to 86 percent for rural hospitals (revised §§ 412.230, 412.232, and 412.234). The purpose of the wage index is to provide, as accurate as possible, a measure of geographic labor cost variations. The reclassification process was intended to provide hospitals that, due to imperfections in the labor market boundaries and/or definitions, compete with hospitals in higher waged labor market areas. It is a fundamental flaw in the reclassification system if payments are inappropriately redistributed because hospitals without statistically comparable labor costs are reclassified to areas with higher wage index values. Therefore, for reclassifications beginning in FY 2010 (for which the application deadline is September 2, 2008), the transitional average hourly wage comparison criteria will be in effect. For reclassifications beginning in FY 2011, the new average hourly wage comparison criteria will be fully in effect.

b. Within-State Budget Neutrality Adjustment for the Rural and Imputed Floors

Section 4410 of the Balanced Budget Act of 1997 (BBA) established the rural floor by requiring that the wage index for a hospital in an urban area of a State cannot be less than the area wage index received by rural hospitals in that State. Section 4410(b) of the BBA imposed the budget neutrality requirement and stated that the Secretary shall ''adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection.'' Therefore, in order to compensate for the increased wage indices of urban hospitals receiving the rural floor, a nationwide budget neutrality adjustment is applied to the wage index to account for the additional payment to these hospitals. As a result, urban hospitals that qualify for their State's rural floor wage index receive enhanced payments at the expense of all rural hospitals nationwide and all other urban hospitals that do not receive their State's rural floor. Tentatively, for the final wage index, we find that 277 hospitals in 28 States would receive the rural floor. (Due to the intervening requirements of section 124 of Pub. L. 110–275, these numbers could change in the final FY 2009 wage index to be published in a separate **Federal Register** notice subsequent to this final rule.) The first chart below lists the percentage of total payments each State could either

receive or contribute to fund the current rural floor and imputed floor provisions with national budget neutrality adjustments (as indicated in the discussion of the imputed floor below in this section III.B.2.b.). The second chart below provides a graphical depiction of the tentative FY 2009 impacts.

FY 2009 IPPS ESTIMATED PAYMENTS WITH TRANSITION TO WITHIN-STATE RURAL FLOOR AND IMPUTED FLOOR BUDGET NEUTRALITY

State	Former policy application of national rural floor and imputed floor budget neutrality	New policy application of rural floor and imputed rural floor with blend of 80% national and 20% state-specific budget neutrality compared to no rural or imputed rural floor	Net effect of the change in policy for FY 2009
Alabama	−0.2	−0.2	0
Alaska	0	0	0
Arizona	−0.2	−0.2	0
Arkansas	−0.2	−0.2	0
California	0.8	0.7	−0.2
Colorado	0	0	0
Connecticut	2.1	1.7	−0.4
Delaware	−0.2	−0.2	0
Washington, DC	−0.2	−0.2	0
Florida	−0.1	−0.1	0
Georgia	−0.2	−0.2	0
Hawaii	−0.2	−0.1	0
Idaho	−0.2	−0.1	0
Illinois	−0.2	−0.2	0
Indiana	−0.2	−0.1	0
Iowa	0	0	0
Kansas	−0.2	−0.1	0
Kentucky	−0.2	−0.1	0
Louisiana	−0.2	−0.1	0
Maine	−0.2	−0.1	0
Massachusetts	−0.2	−0.2	0
Michigan	−0.2	−0.2	0
Minnesota	−0.2	−0.2	0
Mississippi	−0.2	−0.2	0
Missouri	−0.2	−0.1	0
Montana	−0.1	−0.1	0
Nebraska	−0.2	−0.1	0
Nevada	−0.2	−0.2	0
New Hampshire	0.8	0.7	−0.2
New Jersey	0.7	0.5	−0.2
New Mexico	−0.1	−0.1	0
New York	−0.2	−0.2	0
North Carolina	−0.2	−0.2	0
North Dakota	0.1	0.1	0
Ohio	−0.2	−0.1	0
Oklahoma	−0.2	−0.1	0
Oregon	−0.2	−0.2	0
Pennsylvania	−0.2	−0.1	0
Puerto Rico	−0.1	−0.1	0
Rhode Island	−0.2	−0.2	0
South Carolina	−0.1	−0.1	0
South Dakota	−0.2	−0.1	0
Tennessee	−0.1	0	0
Texas	−0.2	−0.1	0
Utah	−0.2	−0.2	0
Vermont	3.4	2.7	−0.7
Virginia	−0.2	−0.2	0
Washington	−0.1	−0.1	0
West Virginia	−0.1	−0.1	0
Wisconsin	−0.1	−0.1	0
Wyoming	0	0	0

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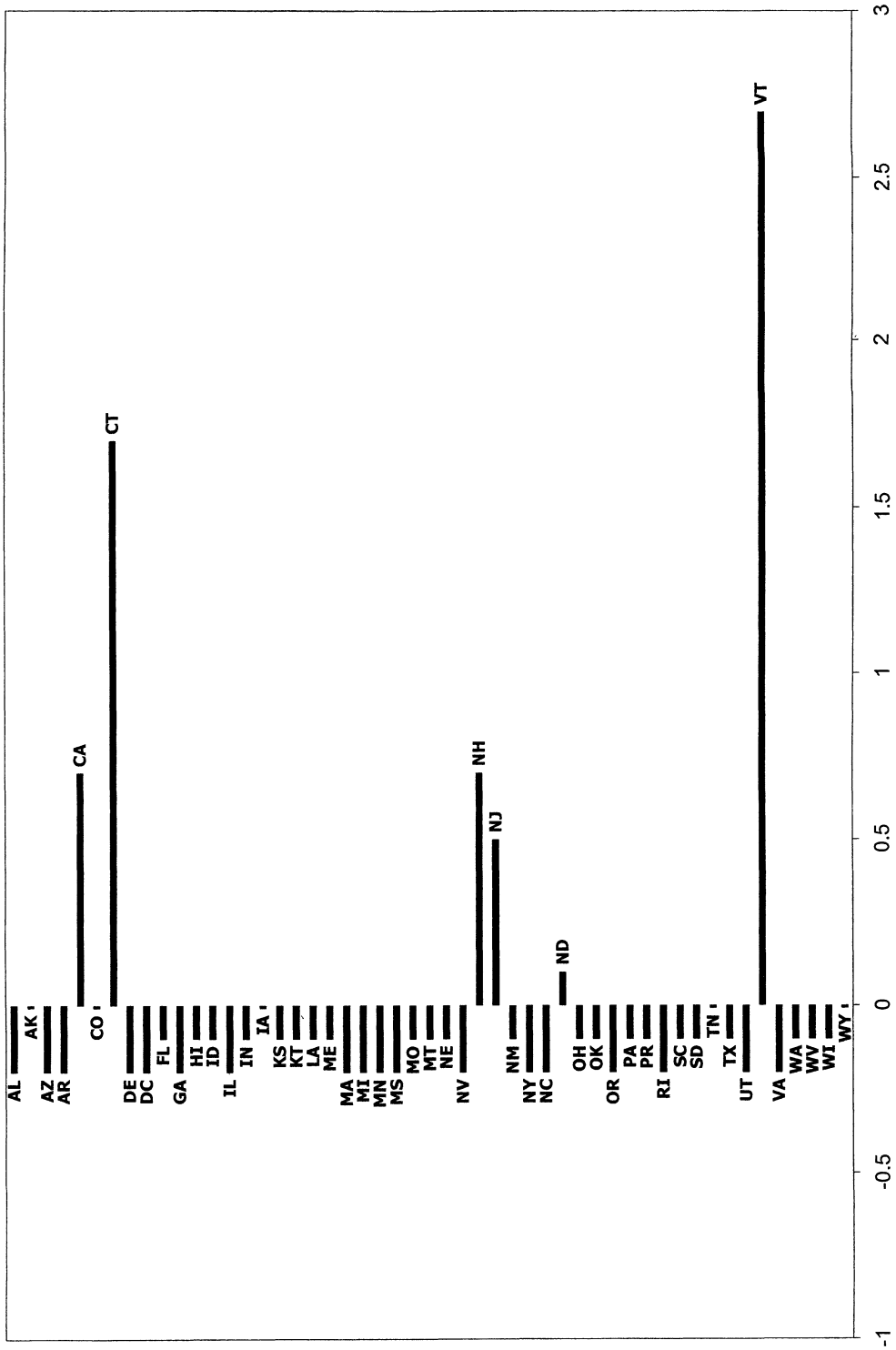
Percentage of Total Payments Attributable to Transitional Statewide Blended Budget Neutrality for the Rural Floor and Imputed Floor



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The above charts demonstrate how, at a State-by-State level, the rural floor is creating a benefit for a minority of States that is then funded by a majority of States, including States that are overwhelmingly rural in character. The rural floor was established to address anomalous occurrences where certain urban areas in a State have unusually depressed wages when compared to the State's rural areas. However, as we indicated in the proposed rule, because these comparisons occur at the State level, we believe it also would be sound policy to make the budget neutrality adjustment specific to the State, redistributing payments among hospitals within the State, rather than adjusting payments to hospitals in other States.

In addition, we stated in the proposed rule that we believed a statewide budget neutrality adjustment would address the situation we discussed in the FY 2008 IPPS final rule with comment period (72 FR 47324) in which rural CAHs were converting to IPPS status, apparently to raise the State's rural wage index to a level whereby all urban hospitals in the State would receive the rural floor. Medicare payments to CAHs are based

on 101 percent of reasonable costs, while the IPPS pays hospitals a fixed rate per discharge. In addition, as a CAH, a hospital is guaranteed to recover its costs, while an IPPS hospital is provided with incentives to increase efficiency to cover its costs. Thus, we stated that the identified CAHs were converting back to IPPS, even though the conversion would not directly benefit them. Because these hospitals' wage levels are higher than most, if not all, of the urban hospitals in the State, the wage indices for most, if not all, of the State's urban hospitals would increase as a result of the rural floor provision if the CAHs convert to IPPS status. In simulating the effect of the hospitals setting the State's rural floor, we estimated that payment to hospitals in the State would increase in excess of $220 million in a single year. The MedPAC, in its June 2007 Report to the Congress stated, ''The fact that the movement of one or two CAHs in or out of the [I]PPS system can increase (or decrease) Medicare payments by $220 million suggests there is a flaw in the design of the wage index system.'' (We refer readers to page 131 of the report.)

For the above reasons, in the FY 2009 IPPS proposed rule (73 FR 23622), we proposed to apply a State level rural floor budget neutrality adjustment to the wage index beginning in FY 2009. We proposed that States that have no hospitals receiving a rural floor wage index would no longer have a negative budget neutrality adjustment applied to their wage indices. Conversely, hospitals in States with hospitals receiving a rural floor would have their wage indices downwardly adjusted to achieve budget neutrality within the State. We proposed that all hospitals within each State would, in effect, be responsible for funding the rural floor adjustment applicable within that specific State.

In the FY 2005 IPPS final rule and the FY 2008 IPPS final rule with comment period (69 FR 49109 and 72 FR 47321, respectively), we temporarily adopted an ''imputed'' floor measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals. Because no rural wage index could be calculated, no rural floor could be applied within such States. We originally limited application of the policy to FYs 2005 through 2007 and then extended it one additional year, through FY 2008. In the FY 2009 IPPS proposed rule (73 FR 23623), we proposed to extend the imputed floor for 3 additional years, through FY 2011, and to revise the introductory text of § 412.64(h)(4) of our regulations to reflect this extension. For FY 2009, 26 hospitals in New Jersey (33.8 percent) would receive the imputed floor. Rhode Island, the only other all-urban State, has no hospitals that would receive the imputed floor. In past years, we applied a national budget neutrality adjustment to the standardized amount to ensure that payments remained constant to payments that would have occurred in the absence of the imputed floor policy. As a result, payments to all other hospitals in the Nation were adjusted downward to subsidize the higher payments to New Jersey hospitals receiving the imputed floor. As the intent of the imputed floor is to create a protection to all-urban States similar to the protection offered to urban-rural mixed States by the rural floor, and the effect of the measure is also State-specific like the rural floor, we indicated that we believe that the budget neutrality adjustments for the imputed floor and the rural floor should be applied in the same manner. Therefore, beginning with FY 2009, we also proposed to apply the imputed floor budget neutrality adjustment to the wage index and at the State level.

In the proposed rule, we specifically requested public comments from national and State hospital associations regarding the proposals, particularly the national associations, as they represent member hospitals that are both positively and negatively affected by the proposed policies, and were, therefore, in the best position to comment on the policy merits of the proposals. We indicated that we would view the absence of any comments from the national hospital associations as a sign that they do not object to our proposed policies.

Comment: Some commenters supported the proposal to apply the rural floor and imputed floor budget neutrality adjustment on a State basis, as opposed to making a national adjustment. A few commenters stated that it was not appropriate and competitively unfair for a provider receiving a wage index lower than the lowest urban providers in another State to have its wage index reduced by CMS to increase payments to the other higher paid providers. Other commenters supported CMS's efforts to protect hospitals from unwarranted reductions in their wage index values due to the current rural floor policy. MedPAC expressed its support for CMS's proposed statewide budget neutrality adjustments for the rural and imputed floors as an interim step in reforming the wage index. MedPAC noted that the rural floor policy itself is troubling because it is ''built on a false assumption that hospital wage rates in all urban labor markets in a (S)tate are always higher than the average hospital wage rate in rural areas of the (S)tate.'' MedPAC agreed with CMS that the proposed State level budget neutrality adjustment ''would improve fairness and reduce opportunities to game the wage index system.''

However, the majority of commenters, including most national and State hospital associations, did not support the proposal to apply a State level budget neutrality adjustment for the rural and imputed floors. Many commenters stated that a major policy initiative should be postponed and included in discussions and planning for more broad-based wage index reform. They suggested that such a policy decision by CMS only makes the Medicare wage index system more variable and unstable, creating onerous difficulties for hospital administrators to plan operations and potentially harming the quality of care provided. Many of the commenters, particularly in States that benefit most from the current national budget neutrality adjustment for the rural and imputed floors, cited the financial losses that would result from our proposal.

Some commenters stated that it is inconsistent with prior CMS policy to apply any wage index adjustment on a State-by-State basis. They suggested that, because the intent of Congress for the rural floor was to address ''anomalous'' situations where urban areas may have lower wages than nearby rural areas, the adjustment should be shared by all hospitals to maximize the benefit of the floor, while minimizing the individual costs to fund it. Similarly, the commenters contended that, ''budget neutrality must remain a national policy in accordance with current practice in order to retain balance and symmetry within a complex wage index environment.''

Response: We continue to believe that, while the majority of wage index budget neutrality adjustments have been applied on a nationwide basis, the particular nature of the rural and imputed floors, for which applicability is determined on a State level basis, is better addressed by a within-State adjustment. The current system requires hospitals nationwide to fund an adjustment to the Medicare payment system to address unrelated situations in a minority of States. The variances between urban and rural wage indices within a State have no relevant causal connection to the wage indices of another State, and it does not follow that such variances should be adjusted

through a national budget neutrality adjustment.

Therefore, we have decided to adopt our proposal for State level budget neutrality for the rural and imputed floors as final in this final rule, to be effective beginning with the FY 2009 wage index. However, in response to the public's concerns and taking into account the potentially drastic payment cuts that may occur to hospitals in some States, we have decided to phase in, over a 3-year period, the transition from the national budget neutrality adjustment to the State level budget neutrality adjustment. In FY 2009, hospitals will receive a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index will reflect 50 percent of the State level adjustment and 50 percent of the national adjustment. In FY 2011, the adjustment will be completely transitioned to the State level methodology.

We are incorporating this final policy in our regulation text at new § 412.64(e)(4). Specifically, we are providing that CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) and the imputed rural floor under § 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected. Beginning October 1, 2008, such adjustments will transition from a nationwide to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2011.

Comment: While some commenters supported CMS's efforts to address the issue of potential gaming of the rural floor, many commenters indicated that it should not be the sole impetus for within-State rural floor budget neutrality because it would unfairly penalize nongaming providers.

Response: As discussed above, as well as in the FY 2008 final and FY 2009 proposed rules (72 FR 47321 and 73 FR 23620, respectively), while the gaming issue was an important concern that we sought to address, it was neither the only nor the primary justification for proposing the within-State budget neutrality adjustment. We believe that, for all providers, the within-State budget neutrality policy is more equitable than the national adjustment because it concentrates the budget neutrality at the State level for a statutory provision that applies benefits at the State level. We note that the statute requires that total payments with a rural floor do not exceed payments that would have been made in the absence of a floor, but does not mandate a national adjustment.

Comment: One commenter stated that adoption of a within-State application of budget neutrality will further complicate the methodology for calculating the wage index, particularly for hospitals in CBSAs that cross State lines, or that reclassify to a CBSA in another State. The commenter expressed concern that the proposal will lead to less transparency in the wage index calculation and make it more difficult for hospitals to evaluate their most beneficial options in regard to reclassification and other wage index exceptions.

Response: Application of the rural floor already requires that, for CBSAs that cross State lines, two or more wage indices may need to be calculated in order to reflect the reality of a rural floor applying in one or more of the States. (We refer readers to Table 4A, to be published in a separate **Federal Register** notice subsequent this final rule, to see how State location may affect the wage index within a single CBSA.) A State's rural or imputed floor budget neutrality adjustment applies to any hospital that is geographically located in the State, even when a hospital is reclassified or redesignated to a CBSA in another State. We explain in section II.A. of the Addendum to this final rule how within-State budget neutrality adjustments for the rural and imputed floors are calculated and how the transitional blended adjustment will be implemented.

Comment: Some commenters disagreed with CMS' decision to further extend the imputed floor policy through FY 2011. The commenters contended that the imputed floor is unnecessary and should never have been implemented without Congressional mandate. Other commenters supported CMS' proposal to extend the imputed floor policy, but some supported the extension only on the condition that CMS applies the imputed floor budget neutrality adjustment in the same manner that it applies the rural floor adjustment.

Response: As proposed, we are extending the imputed floor for 3 additional years, through FY 2011. Beginning with the FY 2009 wage index in this final rule, we are also applying budget neutrality for the imputed floor in the same manner that we apply budget neutrality for the rural floor. (We refer readers to the discussion in section III.B.2.b. of this preamble.)

In the proposed rule, we indicated that based on our impact analysis of these proposals for FY 2009, of the 49 States (Maryland is excluded because it is under a State waiver), the District of Columbia, and Puerto Rico, 39 would see either no change or an increase in total Medicare payments as a result of applying a budget neutrality adjustment to the wage index for the rural and imputed floors at the State level rather than the national level. The total payments of the remaining 12 States would decrease 0.1 percent to 3.4 percent compared to continuing our prior national adjustment policy. For this final rule, the full impact analysis of the final policy is reflected in the two charts presented in section III.B.2.b. of the preamble of this final rule. Table 4D–1, which will be included in a separate **Federal Register** notice subsequent to this final rule reflects the final FY 2009 State level budget neutrality adjustments for the rural and imputed floors for the first year of the 3-year transition of the budget neutrality adjustments for these floors from the national level to the State level, as discussed above.

c. Within-State Budget Neutrality Adjustment for Geographic Reclassification

As discussed in the FY 2009 IPPS proposed rule (73 FR 23623), the FY 2009 President's Budget includes a legislative proposal to apply geographic reclassification budget neutrality at the State level (available at the Web site: *http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf* under FY 2009 Medicare Proposals, page 54).

Comment: A number of commenters objected to the legislative proposal we discussed in the proposed rule that would apply budget neutrality for geographic reclassification at the State level.

Response: Our discussion of within-State budget neutrality for geographic reclassifications related to a legislative proposal included in the FY 2009 President's Budget, and not a new proposed administrative policy. If such a measure were enacted by the Congress, CMS would comply with the law.

C. Core-Based Statistical Areas for the Hospital Wage Index

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas

(CBSAs) established by OMB and announced in December 2003 (69 FR 49027). For a discussion of OMB's revised definitions of CBSAs and our implementation of the CBSA definitions, we refer readers to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032).

As with the FY 2008 final rule, in the FY 2009 IPPS proposed rule (73 FR 23623), we proposed to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we proposed to determine a wage index for FY 2009 employing wage index data from hospital cost reports for cost reporting periods beginning during FY 2005 and using the CBSA labor market definitions. We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, it has been our longstanding policy that where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029). We proposed to codify this longstanding policy into our regulations at § 412.64(b)(1)(ii)(A).

Comment: One commenter supported the CMS proposal to codify its longstanding policy that a Metropolitan Division of an MSA is treated as a labor market area for purposes of calculating the wage index.

Response: We appreciate the commenter's support of our proposal to codify this policy in our regulations. In this final rule, we are adopting the proposed change under § 412.64(b)(1)(ii)(A) as final.

On November 20, 2007, OMB announced the revision of titles for eight urban areas (OMB Bulletin No. 08–01). The revised titles are as follows:

- Hammonton, New Jersey qualifies as a new principal city of the Atlantic City, New Jersey CBSA. The new title is Atlantic City-Hammonton, New Jersey CBSA;
- New Brunswick, New Jersey, located in the Edison, New Jersey Metropolitan Division, qualifies as a new principal city of the New York-Northern New Jersey-Long Island, New York, New Jersey, Pennsylvania CBSA. The new title for the Metropolitan Division is Edison-New Brunswick, New Jersey CBSA;
- Summerville, South Carolina qualifies as a new principal city of the Charleston-North Charleston, South Carolina CBSA. The new title is Charleston-North Charleston-Summerville, South Carolina;
- Winter Haven, Florida qualifies as a new principal city of the Lakeland, Florida CBSA. The new title is Lakeland-Winter Haven, Florida;
- Bradenton, Florida replaces Sarasota, Florida as the most populous principal city of the Sarasota-Bradenton-Venice, Florida CBSA. The new title is Bradenton-Sarasota-Venice, Florida. The new CBSA code is 14600;
- Frederick, Maryland replaces Gaithersburg, Maryland as the second most populous principal city in the Bethesda-Gaithersburg-Frederick, Maryland CBSA. The new title is Bethesda-Frederick-Gaithersburg, Maryland;
- North Myrtle Beach, South Carolina replaces Conway, South Carolina as the second most populous principal city of the Myrtle Beach-Conway-North Myrtle Beach, South Carolina CBSA. The new title is Myrtle Beach-North Myrtle Beach-Conway, South Carolina;
- Pasco, Washington replaces Richland, Washington as the second most populous principal city of the Kennewick-Richland-Pasco, Washington CBSA. The new title is Kennewick-Pasco-Richland, Washington.

The OMB bulletin is available on the OMB Web site at *https://www.whitehouse.gov/OMB*—go to ''Bulletins'' or ''Statistical Programs and Standards.'' CMS will apply these changes to the IPPS beginning October 1, 2008.

D. Occupational Mix Adjustment to the FY 2009 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the FY 2009 Occupational Mix Adjustment

On October 14, 2005, we published a notice in the **Federal Register** (70 FR 60092) proposing to use a new survey, the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to apply an occupational mix adjustment to the FY 2008 wage index. In the proposed 2006 survey, we included several modifications based on the comments and recommendations we received on the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

We made the changes to the occupational categories in response to MedPAC comments to the FY 2005 IPPS final rule (69 FR 49036). Specifically, MedPAC recommended that CMS assess whether including subcategories of registered nurses would result in a more accurate occupational mix adjustment. MedPAC believed that including all registered nurses in a single category may obscure significant wage differences among the subcategories of registered nurses, for example, the wages of surgical registered nurses and floor registered nurses may differ. Also, to offset additional reporting burden for hospitals, MedPAC recommended that CMS should combine the general service categories that account for only a small percentage of a hospital's total hours with the ''all other occupations'' category because most of the occupational mix adjustment is correlated with the nursing general service category.

In addition, in response to the public comments on the October 14, 2005 notice, we modified the 2006 survey. On February 10, 2006, we published a **Federal Register** notice (71 FR 7047) that solicited comments and announced our intent to seek OMB approval on the revised occupational mix survey (Form CMS–10079 (2006)). OMB approved the survey on April 25, 2006.

The 2006 survey provided for the collection of hospital-specific wages and hours data, a 6-month prospective reporting period (that is, January 1, 2006, through June 30, 2006), the transfer of each general service category that comprised less than 4 percent of total hospital employees in the 2003 survey to the ''all other occupations'' category (the revised survey focused only on the mix of nursing occupations), additional clarification of the definitions for the occupational categories, an expansion of the registered nurse category to include functional subcategories, and the exclusion of average hourly rate data associated with advance practice nurses.

The 2006 survey included only two general occupational categories: nursing and ''all other occupations.'' The nursing category has four subcategories: Registered nurses, licensed practical nurses, aides, orderlies, attendants, and medical assistants. The registered nurse subcategory includes two functional subcategories: Management personnel and staff nurses or clinicians. As indicated above, the 2006 survey provided for a 6-month data collection period, from January 1, 2006 through June 30, 2006. However, we allowed flexibility for the reporting period beginning and ending dates to accommodate some hospitals' biweekly payroll and reporting systems. That is, the 6-month reporting period had to begin on or after December 25, 2005, and end before July 9, 2006.

As we proposed in the FY 2009 IPPS proposed rule (73 FR 23624), we are using the entire 6-month 2006 survey data to calculate the occupational mix adjustment for the FY 2009 wage index. The original timelines for the collection, review, and correction of the 2006 occupational mix data were discussed in detail in the FY 2007 IPPS final rule (71 FR 48008). The revision and correction process for all of the data, including the 2006 occupational mix survey data to be used for computing the FY 2009 wage index, is discussed in detail in section III.K. of the preamble of this final rule.

2. Calculation of the Occupational Mix Adjustment for FY 2009

For FY 2009 (as we did for FY 2008), we are calculating the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours (registered nurse management personnel and registered nurse staff nurses or clinicians are treated as separate nursing subcategories). Repeat this computation for each of the five nursing subcategories: registered nurse management personnel; registered nurse staff nurses or clinicians; licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2—Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3—For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from Step 1) by the national average hourly rate for that nursing subcategory (from Step 2). Repeat this calculation for each of the five nursing subcategories.

Step 4—For each hospital, determine the adjusted average hourly rate for the total nursing category by summing the adjusted average hourly rate (from Step 3) for each of the nursing subcategories.

Step 5—Determine the national average hourly rate for the total nursing category by dividing total nursing category salaries for all hospitals in the occupational mix survey database by total nursing category hours for all hospitals in the occupational mix survey database.

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average hourly rate (indicating the hospital employs a less costly mix of nursing employees), the occupational mix adjustment factor is greater than 1.0000. If the hospital's adjusted average hourly rate is greater than the national average hourly rate, the occupational mix adjustment factor is less than 1.0000.

Step 7—For each hospital, calculate the occupational mix adjusted salaries and wage-related costs for the total nursing category by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.G. of this preamble) by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category salaries by the hospital's total salaries for ''nursing and all other'') and by the total nursing category's occupational mix adjustment factor (from Step 6 above).

The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted by the occupational mix. A hospital's all other portion is determined by subtracting the hospital's nursing category percentage from 100 percent.

Step 8—For each hospital, calculate the total occupational mix adjusted salaries and wage-related costs for a hospital by summing the occupational mix adjusted salaries and wage-related costs for the total nursing category (from Step 7) and the portion of the hospital's salaries and wage-related costs for all other employees (from Step 7).

To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.G. of this preamble).

Step 9—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The FY 2009 occupational mix adjusted national average hourly wage is $32.2449.

Step 11—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 9) by the national occupational mix adjusted average hourly wage (Step 10).

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above. The FY 2009 occupational mix adjusted Puerto Rico specific average hourly wage is $13.7851.

The table below is an illustrative example of the occupational mix adjustment.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	Provider Occupational Mix Salaries	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	National Adjusted Nurse AHW	Nurse Occupa-tional Mix Adjust-ment Factor	Provider % by Total
RN Management	202,387.00	$780,640.00	**9.84%**	$50.00	**$4.92**			
RN Staff	1,439,742.00	$17,345,123.00	**70.00%**	$30.00	**$21.00**			
LPNs	67,860.00	$404,822.00	**3.30%**	$20.00	**$0.66**			
Nurse Aides	259,177.00	$1,762,579.00	**12.60%**	$13.00	**$1.64**			
Medical Assistants	87,622.00	$577,045.00	**4.26%**	$12.00	**$0.51**			
Total Nurse Hours and Salaries	2,056,788.00	$20,870,209.00			**$28.73**	**$27.00**	**0.9398**	**52.40%**
					↑			
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**47.60%**
TOTAL	**7,056,788.00**	**$39,827,219.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	**$21.72**							
Nurse Occupational Mix Wages	**$41,030,019**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$39,655,400**	Step 7						

Total Occupational Mix Wages	**$80,685,419**	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	**$21.03**	Step 8						
Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupa-tional Mix Adjustm ent Factor**	**Provider % by Total**
RN Management	70,333.00	$680,650.00	**3.01%**	$50.00	**$1.51**			
RN Staff	1,430,114.00	$17,245,113.00	**61.27%**	$30.00	**$18.38**			
LPNs	159,795.00	$304,832.00	**6.85%**	$20.00	**$1.37**			
Nurse Aides	391,201.00	$2,762,589.00	**16.76%**	$13.00	**$2.18**			
Medical Assistants	282,728.00	$677,035.00	**12.11%**	$12.00	**$1.45**			
Total Nurse Hours and Salaries	2,334,171.00	$21,670,219.00			**$24.89**	**$27.00**	**1.0848**	**53.34%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**46.66%**
TOTAL	**7,334,171.00**	**$40,627,229.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$15,032,916**	Step 7						

All Other Unadjusted Occupational Mix Wages	**$12,122,355**	Step 7						
Total Occupational Mix Wages	**$27,155,271**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.74**	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

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Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the FY 2009 wage index.

For the FY 2008 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area (72 FR 47314). We believed this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's FY 2008 occupational mix adjusted wage index. We indicated in the FY 2008 IPPS final rule that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals (72 FR 47314).

For the FY 2009 wage index, as we proposed, we are handling the data for hospitals that did not respond to the occupational mix survey (neither the 1st quarter nor 2nd quarter data) in the same manner as discussed above for the FY 2008 wage index. In addition, if a hospital submitted survey data for either the 1st quarter or 2nd quarter, but not for both quarters, we are using the data the hospital submitted for one quarter to calculate the hospital's FY 2009 occupational mix adjustment factor. Lastly, if a hospital submitted a survey(s), but that survey data can not be used because we determine it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages were out of range (that is, unusually high or low), and the hospital did not provide sufficient documentation to explain the aberrancy, or the hospital did not submit any registered nurse staff salaries or hours data, we assigned the hospital the average occupational mix adjustment for the labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market area, we replicated Steps 1 through 6 of the calculation for the occupational mix adjustment. However, instead of performing these steps at the hospital level, we aggregated the data at the labor market area level. In following these steps, for example, for CBSAs that contain providers that did not submit occupational mix survey data, the occupational mix adjustment factor ranged from a low of 0.9060 (CBSA 12020, Athens-Clarke County, GA), to a high of 1.0805 (CBSA 22500, Florence, SC). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the area's total workers attributable to the area's total nursing category. For FY 2009, there are no CBSAs for which we did not have occupational mix data for any of its providers.

In the FY 2007 IPPS final rule, we also indicated that we would give serious consideration to applying a hospital-specific penalty if a hospital does not comply with regulations requiring submission of occupational mix survey data in future years. We stated that we believe that section 1886(d)(5)(I)(i) of the Act provides us with the authority to penalize hospitals that do not submit occupational mix survey data. That section authorizes us to provide for exceptions and adjustments to the payment amounts under IPPS as the Secretary deems appropriate. We also indicated that we would address this issue in the FY 2008 IPPS proposed rule.

In the FY 2008 IPPS proposed rule, we solicited comments and suggestions for a hospital-specific penalty for hospitals that do not submit occupational mix survey data. In response to the FY 2008 IPPS proposed rule, some commenters suggested a 1-percent to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. We noted that any penalty that we would determine for nonresponsive hospitals would apply to a future wage index, not the FY 2008 wage index.

In the FY 2008 final rule with comment period, we assigned nonresponsive hospitals the average occupational mix adjustment for the labor market area. For areas where no hospital submitted survey data, we applied the national occupational mix adjustment factor of 1.0000 in calculating the area's FY 2008 occupational mix adjusted wage index. We appreciate the suggestions we received regarding future penalties for hospitals that do not submit occupational mix survey data. We stated in the FY 2008 final rule with comment period that we may consider proposing a policy to penalize hospitals that do not submit occupational mix survey data for FY 2010, the first year of the application of the new 2007–2008 occupational mix survey, and that we expected that any such penalty would be proposed in the FY 2009 IPPS proposed rule so hospitals would be aware of the policy before the deadline for submitting the data to the fiscal intermediaries/MAC. However, in the FY 2009 IPPS proposed rule, we did not propose a penalty for FY 2010. Rather, we reserved the right to propose a penalty in the FY 2010 IPPS proposed rule, once we collect and analyze the FY 2007–2008 occupational mix survey data. Hospitals are still on notice that any failure to submit occupational mix data for the FY 2007–2008 survey year may result in a penalty in FY 2010, thus achieving our policy goal of ensuring that hospitals are aware of the consequences of failure to submit data in response to the most recent survey.

Comment: Several commenters reiterated the comment they had submitted previously with respect to the FY 2008 wage index (72 FR 47314) that full participation in the occupational mix survey is critical, and urged CMS to develop a methodology that encourages hospitals to report occupational mix survey data but does not unfairly penalize neighboring hospitals. The commenters also suggested that, if CMS decides to adopt a penalty for nonresponsive hospitals, CMS should establish an appeal process for hospitals with extenuating circumstances.

Response: We appreciate the commenters' continuous support for a policy to penalize hospitals that do not submit occupational mix survey data. As discussed above, we will consider proposing a penalty for the FY 2010 wage index after we analyze the results of the new 2007–2008 occupational mix survey, for which the data are due to CMS in the fall of 2008. (We refer readers to section III.D.3. of this preamble for a discussion of the 2007–2008 survey).

Comment: One commenter suggested that CMS' methodology for computing the occupational mix adjustment skews the results. The commenter stated that if CMS had selected a different use of the same data, a different and perhaps better adjustment could have resulted. However, the commenter offered no alternative methodology for computing the adjustment.

Response: We welcome the commenter to submit to us its recommendations for computing the occupational mix adjustment, or to identify specific components of our

methodology that it believes are problematic.

3. 2007–2008 Occupational Mix Survey for the FY 2010 Wage Index

As stated earlier, section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. We used occupational mix data collected on the 2006 survey to compute the occupational mix adjustment for FY 2009. In the FY 2008 IPPS final rule with comment period (72 FR 47315), we discussed how we modified the occupational mix survey. The revised 2007–2008 occupational mix survey provides for the collection of hospital-specific wages and hours data for the 1-year period of July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The revised 2007–2008 occupational mix survey will be applied beginning with the FY 2010 wage index.

On February 2, 2007, we published in the **Federal Register** a notice soliciting comments on the proposed revisions to the occupational mix survey (72 FR 5055). The comment period for the notice ended on April 3, 2007. After considering the comments we received, we made a few minor editorial changes and published the final 2007–2008 occupational mix survey on September 14, 2007 (72 FR 52568). OMB approved the survey without change on February 1, 2008 (OMB Control Number 0938–0907). The 2007–2008 Medicare occupational mix survey (Form CMS–10079 (2008)) is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*, and through the fiscal intermediaries/MAC. Hospitals must submit their completed surveys to their fiscal intermediaries/MAC by September 2, 2008. The preliminary, unaudited 2007–2008 occupational mix survey data will be released in early October 2008, along with the FY 2006 Worksheet S–3 wage data, for the FY 2010 wage index review and correction process.

E. Worksheet S–3 Wage Data for the FY 2009 Wage Index

The FY 2009 wage index values (effective for hospital discharges occurring on or after October 1, 2008, and before October 1, 2009, and to be published in a separate **Federal Register** notice subsequent to this final rule) will be based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2005 (the FY 2008 wage index was based on FY 2004 wage data).

1. Included Categories of Costs

The FY 2009 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty)
- Home office costs and hours
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315))
- Wage-related costs, including pensions and other deferred compensation costs. We note that, on March 28, 2008, CMS published a technical clarification to the cost reporting instructions for pension and deferred compensation costs (sections 2140 through 2142.7 of the Provider Reimbursement Manual, Part I). These instructions are used for developing pension and deferred compensation costs for purposes of the wage index, as discussed in the instructions for Worksheet S–3, Part II, Lines 13 through 20 and in the FY 2006 final rule (70 FR 47369).

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2008, the wage index for FY 2009 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The FY 2009 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

3. Use of Wage Index Data by Providers Other Than Acute Care Hospitals under the IPPS

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers. Such comments should be made in response to separate proposed rules for those providers.

F. Verification of Worksheet S–3 Wage Data

The wage data for the FY 2009 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2005 Medicare cost reports. Instructions for completing Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual (PRM), Part II, sections 3605.2 and 3605.3. The data file used to construct the wage index includes FY 2005 data submitted to us as of February 29, 2008. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MAC to revise or verify data elements that resulted in specific edit failures. For the proposed FY 2009 wage index, we identified and excluded 37 providers with data that was too aberrant to include in the proposed wage index, although we stated that if data elements for some of these providers were corrected, we intended to include some of these providers in the FY 2009 final wage index. However, because some unresolved data elements were included in the proposed FY 2009 wage index, we instructed fiscal intermediaries/MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 14, 2008. While the data for four hospitals were resolved, the data for two other hospitals were identified as too aberrant to include in the final wage index. Therefore, we determined that the data for 35 hospitals should not be included in the FY 2009 final wage index.

In constructing the FY 2009 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2005; inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness.

We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397). For this final rule, we removed 22 hospitals that converted to CAH status between February 16, 2007, the cut-off date for CAH exclusion from the FY 2008 wage index, and February 18, 2008, the cut-off date for CAH exclusion from the FY 2009 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the FY 2009 wage index is calculated based on 3,534 hospitals.

1. Wage Data for Multicampus Hospitals

In the FY 2008 final rule with comment period (72 FR 47317), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2009 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. The FY 2009 wage index in this final rule includes separate wage data for campuses of three multicampus hospitals.

For FY 2009, we are again allowing hospitals to use FTE or discharge data for the allocation of a multicampus hospital's wage data among the different labor market areas where its campuses are located. The Medicare cost report was updated in May 2008 to provide for the reporting of FTE data by campus for multicampus hospitals. Because the data from cost reporting periods that begin in FY 2008 will not be used in calculating the wage index until FY 2012, a multicampus hospital will still have the option, through the FY 2011 wage index, to use either FTE or discharge data for allocating wage data among its campuses by providing the information from the applicable cost reporting period to CMS through its fiscal intermediary/MAC. Two of the three multicampus hospitals chose to have their wage data allocated by their Medicare discharge data for the FY 2009 wage index. One of the hospitals provided FTE staff data for the allocation. The average hourly wage associated with each geographical location of a multicampus hospital is reflected in Table 2 of the Addendum to this final rule.

2. New Orleans' Post-Katrina Wage Index

Since 2005 when Hurricane Katrina devastated the Gulf States, we have received numerous comments suggesting that current Medicare payments to hospitals in New Orleans, Louisiana are inadequate, and the wage index does not accurately reflect the increase in labor costs experienced by the city after the storm. The post-Katrina effects on the New Orleans wage index will not be realized in the wage index until FY 2010, when the wage index will be based on cost reporting periods beginning during FY 2006 (that is, beginning on or after October 1, 2005 and before October 1, 2006).

In responding to the health-related needs of people affected by the hurricane, the Federal Government, through the Deficit Reduction Act of 2005 (DRA), appropriated $2 billion in FY 2006. These funds allowed the Secretary to make available $160 million in February 2007 to Louisiana, Mississippi, and Alabama for payments to hospitals and skilled nursing facilities facing financial stress because of changing wage rates not yet reflected in Medicare payment methodologies. In March and May 2007, the Department provided two additional DRA grants of $15 million and $35 million, respectively, to Louisiana for professional health care workforce recruitment and sustainability in the greater New Orleans area, namely the Orleans, Jefferson, St. Bernard, and Plaquemines Parishes. In addition, the Department issued a supplemental award of $60 million in provider stabilization grant funding to Louisiana, Mississippi, and Alabama to continue to help health care providers meet changing wage rates not yet reflected by Medicare's payment policies. On July 23, 2007, HHS awarded to Louisiana a new $100 million Primary Care Grant to help increase access to primary care in the Greater New Orleans area. The resulting stabilization and expansion of the community based primary care infrastructure, post Katrina, helps provide a viable alternative to local hospital emergency rooms for all citizens of New Orleans, especially those who are poor and uninsured. In other Department efforts, the OIG has performed an in-depth review of the post-Katrina infrastructure of five New Orleans hospitals, including the hospitals' staffing levels and wage costs. The OIG's final reports and recommendations, which were published in the Spring of 2008, are available on the following Web site: *http://oig.hhs.gov/oas/cms.html*.

G. Method for Computing the FY 2009 Unadjusted Wage Index

The method used to compute the FY 2009 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the FY 2009 wage index on wage data reported on the FY 2005 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2004, and before October 1, 2005. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2004 and reported a cost reporting period covering all of FY 2004. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2005 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2005 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2004, and before October 1, 2005), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. (We note that, beginning with FY 2008 (72 FR 47315), we include lines 22.01, 26.01, and 27.01 of Worksheet S–3, Part II for overhead services in the wage index. However, we note that the wages and hours on these lines are not incorporated into line 101, column 1 of Worksheet A, which, through the electronic cost reporting software, flows directly to line 1 of Worksheet S–3, Part II. Therefore, the first step in the wage index calculation for FY 2009 is to compute a ''revised'' Line 1, by adding to the Line 1 on Worksheet S–3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01,

6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours because hospitals typically do not provide fringe benefits (wage-related costs) to contract personnel. Therefore, it is not necessary for the wage index calculation to exclude overhead wage-related costs for contract personnel. Further, if a hospital does contribute to wage-related costs for contracted personnel, the instructions for lines 22.01, 26.01, and 27.01 require that associated wage-related costs be combined with wages on the respective contract labor lines.); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2003, through April 15, 2005, for private industry hospital workers from the BLS' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. We also note that, since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SICs), which no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and did not propos to make any changes to the usage for FY 2009. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/2004	11/15/2004	1.05390
11/14/2004	12/15/2004	1.05035
12/14/2004	01/15/2005	1.04690

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
01/14/2005	02/15/2005	1.04342
02/14/2005	03/15/2005	1.03992
03/14/2005	04/15/2005	1.03641
04/14/2005	05/15/2005	1.03291
05/14/2005	06/15/2005	1.02940
06/14/2005	07/15/2005	1.02596
07/14/2005	08/15/2005	1.02264
08/14/2005	09/15/2005	1.01943
09/14/2005	10/15/2005	1.01627
10/14/2005	11/15/2005	1.01308
11/14/2005	12/15/2005	1.00987
12/14/2005	01/15/2006	1.00661
01/14/2006	02/15/2006	1.00333
02/14/2006	03/15/2006	1.00000
03/14/2006	04/15/2006	0.99670

For example, the midpoint of a cost reporting period beginning January 1, 2005, and ending December 31, 2005, is June 30, 2005. An adjustment factor of 1.02596 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2005 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage (unadjusted for occupational mix) is $32.2696.

Step 9—For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7

by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage (unadjusted for occupational mix) of $13.7956 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. The areas affected by this provision will be identified in Table 4D–2 that is to be published in a separate **Federal Register** subsequent to this final rule.

In the FY 2005 IPPS final rule (69 FR 49109), we adopted the ''imputed'' floor as a temporary 3-year measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. The imputed floor was originally set to expire in FY 2007, but we are extending it an additional year in the FY 2008 IPPS final rule with comment period (72 FR 47321). As explained in section III.B.2.b. of the preamble of this final rule, we are extending the imputed floor for an additional 3 years, through FY 2011.

H. Analysis and Implementation of the Occupational Mix Adjustment and the FY 2009 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2009, we apply the occupational mix adjustment to 100 percent of the FY 2009 wage index. We calculated the occupational mix adjustment using data from the 2006 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the first and second quarter occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2009 wage index results in a national average hourly wage of $32.2449 and a Puerto-Rico specific average hourly wage of $13.7851. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2005 Worksheet S–3 cost report data for use in calculating the FY 2009 wage index, we calculated the FY 2009 wage index using the occupational mix survey data from 3,365 hospitals. Using the Worksheet S–3 cost report data of 3,534 hospitals and occupational mix first and/or second quarter survey data from 3,365 hospitals represents a 95.2 percent survey response rate. The FY 2009 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN Management	$38.6364
National RN Staff	33.4698
National LPN	19.2364
National Nurse Aides, Orderlies, and Attendants	13.6892
National Medical Assistants	15.7714
National Nurse Category	28.7265

The national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $28.7265. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the January through June 2006 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the national percentage of hospital employees in the Nurse category is 42.97 percent, and the national percentage of hospital employees in the All Other Occupations category is 57.03 percent. At the CBSA level, the percentage of hospital employees in the Nurse category ranged from a low of 27.26 percent in one CBSA, to a high of 85.30 percent in another CBSA.

The final wage index values for FY 2009 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) will be shown in Tables 4A, 4B, 4C, and 4F that are to be published in a separate **Federal Register** notice subsequent to this final rule.

Tables 3A and 3B in the Addendum to this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals based on FYs 2007, 2008, and 2009 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 2003 and FY 2004 cost reporting periods, as well as the FY 2005 period used to calculate the FY 2009 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

The wage index values in Tables 4A, 4B, 4C, and 4F (to be published in a subsequent **Federal Register** notice) will include the occupational mix adjustment. The average hourly wages in Tables 2, 3A, and 3B in the Addendum to this final rule include the occupational mix adjustment. The wage index values in Tables 4A, 4B, and 4C in the separate issuance also will include the State-specific rural floor and imputed floor budget neutrality adjustments that are discussed in section III.B.2. of this preamble. The State budget neutrality adjustments for the rural and imputed floors will be included in Table 4D–1 in a separate **Federal Register** notice to be published subsequent to this final rule.

I. Revisions to the Wage Index Based on Hospital Redesignations

1. General

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The

regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use average hourly wage data from the 3 most recently published hospital wage surveys in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at 42 CFR 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. In light of the CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. Eligible counties are discussed and identified under section III.I.5. of this preamble.

2. Effects of Reclassification/ Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals are applicable both to the hospitals deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS has also adopted the following policies:

- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- In cases where urban hospitals have reclassified to rural areas under 42 CFR 412.103, the urban hospital wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located.

3. FY 2009 MGCRB Reclassifications

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in 42 CFR 412.230 through 412.280.

At the time this final rule was constructed, the MGCRB had completed its review of FY 2009 reclassification requests. Based on such reviews, there were 314 hospitals approved for wage index reclassifications by the MGCRB for FY 2009. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2009, hospitals reclassified during FY 2007 or FY 2008 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 175 hospitals approved for wage index reclassifications in FY 2007 and 324 hospitals approved for wage index reclassifications in FY 2008. Of all of the hospitals approved for reclassification for FY 2007, FY 2008, and FY 2009, based upon the review at the time of the final rule, 813 hospitals are in a reclassification status for FY 2009.

Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB were permitted to withdraw their applications within 45 days of the publication of the proposed rule. Generally stated, the request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2009 had to be received by the MGCRB within 45 days of the publication of the proposed rule. (We note that special rules for areas affected by section 124 of Pub. L. 110–275 are discussed in section III.I.7. of this preamble.) Hospitals may also cancel prior reclassification withdrawals or terminations in certain circumstances. For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to 42 CFR 412.273, as well as the August 1, 2002, IPPS final rule (67 FR 50065), and the August 1, 2001, IPPS final rule (66 FR 39887).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in a separate **Federal Register** notice, in response to section 124 of Public Law 110–275 (see section III.I.7. of this preamble). These changes affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index that includes the data for

both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may have been affected.

Applications for FY 2010 reclassifications are due to the MGCRB by September 2, 2008 (the first working day of September 2008). We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2008, via the CMS Internet Web site at: *http://cms.hhs.gov/providers/prrb/mgcinfo.asp,* or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

4. FY 2008 Policy Clarifications and Revisions

We note below several policies related to geographic reclassification that were clarified or revised in the FY 2008 IPPS final rule with comment period (72 FR 47333):

- *Reinstating Reclassifications*—As provided for in 42 CFR 412.273(b)(2), once a hospital (or hospital group) accepts a newly approved reclassification, any previous reclassification is permanently terminated.
- *Geographic Reclassification for Multicampus Hospitals*—Because campuses of a multicampus hospital can now have their wages and hours data allocated by FTEs or discharge data, a hospital campus located in a geographic area distinct from the geographic area associated with the provider number of the multicampus hospital will have official wage data to supplement an individual or group reclassification application (§ 412.230(d)(2)(v)).
- *New England Deemed Counties*—Hospitals in New England deemed counties are treated the same as Lugar hospitals in calculating the wage index. That is, the area is considered rural, but the hospitals within the area are deemed to be urban (§ 412.64(b)(3)(ii)).
- *''Fallback'' Reclassifications*—A hospital will automatically be given its most recently approved reclassification (thereby permanently terminating any previously approved reclassifications) unless it provides written notice to the MGCRB within 45 days of publication of the notice of proposed rulemaking that it wishes to withdraw its most recently approved reclassification and ''fall back'' to either its prior reclassification or its home area wage index for the following fiscal year.

5. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act

Section 1886(d)(8)(B) of the Act requires us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met. Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals qualify under section 1886(d)(8)(B) of the Act to receive the wage index of the urban area. Hospitals located in these counties have been known as ''Lugar'' hospitals and the counties themselves are often referred to as ''Lugar'' counties. We provide the FY 2009 chart below with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act. For discharges occurring on or after October 1, 2008, hospitals located in the rural county in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT

[Based on CBSAs and census 2000 data]

Rural county	CBSA
Cherokee, AL	Rome, GA.
Macon, AL	Auburn-Opelika, AL.
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN-GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA-AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis-Carmel, IN.
Spencer, IN	Evansville, IN-KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT—Continued

[Based on CBSAs and census 2000 data]

Rural county	CBSA
Assumption Parish, LA	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Davidson, NC	Greensboro-High Point, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC.
Polk, NC	Spartanburg, SC.
Los Alamos, NM	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Plano-Irving, TX.
Milam, TX	Austin-Round Rock, TX.
Van Zandt, TX	Dallas-Plano-Irving, TX.
Willacy, TX	Brownsville-Harlingen, TX.
Buckingham, VA	Charlottesville, VA.
Floyd, VA	Blacksburg-Christiansburg-Radford, VA.
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA	Winchester, VA-WV.
Island, WA	Seattle-Bellevue-Everett, WA.
Mason, WA	Olympia, WA.
Wahkiakum, WA	Longview, WA.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI	Fond du Lac, WI.
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI.
Walworth, WI	Milwaukee-Waukesha-West Allis, WI.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor

market area in Table 4C in the Addendum to the proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals could have withdrawn from an MCGRB reclassification within 45 days of the publication of the proposed rule. (We refer readers also to section III.I.7. of the preamble of this final rule for special withdrawal and termination rules that apply to areas affected by section 124 of Pub. L. 110–275.)

6. Reclassifications Under Section 1886(d)(8)(B) of the Act

As discussed in last year's FY 2008 IPPS final rule with comment period (72 FR 47336–47337), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index (Table 4C in a separate notice to be published in the **Federal Register** subsequent to this final rule) for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MCGRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). As discussed in section III.B.2.a. of the preamble of this final rule, beginning with the FY 2010 wage index we will be phasing in regulatory changes, so that the hospital must also demonstrate that its average hourly wage is equal to at least 84 percent (in FY 2010) and 86 percent (beginning in FY 2011) of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement. As discussed in the FY 2008 final rule with comment period, we treat New England deemed counties in a manner consistent with how we treat Lugar counties. (We refer readers to 72 FR 47337 for a discussion of this policy.)

7. Reclassifications Under Section 508 of Public Law 108–173

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275 was enacted. Section 124 of Public Law 110–275 extends through FY 2009 wage index reclassifications under section 508 of Public Law 108–173 and certain special exceptions (for example, those special exceptions contained in the final rule promulgated in the **Federal Register** on August 11, 2004 (69 FR 49105, 49107)) and extended under section 117 of the MMSEA of 2007 (Pub. L. 110–173).

Under section 508 of Public Law 108–173, a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary), to an area within a contiguous State. We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661), and February 13, 2004 (69 FR 7340). Such reclassifications were applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Section 106(a) of the MIEA–TRHCA extended any geographic reclassifications of hospitals that were made under section 508 and that would expire on March 31, 2007. On March 23, 2007, we published a notice in the **Federal Register** (72 FR 13799) that indicated how we were implementing section 106(a) of the MIEA–TRHCA through September 30, 2007. Section 117 of the MMSEA further extended section 508 reclassifications and special exceptions through September 30, 2008. On February 22, 2008, we published a notice in the **Federal Register** (73 FR 9807) regarding our implementation of section 117 of the MMSEA.

Section 124 of Public Law 110–275 has now extended the hospital reclassifications provisions of section 508 and certain special exceptions through September 30, 2009 (FY 2009). Because of the timing of enactment of Public Law 110–275, we are not able to recompute the FY 2009 wage index values for any hospital that would be reclassified under the section 508 and special exceptions provisions in time for inclusion in this final rule. Instead, we will issue the final FY 2009 wage index values and other related tables, as specified in the Addendum to this final rule, in a separate **Federal Register** notice implementing this extension that will be published subsequent to this final rule. We will analyze the data of hospitals in labor market areas affected by this extension, including hospitals with Lugar redesignations, and make our best efforts to give those hospitals a wage index value that we believe results in the highest FY 2009 wage index for which they are eligible. The intervening legislation potentially affects only those areas that include the hospitals whose reclassifications or special exceptions were extended, as well as areas to which such hospitals were reclassified for FY 2009. Therefore, we want to make clear that we will not be choosing wage index values for hospitals that are reclassified to or located in areas containing no hospitals whose reclassifications or exceptions were extended by section 124 of Public Law 110–275.

Hospitals will have 15 days from the date of publication of the separate notice to notify us if they wish to revise the decision that CMS makes on their behalf. Members of a group reclassification must ensure that all members of the group (except hospitals whose reclassifications were extended by section 124 of Pub. L. 110–275) have signed the revision request. Written requests to revise CMS' wage index decision must be received at the following address by no later than 5 p.m. EST 15 days from the date of publication of the separate notice in the **Federal Register**: Division of Acute Care, Center for Medicare Management, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Brian Slater.

If we do not receive notice from the hospital within this 15-day timeframe, the determination made by CMS on behalf of the hospital in the separate notice will be deemed final for FY 2009. We will not further recalculate the wage indices or standardized amounts based on hospitals' decisions that further revise decisions made by CMS on the hospitals' behalf. If CMS makes a decision on a hospital's behalf to terminate or withdraw a reclassification so that a hospital will receive a higher qualifying wage index for FY 2009, and the hospital does not reverse or modify CMS' decision within the 15-day timeframe, we will deem the hospital's reclassification is withdrawn or terminated for FY 2009 only, as section 508 reclassifications and special

exceptions are only extended through FY 2009. Such hospitals, if there is at least one remaining year in their 3-year reclassification, will automatically have their MGCRB reclassification reinstated for FY 2010. Thus, for example, if we assign a hospital a section 508 reclassification wage index for FY 2009 and the hospital had been previously granted a reclassification by the MGCRB for FY 2008 through 2010, the hospital's previous reclassification would be automatically reinstated for the remaining year, FY 2010. By the same token, if the omission of a section 508 or special exception hospital from the calculation of the reclassification wage index in Table 4C of the separate issuance results in the reclassification wage index decreasing to the point that a hospital should have terminated its MGCRB reclassification for FYs 2008 through 2010 and accepted its home wage index, we will withdraw or terminate the reclassification on the hospital's behalf. However, such reclassification will then be automatically reinstated for FY 2010. In the case that a hospital had a choice for FY 2009 of two overlapping possible MGCRB 3-year reclassifications, and one such MGCRB reclassification is assigned to the hospital via the process discussed above, then the reclassification not accepted would be permanently terminated. Likewise, if the hospital with the choice of two overlapping MGCRB reclassifications is a section 508 or special exception hospital that receives the section 508 or special exception wage index for FY 2009, then only the reclassification that the hospital had originally chosen for FY 2009 will be reinstated, and the other reclassification will be permanently terminated. In other words, in accordance with our current rules with regard to overlapping MGCRB reclassifications, a hospital will not be permitted to hold in reserve two possible MGCRB reclassifications through these procedures. In addition, if CMS believes that waiving a hospital's Lugar redesignation in order for the hospital to receive its home area wage index plus its out-migration adjustment results in the highest possible wage index for the hospital, and the hospital does not notify CMS within the 15-day timeframe to revise CMS' decision, such waiver will only apply to the FY 2009 wage index.

Our special procedural rules for FY 2009 are authorized under section 1886(d)(10)(D)(v) of the Act, which requires the Secretary to ''establish procedures under which a subsection (d) hospital may elect to terminate'' a reclassification. While the section authorizes the Secretary to establish procedures, it does not dictate the specifics of such procedures. Given the intervening legislation for FY 2009, and the need to expeditiously engage in a series of recalculations for FY 2009, we believe the most reasonable course at this point is for us to make our best efforts to give affected hospitals their highest wage index values, and then allow hospitals to opt out of such selections.

The special procedural rules will be effective upon publication and supersede conflicting procedures included in 42 CFR 412.273. Because these rules are effective only for FY 2009, we are not revising the general rules included in the regulation at § 412.273.

J. FY 2009 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the ''out-migration'' adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. Beginning with the FY 2008 wage index, we use post-reclassified wage indices when determining the out-migration adjustment (72 FR 47339).

For the FY 2009 wage index, we will calculate the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage index areas, multiply this result by the result obtained in Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage index area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 2008 will be eligible to retain the adjustment for FY 2009. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2008.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FY 2005, 2006, 2007, and 2008 IPPS final rules, we are specifying that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, had to

follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of the proposed rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act were deemed to have waived the out-migration adjustment, unless they explicitly notified CMS within 45 days from the publication of the proposed rule that they elected to receive the out-migration adjustment instead. (However, we refer readers to section III.I.7. of the preamble of this final rule for special rules for hospitals in areas affected by section 124 of Pub. L. 110–275.)

Table 4J in the Addendum to this final rule lists the out-migration wage index adjustments for FY 2009. A revised table 4J will be published in a separate **Federal Register** notice, as explained in section III.I.7. of this preamble. Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act (or who receive certain special reclassifications or exceptions under section 124 of Pub. L. 110–275) will automatically receive the listed adjustment. In accordance with the procedures discussed above, except as discussed in section III.I.7. of the preamble of this final rule, redesignated/reclassified hospitals are deemed to have waived the out-migration adjustment unless CMS was otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdrew their application for reclassification should receive the wage index adjustment listed in the final Table 4J (a tentative Table 4J is included in the Addendum to this final rule but will be updated in the separate **Federal Register** notice discussed in section III.I.7. of this preamble).

K. Process for Requests for Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data and occupational mix survey data files for the FY 2009 wage index were made available on October 5, 2007, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we posted an additional public use file on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this new file did not alter the current wage index process or schedule. We notified the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door forum. We encouraged hospitals to sign up for automatic notifications of information about hospital issues and the scheduling of the Hospital Open Door forums at: *http://www.cms.hhs.gov/OpenDoorForums/*.

In a memorandum dated October 5, 2007, we instructed all fiscal intermediaries/MACs to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries/MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 5, 2007 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary/MAC by December 7, 2007. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data files on the Internet, through the October 5, 2007 memorandum referenced above.

In the October 5, 2007 memorandum, we also specified that a hospital requesting revisions to its first and/or second quarter occupational mix survey data was to copy its record(s) from the CY 2006 occupational mix preliminary files posted to our Web site in October, highlight the revised cells on its spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal intermediary/MAC no later than December 7, 2007.

The fiscal intermediaries (or, if applicable, the MACs) notified the hospitals by mid-February 2008 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries/MACs also submitted the revised data to CMS by mid-February 2008. CMS published the proposed wage index public use files that included hospitals' revised wage index data on February 25, 2008. In a memorandum also dated February 25, 2008, we instructed fiscal intermediaries/MACs to notify all hospitals regarding the availability of the proposed wage index public use files and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 11, 2008, to submit requests to the fiscal intermediaries/MACs for reconsideration of adjustments made by the fiscal intermediaries/MACs as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/MACs were required to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2008. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations was April 21, 2008.

Hospitals were given the opportunity to examine Table 2 in the Addendum to the proposed rule. Table 2 in the Addendum to the proposed rule contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2005 data used to construct the proposed FY 2009 wage index. We noted that the hospital average hourly wages shown in Table 2 only reflected changes made to a hospital's data and transmitted to CMS by February 29, 2008.

We released the final wage index data public use files in early May 2008 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*. The May 2008 public use files were made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary/MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the fiscal intermediaries/MACs by April 14, 2008). If, after reviewing the May 2008 final files, a hospital believed that its wage or occupational mix data were incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital had to send a letter to both its fiscal intermediary/MAC and CMS that outlined why the hospital believed an error existed and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable,

the MACs) had to receive these requests no later than June 9, 2008.

Each request also had to be sent to the fiscal intermediary/MAC. The fiscal intermediary/MAC reviewed requests upon receipt and contacted CMS immediately to discuss any findings.

At this point in the process, that is, after the release of the May 2008 wage index data files, changes to the wage and occupational mix data were only made only in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS approved the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 21, 2008.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 25, 2008 wage index public use files.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MACs (that is, by June 9, 2008) were incorporated into the final wage index in this FY 2009 IPPS final rule, which will be effective October 1, 2008.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2009 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's (or, if applicable the MAC's) decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W. A. Foote Memorial Hospital* v. *Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003).) We refer readers also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention. Moreover, because hospitals had access to the final wage index data by early May 2008, they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2009 wage index by August 1, 2008, and the implementation of the FY 2009 wage index on October 1, 2008. If hospitals availed themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 9, 2008, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, ''before the beginning of the fiscal year'' means by the June 9th deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, because CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries or the MAC notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or if applicable the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 9, 2008 deadline for the FY 2009 wage index); and (3) CMS agreed that the fiscal intermediary (or if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June 9th deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS' or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; and it can only be used for the current Federal fiscal year. In other situations where our policies would allow midyear corrections, we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

L. Labor-Related Share for the Wage Index for FY 2009

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: ''The Secretary shall

adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *''. We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of Public Law 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this ''would result in lower payments to a hospital than would otherwise be made.'' However, this provision of Public Law 108–173 did not change the legal requirement that the Secretary estimate ''from time to time'' the proportion of hospitals' costs that are ''attributable to wages and wage-related costs.'' We interpret this to mean that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

We have continued our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

In the FY 2006 IPPS final rule (70 FR 47392), we presented our analysis and conclusions regarding the methodology for updating the labor-related share for FY 2006. We also recalculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket for discharges occurring on or after October 1, 2005. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. In this final rule, as we proposed, we are not making any changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we are continuing to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2008. Tables 1A and 1B in the Addendum to this final rule reflect this labor-related share. However, as noted in the Addendum, these figures are tentative only and will be revised as a result of section 124 of Public Law 110–275 in a separate **Federal Register** notice to be published subsequent to this final rule. We note that section 403 of Public Law 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment ''would result in lower payments to a hospital than would otherwise be made.''

As we proposed, we also are continuing to use a labor-related share for the Puerto Rico-specific standardized amounts of 58.7 percent for discharges occurring on or after October 1, 2008. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, nonmedical professional fees, and other labor-intensive services to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. A Puerto Rico-specific wage index is applied to the Puerto Rico-specific portion of payments to the hospitals. The labor-related share of a hospital's Puerto Rico-specific rate will be either 62 percent or the Puerto Rico-specific labor-related share depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 58.7 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The Puerto Rico labor-related share of 58.7 percent for FY 2008 is reflected in the tentative Table 1C of the Addendum to this final rule. (As explained in this preamble and the Addendum to this final rule, section 124 of Pub. L. 119–275 will require us to recalculate the final rates and publish such rates in a separate **Federal Register** notice.)

IV. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Changes to the Postacute Care Transfer Policy (§ 412.4)

1. Background

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another. Section 412.4(c) establishes the conditions under which we consider a discharge to be a transfer for purposes of our postacute care transfer policy. In accordance with § 412.4(f), in transfer situations, the transferring hospital is paid based on a per diem rate for each day of the stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full MS–DRG payment by the geometric mean length of stay for the MS–DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 5804), our policy generally provides for payment that is double the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full DRG payment (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases (adjusted for geographic variations in costs), divided by the geometric mean length of stay for the MS–DRG, multiplied by the length of stay for the case plus one day. The purpose of the IPPS postacute care transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital, a SNF, or home under a written plan of care for home health services early in the patients' stay in order to minimize costs while still receiving the full MS–DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Beginning with the FY 2006 IPPS, the regulations at § 412.4 specified that, effective October 1, 2005, a DRG would be subject to the postacute care transfer policy if, based on Version 23.0 of the DRG Definitions Manual (FY 2006), using data from the March 2005 update of FY 2004 MedPAR file, the DRG meets the following criteria:

- The DRG had a geometric mean length of stay of at least 3 days;
- The DRG had at least 2,050 postacute care transfer cases; and
- At least 5.5 percent of the cases in the DRG were discharged to postacute care prior to the geometric mean length of stay for the DRG.

In addition, if the DRG was one of a paired set of DRGs based on the presence or absence of a CC or major cardiovascular condition (MCV), both paired DRGs would be included if either one met the three criteria above.

If a DRG met the above criteria based on the Version 23.0 DRG Definitions Manual and FY 2004 MedPAR data, we made the DRG subject to the postacute care transfer policy. We noted in the FY 2006 final rule that we would not revise the list of DRGs subject to the postacute care transfer policy annually unless we made a change to a specific CMS DRG. We established this policy to promote certainty and stability in the postacute care transfer payment policy. Annual reviews of the list of CMS DRGs subject to the policy would likely lead to great volatility in the payment methodology with certain DRGs qualifying for the policy in one year, deleted the next year, only to be reinstated the following year. However, we noted that, over time, as treatment practices change, it was possible that some CMS DRGs that qualified for the policy will no longer be discharged with great frequency to postacute care. Similarly, we explained that there may be other CMS DRGs that at that time had a low rate of discharges to postacute care, but which might have very high rates in the future.

The regulations at § 412.4 further specify that if a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first became effective, using the most recent complete year of MedPAR data:

- The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs; and
- The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs. A short-stay discharge is a discharge before the geometric mean length of stay for the DRG.

A DRG also is a qualifying DRG if it is paired with another DRG based on the presence or absence of a CC or MCV that meets either of the above two criteria.

The MS–DRGs that we adopted for FY 2008 were a significant revision to the CMS DRG system (72 FR 47141). Because the MS–DRGs were not reflected in Version 23.0 of the DRG Definitions Manual, consistent with § 412.4, we established policy to recalculate the 55th percentile thresholds in order to determine which MS–DRGs would be subject to the postacute care transfer policy (72 FR 47186 through 47188). Further, under the MS–DRGs, the subdivisions within the base DRGs are different than those under the previous CMS DRGs. Unlike the CMS DRGs, the MS–DRGs are not divided based on the presence or absence of a CC or MCV. Rather, the MS–DRGs have up to three subdivisions based on: (1) The presence of an MCC; (2) the presence of a CC; or (3) the absence of either an MCC or a CC. Consistent with our previous policy under which both CMS DRGs in a CC/non-CC pair were qualifying DRGs if one of the pair qualified, we established that each MS–DRG that shared a base MS–DRG will be a qualifying DRG if one of the MS–DRGs that shared the base DRG qualifies. We revised § 412.4(d)(3)(ii) to codify this policy.

Similarly, the adoption of the MS–DRGs also necessitated a revision to one of the criteria used in § 412.4(f)(5) of the regulations to determine whether a DRG meets the criteria for payment under the ''special payment methodology.'' Under the special payment methodology, a case subject to the special payment methodology that is transferred early to a postacute care setting will be paid 50 percent of the total IPPS payment (excluding any outlier payments and add-on payments for new technology) plus the average per diem for the first day of the stay. In addition, the hospital will receive 50 percent of the per diem amount for each subsequent day of the stay, up to the full MS–DRG payment amount. A CMS DRG was subject to the special payment methodology if it met the criteria in the regulations under § 412.4(f)(5). Section 412.4(f)(5)(iv) specifies that, for discharges occurring on or after October 1, 2005, and prior to October 1, 2007, if a DRG meets the criteria specified under § 412.4(f)(5)(i) through (f)(5)(iii), any DRG that is paired with it based on the presence or absence of a CC or MCV is also subject to the special payment methodology. Given that this criterion was no longer applicable under the MS–DRG system, in the FY 2008 IPPS final rule with comment period, we added a new § 412.4(f)(6) (42 FR 47188 and 47410). Section 412.4(f)(6) provides that, for discharges on or after October 1, 2007, if an MS–DRG meets the criteria specified under §§ 412.4(f)(6)(i) through (f)(6)(iii), any other MS–DRG that is part of the same MS–DRG group is also subject to the special payment methodology. We updated this criterion so that it conformed to the changes associated with adopting MS–DRGs for FY 2008. The revision makes an MS–DRG subject to the special payment methodology if it shares a base MS–DRG with an MS–DRG that meets the criteria for receiving the special payment methodology.

Section 1886(d)(5)(J) of the Act provides that, effective for discharges on or after October 1, 1998, a ''qualified discharge'' from one of DRGs selected by the Secretary to a postacute care provider would be treated as a transfer case. This section required the Secretary to define and pay as transfers all cases assigned to one of the DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary). In the FY 1999 IPPS final rule (63 FR 40975 through 40976 and 40979 through 40981), we specified that a patient discharged to home would be considered transferred to postacute care if the patient received home health services within 3 days after the date of discharge. In addition, in the FY 1999 IPPS final rule, we did not include patients transferred to a swing-bed for skilled nursing care in the definition of postacute care transfer cases (63 FR 40977).

2. Policy Change Relating to Transfers to Home with a Written Plan for the Provision of Home Health Services

As noted above, in the FY 1999 IPPS final rule (63 FR 40975 through 40976 and 40979 through 40981), we determined that 3 days is an appropriate period within which home health services should begin following a beneficiary's discharge to the home in order for the discharge to be considered a ''qualified discharge'' subject to the payment adjustment for postacute care transfer cases. In that same final rule, we noted that we would monitor whether 3 days would remain an appropriate timeframe.

Section 1886(d)(5)(J)(ii)(III) of the Act provides that the discharge of an individual who receives home health services upon discharge will be treated as a transfer if ''such services are provided within an appropriate period (as determined by the Secretary. * * *''. The statute thus confers upon the Secretary the authority to determine an appropriate timeframe for the application of the postacute care transfer policy in cases where home health services commence subsequent to discharge from an acute care hospital. In the FY 1999 final IPPS rule, we established the policy that the postacute care transfer policy would apply to cases in which the home health care begins within 3 days after the date of discharge from an acute care hospital. We noted in that rule that we did not believe that it was appropriate to limit the transfer definition to cases in which home health care begins on the same day as the patient is discharged from the hospital. We observed that data indicated that less than 8 percent of discharged patients who receive home health care begin receiving those services on the date of discharge. We stated that we did not believe that it was reasonable to expect that patients who are discharged later in the day would receive a home health visit that same day. Furthermore, we believed that the financial incentive to delay needed home health care for only a matter of hours would be overwhelming if we limited the timeframe to one day. At the time of that final rule, we explained that we believed that 3 days would be a more appropriate timeframe because it would mitigate the incentive to delay home health services to avoid the application of the postacute care transfer policy, and because a 3-day timeframe was consistent with existing patterns of care.

In that final rule, we also noted that a number of commenters had raised issues and questions concerning the proposal to adopt 3 days as the appropriate timeframe for the application of the postacute care transfer policy in these cases. While most of the commenters advocated shorter timeframes, on the grounds that postacute care beginning 3 days after a discharge should not be considered a substitute for inpatient hospital care, others suggested that a 3-day window might still allow for needlessly prolonged hospital care or delayed home health in order to avoid the application of the postacute care transfer policy. Although MedPAC agreed with the commenters who asserted that home health care services furnished after a delay of more than one day may not necessarily be regarded as substituting for inpatient acute care, they also noted that a 3-day window allows for the fact that most home health patients do not receive care every day, as well as for those occasions in which there may be a delay in arranging for the provision of planned care (for example, an intervening weekend). MedPAC also stated that a shorter period may create a stronger incentive to delay the provision of necessary care beyond the window so that the hospital will receive the full DRG payment. In the light of these comments and, in particular, of the concern that a 3-day timeframe still allowed for some incentive to delay necessary home health services in order to avoid the application of the postacute care transfer policy, we indicated that we would continue to monitor this policy in order to track any changes in practices that may indicate the need for revising the window.

Since the adoption of this policy in FY 1999, we have continued to receive reports that some providers discharge patients prior to the geometric mean length of stay but intentionally delay home health services beyond 3 days after the acute hospital discharge in order to avoid the postacute care transfer payment adjustment policy. These reports, and the concerns expressed by some commenters in FY 1999 about the adequacy of a 3-day window to reduce such incentives, have prompted us to examine the available data concerning the initiation and program payments for home health care subsequent to discharge from postacute care.

We merged the FY 2004 MedPAR file with postacute care bill files matching beneficiary identification numbers and discharge and admission dates and looked at the 10 DRGs that were subject to the postacute care transfer policy from FYs 1999 through 2003 (DRG 14 (Intracranial Hemorrhage and Stroke with Infarction (formerly ''Specific Cerebrovascular Disorders Except Transient Ischemic Attack'')); DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe); DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity); DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 with CC); DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 without CC); DRG 236 (Fractures of Hip and Pelvis); DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC); DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC); DRG 429 (Organic Disturbances and Mental Retardation); and DRG 483 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses (formerly ''Tracheostomy Except for Face, Mouth, and Neck Diagnoses'')). We selected the original 10 ''qualified DRGs'' because they were the DRGs to which the postacute care transfer policy applied for FYs 1999 through 2003 and because we expect that trends that we found in the data with those DRGs would be likely to accurately reflect provider practices after the inception of the postacute care transfer policy. We expect that provider practices for the original 10 DRGs would be consistent even with the expansion of the DRGs that are subject to the postacute care transfer policy. We note that providers may have even a greater incentive to delay the initiation of home health care in an effort to avoid the postacute care transfer policy now that there are more DRGs to which the policy applies. We compared data on home health services provided to patients who were discharged prior to the geometric mean length of stay to patients who were discharged at or beyond the geometric mean length of stay. For purposes of this analysis, we assumed that home health was the first discharge designation from the acute care hospital setting.

The data showed that, on average, the Medicare payment per home health visit was higher for patients who were discharged prior to the geometric mean length of stay (as compared to patients who were discharged at or beyond the geometric mean length of stay). Specifically, we found that average Medicare payments per home health care visit were consistently higher for patients discharged prior to the geometric mean length of stay than for patients discharged at or after the geometric mean length of stay. The average home health care per visit

payments for patients treated for the relevant DRGs and discharged before the geometric mean length of stay are $204 when the initiation of home health care began on the second day after discharge, $199 on the third day, and $182 on the sixth day, compared to $177, $163, and $171, respectively for patients discharged on or after the geometric mean length of stay. Furthermore, the ratio of the payments for these two groups increased from 1.16 on the third day after discharge to 1.22 on the fourth day, before falling again to 1.04, 1.07, and 1.08 on the fifth, sixth, and seventh days. This suggested to us the possibility that home health care for some relatively sicker patients is being delayed until just beyond the 3-day window during which the postacute care transfer policy applies.

In the light of these data, we indicated in the FY 2009 IPPS proposed rule (73 FR 23641) that we believed it was appropriate to propose extending the applicable timeframe in order to reduce the incentive for providers to delay home health care when discharging patients from the acute care setting. Further examination of the data indicated that the average per day Medicare payments for home health care for those patients, in the DRGs to which the postacute care transfer policy applies, who are discharged from the hospital prior to the geometric mean length of stay, stabilizes at a somewhat lower amount when the initiation of home health visits begins on the seventh and subsequent days after discharge. Specifically, average payments per visit for this group fall from $182 when home health services began on the sixth day after the acute care hospital discharge to $174 on the seventh day, and then remain relatively steady at $171, $177, and $172 on the eighth, ninth, and tenth days. This suggested to us that a 7-day period might be an appropriate point at which to establish a new timeframe.

As a consequence of this analysis, in the proposed rule, we proposed to revise the regulations at § 412.4(c)(3) to extend the timeframe to within 7 days after the date of discharge to home under a written plan for the provision of home health services, effective October 1, 2008. We stated that we believed extending the applicable timeframe would lessen the incentive for providers to delay the start of home health care after discharging patients from the acute care hospital setting. We also indicated that during the comment period on the proposed rule, we planned to continue to search our data on postacute care discharges to home health services. We welcomed comments and suggestions on other data analyses that could be performed to determine an appropriate timeframe for which the postacute care transfer policy would apply.

In addition to the reasons noted above, we stated that we believed that 7 days is currently an appropriate timeframe because we believe that it accommodates current practices and it is sufficiently long enough to lessen the likelihood that providers would delay the initiation of necessary home health services. At the same time, we stated that we believed that 7 days is narrow enough that we would still expect the majority of the home health services to be related to the condition to which the acute inpatient hospital stay was necessary. Further, we noted that there may be some cases for which it is not clinically appropriate to begin home health services immediately following an acute care discharge, and that even when home health services are clinically appropriate sooner than within 7 days of acute care discharge, home health services may not be immediately available.

We note that, as we stated in the FY 2000 IPPS final rule (65 FR 47081), if the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. In addition, if the proposed policy were to be adopted and the continuing care plan is related to the purpose of the inpatient hospital admission but begins after 7 days after discharge, a condition code 43 would have to be entered on the claim. Under the present policy, condition code 43 applies when the home health services begin within 3 days after the date of discharge from the acute care hospital. The presence of either of these condition codes in conjunction with patient status discharge code 06 (Discharged/Transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care) will result in full payment rather than the transfer payment amount.

We received many comments on this proposal. The commenters included hospitals, hospital industry associations, HHAs, representatives of the home health care industry, and MedPAC. The comments were almost uniformly opposed to the proposal. As we discuss in more detail below, we are not proceeding with finalizing this proposal.

Comment: Some commenters expressed opposition to the proposal on the grounds that the postacute care transfer policy in itself is inconsistent with the principles of a PPS. The commenters emphasized the nature of a PPS as a system of averages, designed to reward hospitals for the efficient provision of services. Under a PPS, they asserted, cases with longer-than-average lengths of stay tend to be paid less than costs, while cases with shorter-than-average stays tend to be paid more than costs. These commenters argued that, in general, the postacute care transfer policy penalizes hospitals for the efficient treatment of patients. Expansion of the postacute care transfer policy, they opined, would thus further undercut the basic principles and objectives of a PPS and only penalize hospitals further.

Response: We disagree that the proposed postacute care transfer policy violates the principles of a PPS. The postacute care transfer provision is mandated by statute, and in previous rules we have thoroughly discussed the sound policy reasons for including such a provision within the IPPS. (We refer readers to previous IPPS final rules, including the rules at 63 FR 40975 through 40976 and 63 FR 40979 through 40981, for more details.) Therefore, we do not believe that objections to the postacute care transfer policy in general provide any rationale for refraining from expansions and revisions to the policy, provided those changes are in and of themselves warranted by sound policy considerations.

Comment: Many commenters opposed the proposal for reasons related to the merits of the proposal itself. These commenters presented a number of arguments against the proposal. Some commenters asserted that the data CMS used to support the proposal were outdated and incomplete. Other commenters argued that home health care that begins 4 or more days after the date of discharge is unlikely to be a continuation of acute-level care. Some commenters asserted that it is physicians, not hospitals, who typically order home health services for patients. Therefore, they contended, hospitals should not be financially penalized for decisions made outside of their control. Other commenters suggested that physicians be held responsible for those decisions through the physician fee schedule instead.

Response: In response to the comment that we used outdated and incomplete data in developing our proposal, we note that, for the years for which the analysis was conducted (the data were based on claims from FYs 1999 through 2003), there were only 10 DRGs subject to the postacute care transfer policy. We continue to believe, as we stated in the proposed rule, that the trends we found when there were only 10 DRGs subject

to the policy would be consistent with the trends that will be found in more recent data. Furthermore, we believe that these trends may be even more pronounced in light of the fact that there are now many more MS–DRGs (273) subject to the postacute care transfer policy.

We also do not find persuasive the comments arguing that because physicians typically order home health care rather than hospitals, decisions regarding the commencement of the provision of home health care are made outside of the hospital's control. We note that, even under the current 3-day policy, physicians, not hospitals, typically discharge patients from the acute care hospital setting and that the postacute care transfer policy applies when a ''qualified'' discharge occurs prior to the geometric mean length of stay and the hospital receives a reduced payment even under the current policy. Furthermore, because the physician who orders both the early discharge and the initiation of home health care for the patient is typically employed, contracted, or at least, has privileges at the affected hospital, we believe that the hospital has a relationship with the physician and should have knowledge of the physician's practices. Therefore, we disagree with the contention that the hospital is being inappropriately penalized for actions outside its control. Similarly, in response to the comment related to reducing physician payments, we note that section 1886(d)(5)(J)(ii)(III) of the Act requires that the postacute care transfer policy apply to acute care hospital payments under the IPPS, and not to physicians under the Medicare PFS. Therefore, we disagree with the contention that physician payments under the Medicare PFS should be affected by this provision. We also note that it is the hospital, not the physician, that stands to gain financially from the early discharge of a patient.

We also note that the commenters who expressed the concern that home health care initiated more than 4 days after the discharge would be unrelated to the acute care stay failed to mention an important feature of the postacute care transfer policy. Specifically, it is important to recognize that CMS allows hospitals, through use of a condition code on the claim, to bypass the reduced transfer payment for home health care that is unrelated to the acute care stay. Therefore, we disagree that acute hospitals are financially penalized for appropriate transfers to home health that are unrelated to the acute care stay.

Comment: Some commenters claimed that it is administratively burdensome for hospitals to track whether patients received home health care services up to 7 days after they have been discharged from the hospital, particularly for hospitals that submit their claims within 7 days of discharge. In addition, these and other commenters argued that CMS should not implement a change to the postacute care transfer policy in light of recent changes made to the home health PPS in CY 2008, and in the light of our proposal to implement the CARE tool demonstration that will examine differences in costs and outcomes across postacute care settings (discussed in section IV.B. of this preamble).

Response: We have stated in prior **Federal Register** notices and in provider education articles that, in most instances, we would expect the provider to be aware of the postacute care that its patient would receive. We also note that providers are allowed to adjust claims after they have been submitted, including making adjustments for the purpose of reflecting any home health services that are provided subsequent to the acute care hospital discharge.

Providers made similar arguments when we adopted the 3-day window in FY 1999, which we responded to at that time. We refer readers to the FY 1999 IPPS final rule (63 FR 40979 through 40980) for a complete discussion. We have not become aware of any widespread pattern of providers being unaware of the postacute care received by recently discharged patients, although, as we mentioned in the FY 1999 IPPS final rule (63 FR 40980), there may be occasional instances in which the hospital is unaware that a physician has ordered home health services for a recently discharged patient. Therefore, we are not persuaded by these comments.

In response to the comment related to recent changes in the home health PPS, we again note that the postacute care transfer policy applies to acute IPPS hospital payments, not to home health PPS payments. Based on information provided by the commenter (which did not point out any specific changes in the home health PPS that could potentially have an effect on the postacute care transfer policy), it is unclear exactly how changes to home health payments might have an effect on payments made under the postacute care transfer policy provision. Additionally, the commenter did not provide specific information on how the CARE Tool demonstration is related to postacute care transfer payments to acute care hospitals, and we see no evidence that one should effect the other.

Comment: One commenter acknowledged that it had received anecdotal reports that some hospitals instructed physicians to delay the initiation of home health services until after 3 days. However, the commenter argued that expansion of the existing policy would not alter this behavior. Other commenters argued that there are legitimate reasons that the start of home health care services may be delayed, including: Patient/family preferences, availability of home health care providers, and insurance coverage. Specifically, commenters stated that patients may request that their primary care physician (someone other than the physician taking care of them while they were in the hospital) arrange for home health services. In addition, it is not uncommon for a patient to be discharged home from the hospital, then to visit their physician a day or two later, only to have the physician order home health services that take another day or two to begin—again pushing the start of home health services beyond the 3-day window. These commenters contended that hospitals should not be ''penalized'' because of these legitimate delays.

Response: We agree that there may be legitimate delays in the initiation of home health care services subsequent to an acute care hospital discharge. However, the fact that the delays are legitimate does not establish that it is inappropriate to adjust payments to account for the discharge into postacute care. There may be legitimate delays in the initiation of home health care services even under the 3-day window, but the postacute transfer policy still applies in that situation. This is because one of the primary objectives of the postacute care transfer policy is to pay providers appropriately for services rendered. When the care of a patient is shared between an acute care hospital provider and home health care services within 3 days of the acute care discharge, we believe that it is appropriate to pay the acute care hospital a reduced payment because it only provided services for a shorter than average amount of time. Therefore, we believe that these comments lend support to the continued need to monitor the current policy to see if there are trends of delays in the initiation of home health services, whether such delays are ''legitimate'' or not. As we discuss below, we are not proceeding with finalizing this proposal. We will continue to consider whether the 3-day window is appropriate in light of all the relevant data.

Comment: MedPAC commented that it does not believe that the data presented in the proposed rule support an expansion of the policy from 3 days

to 7 days. MedPAC conducted its own analysis of 2005 and 2006 data and commented that its data do not support an expansion. In particular, MedPAC pointed out that its data provide no evidence of a spike in home health use 4 days after discharge, which it would have expected to see if there was significant gaming under our current 3-day window policy. In addition, MedPAC found that the distribution of claims by the number of days between hospital discharge and the beginning of home heath care is similar between DRGs subject to the postacute care transfer policy and those that are not subject to the postacute care transfer policy, suggesting that there has not been significant gaming of the system under the current 3-day window. MedPAC, therefore, concluded that CMS should provide stronger support for why the change is needed. Other commenters also suggested that CMS analyze the data more thoroughly and make a proposal based on that analysis in FY 2010.

Response: We have not yet received MedPAC's data analysis in support of its conclusion that there is no evidence of a spike in home health care services that begin after 4 days of discharge from the acute care hospital setting. Similarly, we have not seen the specific data indicating that there is no significant difference between the number of days between hospital discharge and postacute care between those DRGs subject to the postacute care transfer policy. Therefore, we are unable to compare their data with our own data, which have shown some evidence of a spike in home heath care services 4 days after discharge. However, we agree with MedPAC that it would be preferable to defer proceeding with this or a similar proposal until stronger evidence (that is, data) is available in support of the change. We also agree with the other commenters who suggested that it is more prudent at this time to continue studying this issue than to proceed with finalizing our proposal to extend the current 3-day window to 7 days. However, we remain concerned that a relatively brief window, such as 3 days, may create a strong incentive to delay the provision of necessary care beyond the window so that the hospital will receive the full MS–DRG payment. Therefore, we will continue to monitor this policy in order to track any changes in practices that may indicate the need for revising the window. We may proceed with this proposal or another proposal to address the issue in a subsequent rulemaking cycle.

After consideration of the public comments received, we are not adopting as final our proposed change to the regulations at § 412.4(c)(3) relating to the proposed 7-day window for postacute care transfers to home health care services. As we indicated above, we will continue to monitor the existing policy and may address the issue in a subsequent rulemaking.

3. Evaluation of MS–DRGs Under Postacute Care Transfer Policy for FY 2009

For FY 2009, we did not propose to make any changes to the criteria by which an MS–DRG would qualify for inclusion in the postacute care transfer policy. However, because we proposed to revise some existing MS–DRGs and to add one new MS–DRG (discussed under section II.G. of this preamble), we proposed to evaluate those MS–DRGs under our existing postacute care transfer criteria in order to determine whether any of the revised or new MS–DRGs will meet the postacute care transfer criteria for FY 2009. Therefore, we indicated that, for 2009, we were evaluating MS–DRGs 001, 002, 215, 245, 901 through 909, 913 through 923, 955 through 959, and 963 through 965. We noted that any revisions made would not constitute a change to the application of the postacute care transfer policy. We included a list indicating which MS–DRGs would be subject to the postacute care transfer policy for FY 2009 in Table 5 in the Addendum to the proposed rule.

We did not receive any public comments on this issue. We completed our evaluation of the MS–DRGs listed above against the criteria for postacture care transfer payments. Table 5 of this final rule contains a complete list of MS–DRGs that are subject to the postacute care transfer policy for FY 2009.

B. Reporting of Hospital Quality Data for Annual Hospital Payment Update

1. Background

a. Overview

CMS is transforming the Medicare program from a passive payer to an active purchaser of higher quality, more efficient health care. Such changes will contribute to the sustainability of the Medicare program, encourage the delivery of high quality care while avoiding unnecessary costs, and help ensure high value for beneficiaries. To support this transformation, CMS has worked with stakeholders to develop and implement quality measures, make provider and plan performance public, link payment incentives to reporting on measures, and ultimately is working to link payment to actual performance on these measures. Commonly referred to as value-based purchasing, this policy aligns payment incentives with the quality of care as well as the resources used to deliver care to encourage the delivery of high-value health care.

The success of this transformation is supported by and dependent upon an increasing number of widely-agreed upon quality measures. The Medicare program has defined measures of quality in almost every setting and measures some aspect of care for almost all Medicare beneficiaries. These measures include clinical processes, patient perception of their care experience, and, increasingly, outcomes.

The Medicare program has established mechanisms for collecting information on these measures, such as QualityNet, an Internet-based process that hospitals use to report all-payer information. Initial voluntary efforts were supplemented beginning in FY 2005 by a provision in the Medicare Prescription Drug Improvement and Modernization Act (MMA), which provided the full annual payment update only to ''subsection (d) hospitals'' (that is, hospitals paid under the IPPS) that successfully reported on a set of widely-agreed upon quality measures. Since FY 2007, as required by subsequent legislation (the Deficit Reduction Act (DRA)) the number of quality measures and the amount of the financial incentive have increased.

As a result, the great majority of hospitals now report on quality measures for heart failure, acute myocardial infarction, pneumonia, and surgical care improvement and received the full annual update for FY 2008. The number of measures has continued to grow and the types of measures have grown as well, with the addition of outcomes measures, such as heart attack and heart failure mortality measures, and the HCAHPS measures of patient satisfaction. In section IV.B.2. of the preamble to the FY 2009 IPPS proposed rule, we sought public comments on proposed additional quality measures (73 FR 23646). Reporting on these measures provides hospitals a greater awareness of the quality of care they provide and provides actionable information for consumers to make more informed decisions about their health care providers and treatments.

Moving beyond pay for reporting to paying for performance, CMS has designed a Hospital Value-Based Purchasing (VBP) Plan that would link hospital payments to their actual performance on quality measures. In accordance with the DRA, the Plan was submitted to Congress in November

2007. We discuss the Plan more fully in section IV.C. of this preamble.

The ongoing CMS Premier Hospital Quality Incentive Demonstration project is another effort linking payments to quality performance. Launched in 2003, the Premier Hospital Quality Incentive Demonstration project promotes measurable improvements in the quality of care, examining whether economic incentives to hospitals are effective at improving the quality of care. Early evidence from the project indicates that linking payments to quality performance is effective. This demonstration project is ongoing with a scheduled end date of September 2009.

As required by section 5001(c) the DRA, CMS also has implemented a program intended to encourage the prevention of certain avoidable or preventable hospital-acquired conditions (HACs), including infections that may occur during a hospital stay. Beginning October 1, 2007, CMS required hospitals to begin reporting information on Medicare claims specifying whether certain diagnoses were present on admission (POA). Beginning October 1, 2008, CMS will no longer pay hospitals for a DRG using the higher-paying CC or MCC associated with one or more of these conditions (if no other condition meeting the higher paying CC or MCC criteria is present) unless the condition was POA (that is, not acquired during the hospital stay). Linking a payment incentive to hospitals' prevention of avoidable or preventable HACs will encourage high quality care and the prevention of these HACs. Combating these HACs can reduce morbidity and mortality as well as reduce unnecessary costs. In the FY 2008 IPPS final rule with comment period (72 FR 47217), CMS identified eight HACs. In section II.F. of the preamble to the FY 2009 IPPS proposed rule, CMS sought comment on additional proposed conditions (73 FR 23547).

CMS is committed to enhancing these value-based purchasing programs, in close collaboration with stakeholders, through the development and use of new measures for quality reporting, expanded public reporting, greater and more widespread incentives in the payment system for reporting on quality measures, and ultimately performance on those measures. These initiatives hold the potential to transform the delivery of health care by rewarding quality of care and delivering higher value to Medicare beneficiaries.

A critical element of value-based purchasing is well-accepted measures. Hospitals can then measure their performance relative to other hospitals. Further, this information can be posted on the Internet for consumers to use to make more informed choices about their care. In this section IV.B. of this preamble, we describe past and current efforts to make this information available and proposals to expand these efforts and make even more useful hospital quality information available to the public.

b. Voluntary Hospital Quality Data Reporting

In December 2002, the Secretary announced a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. These collaborators included the American Hospital Association (AHA), the Federation of American Hospitals (FAH), the Association of American Medical Colleges (AAMC), the Joint Commission on Accreditation of Healthcare Organizations (now called The Joint Commission), the National Quality Forum (NQF), the American Medical Association (AMA), the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons (AARP), the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO), the Agency for Healthcare Research and Quality (AHRQ), as well as CMS and others. In July 2003, CMS began the National Voluntary Hospital Reporting Initiative. This initiative is now known as the Hospital Quality Alliance: Improving Care through Information (HQA).

We established the following ''starter set'' of 10 quality measures for voluntary reporting as of November 1, 2003:

Heart Attack (Acute Myocardial Infarction or AMI)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta blocker given to the patient upon arrival to the hospital?
- Was a beta blocker prescribed when the patient was discharged?
- Was an Angiotensin Converting Enzyme (ACE) Inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an ACE Inhibitor given to the patient?

Pneumonia (PN)

- Was an antibiotic given to the patient in a timely way?
- Had the patient received a pneumococcal vaccination?
- Was the patient's oxygen level assessed?

This starter set of 10 quality measures was endorsed by the NQF. The NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. In addition, this starter set is a subset of measures currently collected for The Joint Commission as part of its hospital inpatient certification program.

We chose these 10 quality measures in order to collect data that would: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement.

Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (*http://www.QualityNet.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements for security of personal health information. Data from this initiative are used to populate the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov*. This Web site assists beneficiaries and the general public by providing information on hospital quality of care for consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to improve the quality of care that they furnish.

c. Hospital Quality Data Reporting Under Section 501(b) of Public Law 108–173

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Public Law 108–173, revised the mechanism used to update the standardized amount of payment for inpatient hospital operating costs. Specifically, the statute provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any subsection (d) hospital that does not submit data on a set of 10 quality indicators established

by the Secretary as of November 1, 2003. The statute also provided that any reduction would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure established an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary.

We initially implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (69 FR 49078). In addition, we established the RHQDAPU program and added 42 CFR 412.64(d)(2) to our regulations. We adopted additional requirements under the RHQDAPU program in the FY 2006 IPPS final rule (70 FR 47420).

d. Hospital Quality Data Reporting Under Section 5001(a) of Public Law 109–171

Section 5001(a) of the Deficit Reduction Act of 2005, Public Law 109–171 (DRA), further amended section 1886(b)(3)(B) of the Act to revise the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary. Section 1886(b)(3)(B)(viii)(III) of the Act requires that the Secretary expand the ''starter set'' of 10 quality measures that were established by the Secretary as of November 1, 2003, as the Secretary determines to be appropriate for the measurement of the quality of care furnished by a hospital in inpatient settings. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act requires that, effective for payments beginning with FY 2007, the Secretary begin to adopt the baseline set of performance measures as set forth in a December 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of the MMA.[23]

The IOM measures include: 21 HQA quality measures (including the ''starter set'' of 10 quality measures); the HCAHPS patient experience of care survey; and 3 structural measures. The structural measures are: (1) Implementation of computerized provider order entry for prescriptions; (2) staffing of intensive care units with intensivists; and (3) evidence-based hospital referrals. These structural measures constitute the Leapfrog Group's original ''three leaps,'' and are part of the NQF's 30 Safe Practices for Better Healthcare.

Sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, the Secretary add other quality measures that reflect consensus among affected parties, and to the extent feasible and practicable, have been set forth by one or more national consensus building entities, and provide the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary is granted broad discretion to replace measures that are no longer appropriate for the RHQDAPU program.

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making quality data available to the public after ensuring that a hospital would have the opportunity to review its data before these data are made public. In addition, this section requires that the Secretary report quality measures of process, structure, outcome, patients' perspective of care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year.

In the FY 2007 IPPS final rule (71 FR 48045), we amended our regulations at 42 CFR 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for subsection (d) hospitals that do not comply with requirements for reporting quality data, as provided for under section 1886(b)(3)(B)(viii) of the Act. In the FY 2007 IPPS final rule, we also added 11 additional quality measures to the 10-measure starter set to establish an expanded set of 21 quality measures (71 FR 48033 through 48037).

Commenters on the FY 2007 IPPS proposed rule requested that we notify the public as far in advance as possible of any proposed expansions of the measure set and program procedures in order to encourage broad collaboration and to give hospitals time to prepare for any anticipated change. Taking these concerns into account, in the CY 2007 OPPS/ASC final rule (71 FR 68201), we adopted six additional quality measures for the FY 2008 IPPS update, for a total of 27 measures. The measure set that we adopted for the FY 2008 payment determination was as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	• Aspirin at arrival.* • Aspirin prescribed at discharge.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • Beta blocker at arrival.* • Beta blocker prescribed at discharge.* • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.** • Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.** • Adult smoking cessation advice/counseling.**
Heart Failure (HF)	• Left ventricular function assessment.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • Discharge instructions.** • Adult smoking cessation advice/counseling.**
Pneumonia (PN)	• Initial antibiotic received within 4 hours of hospital arrival.*

[23] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at: *http://www.iom.edu/CMS/3809/19805/31310.aspx*.

Topic	Quality measure
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• Oxygenation assessment.* • Pneumococcal vaccination status.* • Blood culture performed before first antibiotic received in hospital.** • Adult smoking cessation advice/counseling.** • Appropriate initial antibiotic selection.** • Influenza vaccination status.** • Prophylactic antibiotic received within 1 hour prior to surgical incision.** • Prophylactic antibiotics discontinued within 24 hours after surgery end time.** • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.***
Mortality Measures (Medicare patients)	• Acute Myocardial Infarction 30-day mortality Medicare patients.*** • Heart Failure 30-day mortality Medicare patients.***
Patients' Experience of Care	• HCAHPS patient survey.***

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS/ASC final rule with comment period (data submission required as of January 2007 for three additional SCIP measures).

For FY 2008, hospitals were required to submit data on 25 of the 27 measures. No data submission was required for the two mortality outcome measures (30-Day Risk Standardized Mortality Rates for Heart Failure and AMI), because they were calculated using existing administrative Medicare claims data. The measures used for the payment determination included, for the first time, the HCAHPS patient experience of care survey as well as two outcome measures. These measures expanded the types of measures available for public reporting as required under section 1886(b)(3)(B)(viii)(VII) of the Act. In addition, the outcome measures, which are claims-based measures, did not increase the data submission requirements for hospitals, thereby reducing the burden associated with collection of data for quality reporting.

In the FY 2008 IPPS proposed rule (72 FR 24805), we proposed to add 1 outcome measure and 4 process measures to the existing 27-measure set to establish a new set of 32 quality measures to be used under the RHQDAPU program for the FY 2009 IPPS annual payment determination. We proposed to add the following five measures for the FY 2009 IPPS annual payment determination:

- PN 30-day mortality measure (Medicare patients)
- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal
- SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia
- SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period

We stated that we planned to formally adopt these measures a year in advance in order to provide time for hospitals to prepare for changes related to the RHQDAPU program. We also stated that we anticipated that the proposed measures would be endorsed by the NQF. Finally, we stated that any proposed measure that was not endorsed by the NQF by the time that we published the FY 2008 IPPS final rule with comment period would not be finalized in that final rule.

At the time we published the FY 2008 IPPS final rule with comment period, only the PN 30-day mortality measure had been endorsed by the NQF. Therefore, we finalized only that measure as part of the FY 2009 IPPS measure set and stated that we would further address adding additional measures in the CY 2008 OPPS/ASC final rule and, if necessary, in the FY 2009 IPPS proposed and final rules. We also responded to comments we had received on the five proposed measures (72 FR 47348 through 47351).

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we noted that the NQF had endorsed the following additional process measures that we had proposed to include in the FY 2009 RHQDAPU program measure set:

- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

As we stated in the FY 2008 IPPS proposed rule (72 FR 24805), these measures reflect our continuing commitment to quality improvement in both clinical care and quality. These quality measures reflect consensus among affected parties as demonstrated by endorsement by a national consensus building entity. The addition of these two measures for the FY 2009 measure set bring the total number of measures in that measure set to 30 (72 FR 66876).

The measure set to be used for FY 2009 annual payment determination is as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	• Aspirin at arrival.* • Aspirin prescribed at discharge.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • Beta blocker at arrival.* • Beta blocker prescribed at discharge.* • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.**

Topic	Quality measure
Heart Failure (HF)	• Primary Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.** • Adult smoking cessation advice/counseling.** • Left ventricular function assessment.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • Discharge instructions.**
Pneumonia (PN)	• Adult smoking cessation advice/counseling.** • Initial antibiotic received within 4 hours of hospital arrival.* • Oxygenation assessment.* • Pneumococcal vaccination status.* • Blood culture performed before first antibiotic received in hospital.**
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• Adult smoking cessation advice/counseling.** • Appropriate initial antibiotic selection.** • Influenza vaccination status.** • Prophylactic antibiotic received within 1 hour prior to surgical incision.** • Prophylactic antibiotics discontinued within 24 hours after surgery end time.** • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.*** • SCIP–Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.***** • SCIP Infection 6: Surgery Patients with Appropriate Hair Removal.*****
Mortality Measures (Medicare patients)	• Acute Myocardial Infarction 30-day mortality Medicare patients.*** • Heart Failure 30-day mortality Medicare patients.*** • Pneumonia 30-day mortality Medicare patients.****
Patients' Experience of Care	• HCAHPS patient survey.***

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS/ASC final rule with comment period.
**** Measure added in FY 2008 IPPS final rule with comment period.
***** Measure added in CY 2008 OPPS/ASC final rule with comment period (data submission required effective with discharges starting January 1, 2008).

We also stated in the FY 2008 IPPS final rule with comment period and the CY 2008 OPPS/ASC final rule with comment period that the RHQDAPU program participation requirements for the FY 2009 program would apply to additional measures we adopt for the FY 2009 program (72 FR 47361; 72 FR 66877).

Therefore, hospitals are required to start submitting data for SCIP Infection 4 and SCIP Infection 6 starting with first quarter calendar year 2008 discharges and subsequent quarters until further notice. Hospitals must submit their aggregate population and sample size counts for Medicare and non-Medicare patients. These requirements are consistent with the requirements for the other AMI, HF, PN, and SCIP process measures included in the FY 2009 measure set. The complete list of procedures for participating in the RHQDAPU program for FY 2009 are provided in the FY 2008 IPPS final rule with comment period (72 FR 47359 through 47361).

Because SCIP Cardiovascular 2 and SCIP Infection 7 had not been endorsed by a national consensus building entity by the publishing deadline for the CY 2008 OPPS/ASC final rule with comment period, we did not adopt these measures as part of the FY 2009 IPPS measure set.

In the FY 2008 IPPS proposed rule, we also solicited public comments on 18 measures included within 8 categories of measure sets that could be selected for future inclusion in the RHQDAPU program (72 FR 24805). These measures and measure sets highlight our interest in improving patient safety and outcomes of care, with a particular focus on the quality of surgical care and patient outcomes. In order to engender a broad review of potential performance measures, the list included measures that have not yet received endorsement by a national consensus review process for public reporting. The list also included measures developed by organizations other than CMS as well as measures that can be calculated using administrative data (such as claims).

We solicited public comment not only on the measures and measure sets that were listed, but also on whether there were any critical gaps or ''missing'' measures or measure sets. We specifically requested input concerning the following issues:

- Which of the measures or measure sets should be included in the FY 2009 RHQDAPU program or in subsequent years?
- What challenges for data collection and reporting are posed by the identified measures and measure sets?
- What improvements could be made to data collection or reporting that might offset or otherwise address those challenges?

In the FY 2008 IPPS final rule with comment period (72 FR 47351), after consideration of the public comments received, we decided not to adopt any of these measures or measure sets for FY 2009. We indicated that we will continue to consider some of these measures and measure sets for subsequent years.

2. Quality Measures for the FY 2010 Payment Determination and Subsequent Years

a. Quality Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, for the FY 2010 payment determination, we proposed to require continued hospital submission of data on 26 of the 30 existing AMI, Heart Failure, Pneumonia, HCAHPS, and SCIP measures adopted for FY 2009, and to remove the chart-abstracted Pneumonia Oxygenation Assessment measure from the FY 2010 measure set (73 FR 23646). As noted above, the three outcome measures do not require hospitals to submit data.

Under section 1886(b)(3)(B)(viii)(III) of the Act, the Secretary shall expand the RHQDAPU program measures beyond the measures specified as of November 1, 2003. Under section 1886(b)(3)(B)(viii)(V) of the Act, these measures, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

In the FY 2009 IPPS proposed rule (73 FR 23647), we proposed to adopt the following 72 measures for the FY 2010 payment determination:

Topic	Quality Measure
Heart Attack (Acute Myocardial Infarction)	• AMI–1 Aspirin at arrival.* • AMI–2 Aspirin prescribed at discharge.* • AMI–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • AMI 6 Beta blocker at arrival.* • AMI–5 Beta blocker prescribed at discharge.* • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.** • AMI–4 Adult smoking cessation advice/counseling.** • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI).
Heart Failure (HF)	• HF–2 Left ventricular function assessment.* • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • HF–1 Discharge instructions.** • HF–4 Adult smoking cessation advice/counseling.**
Pneumonia (PN)	• PN–2 Pneumococcal vaccination status.* • PN–3b Blood culture performed before first antibiotic received in hospital.** • PN–4 Adult smoking cessation advice/counseling.** • PN–6 Appropriate initial antibiotic selection.** • PN–7 Influenza vaccination status.** • PN–5c Timing of Receipt of Initial Antibiotic following hospital arrival.******
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• SCIP–1 Prophylactic antibiotic received within 1 hour prior to surgical incision.** • SCIP–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time.** • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis—within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.*** • SCIP–Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.***** • SCIP Infection 6: Surgery Patients with Appropriate Hair Removal.***** • SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period.******
Mortality Measures (Medicare patients)	• MORT–30–AMI Acute Myocardial Infarction 30-day mortality Medicare patients.*** • MORT–30–HF Heart Failure 30-day mortality Medicare patients.*** • MORT–30–PN Pneumonia 30-day mortality Medicare patients.****
Patients' Experience of Care	• HCAHPS patient survey.***
Readmission Measures (Medicare patients)	• Heart Attack (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients).****** • Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients).****** • Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients).******
Inpatient Stroke Care	• STK–1 DVT Prophylaxis.****** • STK–2 Discharged on Antithrombotic Therapy.****** • STK–3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy.****** • STK–5 Antithrombotic Medication By End of Hospital Day Two.****** • STK–7 Dysphasia Screening.******
Venous Thromboembolic Care	• VTE–1: VTE Prophylaxis.****** • VTE–2: VTE Prophylaxis in the ICU.******

Topic	Quality Measure
AHRQ Patient Safety Indicators	• VTE–4: Patients with overlap in anticoagulation therapy.****** • VTE–5/6: (as combined measure) patients with UFH dosages who have platelet count monitoring and adjustment of medication per protocol or nomagram.****** • VTE–7: Discharge instructions to address: follow-up monitoring, compliance, dietary restrictions, and adverse drug reactions/interactions.****** • VTE–8: Incidence of preventable VTE.****** • Death among surgical patients with treatable serious complications.****** • Iatrogenic pneumothorax, adult.****** • Postoperative wound dehiscence.****** • Accidental puncture or laceration.******
AHRQ Inpatient Quality Indicators (IQI)	• Abdominal aortic aneurysm (AAA) mortality rate (with or without volume).****** • Hip fracture mortality rate.******
AHRQ IQI Composite Measures	• Mortality for selected surgical procedures (composite).****** • Complication/patient safety for selected indicators (composite).****** • Mortality for selected medical conditions (composite).******
Nursing Sensitive Measures	• Failure to Rescue.****** • Pressure Ulcer Prevalence and Incidence by Severity.****** • Patient Falls Prevalence.****** • Patient Falls with Injury.******
Cardiac Surgery Measures	• Participation in a Systematic Database for Cardiac Surgery.****** • Pre-operative Beta Blockade.****** • Prolonged Intubation.****** • Deep Sternal Wound Infection Rate.****** • Stroke/CVA.****** • Post-operative Renal Insufficiency.****** • Surgical Reexploration.****** • Anti-platelet Medication at Discharge.****** • Beta Blockade Therapy at Discharge.****** • Anti-lipid Treatment at Discharge.****** • Risk-Adjusted Operative Mortality for CABG.****** • Risk-Adjusted Operative Mortality for Aortic Valve Replacement.****** • Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair.****** • Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery.****** • Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery.******

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS/ASC final rule with comment period.
**** Measure added in FY 2008 IPPS final rule with comment period.
***** Measure added in CY 2008 OPPS/ASC final rule with comment period.
****** Measure proposed in FY 2009 IPPS proposed rule.

(1) Pneumonia Oxygenation Assessment Measure Removal and Measure Retirement Generally

CMS proposed to remove the Pneumonia Oxygenation Assessment measure from the RHQDAPU program measure set. We proposed to discontinue requiring hospitals to submit data on the Pneumonia Oxygenation Assessment measure, effective with discharges beginning January 1, 2009. Section 1886(b)(3)(B)(viii)(VI) of the Act provides the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure. We interpret this to authorize the Secretary to remove or retire measures from the RHQDAPU program.

In the case of the Pneumonia Oxygenation Assessment measure, the vast majority of hospitals are performing near 100 percent. In addition, oxygenation assessment is routinely performed by hospitals for admitted patients without regard to the specific diagnosis. Thus, the measure is topped out so completely across virtually all hospitals as to provide no significant opportunity for improvement. We believe that the burden to hospitals to abstract and report these data outweighs the benefit in publicly reporting hospital level data with very little variation among hospitals. We do not expect that the retirement of the Pneumonia Oxygenation Assessment measure will result in the deterioration of care. However, if we determine otherwise, we may seek to reintroduce the measure.

The proposed removal of the Pneumonia Oxygenation Assessment measure represents the first instance of retiring a measure. We intend to review other existing chart-abstracted measures recognizing the significant burden to hospitals that chart abstraction requires. In this way, we seek to maximize the value of the RHQDAPU program to promote quality improvement by hospitals and to report information that the public will find beneficial in choosing inpatient hospital services. In the FY 2009 IPPS proposed rule, we invited comment on the retirement of the Pneumonia Oxygenation Assessment measure (73 FR 23647). In addition, we invited comment on other measures that may be suitable for retirement from the RHQDAPU program measure set. Finally, we invited comment on the following general

considerations relevant to retiring measures:

- Should CMS retire a RHQDAPU program measure when hospital performance on the measure has reached a high threshold (that is, performance on the measure has topped out) even if the measure still reflects best practice?
- Are there reasons to consider retiring a measure other than high overall performance?
- When a measure is retired on the basis of substantially complete compliance by hospitals, should data collection on the measure again be required after 1 or 2 years to assure that high compliance level remains, or should some other way of monitoring continued hospital compliance be used?

Comment: A number of commenters supported CMS' proposal to retire the Pneumonia Oxygenation Assessment measure because the commenters believed that the measure did not appear to present a significant opportunity for improvement. In addition, some commenters suggested the retirement of AMI–1 and AMI–2 as the commenters believed that these measures are topped out as well.

Response: We appreciate the comments received on the topic of retirement. At this time, we are finalizing the retirement of the Pneumonia Oxygenation Assessment measure and hospitals will no longer have to report on this measure effective with January 1, 2009 discharges. We did not propose to retire any other measures but we will consider the retirement of other topped off measures (those with very high performance levels) such as AMI–1 and AMI–2.

Comment: Many commenters suggested that hospitals continue to submit data regarding the Pneumonia Oxygenation Assessment measure for several years. In addition, several other commenters indicated that CMS should remove topped off measures from the *Hospital Compare* Web site, but continue to conduct monitoring activities to ensure that ''backsliding'' does not take place.

Response: We interpret backsliding to mean a reduction in performance if a measure is no longer reported by hospitals. We agree that continued collection even for topped off measures may be warranted if backsliding is expected. However, we do not believe that this would occur for the Pneumonia Oxygenation Assessment measure, which has become a routine assessment for essentially all admitted hospitalized patients without regard to diagnosis.

After consideration of the comments received, CMS will retire the Pneumonia Oxygenation measure. Hospitals will no longer be required to submit data on this measure beginning with January 1, 2009 discharges.

(2) Updating Measures

The specifications for two of the existing measures have been updated by the NQF, effective May 2007, with respect to the applicable timing interval. For the measures previously identified as:

- AMI—Primary Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival, the NQF has revised its endorsement of the specifications to reflect that the timing interval has been changed to PCI within 90 minutes of arrival.
- Pneumonia—Initial antibiotic received within 4 hours of hospital arrival, the NQF has revised its endorsement of the specifications to reflect that the initial antibiotic must be received within 6 hours of arrival.

In the FY 2009 IPPS proposed rule, because the NQF is now endorsing different timing intervals with respect to these measures, we proposed to also update these measures for the purposes of the FY 2010 RHQDAPU program (73 FR 23647). The updated measures are as follows:

- AMI—Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI); and
- Pneumonia—Timing of receipt of initial antibiotic following hospital arrival.

We note that the technical specifications for these measures will not change, and hospitals will continue to submit the same data that they currently submit. However, beginning with discharges on or after January 1, 2009, CMS will calculate the measures using the updated timing intervals.

The NQF updated these two measures to reflect the most current consensus standards effective May 2007. Because this was after we issued the FY 2008 IPPS proposed rule, we could not adopt the updated measures in the FY 2008 IPPS final rule with comment period or CY 2008 OPPS/ASC final rule with comment period. Instead, we allowed hospitals to suppress the public reporting of the quality data for the two measures for hospital discharges starting with April 1, 2007 discharges. This was the case so that hospitals would not be held to out-of-date consensus standards for public reporting pending the next regulatory cycle.

We proposed using a subregulatory process to act upon updates made to existing RHQDAPU program measures by a consensus building entity such as the NQF. We stated that we believe this is necessary to be able to utilize the most up-to-date consensus standards in the RHQDAPU program, and to recognize that neither scientific advances nor consensus building entity standard updates are linked to the timing of regulatory actions. We proposed to implement updates to existing RHQDAPU program measures and provide notification through the QualityNet Web site, and additionally in the Specifications Manual where data collection and measure specifications changes are necessary (73 FR 23647). We invited comment on this proposal.

Comment: Numerous commenters indicated that they would prefer that any changes to existing measures be made through the regulatory process, which allows for public comment, and that no changes should be made to existing measures through a subregulatory process, as proposed in the FY 2009 IPPS proposed rule.

Response: After consideration of comments received, we have decided not to adopt a separate subregulatory process to implement measure updates made to existing measures by consensus building entities. Instead, as we currently do, we will continue to update technical specifications for each of the measures in the Specifications Manual. Substantive changes to existing measures will be made through the rulemaking process.

Comment: Several commenters recommended that CMS not revise the pneumococcal and influenza vaccination measures without consulting the HQA or seeking public input. In certain instances where a change in science or an implementation issue has occurred, such as with past influenza vaccine shortages, the commenters noted that it may be necessary to temporarily suspend measure reporting. However, commenters urged that all permanent changes to existing measures be made through the regulatory process to allow for public input.

Response: As discussed previously, we will not finalize our proposal to implement a subregulatory process to update existing RHQDAPU program measures that have been updated by a consensus building entity. We also recognize that the temporary suppression of public reporting on measures might be necessary under certain circumstances, such as when clinical practices change or implementation issues occur, until we can formally update those measures through the rulemaking process.

Comment: Some commenters expressed concerns that some of the proposed measures were not actionable

for quality improvement, and were heavily reliant upon provider documentation. In addition, some commenters stated that the adoption of measures such as failure to rescue, patient falls with injury, and pressure ulcer prevalence and incidence by severity will create higher legal risks for providers.

Response: We disagree with the comment that the measures we proposed are not actionable for quality improvement. All finalized measures have gone through an extensive development process and have achieved NQF endorsement for accountability and public reporting. NQF endorsement occurs after thorough review of the measures, public comment, and consensus agreement as to their importance, scientific acceptability, feasibility and usability. As part of its review for scientific acceptability, the NQF considers the validity of the measure as a measure of quality. Evaluation of the usability of a measure considers the use of the measure for continued quality improvement. We are uncertain what legal risk that the commenters contemplate, but we believe that outcomes such as failure to rescue, falls with injury and pressure ulcers are important measures of outcome.

In the FY 2009 IPPS proposed rule we noted that, for the purposes of proposing the FY 2010 RHQDAPU program measure set, we believe that NQF endorsement of a measure represents a standard for consensus among affected parties as specified in section 1886(b)(3)(B)(viii)(V) of the Act (73 FR 23647–48). The NQF is an independent health care quality endorsement organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations.

Comment: Numerous commenters encouraged CMS to work through the HQA to identify measures for public reporting. Because CMS chose to propose some measures that represented a ''consensus among affected stakeholders'' but that were not endorsed by the NQF and adopted by the HQA, many commenters believed that the FY 2009 IPPS proposed rule did not follow the DRA requirement. Specifically, the commenters noted that only 10 of the proposed measures have been adopted by the HQA, including 3 of the 9 proposed AHRQ indicators, the surgical care measure, and the 6 venous thromboembolism measures. The commenters also noted that the proposed stroke measures and the AMI/Pneumonia readmission measures have not been endorsed by the NQF nor adopted by the HQA, and that the heart failure readmission measure has not been adopted by the HQA, and thus should not be included in the FY 2010 payment determination. Some of the commenters concluded that any measures added to the RHQDAPU program should first go through the rigorous, consensus-based assessment processes of both the NQF and HQA.

Response: Section 1886(b)(3)(B)(viii)(V) of the Act, as added by section 5001(a) of the DRA, provides that measures must reflect consensus among affected parties and, to the extent feasible and practicable, must include measures set forth by one or more national consensus building entities. Thus, the Secretary is not required to limit measures to those endorsed or adopted by any particular consensus organization or quality alliance, as long as the statutory standard has been met. The NQF is a voluntary consensus standards organization that meets the requirements of the National Technology Transfer and Advancement Act (NTTAA); and we believe that measures that are NQF endorsed meet the statutory requirement. Indeed, all of the measures that we finalize for the FY 2010 IPPS payment determination will be NQF endorsed.

Comment: A number of commenters indicated that CMS should adopt certain measures that were not proposed, but which have been adopted by HQA, including surgical site infection, central line catheter-associated blood stream infection, and measures on the care provided in pediatric intensive care units as well as the care provided to maternity patients.

Response: We did not propose for FY 2010 payment determination to adopt the suggested infection rate measures, pediatric intensive care measures, or maternity care measures mentioned by the commenters. We are unable to finalize measures that were not proposed for which the public at large did not have the opportunity to provide comments. We also note that the suggested infection measures were developed by the CDC for public health surveillance purposes only, rather than for hospital quality assessment. Therefore, we do not believe, as currently specified, these infection rate measures are appropriate for use in the RHQDAPU program. Further, CDC is currently working with the NQF Hospital Acquired Infection committee to better define the measures. Although these two infection measures are not ready for our use in the RHQDAPU program, infection measures are a high priority for CMS. We may consider adding these measures in the future when specifications are further developed and the NQF has further considered them.

(3) SCIP Cardiovascular 2 Measure for the FY 2010 Payment Determination

In November 2007, the NQF endorsed SCIP Cardiovascular 2. CMS believes that this measure targets an important process of care, beta blocker administration for noncardiac surgery patients. Therefore, in the FY 2009 IPPS proposed rule, we proposed to add SCIP Cardiovascular 2 to the RHQDAPU program measures for the FY 2010 payment determination (73 FR 23648). The specifications and data collection tools are currently available through the QualityNet Web site and in the Specifications Manual for hospitals to utilize and submit data for this measure. In this final rule, we are adopting this proposal. Hospitals will be required to submit data on the SCIP Cardiovascular 2 measure for discharges occurring on or after January 1, 2009. The initial data submission deadline for this measure will be August 15, 2009.

We received no comments specific to this measure. We did receive general comments on the burden associated with chart-abstracted measures and the burden associated with adopting large numbers of measures at once. Those comments are discussed below.

(4) Nursing Sensitive Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, we proposed to add four nursing sensitive measures to the RHQDAPU program measure set for the FY 2010 payment determination (73 FR 23648). The four proposed measures were:

- Failure to Rescue
- Pressure Ulcer Prevalence and Incidence by Severity (Joint Commission developed measure; all patient data from chart abstraction)
- Patient Falls Prevalence
- Patient Falls with Injury

We stated that these measures broaden the ability of the RHQDAPU program measure set to assess care generally associated with nursing staff. In addition, we stated that these measures are directed toward outcomes that are underrepresented among the RHQDAPU program measures. These measures apply to the vast majority of inpatient stays and provide a great deal of critical information about hospital quality to consumers and stakeholders. We stated that the specifications and data collection tools are scheduled to be available in the specifications manual

by December 2008 for hospitals to utilize and submit data for these measures. We also proposed that hospitals be required to submit data on these four measures effective with discharges beginning April 1, 2009. We noted that these measures have been endorsed by the NQF; however, The Joint Commission has initiated rigorous field testing of the measures, which will not be completed until late 2008. Therefore, it was possible that the endorsement status of these measures might change in the next several months. We stated that if this rigorous field testing resulted in uncertainty as to the NQF endorsement status at the time we issue the FY 2009 IPPS final rule, we would defer our final decision on whether to require these measures for the RHQDAPU program for FY 2010 until we published the CY 2009 OPPS/ASC final rule with comment period.

Comment: Many commenters indicated that it is inappropriate to include the nursing sensitive measures if they are still undergoing field testing, and there is no mechanism specified to collect data on the nursing sensitive measures. The commenters also noted that while many of the measures are used by the National Database of Nursing Quality Indicators (NDNQI), not all organizations participate in this database and there may be discrepancies in data definitions if different information systems are used.

Response: We appreciate these comments and are aware of the ongoing testing of the nursing sensitive measures. This testing involves the feasibility of calculating these measures based on patient-level data, and we recognize that this testing should be completed prior to adopting any of these measures, insofar as there is no alternative but to calculate them based on hospital submitted patient-level data. However, claims based measures can be implemented without requiring additional data submission by hospitals beyond existing claims data. Therefore, in this final rule we are adopting only one Nursing Sensitive measure: Failure to Rescue for the FY 2010 payment determination. We believe there is no uncertainty regarding the NQF endorsement status of this measure because it can be calculated using Medicare claims data only, as opposed to using patient-level data submitted by hospitals. We intend to propose the remaining NQF nursing sensitive measures during the FY 2010 IPPS rulemaking cycle as requirements for the FY 2011 payment determination.

Comment: Many commenters indicated that the addition of a number of chart-abstracted measures would be overly burdensome to implement in FY 2009 for use in the FY 2010 payment determination.

Response: We recognize the additional burden that would result if many chart-abstracted measures were required on such an aggressive timeframe. Therefore, we are finalizing only the failure to rescue measure at this time, in part, because it can be calculated using Medicare claims data instead of using data culled from patient charts. This alternative means of measure calculation cannot be used for the three other proposed nursing sensitive measures, and for this reason and the other reason stated above, we are not finalizing those measures at this time. We believe that this decision will help to lessen the overall burden on hospitals by reducing their obligation to submit patient-level data on too large a number of new chart-abstracted measures at the same time. We plan to use the same claims data for the failure to rescue measure that we use for other RHQDAPU program measures that are based solely on Medicare claims. The claims data that will be used to calculate this measure, as well as all the Medicare claims based measures for the FY 2010 payment determination, will be from July 1, 2007 through June 30, 2008 (3rd quarter 2007 discharges through 2nd quarter 2008 discharges). We discuss these dates more fully below.

(5) Readmission Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, we proposed to adopt three readmission measures for the FY 2010 payment determination that will be calculated using Medicare claims data (73 FR 23648). The proposed measures were:

- Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients)
- Heart Attack (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients)
- Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)

These readmission measures assess both quality of care and efficiency of care. They also promote coordination of care among hospitals and other providers. They compliment the existing 30-Day Risk Standardized Mortality Measures for Pneumonia, Heart Attack, and Heart Failure. These measures require no additional data collection from hospitals. The measures are risk adjusted to account for differences between hospitals in the characteristics of their patient populations.

Since the time we issued the proposed rule, the HF readmission measure has received NQF endorsement. Therefore, we are adopting the HF readmission measure as a RHQDAPU program requirement for the FY 2010 payment determination in this final rule. The AMI and PN readmission measures are still pending endorsement by the NQF. We intend to finalize the AMI and PN readmission measures for the FY 2010 payment determination in the CY 2009 OPPS/ASC final rule with comment period, contingent upon endorsement from a national consensus-based entity such as the NQF. As we stated in the FY 2009 IPPS proposed rule, this is consistent with our measure expansion during the past 2 years, when we finalized some RHQDAPU program measures in the annual OPPS/ASC final rule with comment periods. CMS will calculate the rates of the HF readmission measure using Medicare claims only. The claims data will be for dates July 1, 2007 through June 30, 2008 (3rd quarter 2007 through 2nd quarter 2008 discharges). This is the same time frame as for the other Medicare claims data based measures.

Comment: Commenters noted that the AMI and Pneumonia readmissions measures are not endorsed by the NQF.

Response: We recognize that the AMI and Pneumonia readmissions measures are not yet endorsed by the NQF, and we are only finalizing the Heart Failure readmission measure in this final rule. We intend to adopt the AMI and PN readmission measures for the FY 2010 payment determination in the CY 2009 OPPS/ASC final rule with comment period, contingent upon endorsement from a national consensus-based entity such as the NQF.

Comment: Several commenters disagreed with having staggered start dates and submission time frames for the RHQDAPU required measures and stated that this would add unnecessary confusion and additional complexity. Commenters urged CMS to adopt one consistent submission time frame.

Response: We acknowledge that we sometimes implement different time frames to commence chart abstraction data submission. However, in the context of chart-abstracted measures we believe that this is necessary and desirable given the burden of chart abstraction and the ongoing phase-in of infrastructure capabilities. Furthermore, the chart-abstracted measures are recalculated quarterly on a rolling basis and data that is publicly reported is refreshed quarterly. On the other hand, for our claims based measures, our calculations are done annually. We

believe that consistency of time frame for the annual calculation of Medicare claims based measures is important for comparison purposes because we can then rely on a single year-long or multiple year data set. We will use the same annual data time frame for the payment determination for FY 2010 (July 2007 through June 2008 discharges) for all Medicare claims based measures that we used for the FY 2009 program. This will apply to the AHRQ measures, the Nursing Sensitive Failure to Rescue measure, the 30 day mortality measures for Heart Failure, Pneumonia, and AMI, and the 30 day readmission measure for Heart Failure.

(6) Venous Thromboembolism (VTE) Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, we also proposed to add six Venous Thromboembolism (VTE) measures for the FY 2010 payment determination (73 FR 23648). These measures comprehensively address a major cause of morbidity and mortality among hospitalized patients.

- VTE–1: VTE Prophylaxis
- VTE–2: VTE Prophylaxis in the ICU
- VTE–4: Patients with overlap in anticoagulation therapy
- VTE–5/6: (as combined measure) Patients with UFH dosages who have platelet count monitoring and adjustment of medication per protocol or nomogram
- VTE–7: Discharge instructions to address: follow-up monitoring, compliance, dietary restrictions and adverse drug reactions/interactions
- VTE–8: Incidence of preventable VTE

Since the time we issued the proposed rule, these VTE measures have received NQF endorsement. However, these measures would require submission of chart-abstracted data for which current submission mechanisms will not be available for use for the FY 2010 payment determination. Therefore, we are not adopting these proposed measures for the FY 2010 payment determination. We intend to propose these measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination. In addition, we intend to explore whether data needed to calculate these measures could be submitted using electronic health records (EHRs).

Comment: Commenters were generally supportive of the VTE measures proposed by CMS.

Response: The VTE measures comprehensively address a major cause of morbidity and mortality among hospitalized patients, and we believe that their inclusion in the RHQDAPU program will promote quality in these areas. However, we are not finalizing the VTE measures at this time for two reasons: (1) We are sensitive to the concerns of commenters that we proposed to add a large number of chart-abstracted measures all at once and wish to decrease the immediate burden on hospitals to implement such a large number of these measures; and (2) the additional infrastructure needed to collect this data is not yet available for our use. We intend to propose these measures in future rulemaking.

Comment: Some commenters suggested that CMS implement additional surgical care measures (continuity of beta blocker therapy, post-op wound dehiscence) and VTE measures (prevention, appropriate treatments, readmissions, discharge instructions).

Response: We appreciate the suggestions that we implement additional surgical care and VTE measures. We will consider these types of measures for future implementation.

(7) Stroke Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, we also proposed to add five stroke measures which will apply only to certain identified groups under specific ICD–9–CM codes as specified in the Specifications Manual (73 FR 23648). These measures comprehensively address an important condition not currently covered by the RHQDAPU program that is associated with significant morbidity and mortality.

- STK–1 DVT Prophylaxis
- STK–2 Discharged on Antithrombotic Therapy
- STK–3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy
- STK–5 Antithrombotic Medication By End of Hospital Day Two
- STK–7 Dysphasia Screening

These stroke measures are pending NQF endorsement. Due to the lack of endorsement from a national consensus building entity, we have decided not to adopt these measures for the FY 2010 payment determination. CMS intends to propose these measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination.

Comment: One commenter commended CMS on its proposal to include stroke quality data among the quality measures adopted in the FY 2009 IPPS rulemaking. However, the commenter believed that an important quality measurement was missing from the list; the administration of thrombolytic therapy.

Response: We appreciate this comment. While the stroke measures would add a topic area that is important to Medicare beneficiaries, we will not be implementing stroke measures for the FY 2010 payment determination because they have not yet received endorsement from a consensus building entity such as the NQF. We intend to propose the stroke measure set during the FY 2010 IPPS rulemaking process for inclusion in the FY 2011 RHQDAPU program measure set and we will consider whether to include the administration of thrombolytic therapy as part of that proposal.

Comment: Commenters indicated that new chart-abstracted measures such as the stroke measures proposed by CMS would be overly burdensome to implement in FY 2009 for use in the FY 2010 payment determination.

Response: As previously stated, we recognize the additional burden that would result if many chart-abstracted measures were required on such an aggressive timeframe. We are not finalizing the stroke measures, which would require additional chart abstraction burden, at this time. We intend to propose these measures in future rulemaking.

(8) AHRQ Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule (73 FR 23649), we proposed to add the following nine AHRQ Patient Safety Indicators (PSIs) and Inpatient Quality Indicators (IQIs) that have been endorsed by the NQF:

- Patient Safety Indicator (PSI) 4—Death among surgical patients with treatable serious complications
- PSI 6—Iatrogenic pneumothorax, adult
- PSI 14—Postoperative wound dehiscence
- PSI 15—Accidental puncture or laceration
- Inpatient Quality Indicator (IQI) 4 and 11—Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
- IQI 19—Hip fracture mortality rate
- IQI Mortality for selected medical conditions (composite)
- IQI Mortality for selected surgical procedures (composite)
- IQI Complication/patient safety for selected indicators (composite)

These are claims-based outcome measures. They are important additional measures that can be calculated for hospital inpatients without the burden of additional chart abstraction. Hospitals currently collect and submit these data to CMS and other insurers for

reimbursement. These measures will be calculated using all-payer claims data those hospitals currently collect with respect to each patient discharge. We proposed to require hospitals to submit to CMS the all-payer claims data that we specify in the technical Specifications Manual as necessary to calculate the AHRQ PSI/IQI measures. We proposed that hospitals begin submitting data on a quarterly basis on these measures to CMS by April 1, 2010 beginning with October 1, 2009 discharges. However, we are aware that a large number of hospitals already submit these data on a voluntary basis to third party data aggregators such as State health agencies or State hospital associations. We solicited comments on whether a hospital that already submits the data necessary to calculate these measures to such entities should be permitted to authorize such an entity to transmit these data to CMS, in accordance with applicable confidentiality laws, on their behalf. This would relieve the hospital of the burden of having to submit the same data directly to CMS via the QIO Clinical Warehouse. As an alternative to requiring that hospitals submit all-payer claims data for purposes of calculating the AHRQ PSI/IQI measures, CMS considered whether it should initially calculate the AHRQ PSI/IQI measures using Medicare claims data only, and at a subsequent date require submission of all-payer claims data. We also sought comment on this alternative.

As explained below, in this final rule we are adopting these measures, and will calculate these measures using Medicare claims only for the FY 2010 payment determination.

Comment: We received many comments supporting the use of the AHRQ measures. For reporting the nine AHRQ IQIs and PSIs, several commenters recommended using existing State or other third party collection entities to acquire ''all payer'' data, rather than requiring hospitals to duplicate the same information for CMS. Other commenters recommended identifying the key data elements needed for the specific measures and requesting those States and other third party entities to only submit those specific data elements, rather than entire datasets, and that compensation for recoding should also be considered. Several commenters noted the burden of submitting additional data. Some commenters indicated that they did not favor using only Medicare claims for calculation of the AHRQ indicators because artificial skewing of the data may occur. Many of the commenters recommended inclusion of PSI–9 (Postoperative Bleeding/Hemorrhage), as recent evidence indicates that PCI patients with bleeding are more likely to die within one year than patients without bleeding. Some commenters further recommended that CMS extensively test whether the AHRQ PSIs and IQIs should be considered ready for implementation in the RHQDAPU program because the commenters believed that these measures lack the sensitivity required for use as publicly reported measures.

Response: After considering the comments, and more general comments regarding the burden of additional chart abstraction and the large number of proposed measures, we will adopt the 9 AHRQ measures but initially calculate them based on existing Medicare claims data. We will use the same Medicare claims data set that we will use to calculate the 30-day HF readmission measure, as well as the three mortality measures. Consistent with the practice that we adopted for the FY 2009 payment determination for other measures calculated using existing Medicare claims data only, we will use existing claims data for index hospitalizations from July 1, 2007 through June 30, 2008 (3rd quarter 2007 through 2nd quarter 2008 discharges) for purposes of calculating the measures for the FY 2010 payment determination.

While the distribution of the rates may be different when calculated using Medicare claims only, we believe that these calculations will be sufficient to account for performance in our population of interest because Medicare claims make up a substantial portion of the overall inpatient claims to which these measures apply. However, we remain interested in collecting all-payer claims and may propose to collect such data in the future.

Because PSI–9 has not yet been endorsed by a consensus building entity such as the NQF, we did not propose to adopt it for the RHQDAPU program.

Comment: Many commenters recommended that CMS adopt the AHRQ IQI AAA mortality measure and AHRQ's stroke mortality measure.

Response: We agree with the suggestion to adopt the AAA mortality measure. In this final rule, we are adopting this measure and will consider the other measure for implementation in a future rulemaking.

(9) Cardiac Surgery Measures for the FY 2010 Payment Determination

In the FY 2009 IPPS proposed rule, we proposed to add 15 cardiac surgery measures for the FY 2010 payment determination (73 FR 23649). Cardiac surgical procedures carry a significant risk of morbidity and mortality. We believe that the nationwide public reporting of these cardiac surgery measures would provide highly meaningful information for the public. Currently, over 85 percent of hospitals with a cardiac surgery program submit data on the proposed cardiac surgery measures listed below to the Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry. We proposed to accept these data from the STS registry beginning on July 1, 2009, on a quarterly basis for discharges on or after January 1, 2009. Hospitals that participate in the RHQDAPU program, but do not submit data on the proposed cardiac surgery measures to the STS registry for discharges on or after January 1, 2009, would need to submit such data to CMS. Although we would accept cardiac surgery data from other clinical data registries, we are unaware of any other registries that collect all of the data necessary to support calculation of the cardiac surgery measures. Hospitals and CMS would need to establish appropriate legal arrangements, to the extent such arrangements are necessary, to ensure that the transfer of these data from the STS registry to CMS complies with all applicable laws. By accepting these registry-based data, only hospitals with cardiac surgery programs that do not already collect such data to submit to the STS registry will have additional data submission burden. All of the proposed measures are currently NQF-endorsed. We proposed that hospitals begin submitting data by July 1, 2009, on a quarterly basis on the following 15 cardiac surgery measures to the STS data registry or CMS for 1st quarter calendar year 2009 discharges:

- Participation in a Systematic Database for Cardiac Surgery
- Pre-Operative Beta Blockade
- Prolonged Intubation
- Deep Sternal Wound Infection Rate
- Stroke/CVA
- Post-Operative Renal Insufficiency
- Surgical Reexploration
- Anti-Platelet Medication at Discharge
- Beta Blockade Therapy at Discharge
- Anti-Lipid Treatment at Discharge
- Risk-Adjusted Operative Mortality for CABG
- Risk-Adjusted Operative Mortality for Aortic Valve Replacement
- Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair
- Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery
- Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery

As discussed below, for the FY 2010 payment determination, we are adopting

only one of these proposed measures: Participation in a Systematic Database for Cardiac Surgery. This is an NQF-endorsed measure. The data submission window for this measure will be from July 1, 2009 to August 15, 2009. Specifications for the measure will be posted on QualityNet and hospitals will submit data for this measure using QualityNet. This measure does not require the hospital to participate in a registry, rather, it only measures whether the hospital participates in a cardiac surgery registry. CMS intends to propose the other 14 cardiac surgery measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination.

Comment: A few commenters suggested that CMS add the NQF-endorsed measure ''Anti-Platelet medications at discharge for Cardiac Surgery'' to the hospital data reporting requirements for FY 2009, noting that this measure corresponds to a PQRI measure.

Response: We appreciate this comment, and will review the measure in question for possible inclusion in the RHQDAPU program in future years.

Comment: Many commenters provided a number of reasons why the cardiac surgery measures should not be included in the RHQDAPU program; the measures have not yet been adopted by the HQA, the third-party collecting data on these measures does not require any type of validation for data submitted to them, and the methodology of risk adjustment used by the third party is not transparent.

A few commenters believed it was inappropriate for CMS to institute a data reporting requirement under the RHQDAPU program that would require hospitals to pay money to participate in a specific registry (the Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry). Other commenters were concerned that ''participation in a systematic database for cardiac surgery'' could be viewed as serving the financial interests of a third-party organization.

Some commenters stated that while they were not opposed to using the STS registry to submit the proposed cardiac surgery measures, hospitals currently not submitting data to this registry may have trouble meeting the upcoming submission deadline, and suggested that CMS postpone the date of discharge for reporting data on the 15 cardiac surgery measures from January 1, 2009, to July 1, 2009.

Response: While HQA provides informative input regarding measure selection the ultimate responsibility of the measures' selection for the RHQDAPU program is at the discretion of the Secretary. We believe that cardiac surgery measures should be part of the RHQDAPU program because cardiac procedures are commonly performed on Medicare patients and that the public reporting of those processes of care will benefit Medicare beneficiaries. However, based on our consideration of the comments received, in this final rule we are only adopting one of the cardiac surgery measures. We will collect data regarding whether hospitals are participating in a registry for cardiac surgery. The window for submission of these data (which requires little more than a hospital saying ''yes'' or ''no'' as to whether it participates in a cardiac surgery registry) for FY 2010 will be between July 1, 2009 (when the ability to receive the data submission by CMS will be available) and August 15, 2009. This is a structural measure which requires reporting whether the hospital participates in a registry for cardiac surgery but does not require that hospitals actually participate in a registry. Therefore, hospitals that do not currently report to a registry will not be required to do so, and will not be penalized for not participating in a registry. Currently, we believe that over 85 percent of cardiac surgery programs already report data to the STS. Reporting of the structural measure will provide further information regarding the extent of participation. In addition, it will provide valuable information for the Medicare beneficiary. We believe that participation in a cardiac surgery registry provides participants valuable ongoing quality improvement information and demonstrates a commitment to improvement.

We are collecting this information directly from hospitals rather than STS because hospitals may be participating in registries other than STS. We are not finalizing the other 14 process and outcome measures that we proposed to collect from STS due to hospitals' concern about the perceived requirement to participate specifically in the STS registry, and because we have not yet established the infrastructure to collect these measures directly from hospitals. We will consider the best alternative for data collection for the other STS measures and whether the data should be received from the STS registry as proposed in the proposed rule or submitted directly to CMS. We intend to propose the other 14 cardiac surgery measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination.

(10) Summary of Measures for the FY 2010 Payment Determination Adopted in This Final Rule

In this final rule, one of the 30 current measures is being retired and 13 new measures are being added into the RHQDAPU program for the FY 2010 payment determination. The 13 new measures are being added into the RHQDAPU program in this final rule are:

- Surgical Care Improvement Project (SCIP)
  - SCIP Cardiovascular 2 Surgery Patients on a Beta-Blocker prior to arrival who received beta blocker during the perioperative period
- Nursing Sensitive Measures
  - Failure to Rescue
- Readmission measures
  - Heart Failure readmission (Medicare only)
- AHRQ Quality Indicators: Inpatient Quality Indicators and Patient Safety Indicators
  - Death among surgical patients with treatable serious complications
  - Iatrogenic pneumothorax, adult
  - Postoperative wound dehiscence
  - Accidental puncture or laceration
  - Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
  - Hip fracture mortality rate
  - Mortality for selected medical conditions (composite)
  - Mortality for selected surgical procedures (composite)
  - Complication/patient safety for selected indicators (composite)
- Cardiac Surgery Measures
  - Participation in a systematic database for cardiac surgery

The following table lists the 42 RHQDAPU program quality measures that will be used for the FY 2010 payment determination

Topic	Quality measures for the FY 2010 payment determination
Acute Myocardial Infarction (AMI)	• AMI–1 Aspirin at arrival.* • AMI–2 Aspirin prescribed at discharge.*

Topic	Quality measures for the FY 2010 payment determination
Heart Failure (HF)	• AMI–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • AMI–6 Beta blocker at arrival.* • AMI–5 Beta blocker prescribed at discharge.* • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.** • AMI–4 Adult smoking cessation advice/counseling.** • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI).******* • HF–2 Left ventricular function assessment.* • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • HF–1 Discharge instructions.** • HF–4 Adult smoking cessation advice/counseling.**
Pneumonia (PN)	• PN–2 Pneumococcal vaccination status.* • PN–3b Blood culture performed before first antibiotic received in hospital.** • PN–4 Adult smoking cessation advice/counseling.** • PN–6 Appropriate initial antibiotic selection.** • PN–7 Influenza vaccination status.** • PN–5c Timing of receipt of initial antibiotic following hospital arrival.*******
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• SCIP–1 Prophylactic antibiotic received within 1 hour prior to surgical incision.** • SCIP–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time.** • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.*** • SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.***** • SCIP Infection 6: Surgery Patients with Appropriate Hair Removal.***** • SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period.******
Mortality Measures (Medicare Patients)	• MORT–30–AMI Acute Myocardial Infarction 30-day mortality—Medicare patients.*** • MORT–30–HF Heart Failure 30-day mortality Medicare patients.*** • MORT–30–PN Pneumonia 30-day mortality-Medicare patients.****
Patients' Experience of Care	• HCAHPS patient survey.***
Readmission Measure (Medicare Patients)	• Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients).******
AHRQ Patient Safety Indicators (PSI), Inpatient Quality Indicators (IQI0 and Composite Measures.	• Death among surgical patients with treatable serious complications.****** • Iatrogenic pneumothorax, adult.****** • Postoperative wound dehiscence.****** • Accidental puncture or laceration.****** • Abdominal aortic aneurysm (AAA) mortality rate (with or without volume).****** • Hip fracture mortality rate.****** • Mortality for selected surgical procedures (composite).****** • Complication/patient safety for selected indicators (composite).****** • Mortality for selected medical conditions (composite).******
Nursing Sensitive	• Failure to Rescue (Medicare claims only).*****
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.******

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS/ASC final rule with comment period.
**** Measure added in FY 2008 IPPS final rule with comment period.
***** Measure title proposed to be replaced for FY 2009 with the Timing of receipt of Primary Percutaneous Coronary Intervention (PCI).
****** Measure title proposed to be replaced for FY 2009 with Timing of initial antibiotic following hospital arrival.
******* Measure updated in FY 2009 IPPS final rule.

In this final rule, we are increasing the RHQDAPU program measures from 30 measures for FY 2009 to a total of 42 measures for the FY 2010 payment determination. The following table lists the increase in the RHQDAPU program measure set since the program's inception:

IPPS payment year	Number of RHQDAPU program quality measures	Topics covered
2005–2006	10	AMI, HF, PN.
2007	21	AMI, HF, PN, SCIP.
2008	27	AMI, HF, PN, SCIP, Mortality, HCAHPS.
2009	30	AMI, HF, PN, SCIP, Mortality, HCAHPS.
2010	42	AMI, HF, PN, SCIP, Mortality, HCAHPS, Nursing Sensitive, Readmission, AHRQ IQI/PSI measures and composites, Cardiac Surgery.

The above measures reflect our continuing commitment to quality improvement in both clinical care and patient safety. These additional measures also demonstrate our commitment to include in the RHQDAPU program only those quality measures that reflect consensus among the affected parties and that have been reviewed by a consensus building process.

(11) Additional Measures for the FY 2010 Payment Determination That May Be Finalized in the CY 2009 OPPS/ASC Final Rule With Comment Period

In the FY 2009 IPPS proposed rule we noted that, to the extent that the proposed measures had not already been endorsed by a consensus building entity such as the NQF, we anticipated that they would be endorsed prior to the time that we issued this final rule (73 FR 23651). We stated that we intended to finalize the FY 2010 RHQDAPU program measure set for the FY 2010 payment determination in this final rule, contingent upon the endorsement status of the proposed measures. However, we stated that, if a measure had not received NQF endorsement by the time we issued this final rule, we intended to adopt that measure for the RHQDAPU program measure set in the CY 2009 OPPS/ASC final rule with comment period if the measure received endorsement prior to the time we issued the CY 2009 OPPS/ASC final rule with comment period. We requested public comment on these measures. Set out below are the measures which have not yet received NQF endorsement, and that we intend to adopt for the FY 2010 RHQDAPU program measure set in the CY 2009 OPPS/ASC final rule with comment period if the measures receive endorsement from a national consensus-based entity such as NQF:

Topic	Proposed quality measure to be finalized in the CY 2009 OPPS/ASC final rule contingent on national consensus-based endorsement
Readmission Measures (Medicare Patients)	• AMI 30-Day Risk Standardized Readmission Measure (Medicare patients). • Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients).

b. Possible New Quality Measures, Measure Sets, and Program Requirements for the FY 2011 Payment Determination and Subsequent Years

In the FY 2009 IPPS proposed rule, we included the following table which describes possible quality measures and measure sets from which additional quality measures could be selected for inclusion in the RHQDAPU program for the FY 2011 payment determination and subsequent years (73 FR 23651). The table includes measures and measure sets that highlight CMS' interest in improving patient safety and outcomes of care, with a particular focus on the quality of surgical care and patient outcomes. In order to engender a broad review of potential performance measures, the list includes measures that have not yet been considered for approval by the HQA or endorsed by a consensus review process such as the NQF. The table also includes measures developed by organizations other than CMS as well as measures that are to be derived from administrative data (such as claims) that may need to be modified for specific use by the Medicare program if implemented under the RHQDAPU program.

We solicited public comment on the following measure sets for consideration in the FY 2011 payment determination and subsequent years:

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS

Topic	Quality measure
Chronic Pulmonary Obstructive Disease Measures.	
Complications of Vascular Surgery	• AAA stratified by open and endovascular methods. • Carotid Endarterectomy. • Lower extremity bypass.
Inpatient Diabetes Care Measures.	
Healthcare Associated Infection	• Central Line-Associated Blood Stream Infections. • Surgical Site Infections.
Timeliness of Emergency Care Measures, including Timeliness	• Median Time from ED Arrival to ED Departure for Admitted ED Patients. • Median Time from ED Arrival to ED Departure for Discharged ED Patients.

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS—Continued

Topic	Quality measure
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• Admit Decision Time to ED Departure Time for Admitted Patients. • SCIP Infection 8—Short Half-life Prophylactic Administered Preoperatively Redosed Within 4 Hours After Preoperative Dose. • SCIP Cardiovascular 3—Surgery Patients on a Beta Blocker Prior to Arrival Receiving a Beta Blocker on Postoperative Days 1 and 2.
Complication Measures (Medicare patients).	
Healthcare Acquired Conditions	• Serious reportable events in health care (never events). • Pressure ulcer prevalence and incidence by severity. • Catheter-associated UTI.
Hospital Inpatient Cancer Care Measures	• Patients with early stage breast cancer who have evaluation of the axilla. • College of American Pathologists breast cancer protocol. • Surgical resection includes at least 12 nodes. • College of American Pathologists colon and rectum protocol. • Completeness of pathologic reporting.
Serious Reportable Events in Healthcare (“Never Events”)	• Surgery performed on the wrong body part. • Surgery performed on the wrong patient. • Wrong surgical procedure on a patient. • Retention of a foreign object in a patient after surgery or other procedure. • Intraoperative or immediately post-operative death in a normal health patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative). • Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility. • Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. • Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility. • Patient death or serious disability associated with patient elopement (disappearance) for more than four hours. • Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility. • Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration). • Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products. • Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. • Stage 3 or 4 pressure ulcers acquired after admission to a health care facility. • Patient death or serious disability due to spinal manipulative therapy. • Patient death or serious disability associated with an electric shock while being cared for in a health care facility. • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances. • Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility. • Patient death associated with a fall while being cared for in a health care facility. • Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility. • Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider. • Abduction of a patient of any age. • Sexual assault on a patient within or on the grounds of a health care facility. • Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility.
Average Length of Stay Coupled with Global Readmission Measure.	
Preventable Hospital-Acquired Conditions (HACs)	• Catheter-Associated Urinary Tract Infection (UTI). • Vascular Catheter-Associated Infection.

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS—Continued

Topic	Quality measure
	• Surgical Site Infections—Mediastinitis after Coronary Artery Bypass Graft (CABG). • Surgical Site Infections following Elective Procedures—Total Knee Replacement, Laparoscopic Gastric Bypass, Ligation and Stripping of Varicose Veins. • Legionnaires' Disease. • Glycemic Control—Diabetic Ketoacidosis, Nonketotic Hypersmolar Coma, Hypoglycemic Coma. • Iatrogenic pneumothorax. • Delirium. • Ventilator-Associated Pneumonia (VAP). • Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE). • *Staphylococcus aureus* Septicemia. • Clostridium-Difficile Associated Disease (CDAD). • Methicillin-Resistant *Staphylococcus aureus* (MRSA).

Comment: Because only 37 percent of colon cancer patients receive adequate lymph node evaluation of at least 12 nodes, many commenters recommended that CMS adopt the Hospital Inpatient Cancer Care measure—Surgical resection includes at least 12 nodes.

Response: We appreciate the commenters' recommendation. We are developing cancer care measures for future implementation. Cancer is a prevalent diagnosis among Medicare beneficiaries, and warrants further measurement.

Comment: Many commenters supported the development and implementation of care coordination measures, and additional glycemic control measures.

Response: In the future, we will consider adopting additional glycemic control measures endorsed by a consensus building entity such as the NQF based on our assessment of whether they are appropriate for inclusion in the RHQDAPU program. We will also consider these comments as we continue to develop care coordination measures.

Comment: Some commenters suggested that CMS review existing measures related to AMI in order to ensure that they represent the most current information that exists, and consider deeming participation in a heart registry a sufficient criterion to meet AMI data reporting requirements. Another commenter requested that CMS display the reporting methodology for AMI measures and exclude those cases with the non-diagnostic presentations.

Response: We agree that it is imperative for us to ensure that the RHQDAPU program measures reflect the most current information. Therefore, it is our practice to utilize the most current science and the guidance of technical experts in the respective fields when selecting measures for inclusion in the program. As set out in the Specification Manual, the AMI measures rely upon principal diagnosis codes, and not on presentation to determine inclusion and exclusion. We view participation in a registry as a structural measure of quality. However, it is not a substitute for reporting data on clinical processes and outcomes of care.

c. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program

The RHQDAPU program has significantly expanded from an initial set of 10 measures to 30 measures for the FY 2009 payment determination. Initially, the conditions covered by the RHQDAPU program measures were limited to Acute Myocardial Infarction, Heart Failure, and Pneumonia, three high-cost and high-volume conditions. In expanding the process measures, Surgical Infection Prevention was the first additional focus, now supplemented by the two SCIP Venous Thromboembolism measures, SCIP VTE–1, and SCIP VTE–2, for surgical patients. Of the 30 current measures, 27 require data collection from chart abstraction and surveying patients as well as submission of detailed data elements.

In looking forward to further expansion of the RHQDAPU program, we believe it is important to take several goals into consideration. These include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being broadly reported by hospitals, such as clinical data registries or all-payer claims data bases; and (f) weighing the meaningfulness and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program.

In the FY 2009 IPPS proposed rule, we requested comments on how to reduce the burden on the hospitals participating in the RHQDAPU program (73 FR 23653). We also requested comment about which measures would be most useful while minimizing burden. We realize that our decisions in this final rule to expand the RHQDAPU program measure set from submission of 30 measures in FY 2009 to 42 measures for the FY 2010 payment determination is potentially burdensome. However, to minimize the hospitals' burden, 11 of the 13 additional measures adopted in this final rule, as well as the 2 additional measures we intend to adopt in the CY 2009 OPPS/ASC final rule with comment period (if these measures receive NQF endorsement) for the FY 2010 payment determination use Medicare claims data. We also note that we are retiring a measure (Pneumonia Oxygenation Assessment) that requires chart abstraction.

Comment: Several commenters supported including composite measures such as mortality for selected medical conditions, mortality for selected surgical procedures, and complication/patient safety as part of the RHQDAPU program measure set.

Response: We appreciate the commenters' support for the proposal to include the inclusion of composite measures such as mortality for selected medical conditions, mortality for selected surgical procedures, and complication/patient safety in the RHQDAPU program measure set. We are implementing some of these composite measures in this final rule. Specifically, we are adopting the 3 AHRQ composite measures for mortality for selected surgical procedures, complication/patient safety for selected indicators, and mortality for selected medical conditions.

Comment: Many commenters asked that CMS make its risk adjustment model public so that others may assess its validity. In addition, several commenters expressed concerns that the rates must be acuity adjusted and must allow for random variation around the mean for the AMI, Heart Failure, and Pneumonia readmission measures.

Response: In an effort to provide the public access to the reports on our risk adjustment models, we have made reports from the measures developers available on the QualityNet Web site (*http://www.QualityNet.org*) since June 2006. These reports, which contain risk adjustment methodologies for claims based measures that require risk adjustment, will continue to be made available on QualityNet. The HF readmission measure that we are finalizing in this final rule will be risk adjusted by taking into account the patient comorbidities reflected from the patient claims across all care settings one year prior to the index hospitalization. The claims-based risk adjustment model does not include patient vital signs as predictors, but this model is validated against a chart-based model that includes patient vital signs and lab test results. We use hierarchical modeling to calculate the hospital Risk Standardized Readmission Rate (RSRR) and the interval estimate (like confidence interval) around the RSRR. Hospitals will be presented with the RSRR together with their respective interval estimate to show the random variation. This risk adjustment model will be used for the Heart Failure, AMI, and Pneumonia readmission measures.

Comment: Several commenters expressed concerns that increasing the amount of information publicly reported on *Hospital Compare* by the number of measures proposed only make it more of a challenge for the public to understand, make the Web site cumbersome to navigate, and discourage public interest in the site. Many commenters supported the development and use of composite measures for evaluating hospitals on *Hospital Compare*, as they provide useful indices to consumers and others when comparing hospital performance. The commenters also suggested that CMS pursue alternative strategies and methods for reporting differences among hospitals, including ranking of hospitals in an area, providing information to consumers on low performers rather than on just the high performers, and beginning to include cost and resource use measures in public reporting initiatives. One commenter questioned whether or not an on-going process or plan was in place to survey the Medicare beneficiaries after implementation of additional measures to evaluate whether publicly reporting the measures meets the intended goals and has perceived value to beneficiaries.

Response: Regarding the *Hospital Compare* Web site, we agree that it is important that information be displayed in a way that is most useful, beneficial, and understandable to the consumer. We appreciate the comments on ways to enhance the *Hospital Compare* Web site and recognize the valuable feedback that a survey would provide. CMS uses focus groups to test all of the RHQDAPU program measures on *Hospital Compare* and will continue to do so when revising the *Hospital Compare* Web site. We are finalizing three composite measures in this rule and are working toward including more composite measures on *Hospital Compare*.

(1) Expanding the Types of Measures

Section 1886(b)(3)(B)(viii)(III) of the Act requires the Secretary to add other quality measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings. We intend to expand outcome measures such as mortality measures and measures of complications. For the FY 2010 RHQDAPU program, the proposed measure set includes:

- Patient Experience of Care. HCAHPS collects data regarding a patient's experience of care in the hospital and provides a very meaningful perspective from the patient standpoint.
- Efficiency. Efficiency is a Quality Domain, as defined by the IOM that relates Quality and Cost. The three proposed readmission measures address hospital efficiency.

(As discussed above, we are adopting one of these readmission measures in this final rule and intend to adopt the other two in the OPPS/ASC final rule with comment period if they receive NQF endorsement by the time that final rule is issued.) These are considered efficiency measures because higher hospital readmission rates are linked to higher costs and also to lower quality of care received during hospitalization and after the initial hospital stay. We are also seeking additional ways in which to address efficiency.

- Outcomes. The three 30-day mortality measures, the cardiac surgery measure, the AHRQ PSI/IQI measures, and the outcome-related nursing sensitive measure represent significant expansion of the RHQDAPU program outcome measures because these measures allow us to report more comprehensive information on outcomes and the results of treatment to consumers. Additional outcome measures are provided in the list under consideration for inclusion in the RHQDAPU program for FY 2011 and beyond.

(2) Expanding the Scope of Hospital Services To Which Measures Apply

Many of the most common and high-cost Medicare DRGs were posted on the *Hospital Compare* Web site in March 2008 as part of the President's transparency initiative. We have assessed these DRGs and have found that the FY 2009 RHQDAPU program measure set does not capture data regarding care in important areas such as Inpatient Diabetes Care, Chronic Obstructive Pulmonary Disease (COPD), and Chest Pain. These are areas for which we currently do not have quality measures but which constitute a significant portion of the top paying DRGs for Medicare beneficiaries. We intend to develop measures in these areas in order to provide additional quality information on the most common and high-cost conditions that affect Medicare beneficiaries.

(3) Considering the Burden on Hospitals in Collecting Chart-Abstracted Data for Measures

In the FY 2009 IPPS proposed rule, we proposed to add 15 additional chart-abstracted measures. In this final rule, we have retired one measure (Pneumonia Oxygenation Assessment) that required chart abstraction and added only 1 additional chart-abstracted measure (SCIP Cardiovascular 2) for the FY 2010 payment determination. While the cardiac surgery registry participation indicator requires submission of information by hospitals, it does not require chart abstraction, and does not significantly increase the burden on hospitals to submit data. We also intend to work to simplify the data abstraction specifications that add to the burden of data collection and to explore mechanisms for data submission using electronic health records.

(4) Harmonizing With Other CMS Programs

We intend to harmonize measures across settings and other CMS programs as evidenced by the implementation of the readmission measures, not only for the RHQDAPU program, but also for the Quality Improvement Organizations' (QIOs') 9th Scope of Work (SOW) Patient Pathways/Care Transitions Theme, which also uses the 30-Day Readmission Measures and will provide assistance to engage hospitals in improving care. The 9th SOW also focuses on disparities in health care, which is another important area of interest for CMS. We plan to analyze current RHQDAPU program measures to identify particular measures needed to evaluate the existence of health care disparities, to require data elements that would support better identification of health care disparities, and to find more efficient ways to ascertain this information from claims data. In addition, some of the CY 2008 Physician Quality Reporting Initiative (PQRI) measures align with the current RHQDAPU program, for example, AMI and SCIP measures reported data starting with the FY 2007 RHQDAPU program measure set. In other words, there are financial incentives that cover the same clinical processes of care across different providers and settings. Other examples are the RHQDAPU program measure Aspirin for Heart Attack which corresponds to PQRI measure number 28, and the RHQDAPU program measure Surgical Infection Antibiotic Timing which corresponds to PQRI measure number 20. Outpatient quality measures under the Hospital Outpatient Data Quality Data Reporting Program (HOP QDRP) are also aligned with the RHQDAPU program measures. For example, the HOP QDRP addresses Acute Myocardial Infarction treatment for transferred patients and surgical infection prevention for outpatient surgery.

(5) Use of Data Collected by State Data Organizations, State Hospital Associations, Federal Entities, and/or Other Data Warehouses

We are actively pursuing alternative data sources, including data sources that are electronically maintained. Alternative data submission methodologies that we proposed in the FY 2009 IPPS proposed rule include:

- Use of registry-collected clinical data for which there is broad existing hospital participation as previously described with the STS registry.
- Use of data collected by State data organizations, State hospital associations, Federal entities such as AHRQ, and/or other data warehouses.

In addition, we are considering adopting the following methods of data collection in the future and requested comments on these methods:

- Use of the CMS Continuity Assessment Record & Evaluation (CARE) tool, a standardized data collection instrument, which would allow data to be transmitted in ''real time.'' This recently developed, Internet-based, quality data collection tool was developed as a part of the Post Acute Care Reform Demonstration Program mandated by section 5008 of the DRA. The CARE tool consists of a core set of assessment items, common to all patients and all care settings (meeting criteria of being predictive of cost, utilization, outcomes, among others), organized under five major domains: Medical, Functional, Social, Environmental, and Cognitive—Continuity of Care. The Internet-based CARE tool will communicate critical information across settings accurately, quickly, and efficiently with reduced time burden to providers and is intended to enhance beneficiaries' safe transitions between settings to prevent avoidable, costly events such as unnecessary rehospitalizations or medication errors. We believe that the CARE tool may provide a vehicle for collection of data elements to be used for calculating RHQDAPU program quality measures. CMS is considering utilizing the CARE tool in this manner. The Care tool is available at: *http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage*. (Viewers should select ''Show only items with the word 10243,'' click on show items, select CMS–10243, click on downloads, and open Appendices A & B, pdf files.)

In the FY 2009 IPPS proposed rule, we indicated that we were particularly interested in receiving public comment on this tool (73 FR 23654). Our goal is to have a standardized, efficient, effective, interoperable, common assessment tool to capture key patient characteristics that will help CMS capture information related to resource utilization; expected costs as well as clinical outcomes; and post-discharge disposition. The CARE tool will also be useful for guiding payment and quality policies. Specifically, we indicated that we were interested in receiving public comments on how CARE might advance the use of health information technology in automating the process for collecting and submitting quality data.

- Submission of data derived from electronic versions of laboratory test reports that are issued by the laboratory in accordance with CLIA to the ordering provider and maintained by the hospital as part of the patient's medical record during and after the patient's course of treatment at the hospital. We are considering using these data to support risk adjustment for claims-based outcome measures (for example, mortality measures) and to develop other outcomes measures. This would support use of electronically maintained data and our goal of reducing manual data collection burden on hospitals.
- Submission of data currently being collected by clinical data registries in addition to the STS registry. This would support and leverage existing clinical data registries and existing voluntary clinical data collection efforts, such as:
  - American College of Cardiology (ACC) data registry for Cardiac Measures
  - ACC data registry for ICD
  - ACC data registry for Carotid Stents
  - Vascular Surgery Registry for Vascular Surgical Procedures
  - ACC-sponsored ''Get with the Guidelines'' registry for Stroke Care

Comment: Several commenters expressed concern about using the CARE tool. The commenters perceived the tool as time consuming (taking up to 20 minutes per patient) and increased facility burden. These commenters stated that the tool should not be used until it has been fully tested, and can be made interoperable with provider systems.

Response: We did not propose to implement the CARE tool in the FY 2009 IPPS proposed rule. Before we can consider implementation of the CARE tool, we agree that the CARE tool must be fully tested and that data collection issues must be addressed. We will continue development of the CARE tool so that it can be used to efficiently capture valuable information regarding care coordination for Medicare beneficiaries.

Comment: Some commenters recommended that CMS work with other agencies to foster better alignment of quality improvement and health information technology (Health IT) initiatives. The commenters encouraged more intense collaboration with standard-setting and certification bodies to provide an interoperable environment for hospitals to automate data submission in a reliable and cost-effective way, and encouraged CMS to support payment policies to facilitate and encourage adoption of Health IT.

Response: We agree with these comments and support the adoption of Health IT to facilitate the effective and efficient administration of quality patient care, monitoring, care

coordination, data reporting and performance improvement. We intend to pursue electronic data submission based on Health IT standards as an alternative to manual chart abstraction.

(6) Weighing the Meaningfulness and Utility of the Measures Compared to the Burden on Hospitals in Submitting Data Under the RHQDAPU Program

In the FY 2009 IPPS proposed rule, we proposed to retire one measure from the RHQDAPU program for the FY 2010 payment determination because we have determined that the burden on hospitals in abstracting the data outweighs the meaningful benefit that we can ascertain from the measure (73 FR 23655). In this final rule, we are adopting the proposal to retire one measure. As we explained in the FY 2009 IPPS proposed rule, we sought comments on the applicability to the RHQDAPU program of criteria currently described in the Hospital VBP Issues Paper for inclusion and retirement of measures. The Hospital VBP Issues Paper is located on the CMS Web site at the following location: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf*.

3. Form and Manner and Timing of Quality Data Submission

In the FY 2007 IPPS final rule (71 FR 48031 through 48045), we set out RHQDAPU program procedures for data submission, program withdrawal, data validation, attestation, public display of hospitals' quality data, and reconsiderations. Section 1886(b)(3)(B)(viii)(I) of the Act requires that subsection (d) hospitals submit data on measures selected under that clause with respect to the applicable fiscal year. In addition, section 1886(b)(3)(B)(viii)(II) of the Act requires that each subsection (d) hospital submit data on measures selected under that clause to the Secretary in a form and manner, and at a time, specified by the Secretary. The technical specifications for each RHQDAPU program measure are listed in the Specifications Manual. We update this Manual semiannually, or more frequently in unusual cases, and include detailed instructions and calculation algorithms for hospitals to collect and submit the data for the required measures.

The maintenance of the specifications for the measures selected by the Secretary occurs through publication of the Specifications Manual. Thus, measure selection by the Secretary occurs through the rulemaking process; whereas the maintenance of the technical specifications for the selected measures occurs through a subregulatory process so as to best maintain the specifications consistent with current science and consensus. The data submission, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at *http://www.QualityNet.org*. CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods. When measure the specifications were updated, we proposed in the FY 2009 IPPS proposed rule to require that hospitals submit all of the data required to calculate the required measures as currently outlined in the Specifications Manual as of the patient discharge date (73 FR 23655).

4. RHQDAPU Program Procedures for FY 2009 and FY 2010

a. RHQDAPU Program Procedures for FY 2009

In the FY 2008 IPPS final rule with comment period, we stated that the requirements for FY 2008 would continue to apply for FY 2009 (72 FR 47361). The ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Web site contains all of the forms to be completed by hospitals participating in the RHQDAPU program.

Under these requirements hospitals must—

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.
  - —Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*http://www.QualityNet.org*).
  - —Complete the revised RHQDAPU program Notice of Participation form (only for hospitals that did not submit a form prior to August 15, 2007). For hospitals that share the same CMS Certification Number (CCN) (formerly Medicare Provider Number), report the name and address of each hospital campus on this form.
  - —Collect and report data for each of the required measures except the Medicare mortality measures (AMI, HF, and PN 30-day Mortality for Medicare Patients). Hospitals must continuously report these data. Hospitals must submit the data to the QIO Clinical Warehouse using the CMS Abstraction & Reporting Tool (CART), The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through QualityNet. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.
- Submit complete data regarding the quality measures in accordance with the joint CMS/Joint Commission sampling requirements located on the QualityNet Web site for each quality measure that requires hospitals to collect and report data. These requirements specify that hospitals must submit a random sample or complete population of cases for each of the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.
- Submit to CMS on a quarterly basis aggregate population and sample size counts for Medicare and non-Medicare discharges for the four topic areas (AMI, HF, PN, and SCIP).
- Continuously collect and submit HCAHPS data in accordance with the HCAHPS *Quality Assurance Guidelines, V3.0,* located at the Web site *http://www.hcahpsonline.org*. The QIO Clinical Warehouse has been modified to accept zero HCAHPS-eligible discharges. We remind the public to refer to the QualityNet Web site for any questions about how to submit ''zero cases'' information.

For the AMI 30-day, HF 30-day, and PN 30-day mortality measures, CMS uses Part A and Part B claims for Medicare fee-for-service patients to calculate the mortality measures. For FY 2009, hospital inpatient claims (Part A) from July 1, 2006 to June 30, 2007, will be used to identify the relevant patients and the index hospitalizations. Inpatient claims for the index hospitalizations and Part A and Part B claims for all inpatient, outpatient, and physician services received one year prior to the index hospitalizations are used to determine patient comorbidity, which is used in the risk adjustment calculation. (For more information, we refer readers to the Web site: *http://www.QualityNet.org/dcs/ContentServer?cid=1163010398556&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page*.) No other hospital data submission is required to calculate the mortality rates.

b. RHQDAPU Program Procedures for FY 2010

In the FY 2009 IPPS proposed rule (73 FR 23656), we proposed to continue

requiring the FY 2009 RHQDAPU program procedures for FY 2010 for hospitals participating in the RHQDAPU program, with the following modifications:

• Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in the RHQDAPU program for the first time must complete a revised ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' that includes the name and address of each hospital campus that shares the same CCN.

• Data Submission. In order to reduce the burden on hospitals that treat a low number of patients who are covered by the submission requirements, we proposed the following:

—AMI. In the FY 2009 IPPS proposed rule, we proposed that a hospital that has five or fewer AMI discharges (both Medicare and non-Medicare combined) in a quarter will not be required to submit AMI patient level data for that quarter (73 FR 23656). We proposed to begin implementing this requirement with discharges on or after January 1, 2009. However, the hospital must still submit its aggregate AMI population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU program data submission.

—HCAHPS. In the FY 2009 IPPS proposed rule, we proposed that a hospital that has five or fewer HCAHPS-eligible discharges in any month will not be required to submit HCAHPS surveys for that month (73 FR 23656). However, the hospital must still submit its total number of HCAHPS-eligible cases for that month as part of its quarterly HCAHPS data submission. We proposed to begin implementing this requirement with discharges on or after January 1, 2009.

—HF. In the FY 2009 IPPS proposed rule, we proposed that a hospital that has five or fewer HF discharges (both Medicare and non-Medicare combined) in a quarter will not be required to submit HF patient level data for that quarter (73 FR 23656). However, the hospital must still submit its aggregate HF population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU program data submission. We proposed to begin implementing this requirement with discharges on or after January 1, 2009.

—PN. In the FY 2009 IPPS proposed rule, we proposed that a hospital that has five or fewer PN discharges (both Medicare and non-Medicare combined) in a quarter will not be required to submit PN patient level data for that quarter (73 FR 23656). However, the hospital must still submit its aggregate PN population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU program data submission. We proposed to begin implementing this requirement with discharges on or after January 1, 2009.

—SCIP. In the FY 2009 IPPS proposed rule, we proposed that a hospital that has five or fewer SCIP discharges (both Medicare and non-Medicare combined) in a quarter will not be required to submit SCIP patient level data for that quarter (73 FR 23656). However, the hospital must still submit its aggregate SCIP population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU program data submission. We proposed to begin implementing this requirement with discharges on or after January 1, 2009.

Comment: Several commenters supported CMS' proposal to allow hospitals that have five or fewer HCAHPS-eligible patients in a month, or five or fewer heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter to not submit HCAHPS survey or quality measure data for those patients beginning in FY 2010. The commenters supported this approach because it is a sensible way to reduce the reporting burden on hospitals with a very small number of cases; however, the commenters believed that hospitals should always be able to voluntarily report on quality measures if they want to do so.

Response: We appreciate the commenters' support. This proposal strives to minimize the reporting burden for hospitals with small patient caseloads. We welcome hospitals with smaller than the required minimum number of cases to submit data voluntarily.

Comment: One commenter asked CMS to provide the statistical rationale for its proposal to allow hospitals that have five or fewer heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter to not submit quality measures data for those patients beginning in FY 2010.

Response: We selected more than five cases per quarter as the minimum threshold to ensure that the vast majority of hospitals with sufficient caseload would be required to submit data, while easing the burden on hospitals whose patient counts were too small to reliably predict hospital performance. We believe that hospital level performance can be reliably estimated with 20 to 30 cases reported annually, consistent with commonly used statistical sampling practice. We also chose the more than five cases minimum quarterly threshold as a fair, consistent, and easily understandable requirement that would not reduce the amount of reliable publicly reported data posted on the *Hospital Compare* Web site. It is likely that the vast majority of hospitals affected by this requirement would not have sufficient annual caseload for CMS to publicly report reliable hospital level estimates for RHQDAPU program measures. We believe that the relative burden on hospitals treating these small patient caseloads outweighs the improved reliability from increased measure denominators of a few cases. We believe that this proposal does not adversely impact quality data for smaller and specialty hospitals treating five or fewer heart attack, heart failure, pneumonia or surgical care patients in a calendar quarter.

In the FY 2009 IPPS proposed rule, we proposed the following quarterly deadlines for hospitals to submit the FY 2010 AMI, HF, SCIP, PN, Stroke, VTE, and nursing sensitive measure data:

• The data submission deadline for hospitals to submit the patient level measure data for 1st calendar quarter of 2009 discharges would be August 15, 2009. Data must be submitted for each of these measures 4.5 months after the end of the preceding quarter. The specific deadlines will be listed on the QualityNet Web site.

• Even though data on applicable measures will not be due until 4.5 months after the end of the preceding quarter, hospitals must submit their aggregate population and sample size counts no later than 4 months after the end of the preceding quarter (the exact dates will be posted on the QualityNet Web site). This deadline falls approximately 15 days before the data submission deadline for the clinical process measures, and we proposed it so that we can inform hospitals about their data submission status for the quarter before the 4.5 month clinical process measure deadline. We have found from past experience that hospitals need sufficient time to submit additional data when their counts differ from Medicare claims counts generated by CMS. We will provide hospitals with these Medicare claims counts and submitted patient level data counts on the QualityNet Web site approximately 2 weeks before the quarterly submission deadline. We plan to use the aggregate population and sample size data to assess submission completeness and

adherence to sampling requirements for Medicare and non-Medicare patients.

As discussed above in our responses to previous commenters, we decided not to adopt all of our proposed measures. Therefore, these requirements will only apply with respect to the SCIP, HF, AMI, and PN chart-abstracted measures that we are adopting in this final rule.

Comment: Several commenters addressed the CMS data resubmission policy which allows resubmission of data up to, but not after, the quarterly deadline. The commenters noted that the FY 2009 IPPS proposed rule did not address the issue of data resubmission when a hospital or its vendor becomes aware of an error in the data that was sent for posting on *Hospital Compare*, and that the proposed rule also did not address the issue of appealing to resubmit data after the submission deadline. These commenters urged CMS to immediately adopt an effective mechanism for allowing hospitals and their vendors to resubmit quality measure data if they discover errors.

Response: We believe that the current data submission deadlines for the chart-abstracted measures are sufficient to allow hospitals time to submit accurate and complete data before the submission deadline. Our past experience has indicated that the vast majority of hospitals submit accurate data in a timely manner before the quarterly submission deadline. We encourage hospitals to submit their data as early as possible to correct data through resubmissions before the submission deadline. We believe that data submission after the quarterly deadline would result in delays in the quarterly CDAC validation processing, and would adversely impact our ability to deliver timely validation results to hospitals.

We will consider allowing future resubmissions of data after the submission deadline has elapsed for public reporting purposes only. This resubmission would not adversely impact our CDAC validation processing, but would allow hospitals to correct errors that would impact their publicly reported RHQDAPU program measures.

Comment: One commenter requested that CMS provide 30 days between the final count of Medicare claims currently provided by CMS to the hospitals and the submission deadline. This extension of time would provide hospitals and vendors with the necessary time to reabstract and submit the necessary cases to comply with the submission requirement.

Response: We provide the final claims counts to hospitals approximately 15 days before the quarterly submission deadline of 4.5 months following the last quarterly discharge date. We believe that providing additional time to provide a final claims count would result in an incomplete count of Medicare claims for hospitals lagging in their claims submissions to Medicare. In the future, our goal is to utilize the hospital submitted aggregate population and sample counts to replace these Medicare claims counts. We believe that hospital submitted aggregated population and sample counts will provide a complete and accurate assessment of the entire list of patients treated by hospitals. These counts include both Medicare and non-Medicare patients, including Medicare fee-for-service and Medicare Advantage patients. The current claims counts we provide include only Medicare fee-for-service patients, so they are limited in assisting hospitals to assessment submission completeness.

Comment: Some commenters objected to the proposed requirement for hospitals to submit aggregate patient population counts for Medicare and non-Medicare patients. The commenters stated that the requirement was burdensome and duplicative of Medicare claims counts provided by CMS to hospitals.

Response: We do not currently possess any patient population counts for non-Medicare patients. Since we do not possess patient population counts for non-Medicare patients, this information is necessary for us to better assess the completeness of hospital submitted RHQDAPU program data for all treated patients, Medicare and non-Medicare. The RHQDAPU program measures are intended to provide the public with information on all patients treated by hospitals, including Medicare and non-Medicare patients. We require hospitals to comply with the CMS/Joint Commission sampling requirements for submitting data. These requirements require hospitals to submit a random sample or a population of their caseloads for RHQDAPU program measures for both Medicare and non-Medicare patients. We are actively educating hospitals and data vendors to utilize billing and other information to compile a list of patients. We encourage hospitals and data vendors to collaborate on minimizing the burden and ensuring that the data reported on *Hospital Compare* are representative of their entire list of patients.

Comment: One commenter commented on potential problems that may occur when CMS uses unvalidated aggregate population count numbers submitted by hospitals to assess submission completeness.

Response: We believe that we can adequately validate the aggregate population count numbers submitted by hospitals, but are looking at the issue raised by the commenter. We also plan to assess the accuracy of non-Medicare aggregate population counts using existing all-payer data sources, including State lists of patients. Based on this assessment, we will consider approaches in future years designed to ensure that hospitals are reporting accurate population counts for all Medicare and non-Medicare patients. These approaches should also factor in the burden on the hospitals.

Comment: Some commenters wrote that the CMS Abstraction & Reporting Tool (CART) used by hospitals to abstract quality data should be modified to include all required RHQDAPU program measures.

Response: The CMS CART includes all the RHQDAPU program required chart-abstracted measures that we are adopting for the FY 2010 payment determination. It is not necessary to include the claims-based measures, since hospitals are not required to submit any additional data to us for these measures.

After careful consideration of the public comments received, we are adopting as final the aggregate population and sample size submission requirements we proposed. We are establishing submission deadlines as set out below. We believe that these requirements greatly improve our ability to ensure the accuracy and completeness of hospital reported quality data for the RHQDAPU program.

- Data must be submitted for these measures on the QualityNet Web site.
- The window for submission for the participation in a cardiac surgery registry measure will be between July 1, 2009 (when the ability to receive the data submission by CMS will be available) and August 15, 2009. Data must be submitted for this measure on the QualityNet Web site.
- The data submission deadline for hospitals to submit patient level data for the 26 SCIP, AMI, HF, PN measures for 1st calendar quarter of 2009 discharges will be August 15, 2009.
- The data submission deadline for hospitals to submit aggregate population and sample size count data for SCIP, AMI, HF, PN for 1st calendar quarter of 2009 discharges will be August 1, 2009.

The following RHQDAPU program measures will be calculated using Medicare claims with no additional data submitted by hospitals:

Topic	Quality measure
Mortality Measures (Medicare Patients)	• MORT–30–AMI Acute Myocardial Infarction 30-day mortality Medicare patients. • MORT–30–HF Heart Failure 30-day mortality Medicare patients. • MORT–30–PN Pneumonia 30-day mortality Medicare patients.
Readmission Measure (Medicare Patients)	• Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSI), Inpatient Quality Indicators (IQI) and Composite Measures.	• Death among surgical patients with treatable serious complications. • Iatrogenic pneumothorax, adult. • Postoperative wound dehiscence. • Accidental puncture or laceration. • Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
Nursing Sensitive	• Failure to Rescue (Medicare claims only).

Consistent with the practice that we adopted for the FY 2009 payment determination for measures calculated using existing Medicare claims data only, we will calculate these measures for FY 2010 by using existing claims data for hospitalizations from July 1, 2007, through June 30, 2008 (3rd quarter 2007 through 2nd quarter 2008 discharges).

5. HCAHPS Requirements for FY 2009 and FY 2010

a. FY 2009 HCAHPS Requirements

For FY 2009, hospitals must continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines posted on the Web site at: *http://www.hcahpsonline.org*. The data submission deadline for first quarter CY 2008 (January through March) discharges is July 16, 2008. To collect HCAHPS data, a hospital can either contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse, or a hospital can self-administer the survey without using a survey vendor, provided that the hospital meets Minimum Survey Requirements as specified on the Web site at: *http://www.hcahpsonline.org*. A current list of approved HCAHPS survey vendors can be found on the Web site at: *http://www.hcahpsonline.org*.

Every hospital choosing to contract with a survey vendor should provide the sample frame of hospital-eligible discharges to its survey vendor with sufficient time to allow the survey vendor to begin contacting each sampled patient within 6 weeks of discharge from the hospital (we refer readers to the *Quality Assurance Guidelines* for details about HCAHPS eligibility and sample frame creation) and must authorize the survey vendor to submit data via QualityNet on the hospital's behalf. CMS strongly recommends that the hospitals employing a survey vendor promptly review the two HCAHPS Feedback Reports (the Provider Survey Status Summary Report and the Data Submission Detail Report) that are available after the survey vendor submits the data to the QIO Clinical Warehouse. These reports enable a hospital to ensure that its survey vendor has submitted the data on time and it has been accepted into the Warehouse.

In the FY 2008 IPPS final rule with comment period (72 FR 47362), we stated that hospitals and survey vendors must participate in a quality oversight process conducted by the HCAHPS project team. Starting in July 2007, we began asking hospitals/survey vendors to correct any problems that were found and provide follow-up documentation of corrections for review within a defined time period. If the HCAHPS project team finds that the hospital has not made these corrections, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements for the RHQDAPU program. As part of these activities, HCAHPS project staff reviews and discusses with survey vendors and hospitals self-administering the survey their specific Quality Assurance Plans, survey management procedures, sampling and data collection protocols, and data preparation and submission procedures.

b. FY 2010 HCAHPS Requirements

In the FY 2009 IPPS proposed rule, for FY 2010, we proposed continuous collection of HCAHPS in accordance with the *Quality Assurance Guidelines* located at the Web site: *http://www.hcahpsonline.org*, by the quarterly data submission deadlines posted on the Web site: *http://www.hcahpsonline.org* (73 FR 23657). As stated above, starting with January 1, 2009, discharges, we proposed that hospitals that have five or fewer HCAHPS-eligible discharges in a month would not be required to submit HCAHPS patient-level data for that month as part of the quarterly data submission that includes that month, but they would still be required to submit the number of HCAHPS-eligible cases for that month as part of their HCAHPS quarterly data submission.

With respect to HCAHPS oversight, we proposed that the HCAHPS Project Team would continue to conduct site visits and/or conference calls with hospitals/survey vendors to ensure the hospitals' compliance with the HCAHPS requirements. During the onsite visit or conference call, the HCAHPS Project Team will review the hospital's/survey vendor's survey systems and will assess protocols based upon the most recent *Quality Assurance Guidelines*. All materials relevant to survey administration will be subject to review. The systems and program review includes, but it is not necessarily limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) telephone/IVR materials and facilities; (d) data receipt, entry and storage facilities; and (e) written documentation of survey processes. Organizations will be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. Hospitals/survey vendors will be subject to follow-up site visits and/or conference calls, as needed. If CMS determines that a hospital is noncompliant with HCAHPS program requirements, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements of the RHQDAPU program.

Comment: One commenter expressed concern about hospitals having sufficient warning if they or their vendors were not complying with the HCAHPS protocols as determined through a site visit review as part of the oversight process.

Response: We strongly encourage hospitals that choose to use a survey vendor to be fully appraised of the methods and actions of their survey vendors—especially the survey vendors' full compliance with HCAHPS *Quality Assurance Guidelines*—and to carefully inspect all data warehouse reports in a timely manner. If a hospital is using a survey vendor and we find a problem at the survey vendor in its survey operations, a request to fix the issue(s) will be initially directed to the survey vendor. If the problem is one that could potentially impact whether the hospital client(s) meet the RHQDAPU program requirements, we would, within seven calendar days of determining that the problem could impact whether the hospital meets the RHQDAPU requirements, notify the affected hospital(s). The client hospital(s) would also be notified, within seven calendar days of determining that the problem could impact whether the hospital(s) meets the RHQDAPU program requirements, should their survey vendor fail to fix any issue(s) identified through the oversight process. Examples of problems or practices that could jeopardize a hospital's meeting the HCAHPS requirement for the RHQDAPU program include but are not limited to the following: Administering the HCAHPS survey at patient discharge rather than two days to six weeks following discharge; using a mode of survey administration other than the four approved survey modes; creating and using a translation of the HCAHPS survey other than the approved survey translations; consistently surveying patients after the six week time limit; or consistently failing to include in the sampling frame the entire population of HCAHPS-eligible discharges. Detailed information on HCAHPS survey administration protocols can be found in the HCAHPS *Quality Assurance Guidelines*.

If reasonable attempts (which normally include a review of survey vendor's Quality Assurance Plan, an on-site visit, correspondence and conference calls, and review of the vendor's plan to correct any issues identified) to bring the survey vendor into compliance are not successful, then we will within seven calendar days of determining that the problem could impact whether the hospital meets the RHQDAPU requirements, notify all affected client hospitals so that they can engage an alternative survey vendor if they so choose.

If we determine that a hospital's non-compliance with HCAHPS requirements is the fault of the hospital rather than its survey vendor, we will notify the hospital within seven calendar days and consult with it on how to achieve and maintain compliance. If the hospital fails to achieve compliance, it may be at risk of not meeting RHQDAPU program requirements.

Comment: One commenter expressed concern regarding penalizing hospitals that use telephone mode.

Response: We do not ''penalize'' hospitals based on the mode in which they choose to administer the HCAHPS survey. We have developed and consistently apply survey mode and patient-mix adjustments to HCAHPS results in order to allow fair comparisons to be made across hospitals for public reporting, irrespective of the mix of patients they serve or the survey mode they employ. Because research has found that patient responses differ systematically by mode of survey administration, we believe it is necessary to adjust for survey mode. When reporting the data, the mode adjustment approach assures no net advantage on average for any choice of survey mode. The adjustments counteract advantages or disadvantages that would otherwise accrue on the basis of survey mode.

We conducted a large-scale, randomized Mode Experiment in order to develop adjustments for the effects of survey mode on responses to HCAHPS. The HCAHPS Mode Experiment was based on a nationwide random sample of short-term acute care hospitals. Hospitals from each of our ten geographic regions participated in the Mode Experiment. A hospital's probability of being selected for the sample was proportional to its volume of discharges, which guaranteed that each patient would have an equal probability of being sampled for the experiment. The participating hospitals contributed patient discharges from a four-month period: February, March, April, and May 2006. Within each hospital, an equal number of patients were randomly assigned to each of the four modes of survey administration. A randomized mode experiment of 27,229 discharges from 45 hospitals was used to develop adjustments for the effects of survey mode (Mail Only, Telephone Only, Mixed mode, or Active Interactive Voice Response) on responses to the HCAHPS survey.

In general, patients randomized to the Telephone Only and Active Interactive Voice Response modes provided more positive evaluations than patients randomized to Mail Only and Mixed (Mail with Telephone follow-up) modes. Established research on surveys demonstrates that patients responding to a survey conducted over the telephone, as opposed to a mail survey, tend to provide more favorable responses. This is commonly known as ''social desirability bias.'' If the modes in which the HCAHPS survey was conducted (there are four available options) were not taken into account through the mode adjustment, then hospitals choosing to use the telephone methodology would receive artificially high HCAHPS results, which would undermine the comparability of HCAHPS results across hospitals. The mode and patient-mix adjustments are applied to ensure that fair comparisons of HCAHPS results can be made across hospitals, irrespective of the survey methodology that hospitals employ or the mix of patients that hospitals serve. Detailed information on mode and patient-mix adjustments may be found in ''Mode and Patient-mix Adjustment of the CAHPS® Hospital Survey (HCAHPS),'' located at *http://www.hcahpsonline.org/modeadjustment.aspx*.

Comment: Another commenter noted that it was a challenge for small hospitals that do not have HCAHPS-eligible discharges every day to conduct daily follow-up with discharges.

Response: The commenter erroneously believes that patients must be sampled every day for the HCAHPS survey. We are aware that not all hospitals participating in the HCAHPS survey will have HCAHPS-eligible discharges every day. HCAHPS requires survey vendors or hospitals to take a random sample of eligible discharges over a month. Daily follow-up with discharges is not required. Hospitals, or their survey vendor if they use one, may either sample their HCAHPS-eligible discharges at one time at the end of each month, or sample continuously throughout each month. If a hospital is using a survey vendor, the hospital must assure that its sample frame or the sample itself is delivered to the survey vendor in sufficient time to allow the survey vendor to contact patients within the timeframe established in the HCAHPS protocols. See *Quality Assurance Guidelines, V3.0*, pp. 33–46 for details regarding sampling protocols.

Comment: One commenter believed that underlying patient demographics such as socioeconomic status (SES) and psychiatric comorbidities affect scores and that additional analysis should be conducted.

Response: Certain patient characteristics that are beyond the control of hospitals have been found to influence how patients respond to the HCAHPS survey. One such characteristic is the patient's level of education, which can be seen as a proxy for SES.

Because different hospitals serve different mixes of patients, we adjust for the influence of these patient-level characteristics on HCAHPS results. Doing so allows fair comparisons of HCAHPS results to be made across hospitals. The particular characteristics included in patient-mix adjustment were identified by AHRQ in previous Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, then tested in the HCAHPS Three-State Pilot Study, and re-examined in the HCAHPS Mode Experiment, described above. One characteristic included in the patient-mix adjustment is patient's level of education. This is considered to be the best and most stable single indicator of SES for adults of all ages. More details of this and other patient-mix adjustments may be found in ''*Mode and Patient-mix Adjustment of the CAHPS® Hospital Survey (HCAHPS),*'' located at *http://www.hcahpsonline.org/modeadjustment.aspx*.

With respect to the effect of psychiatric comorbidities on HCAHPS scores, the patient-level data record of the administrative section of the HCAHPS survey requires that the hospital report only the principal service line (medical, surgical or maternity care) in which the patient was admitted. Requiring hospitals to collect information on co-morbidities would constitute an additional burden on them. In addition, because the HCAHPS survey is not deemed suitable for patients admitted primarily for psychiatric care, such patients are ineligible for the survey; psychiatric hospitals are excluded as well. More details about patient eligibility for HCAHPS may be found in *Quality Assurance Guidelines,* V3.0, pp. 33–36.

If, in the future, we reassess the content of the HCAHPS survey, notice will be taken of requests to add or alter survey items. A self-rated mental health status item, perhaps something similar to the current self-rated health status item, might be considered at that time. However, we do not plan to alter the HCAHPS survey for several years in order to allow hospitals and survey vendors to become accustomed to its content and methodology.

After careful consideration of the public comments received, we are finalizing the proposed HCAHPS measure requirements in their entirety.

6. Chart Validation Requirements for FY 2009 and FY 2010

a. Chart Validation Requirements for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47361), we stated that, until further notice, we would continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, continue and are being placed on the QualityNet Web site.

We also stated in the FY 2008 IPPS final rule with comment period that, until further notice, hospitals must pass our validation requirement that requires a minimum of 80-percent reliability, based upon our chart-audit validation process (72 FR 47361).

In the FY 2008 IPPS final rule with comment period (72 FR 47362), we indicated that, for the FY 2009 update, all FY 2008 validation requirements would apply, except for the following modifications. We would modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges. We would also expand the list of validated measures in the FY 2009 update to add SCIP Infection-2, SCIP VTE–1, and SCIP VTE–2 (starting with 4th quarter CY 2006 discharges). We would also drop the current two-step process to determine if the hospital is submitting validated data. For the FY 2009 update, we stated that we will pool validation estimates covering the four quarters (4th quarter CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the current 3rd quarter pooled confidence interval.

In summary, the following chart validation requirements apply for the FY 2009 RHQDAPU program:

- The 21-measure expanded set will be validated using 4th quarter CY 2006 (4Q06) through 3rd quarter CY 2007 (3Q07) discharges.
- SCIP VTE–1, VTE–2, and SCIP Infection 2 will be validated using 2nd quarter CY 2007 and 3rd quarter CY 2007 discharges.
- SCIP Infection 4 and SCIP Infection 6 must be submitted starting with 1st quarter CY 2008 discharges but will not be validated.
- HCAHPS data must continuously be submitted and will be reviewed as discussed above.
- AMI, HF, and PN 30-day mortality measures will be calculated as discussed below.

In the FY 2008 IPPS final rule with comment period (72 FR 47364), we stated that, for the FY 2008 update and in subsequent years, we would revise and post up-to-date confidence interval information on the QualityNet Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to ensure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received.

b. Chart Validation Requirements for FY 2010

In the FY 2009 IPPS proposed rule (73 FR 23658), for FY 2010, we proposed the following chart validation requirements:

- The following 21 measures from the FY 2009 RHQDAPU program measure set would be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

Topic	Quality measure validated from 4th quarter 2007 through 3rd quarter 2008 discharges
Heart Attack (Acute Myocardial Infarction or AMI)	• Aspirin at arrival. • Aspirin prescribed at discharge. • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • Beta blocker at arrival. • Beta blocker prescribed at discharge. • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.
Heart Failure (HF)	• Adult smoking cessation advice/counseling. • Left ventricular function assessment.

Topic	Quality measure validated from 4th quarter 2007 through 3rd quarter 2008 discharges
Pneumonia (PN)	• Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • Discharge instructions. • Adult smoking cessation advice/counseling. • Pneumococcal vaccination status.
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• Blood culture performed before first antibiotic received in hospital. • Adult smoking cessation advice/counseling. • Appropriate initial antibiotic selection. • Influenza vaccination status. • Prophylactic antibiotic received within 1 hour prior to surgical incision. • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.*** • SCIP-Infection 3: Prophylactic antibiotics discontinued within 24 hours after surgery end time.

• SCIP Infection 4 and Infection 6 would be validated using data from 2nd and 3rd quarter CY 2008 discharges.

In addition, we proposed to include the following three measures in the FY 2010 RHQDAPU program validation process that are included the FY 2009 RHQDAPU program measure set but have been updated or deleted for the FY 2010 measure set:

• Pneumonia antibiotic prophylaxis timing within 4 hours would be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

• Percutaneous Coronary Intervention (PCI) Timing within 120 minutes would be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

• Pneumonia Oxygenation Assessment would be validated using data from 4th quarter through 3rd quarter 2008 discharges.

These measures would be submitted by hospitals during 2008 and early 2009, and are available to be validated by CMS in time for the FY 2010 RHQDAPU program payment eligibility determination.

As explained above, we will also revise and post up-to-date confidence interval information on the QualityNet Web site explaining the application of the confidence interval to the overall validation results.

Comment: One commenter proposed not validating SCIP Infection 4 and 6 for 2nd and 3rd quarter 2008 discharges, because hospitals would not possess sufficient time to educate themselves about the abstraction instructions.

Response: We believe that adding these measures to the validation requirement is a reasonable approach to ensure accurately submitted data. We initially published abstraction instructions for these measures in the Specifications Manual located on the QualityNet Web site in 2006, and voluntary data submission for these measures began with July 2006 discharges. We believe that this time frame has been sufficient for hospitals to educate themselves regarding the abstraction instructions for these measures. In addition, to the extent we need to update the technical specifications for these measures, we do so on a semiannual basis at least six months in advance of the initial discharge date to which the updates apply.

After careful consideration of the public comments received, we are adopting as final the FY 2010 RHQDAPU program chart validation requirements we proposed.

c. Chart Validation Methods and Requirements Under Consideration for FY 2011 and Subsequent Years

Under the current and proposed RHQDAPU program chart validation process, we validate measures by reabstracting on a quarterly basis a random sample of five patient records for each hospital. This quarterly sample results in an annual combined sample of 20 patient records across 4 calendar quarters, but because the samples are random, they do not necessarily include patient records covering each of the clinical topics.

We anticipate that the proposed expansion of the RHQDAPU program measure set to include additional clinical topics will decrease the percentage of RHQDAPU program clinical topics, as well as the total number of measures, covered in many hospitals' annual chart validation.

However, in the FY 2009 IPPS proposed rule, we noted that we are considering whether registries and other external parties that may be collecting data on proposed RHQDAPU program measures could validate the accuracy of those measures beginning in FY 2011 (73 FR 23658). In addition, we noted that the proposed readmission measures are calculated using Medicare claims information and do not require chart validation.

In the FY 2009 IPPS proposed rule, we stated that we were interested in receiving public comments from a broad set of stakeholders on the impact of adding measures to the validation process, as well as modifications to the current validation process that could improve the reliability and validity of the methodology (73 FR 23658). We specifically requested input concerning the following:

• Which of the measures or measure sets should be included in the FY 2010 RHQDAPU program chart validation process or in the chart validation process for subsequent years?

• What validation challenges are posed by the RHQDAPU program measures and measure sets? What improvements could be made to validation or reporting that might offset or otherwise address those challenges?

• Should CMS switch from its current quarterly validation sample of five charts per hospital to randomly selecting a sample of hospitals, and selecting more charts on an annual basis to improve reliability of hospital level validation estimates?

• Should CMS select the validation sample by clinical topic to ensure that all publicly reported measures are covered by the validation sample?

Comment: Many commenters requested that improvements be made to the current validation process. The commenters noted that many hospitals

have been notified that there have been problems validating the data they submitted and argued that in several instances, these validation problems have been due to inconsistencies in the definitions of variables used by the contractors that are reabstracting patient-level data and comparing it to the data submitted by the hospitals. The commenters stated that, in other instances, discrepancies between single data elements unrelated to the quality of care provided by a hospital, such as the patient's birth date, have caused hospitals to fail validation. The commenters believed that reabstraction of five charts per quarter for each hospital is insufficient to ensure the reliability of the data and that a more resilient and less resource-intensive method of validation is needed. The commenters believed that the ideas for reforming the data validation process that were put forward by CMS in its VBP Report to Congress hold promise as an improved approach toward data validation. The commenters were disappointed that CMS did not propose similar changes for the RHQDAPU program in the FY 2009 IPPS proposed rule and urged CMS to propose an alternative data validation process for the RHQDAPU program as soon as possible.

Response: We appreciate these comments. We have used a single CDAC contractor to abstract the validation data since the inception of the RHQDAPU program, and are currently using a single CDAC contractor for validation abstraction. The current validation approach was originally designed several years ago to provide a reliable estimate of data element accuracy, and to provide feedback to all hospitals about their abstraction accuracy. We wanted all participating hospitals with sufficient patient size to receive quarterly feedback about data accuracy during the initial years of the RHQDAPU program. We believe that the current approach is adequate to assess overall accuracy for submitted data. Our experience in validating RHQDAPU program data has demonstrated that the vast majority of hospitals have submitted accurate data. Indeed, 99.5 percent of hospitals met the FY 2008 RHQDAPU program validation requirements. The majority of the 0.5 percent of hospitals that did not pass the FY 2008 RHQDAPU program validation requirements failed to return at least one entire quarterly sample of five medical records to the CDAC contractor in a timely manner.

For the future, we are considering alternative validation approaches that minimize the burden on hospitals while ensuring that accurate data continue to be submitted.

Comment: One commenter opposed selecting more charts from a random sample of hospitals, because it increases the burden that hospitals already must incur to track down, copy, and return requested validation charts. The commenter believed that hospitals would be more likely to not return charts, and consequently fail validation.

Response: We will consider this issue of burden as we continue to assess future validation approaches. However, we remind hospitals that under the current validation methodology, this burden is necessary in order for us to adequately assess whether the hospital has submitted accurate data for the year in question.

Comment: One commenter was concerned that CMS is validating data elements that have no bearing on the actual RHQDAPU quality measures, including antibiotic timing. Some elements, such as antibiotic route, are not required for calculating all RHQDAPU program quality measures related to antibiotic administration.

Response: We validate only data elements that are used to calculate at least one RHQDAPU measure. For example, documentation of antibiotic route is required to calculate all of the SCIP and PN antibiotic timing and administration measures. We utilize a single antibiotic administration route data element to provide consistent instructions that are applicable to all of the SCIP and PN antibiotics measures.

Comment: Many commenters supported keeping the current validation process, which involves five charts per quarter, and argued that in light of the proposed increases in measure data elements to be collected, changing the validation process this year would only add more chaos to the system. The commenters argued that randomly selecting a sample of hospitals for validation does not appear to work with a required threshold for payment. The commenters suggested that in the absence of documented evidence that the current validation process is unworkable, a thorough review with all stakeholders should be done to determine the best sampling methodology. One commenter recommended that CMS keep the number of requested validation charts to be reviewed small in order to minimize the burden on hospitals to print paper documentation from electronic medical records.

Response: We appreciate the concern that changing the current system would require sufficient time to educate hospitals about the new process. Any changes to the current validation process in future years would be proposed through the rulemaking process, so hospitals and other stakeholders would be able to review and comment on the best sampling methodology and other proposed validation requirements.

However, we believe that the current approach is adequate to assess overall accuracy for submitted data because our experience in validating RHQDAPU program data has demonstrated that the vast majority of hospitals have submitted accurate data.

Comment: One commenter supported CMS validating RHQDAPU program data, as opposed to registry or other external party validation.

Response: While ensuring the accuracy of the data, we are considering utilizing third party sources to validate RHQDAPU program data to minimize burden. We believe the STS and other organizations are validating by utilizing third party vendors to validate measures currently under consideration in the RHQDAPU program. We will consider this comment when proposing the validation approaches for future years.

Comment: One commenter supported stratified validation samples and targeting additional samples when the hospital scores less than 80 percent as an annual validation score.

Response: We appreciate the comment and will consider approaches such as selected separate stratified validation samples by clinical topic area (for example, AMI, Heart Failure, Pneumonia, and SCIP), increasing the validation sample size for randomly selected hospitals, and criteria for targeted validation in the future. These suggested approaches are potentially useful to ensure that all measure sets are validated, and that a sufficient sample is selected that represents the entire RHQDAPU program measure set.

Comment: A commenter agreed with the methodology of selecting an annual random sample of hospitals for validation each year, but raised the issue of whether this approach would increase the possibility that hospitals that are not selected for validation in a given year would not submit accurate data. Hospitals not selected for the annual random sample would know early in the submission year that they were not selected in the random sample of hospitals.

Response: We strive to ensure that accurate data is submitted by all hospitals each year. One possible approach in future years to ensure accuracy is to use submitted data as targeting criteria for validating a hospital's data. For example, hospitals

submitting a very high percentage of cases excluded from RHQDAPU program measures might be targeted for validation of their data to ensure that they are not improperly excluding cases in order to minimize their abstraction burden or limit the amount of their data that will be publicly reported. This approach might be used in conjunction with selecting an annual random sample of hospitals for validation to ensure accurate data submission.

Comment: Some commenters supported random sampling as a way to minimize the validation burden on hospitals. The commenters stated that sample selection by clinical topic is preferable, as long as a maximum quarterly limit per topic is set.

Response: We agree that random sampling of hospitals would eliminate annual recordkeeping and copying burden for the majority of hospitals. Sample selection by topic can be beneficial to ensure that all RHQDAPU measures are validated, but requires sufficient sample size per hospital to ensure that all topics are reliably sampled. We must consider the need to ensure accurate data, while minimizing burden when considering approaches in future years.

Comment: Several commenters recommended decreasing validation reviews for specific measures in which individual hospitals continually demonstrate consistent patterns and high validation rates.

Response: We appreciate this thoughtful recommendation for targeting the validation process and will consider it for future improvements to our process.

Comment: A commenter noted that as long as hospital medical records continue to reside in a paper-based format or non-electronic formats and do not allow for the necessary data capture and architecture to permit uniform automated reporting, the validation process will remain labor intensive. During this interim period before a substantial number of hospitals have implemented electronic health records (EHRs), the commenter recommended that CMS consider a process for accepting electronic copies of medical records from early EHR adopter hospitals.

Response: We will consider this recommendation in our plans to improve our validation process. We must design a process that will be consistent with the information practices of these leading-edge hospitals, while ensuring that hospitals still utilizing paper documentation are not adversely impacted by our process.

Comment: One commenter suggested that CMS propose to implement a validation process for all of the proposed measures and that it would be prudent for CMS to entertain a formal relationship with The Joint Commission to utilize the Joint Commission's existing auditing and validation process, and increase the power to validate RHQDAPU measures.

Response: We believe that the current approach is adequate to assess overall accuracy for submitted data. Our experience in validating RHQDAPU program data has demonstrated that the vast majority of hospitals have submitted accurate data. Indeed, 99.5 percent of hospitals met the FY 2008 RHQDAPU program validation requirements. We will consider this idea in our future plans for validating RHQDAPU program data as our RHQDAPU program measure set evolves.

Comment: One commenter strongly encouraged CMS to modify its CDAC review process to follow CMS specifications and incorporate skip logic. The commenter believed that this would reduce the abstraction burden on hospitals and prevent hospitals from being unfairly penalized when a parent question is incorrect.

Response: We interpret the commenter's term ''parent question'' to mean data elements occurring earlier in the RHQDAPU program measure's flow. If a parent question is answered ''no'' by the hospital, then no additional data elements occurring later in the measure's flow are used to calculate the measure for that patient stay. The CDAC follows the Specifications Manual's instructions when it abstracts validation data elements. The primary purpose of the current RHQDAPU program chart validation process is to assess the accuracy of hospitals' submitted data elements, compared to an independent abstraction using the hospitals' submitted paper medical record documentation. The CDAC abstracts each data element that is part of the measure being validated and compares that data element to the hospital's electronically submitted data element for the same patient case. If the data elements in a hospital's submitted RHQDAPU program measure do not match the CDAC's abstracted data elements, then the data elements are classified as mismatches counting against the hospital's validation score. We do not count any element not abstracted by the CDAC in the hospital's validation score.

The use of skip logic by hospitals is optional and not required under the RHQDAPU program. Hospitals should be aware the potential impact of skip logic on data quality, abstraction burden, and CMS chart audit validation scores. Hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow.

We will consider the issues raised by these commenters if we decide to make changes to the RHQDAPU program chart validation methodology for future years. Any changes we make to this process will be through rulemaking.

7. Data Attestation Requirements for FY 2009 and FY 2010

a. Data Attestation Requirements for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47364), we stated that we would require for FY 2008 and subsequent years that hospitals attest each quarter to the completeness and accuracy of their data, including the volume of data, submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks. We stated that we would provide additional information to explain this attestation requirement, as well as provide the relevant form to be completed on the QualityNet Web site, at the same time as the publication of the FY 2008 IPPS final rule with comment period.

In the FY 2009 IPPS proposed rule, we proposed to defer the requirement in FY 2009 for hospitals to separately attest to the accuracy and completeness of their submitted data due to the burden placed on hospitals to report paper attestation forms on a quarterly basis (73 FR 23659). We continue to expect that hospitals will submit quality data that are accurate to the best of their knowledge and ability. We received many comments in support of the proposed deferral of this requirement for FY 2009.

Comment: Many commenters supported the proposed plan for hospitals to defer attestation for FY 2009 and to electronically attest to completeness and accuracy of their submitted data when all hospitals possess electronic medical records. One commenter opposed the quarterly attestation requirement, and stated that the requirement is unnecessary and added no value.

Response: We agree with the commenters that quarterly attestation is more burdensome than annual attestation, and will consider this approach in future years. We must consider the relative burden on the hospitals to attest, relative to the need

to ensure accurate and complete data. The hospital is ultimately responsible for ensuring the accuracy and completeness of its RHQDAPU program data.

After careful consideration of the public comments received, we are deferring the attestation requirement for FY 2009, and will consider this information as we consider proposed attestation requirements for future years.

b. Data Attestation Requirements for FY 2010

In the FY 2009 IPPS proposed rule, for FY 2010 and subsequent years, we solicited public comment on the electronic implementation of the attestation requirement at the point of data submission to the QIO Clinical Warehouse (73 FR 23659). Hospitals would electronically pledge to CMS that their submitted data are accurate and complete to the best of their knowledge. Hospitals would be required to designate an authorized contact to CMS for attestation in their patient-level data submission.

Resubmissions would continue to be allowed before the quarterly submission deadline, and hospitals would be required to electronically update their pledges about data accuracy at the time of resubmission. We welcomed comments on this approach.

Comment: One commenter requested that CMS change the frequency of attestation to an annual requirement for FY 2010 and future years, or once on the initial participation form and argued that the burden of quarterly attestation is too high for hospitals. The commenter also supported electronic attestation.

Response: We appreciate this comment, and must weigh the options of reducing burden through annual submission of attestation or an initial attestation on the Notice of Participation form against the need to ensure data quality by requiring attestation during every quarterly data submission. We agree that annual or one-time initial attestation would minimize burden to hospitals.

We will also consider the option to allow hospitals to electronically submit their attestation to CMS at the point of submission. We believe that requiring hospitals to electronically attest when submitting data accomplishes the intended program goal, to ensure accurate and complete data while minimizing hospital burden.

8. Public Display Requirements

Section 1886(b)(3)(B)(viii)(VII) of the Act provides that the Secretary shall establish procedures for making data submitted under the RHQDAPU program available to the public. The RHQDAPU program quality measures are posted on the *Hospital Compare* Web site (*http://www.hospitalcompare.hhs.gov*). CMS requires that hospitals sign a ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form when they first register to participate in the RHQDAPU program. Once a hospital has submitted a form, the hospital is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS (72 FR 47360). Hospitals signing this form agree that they will allow CMS to publicly report the quality measures as required in the applicable year's RHQDAPU program requirements.

In the FY 2009 IPPS proposed rule, we proposed to continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act (73 FR 23659). Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

Currently, hospital campuses that share the same CCN must combine data collection and submission across their multiple campuses (for both clinical measures and for HCAHPS). These measures are then publicly reported as if they apply to a single hospital. We estimate that approximately 5 to 10 percent of the hospitals reported on the *Hospital Compare* Web site share CCNs. Beginning with the FY 2008 RHQDAPU program, hospitals must report the name and address of each hospital campus that shares the same CCN. This information will be gathered through the RHQDAPU program Notice of Participation form for new hospitals participating in the RHQDAPU program. To increase transparency in public reporting and improve the usefulness of the *Hospital Compare* Web site, we will note on the Web site where publicly reported measures combine results from two or more hospital campuses.

Comment: Several commenters stated that they wanted data displayed on *Hospital Compare* at the campus level rather than by CCN.

Response: We appreciate these comments and are exploring this issue. Currently, we are still gathering data from individual hospitals as to whether they share a CCN across campuses. The first step will be to note this on *Hospital Compare*. The next step will be to determine the feasibility of collecting data at the campus level.

Comment: One commenter urged CMS to ensure that the *Hospital Compare* Web site is user-friendly, especially with the addition of multiple measures.

Response: As explained earlier in this section, we use focus groups to test all measures before we publicly post them on *Hospital Compare*. We also test the usability of computer screens and language *Hospital Compare* Web site with consumers to make enhancements to ensure that the site is easy to use and is understandable. Through this testing, draft language and draft Web site displays are revised based on feedback.

9. Reconsideration and Appeal Procedures

In the FY 2009 IPPS proposed rule, for FY 2009, we proposed to continue the current RHQDAPU program reconsideration and appeal procedures finalized in the FY 2008 IPPS final rule with comment period (73 FR 23659). The deadline for submitting a request for reconsideration in connection with the FY 2009 payment determination is November 1, 2008. We also proposed to use the same procedural rules finalized in the FY 2008 IPPS final rule with comment period (72 FR 47365). We posted these rules on the *QualityNet* Web site for the FY 2008 RHQDAPU program reconsideration process.

Under the procedural rules, in order to receive reconsideration for FY 2009, the hospital must—

- Submit to CMS, via *QualityNet,* a Reconsideration Request form (available on the *QualityNet* Web site) containing the following information:

Hospital Medicare ID number
—Hospital Name
—CMS-identified reason for failure (as provided in the CMS notification of failure letter to the hospital)
—Hospital basis for requesting reconsideration. (This must identify the hospital's specific reason(s) for believing it met the RHQDAPU program requirements and should receive the full FY 2009 IPPS annual payment update.)
—CEO contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just the post office box)
—QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just the post office box)

- The request must be signed by the hospital's CEO.

Following receipt of a request for reconsideration, CMS will—

- Provide an e-mail acknowledgement, using the contact

information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the letter has been received.

• Provide a formal response to the hospital CEO, using the contact information provided in the reconsideration request, notifying the facility of the outcome of the reconsideration process. CMS expects the process to take 60 to 90 days from the due date of November 1, 2008.

If a hospital is dissatisfied with the result of a RHQDAPU program reconsideration decision, the hospital may file a claim under 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal).

Comment: Several commenters stated that hospitals should have clear guidance on how to submit their appeals, and CMS should provide timely appeals decisions. In the FY 2009 IPPS proposed rule, CMS stated that it would provide hospitals with a decision within 60 to 90 days of their appeals. The commenters believed that this time period is burdensome to hospitals and unnecessary. In addition, because CMS decreases a hospital's payments during the appeals process, the commenters believed that it may cause unnecessary cash flow problems for hospitals whose validation results are later overturned and that this could be particularly harmful for hospitals serving large numbers of uninsured patients. The commenters noted that in FY 2008, CMS processed all appeals within 60 days and argued that there is no reason why this timeline should be expanded to 90 days for FY 2009. The commenters noted that in the Department's VBP Report to Congress, the Department outlines an appeals process through which hospitals that initially fail validation will not receive lower payment while their appeals are ongoing; instead, only after a final decision is reached would any payment adjustments be made. The commenters believed that this logical process should be established now in the RHQDAPU program. One commenter suggested that CMS implement an approach for withholding the 2.0 percentage points from the annual payment update similar to Medicare's process for recouping overpayments. The commenter stated that the recoupment process prohibits Medicare contractors from recouping funds during the first two levels of an appeal.

Response: We believe that the commenters are referring to the proposed 60 to 90 day timeframe for the RHQDAPU program reconsideration process. We agree that hospitals need to know the results of this process as quickly as possible. The commenter is confused about the nature of recoupment and has raised an issue that does not apply here. Recoupment is a defined term in CMS regulations (42 CFR 405.370) and refers to the recovery of outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. This is not the same as a downward adjustment of a hospital's payment update and does not concern any ''debt'' owed to Medicare. The ''limitation on recoupment'' policy the commenter discusses would not apply to CMS' decision to adjust downward a hospital's annual payment update by 2.0 percentage points based on the hospital failing to meet RHQDAPU program requirements.

After careful consideration of the public comments received, we are adopting as final the RHQDAPU program reconsideration and appeals requirements we proposed. We believe that the FY 2009 RHQDAPU program reconsideration review will require 60 to 90 days for completion, based on last year's workload. This time frame is necessary to ensure thorough and complete review of all hospitals' submitted reconsideration requests. We will communicate all determinations within 60 to 90 days following the deadline for requesting reconsideration. We will strive to provide hospitals with a clear and prompt process for reconsideration.

10. RHQDAPU Program Withdrawal Deadlines for FY 2009 and FY 2010

In the FY 2009 IPPS proposed rule, we proposed to accept RHQDAPU program withdrawal forms for FY 2009 from hospitals through August 15, 2008 (73 FR 23660). We proposed this deadline to provide CMS with sufficient time to update the FY 2009 payment to hospitals starting on October 1, 2008. If a hospital withdraws from the program for FY 2009, it will receive a 2.0 percentage point reduction in its FY 2009 annual payment update.

We also proposed to accept RHQDAPU program withdrawal forms for FY 2010 from hospitals through August 15, 2009. If a hospital withdraws from the program for FY 2010, it will receive a 2.0 percentage point reduction in its FY 2010 annual payment update.

We received no comments on this proposed requirement, and we are adopting as final the RHQDAPU program withdrawal deadlines we proposed for FY 2009 and FY 2010.

11. Requirements for New Hospitals

In the FY 2008 IPPS final rule with comment period (72 FR 47366), we stated that a new hospital that receives a CCN (formerly called Medicare provider number) on or after October 1 of each year (beginning with October 1, 2007) will be required to report RHQDAPU program data beginning with the first day of the quarter following the date the hospital registers to participate in the RHQDAPU program. For example, a hospital that receives its CCN on October 2, 2008, and signs up to participate in the RHQDAPU program on November 1, 2008, will be expected to meet all of the data submission requirements for discharges on or after January 1, 2009.

In addition, we strongly recommended that each new hospital participate in an HCAHPS dry run, if feasible, prior to beginning to collect HCAHPS data on an ongoing basis to meet RHQDAPU program requirements. We refer readers to the Web site at *http://www.hcahpsonline.org* for a schedule of upcoming dry runs. The dry run will give newly participating hospitals the opportunity to gain first-hand experience collecting and transmitting HCAHPS data without the public reporting of results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect HCAHPS data and submit the data to QualityNet.

12. Electronic Health Records

In the FY 2006 IPPS final rule, we encouraged hospitals to take steps toward the adoption of electronic health records (EHRs) (also referred to in this preamble and in previous rulemaking documents as electronic medical records) that will allow for reporting of clinical quality data from the EHRs directly to a CMS data repository (70 FR 47420). We intend to begin working toward creating measures' specifications, and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as is currently done. The Department continues to work cooperatively with other Federal agencies through our participation in the Healthcare Information Technology Standards Panel (HITSP)—a public/private partnership—to advance the harmonization of interoperability standards for electronic health information exchange. We encouraged hospitals that are developing systems to conform them to industry standards, and in particular to Secretary

recognized interoperability standards, where applicable, taking measures to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables detection of high levels of performance on the measures. Hospitals using EHRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EHRs.

Due to the low volume of comments we received on this issue in response to the FY 2006 proposed IPPS rule, in the FY 2007 IPPS proposed (71 FR 24095), we again invited public comment on these requirements and related options. In the FY 2007 IPPS final rule (71 FR 48045), we summarized and addressed the additional comments we received. In the FY 2008 IPPS proposed rule (72 FR 24809), we noted that we would welcome additional comments on this issue.

In the FY 2008 IPPS final rule with comment period (72 FR 47366), we responded to the additional comments we received and noted that CMS plans to continue participating in the American Health Information Community (AHIC) workgroups and other entities to explore processes through which an EHR could speed the collection and minimize the resources necessary for quality reporting. (The AHIC is a Federal advisory body, chartered in 2005 to make recommendations to the Secretary on how to accelerate the development and adoption of health information technology.) In addition, we noted that we will continue to participate in appropriate HHS studies and workgroups, as mentioned by a GAO report (GAO–07–320) about hospital quality data and the use of information technology. As appropriate, CMS will inform interested parties regarding progress in the implementation of HIT for the collection and submission of hospital quality data as specific steps, including timeframes and milestones, are identified. Current mechanisms include publication in the **Federal Register** as well as ongoing collaboration with external stakeholders such as the HQA, the AHA, the FAH, the AAMC and The Joint Commission. We further anticipate that as HIT is implemented, a formal plan, including training, will be developed to assist providers in understanding and utilizing HIT in reporting quality data. In addition, we will assess the effectiveness of our communications with providers and stakeholders as it relates to all information dissemination pertinent to collecting hospital quality data as part of an independent and comprehensive external evaluation of the RHQDAPU program.

In the FY 2009 IPPS proposed rule, we again solicited comments on the issues and challenges associated with EHRs (73 FR 23660). Specifically, we invited comment on our proposed changes to our data submission requirements to be more aligned with currently implemented HIT systems, including data collection from registries and laboratory data.

We recognize the potential burden on hospitals of increased data reporting requirements for process measures that require chart abstraction. In FY 2007 IPPS rulemaking, we listed a variety of additional possible measures for future years. The measures included and emphasized additional outcomes measures. Additional measures were included for which the data sources are claims. For these, no additional data abstraction or submission would be required for reporting hospitals beyond the claims data. In proposing measures for FY 2010, we sought to emphasize outcome measures and to minimize any additional data collection burden. In addition, as provided in section 1886(b)(3)(B)(viii)(VI) and discussed in section IV.B.2.a. of the FY 2009 IPPS proposed rule, we proposed to retire one measure where there is no meaningful difference among hospitals as a means of reducing data collection burden.

Comment: Several commenters stated that the current Specifications Manual is very complex, burdensome, and difficult for hospitals to understand.

Response: We appreciate the comments and understand that abstracting information from medical record documentation is burdensome and complex. We strive to improve the quality and clarity of the abstraction instructions by regularly updating them on a semiannual basis. We currently provide hospitals with updated instructions six months prior to the first effective discharge date to which the updated instructions apply, and actively educate hospitals on the specifications through our QIOs. These updates strive to improve the clarity and conciseness of the specifications, while attempting to minimize unnecessary updates.

We will actively work to further simplify our specifications in the future, and develop new measures that are less burdensome and more easily utilize electronic medical records.

Comment: One commenter expressed concern about priority source document guidelines in RHQDAPU program measure specification abstraction instructions. The commenter stated that these guidelines do not necessarily align with the practices and documentation of hospitals using electronic medical records.

Response: We believe that the priority source document guidelines in RHQDAPU program measure specification abstraction instructions currently align with the practices and documentation of the vast majority of hospitals. We strive to align our measures specifications with current recordkeeping practices of hospitals. We constantly review feedback from hospitals to improve our current specifications through our semiannual updates to the Specifications Manual.

Comment: One commenter stated that measures developed outside the sphere of joint development by CMS and The Joint Commission must be identified as such and published and maintained outside of the Specifications Manual.

Response: We understand that many of the 43 additional RHQDAPU program measures we proposed for the FY 2010 payment determination were not developed by CMS or The Joint Commission. These measures are currently posted on many different Web sites, including the AHRQ Web site for AHRQ PSI and IQI measures. In the near future, we plan to display RHQDAPU program measures developed outside the sphere of joint development by CMS and The Joint Commission on the QualityNet Web site.

Comment: Two commenters encouraged CMS to implement payment policies, like incentives, add-ons, or bonuses to current payments, to facilitate and encourage the effective use of information technology that includes electronic health records. The commenters believed that smaller and rural hospitals would particularly benefit from this recommendation.

Response: We appreciate the comments. Generally, the Federal government supports the adoption of health information technology as the normal cost of doing business. However, we believe that add-ons and bonuses of this nature would require legislative mandate to modify the payment system.

Comment: One commenter urged CMS to support interoperable standards for collecting, transmitting, and reporting information and urged CMS to work with the private sector to begin embedding requirements for performance measurement into the design of medical and healthcare record systems.

Response: We will consider these suggestions in our plans for measure development for the RHQDAPU program in future years. We will also strive to update current measures to more closely align with current

electronic medical records in use such as utilizing data element instructions that are utilized by current electronic medical records.

Comment: One commenter stated that uniform data content standards are crucial to the effort to reduce the burden on hospitals and recommended that CMS promote the development and adoption of data content and information technology standards that will support automated data collection and reporting of clinical data from EHR systems.

Response: We appreciate this comment and will consider whether it is appropriate to develop and adopt the standards suggested by the commenter. We will also consider this suggestion in our plans for measure development in future years. As we explained more fully above, we will also strive to update current measures to more closely align with current electronic medical records in use.

13. RHQDAPU Program Data Infrastructure

In addition to the specific comments on data submission requirements discussed in section IV.B.4.b. of this preamble, we received many general comments about the RHQDAPU program data infrastructure related to current submissions and its capability to handle the proposed expanded measure set.

Comment: Some commenters identified what they believed to be infrastructure problems at the QIO Clinical Warehouse that receives hospital submitted RHQDAPU program quality data. Other commenters conveyed the difficulty associated with using QualityNet Web site applications, including QNet Quest and My QualityNet. The commenters urged CMS to devote more resources to the data infrastructure and to seek comment through the regulatory process for what changes should be made most urgently.

Response: We have made recent improvements to the infrastructure to process the increased data volume submitted by hospitals for the RHQDAPU program, such as procuring additional bandwidth to accommodate the increased data flow into the QIO Clinical Warehouse. We also are working to improve the QNet Quest question and answer application for hospitals to submit technical and measures questions. This application is located on the QualityNet Web site. We also are working to improve other applications used by hospitals in support of the RHQDAPU program. We will consider these comments when planning further infrastructure improvements to keep pace with the evolution of the RHQDAPU program measure set.

Comment: Some commenters supported the use of a single data repository for all hospital quality data.

Response: We must consider many factors about this approach, and its impact on CMS programmatic needs, hospital burden, and other issues. We must consider our programmatic needs to own the RHQDAPU program data and infrastructure in order to ensure accurate publicly reported data and to support the Medicare IPPS in determining annual payment update eligibility. We understand that a single Federal/non-Federal quality data repository would reduce burden and provide more research capabilities to non-Federal researchers. However, we must also abide by Federal statutes and rules for sharing the RHQDAPU program patient-level data with non-QIO users.

C. Medicare Hospital Value-Based Purchasing (VBP) Plan

1. Medicare Hospital VBP Plan Report to Congress

Through section 5001(b) of the Deficit Reduction Act of 2005 (DRA), Congress required the development of a plan to implement value-based purchasing (VBP) for IPPS hospital services beginning FY 2009. By statute, the plan must address: (a) The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (b) reporting, collection, and validation of quality data; (c) the structure, size, and source of value-based payment adjustments; and (d) public disclosure of hospital performance data. The Report was submitted to Congress on November 21, 2007.

The Medicare Hospital VBP Plan builds on the foundation of Medicare's current RHQDAPU program (discussed in section IV.B. of the preamble of this final rule), which, since FY 2005, has provided differential payments to hospitals that report their performance on a defined set of inpatient measures for public posting on the *Hospital Compare* Web site. If authorized by Congress, the VBP Plan would include both public reporting and new financial incentives to drive improvements in clinical quality, patient-centeredness, and efficiency.

The proposed Plan contains the following key components: (a) A performance assessment model that incorporates measures from different quality domains (that is, clinical process of care, patient experience of care, and others, when developed) to calculate a hospital's total performance score; (b) options for translating this score into an incentive payment that would make a portion of the hospital's base DRG payment contingent on its total performance score; (c) criteria for selecting performance measures for the financial incentive and candidate measures for FY 2009 and beyond; (d) a phased approach for transitioning from the RHQDAPU program to the VBP Plan; (e) proposed enhancements to the current data transmission and validation infrastructure to support VBP program requirements; (f) refinements to the *Hospital Compare* Web site to support expanded public reporting; and (g) an approach to monitoring VBP impacts.

The Medicare Hospital VBP Plan Report to Congress is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.*

2. Testing and Further Development of the Medicare Hospital VBP Plan

A Hospital VBP Workgroup has undertaken testing of the VBP Plan. This ''dry run'' or ''simulation'' of the Plan is using the most recent clinical process-of-care and HCAHPS measurement data available from the RHQDAPU program. New information generated by the VBP Plan testing will include: (a) Performance scores by domain; (b) total performance scores; and (c) financial impacts. Following a process similar to that used in developing the Plan, CMS will analyze this information by each individual IPPS hospital, by segment of the hospital industry (that is, geographic location, size, teaching status, among others), and in aggregate for all IPPS hospitals.

The results of VBP Plan testing will be used to further develop the Plan. Priorities for Plan completion include addressing the small numbers issue (described on pages 74 and 75 of the Hospital VBP Plan Report to Congress) and developing a scoring methodology for the outcomes domain (pages 57–58 of the Hospital VBP Plan Report to Congress), which will become an additional aspect of the performance model. After completion, the Plan will be retested.

In the FY 2009 IPPS proposed rule (73 FR 23661), we sought public comments on how to take full advantage of the new information generated through this testing and further Plan development. For example: Should the testing and retesting results be publicly posted? If the testing results were to be posted, would the best location be the *Hospital*

Compare Web site or the CMS Web site at: *http://www.cms.hhs.gov*? In what format would public posting be most useful to potential audiences? At what level would the data be posted—individual hospital or some higher level? Which data elements from the testing results would be most useful to share?

We received 65 public comments regarding this section of the proposed rule. These public comments are summarized below.

Comment: Overall, the commenters agreed that testing will provide valuable information for understanding the range of performance results under the Hospital VBP Plan and could provide a useful planning tool for individual hospitals. The comments are categorized here into eight themes, the first three of which are directly responsive to questions posed in the proposed rule.

• What Testing Results Should Be Posted

Commenters were generally opposed to publicly posting performance information at the individual hospital level. The commenters noted that the VBP Plan has not yet been authorized by Congress, that the methodology might be changed during authorization, and that the impacts of the current methodology on different types of hospitals are still being evaluated. The commenters were particularly concerned that Medicare beneficiaries and others might use premature testing results to inform healthcare decisions. Several commenters emphasized that, if results are to be posted at the individual hospital level, each hospital should be given access to its preliminary results prior to publication, be given sufficient time to evaluate the results, and have the option to appeal to CMS for modifications.

• Where Testing Results Should Be Posted

Most commenters recommended not posting testing results on Hospital Compare because of concerns that posting on Hospital Compare would be confusing for beneficiaries who use the Web site to make comparisons of hospital quality. Alternatively, several commenters suggested posting testing results on the CMS Web site at: *http://www.cms.hhs.gov*. Irrespective of which Web site, the commenters urged CMS to state clearly in any posting that VBP has not yet been authorized by Congress, that the results are from Plan testing, and that the testing results should not be used to compare hospital quality. The commenters suggested that CMS instead note that the results have been posted as part of testing the proposed VBP Plan methodology and are intended to promote feedback for refining the methodology.

• At What Level Testing Results Should Be Posted

Many commenters supported publicly posting aggregate-level performance results without individual hospital identification, such as at the National and State levels and by different hospital characteristics such as urban vs. rural, teaching status, bed size, and geographic location. The commenters indicated that this information could help various stakeholder groups understand how the VBP Plan would work and its potential impacts on improving quality of care for Medicare beneficiaries.

• Sharing Results With Individual Hospitals

Although most commenters opposed posting individual hospital data, nearly all of the commenters favored sharing testing results with each individual hospital. In addition, the commenters requested that CMS create opportunities for hospital leaders to ask questions and provide feedback regarding their hospitals' results. One commenter suggested that CMS use MyQualityNet (formerly QualityNet Exchange) to share testing results confidentially, enabling hospitals to verify the scores and also to see the financial implications of the VBP methodology.

• Application of Incentives

Many commenters, particularly hospitals, expressed concern about how incentives would be distributed under the VBP Plan. Several commenters stressed that the VBP financial incentive should not be used to generate Medicare program savings, urging instead that any at-risk funds should be returned to hospitals as incentives. Several commenters expressed concern that some hospitals, especially safety net and under-performing hospitals, could be disadvantaged if top-performing hospitals were to earn a majority of the incentives. One commenter suggested that CMS withhold a portion of the incentive pool to create a funding source for quality improvement grants to under-performing hospitals.

• Sensitivity to Hospital Burden

A majority of commenters urged CMS to be sensitive to the limited resources of hospitals, especially safety net hospitals, and expressed concern that the VBP Plan could significantly increase the reporting burden for hospitals. Some commenters suggested that if VBP were to incorporate too many different quality domains, hospitals' attention could be diffused and patient care resources further stretched.

• Convening a Technical Advisory Panel

Following the lead of a national hospital association, approximately half of the commenters on this section in the proposed rule requested that CMS bring together a technical advisory panel to review the VBP Plan testing results. The commenters indicated that this advisory panel could help CMS assess the impact of VBP Plan design choices and could suggest refinements to the Plan. Other commenters suggested using focus groups to vet the results from testing the VBP incentive methodology to assess the usefulness and clarity of this information.

• Nursing-Specific Issues

Several commenters proposed including nursing-based performance measures in VBP.

Response: We appreciate the thoughtful public comments that were submitted on this topic and will consider the commenters' input as we undertake further testing and refinement of the Hospital VBP Plan.

D. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs) (§§ 412.78, 412.92, 412.108, and 412.109)

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary) is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in 42 CFR 412.92 of the regulations. Our regulations at § 412.109 also provide that certain essential access community hospitals (EACHs) will be treated as an SCH for payment purposes.

Under the IPPS, separate special payment protections also are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not

less than 60 percent of its inpatient days or discharges in its 1987 cost reporting year or in two of its most recent three settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located in 42 CFR 412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are hospitals that are paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

For SCHs, effective with hospital cost reporting periods beginning on or after October 1, 2000, and before January 1, 2009, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101–239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106–113 and further amended by section 213 of Pub. L. 106–554) provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge; or
- The updated hospital-specific rate based on FY 1996 costs per discharge.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are based on 100 percent of the updated FY 1996 hospital-specific rate.

As discussed in detail in section IV.D.2. of this preamble, the recently enacted Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275), contains a provision under section 122 that changes the provisions for rebasing the payments for SCHs, effective for cost reporting periods beginning on or after January 1, 2009.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 50 percent of the difference between the Federal rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. However, section 5003 of Public Law 109–171 (DRA) modified these rules for discharges occurring on or after October 1, 2006. Section 5003(c) changed the 50 percent adjustment to 75 percent. Section 5003(b) also requires using the FY 2002 costs per discharge (that is, the FY 2002 updated hospital-specific rate) if that results in a higher payment. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary/MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary/MAC makes the determination. However, it may not be possible for the fiscal intermediary/MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. In many instances, it is not possible to forecast the outlier payments, or the amount of the DSH adjustment or the IME adjustment, all of which are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The fiscal intermediary/MAC makes a final adjustment at the close of the cost reporting period after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital.

If a hospital disagrees with the fiscal intermediary's or MAC's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's or MAC's decision in accordance with the procedures set forth in 42 CFR Part 405, Subpart R, which concern provider payment determinations and appeals.

2. Rebasing of Payments to SCHs

Since the issuance of the FY 2009 IPPS proposed rule, a new law has been enacted that changed the rebasing provisions for payments to SCHs, effective with cost reporting periods beginning on or after January 1, 2009. Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) provides that, for cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on a FY 2006 hospital-specific rate (that is, based on their updated costs per discharge from their 12-month cost reporting period beginning during Federal fiscal year 2006), if this results in the greatest payment to the SCH. Therefore, effective with cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on the rate that results in the greatest aggregate payment using either the Federal rate or their hospital-specific rate based on their 1982, 1987, 1996, or 2006 costs per discharge.

Because this statutory provision is self-implementing, in this final rule, we are incorporating the provision in our regulations. Specifically, we are adding a new § 412.77A to include the provisions of the law and revising § 412.92 to make a conforming technical change.

3. Volume Decrease Adjustment for SCHs and MDHs: Data Sources for Determining Core Staff Values

Section 1886(d)(5)(D)(ii) of the Act requires that the Secretary make a payment adjustment to an SCH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the SCH's control. Section 1886(d)(5)(G)(iii) of the Act requires that the Secretary also make a payment adjustment to an MDH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the MDH's control. These adjustments were designed to compensate an SCH or MDH for the fixed costs it incurs in the year in which the reduction in discharges occurred, which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services. Our records indicate that less than 10 SCHs/MDHs request and receive this payment adjustment each year.

We believe that not all staff costs can be considered fixed costs. Using a specified standardized formula, the SCH or MDH must demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. This formula examines nursing staff in particular. If an SCH or MDH has an excess number of nursing staff, the cost of maintaining those staff members is deducted from the total adjustment. One exception to this policy is that no SCH or MDH may reduce its number of staff to a level below what is required by State or local law. In other words, an SCH or MDH will not be penalized for maintaining a level of staff that is consistent with State or local requirements.

The process for determining the amount of the volume decrease

adjustment can be found in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1). Fiscal intermediaries/MACs are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A decrease of more than 5 percent in the total number of inpatient discharges as compared to the prior cost reporting period has occurred; and (b) the circumstances that caused the decrease in discharges were beyond the control of the hospital. Once the fiscal intermediary/MAC has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's MS–DRG payment from the lesser of: (a) The second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

In order to determine whether or not the hospital's nurse staffing level is appropriate, the fiscal intermediary/MAC compares the hospital's actual number of nursing staff in each area with the staffing of like-size hospitals in the same census region. If a hospital employs more than the reported average number of nurses for hospitals of its size and census region, the fiscal intermediary/MAC reduces the amount of the adjustment by the cost of maintaining the additional staff. The amount of the reduction is calculated by multiplying the actual number of nursing staff above the reported average by the average nurse salary for that hospital as reported on the hospital's Medicare cost report. The complete process for determining the amount of the adjustment can be found at Section 2810.1 of the PRM–1.

Prior to FY 2007, our policy was for fiscal intermediaries/MACs to obtain average nurse staffing data from the AHA HAS/Monitrend Data Book. However, in light of concerns that the Data Book had been published in 1989 and is no longer updated, in the FY 2007 IPPS rules, we proposed and finalized our policy to update the data sources and methodology used to determine the core staffing factors (that is, the average nursing staff for similar bed size and census region) for purposes of calculating the volume decrease adjustment (71 FR 48056 through 48060). We specified that for adjustment requests for decreases in discharges beginning with FY 2007 (that is, a decrease in discharges in FY 2007 as compared to FY 2006), an SCH or MDH could opt to use one of two data sources: the AHA Annual Survey or the Occupational Mix Survey, but could not use the HAS/Monitrend Data Book. (For any open adjustment requests prior to FY 2007, we allowed SCHs and MDHs the option of using the results of any of three sources: (1) The 2006 Occupational Mix Survey for cost reporting periods beginning in FY 2006; (2) the AHA Annual Survey (where available); or (3) the AHA HAS/Monitrend Data Book.) We also specified a methodology for calculating those core staffing factors. For purposes of explaining the methodology, we applied it to the 2003 Occupational Mix Survey data. In our explanation, we recognized that some of the 2003 data seemed anomalous, and we solicited comments on a possible alternative methodology. However, there were no suggested alternative methodologies from the commenters. We also explained that, while we used the 2003 Occupational Mix Survey data ''for purposes of describing how we would implement this methodology,'' the final policy was to use FY 2006 Occupational Mix Survey data going forward. At the time we published the proposed and final rules, however, we had not yet processed the FY 2006 data, and could not present the core staffing figures that resulted from such data. In the FY 2007 IPPS final rule (71 FY 48057), we stated that because the occupational mix survey is conducted once every 3 years, we would update the data set every 3 years.

We have now processed the 2006 Occupational Mix Survey data using the methodology specified in the FY 2007 IPPS final rule and continue to see some results that cause us to believe that the methodology for calculating the core staffing factors should be slightly revised from the methodology discussed in the FY 2007 IPPS final rule (71 FR 48056 through 48060). The new methodology uses a revised formula to remove statistical outliers from the core staffing values.

a. Occupational Mix Survey

In the FY 2007 IPPS final rule (71 FR 48055), we explained the methodology we would use for calculating core staffing values from the Occupational Mix Survey. We stated that we would calculate the nursing hours per patient day for each SCH or MDH by dividing the number of paid nursing hours (for registered nurses, licensed practical nurses and nursing aides) reported on the Occupational Mix Survey by the number of patients days reported on the Medicare cost report. The results would be grouped in the same bed-size groups and census regions as were used in the HAS/Monitrend Data Book.

We indicated that we would publish the mean number of nursing hours per patient day for each census region and bed-size group in the **Federal Register** and on the CMS Web site. For purposes of the volume decrease adjustment, the published data would be utilized in the same way as the HAS/Monitrend data: The fiscal intermediary/MAC would multiply the SCH's and MDH's number of patient days by the applicable published hours per patient day. This figure would be divided by the average number of worked hours per year per nurse (for example, 2,080 for a standard 40-hour week). The result would be the target number of core nursing staff for the particular SCH or MDH. If necessary, the cost of any excess staff (number of FTEs that exceed the published number) would be removed from the second year's costs or, if applicable, the previous year's costs multiplied by the IPPS update factor when determining the volume decrease adjustment.

In the FY 2007 IPPS final rule, to illustrate how we would calculate the average number of nursing hours per patient day by bed size and region, we first merged the FY 2003 Occupational Mix Survey data with the FY 2003 Medicare cost report file. We eliminated all observations for non-IPPS providers, providers who failed to complete the occupational mix survey, and the providers for which provider numbers, bed counts, and/or days counts were missing.

For each provider in the pool, we calculated the number of nursing hours by adding the number of registered nurses, licensed practical nurses, and nursing aide hours reported on the Occupational Mix Survey. We divided the result of this calculation by the total number of inpatient days reported on the cost report to determine the number of nursing hours per patient day. For purposes of calculating the census regional averages for the various bed-size groups, we finalized our rule to only include observations that fell within 3 standard deviations of the mean of all observations, thus removing potential outliers in the data.

When the FY 2006 Occupational Mix Survey data became available, our analysis of the results indicated that the methodology for computing core staffing factors should be further revised in order to further eliminate outlier data.

After consulting with the Office of the Actuary on appropriate statistical

methods to remove outlier data, in the FY 2009 IPPS proposed rule (73 FR 23663), we proposed to modify our methodology for calculating the average nursing hours per patient day using the FY 2006 Occupational Mix Survey data and FY 2006 Medicare cost report data. Similar to what was finalized in the FY 2007 IPPS final rule, we proposed to merge the FY 2006 Occupational Mix Survey data with the FY 2006 Medicare cost report file. We proposed to then eliminate all observations for non-IPPS providers, providers with hospital-based SNFs, providers who failed to complete the occupational mix survey, and the providers for which provider numbers, bed counts and/or days counts were missing. We proposed to annualize the results so that the nursing hours from the Occupational Mix Survey and the patient days reported on the Medicare cost report are representative of one year.

For each provider in the pool, we proposed to calculate the number of nursing hours by adding the number of registered nurses, licensed practical nurses, and nursing aide hours reported on the Occupational Mix Survey. We proposed to divide the result of this calculation by the total number of patient days reported on line 12 on Worksheet S–3, Part I, Column 6 of the Medicare cost report. This includes patient days in the general acute care area and the intensive care unit area. The result is the number of nursing hours per patient day.

For purposes of calculating the census regional averages for the various bed-size groups, we proposed a different method to remove outliers in the data. First, we proposed to calculate the difference between the observations in the 75th percentile and the 25th percentile, which is the inter-quartile range. We would then remove observations that are greater than the 75th percentile plus 1.5 times the inter-quartile range and less than the 25th percentile minus 1.5 times the inter-quartile range. This methodology, proposed by Tukey in the mid-1970's, also has been used by the Office of the Actuary to trim data outliers. Under the standard deviation method described in the FY 2007 IPPS final rule, the mean and standard deviation can be influenced by extreme values (because the standard deviation is increased by the very observations that would otherwise be discarded from the analysis). Our proposed methodology is a more robust technique because it uses the quartile values instead of variance to describe the spread of the data, and quartiles are less influenced by extreme outlier values that may be present in the data.

Comment: One commenter requested that CMS indicate what data it used in the Occupational Mix Survey to calculate the average nursing staff levels. In particular, the commenter wanted to know what type of staff was used to determine average nursing hours per inpatient day.

Response: As discussed in the FY 2007 IPPS final rule (71 FR 48057) and reiterated in this final rule, the 2006 Occupational Mix Survey includes nursing hours for the following categories: (1) Registered nurses; (2) licensed practical nurses; and (3) nursing aides, orderlies, and attendants. (We note that we are not including the hours associated with medical assistants—a fourth category of hours collected by the Occupational Mix Survey.) The registered nurse category is divided into two subcategories: management personnel; and staff nurses or clinicians. We are finalizing our proposed methodology so that the average nursing hours per inpatient day includes the hours of registered nurses, licensed practical nurses, and nursing aides (which includes the nursing aides, orderlies and attendants) as reported on the FY 2006 Occupational Mix Survey (we are not including hours for medical assistants). The FY 2006 Occupational Mix Survey data are available on the CMS Web site (*http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*).

Comment: One commenter stated that there was an inconsistency in the Medicare Cost Report data that CMS was using to determine patient days because CMS used line 12 of Worksheet S–3, Part I, Column 6 that includes nursery days. The commenter did not believe nursery days should be included in the adjustment because it is inconsistent with the PRM that states that ''Core nursing staff is determined by comparing full-time equivalent (FTE) staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals.''

Response: The guidance in the PRM on how the core nursing staff is determined is based on the use of the HAS/Monitrend data, which provide average staffing levels by census region and bed size for the ICU and Adult and Pediatric areas. However, with our updated data sources, we cannot isolate nursing hour per patient day to only the ICU and Routine Care areas. As we stated in the FY 2007 IPPS final rule (71 FR 48059), the Occupational Mix Survey data collects data on both the inpatient and outpatient areas of the hospital, including the nursery area. In addition, it is our understanding that nursing staff may, and often do, rotate between the inpatient and outpatient areas of the hospital as necessary. Further, inpatients often utilize services in the outpatient (or ancillary) areas of the hospital. As a result, we believe that the total nursing hours derived from the Occupational Mix Survey should be divided by total inpatient days, or line 12 of Worksheet S–3, Part I, Column 6. We plan to update the guidance in the PRM to reflect the use of our updated data sources to determine the core nursing staff levels.

As we stated in the FY 2009 IPPS proposed rule, we believe the revised method would prevent the mean from being influenced by extreme observations and assumes that the middle 50 percent of the data has no outlier observations. Therefore, we are finalizing our methodology, and the results of the average nursing hours per patient day by bed size and region using the FY 2006 Occupational Mix Survey Data and the March 2008 update to the FY 2006 hospital cost report data are shown in the table below. The application of this methodology results in a pool of approximately 2,969 providers. Each census region and bed group category required at least three providers in order for their average to be published. As stated in the FY 2007 IPPS final rule (71 FR 48059), the results of the FY 2006 Occupational Mix Survey may be used for the volume decrease adjustment calculations for decreases in discharges occurring in cost reporting periods beginning in FYs 2006, 2007, and 2008.

Comment: Another commenter asked if fiscal intermediaries/MAC must recalculate completed volume adjustment calculations for this period (FYs 2006, 2007 and 2008) to apply the FY 2006 Occupational Mix Survey data in cases where the volume adjustment has already been determined using the HAS Monitrend data.

Response: As stated in the FY 2007 IPPS final rule (71 FR 48059) and in the FY 2009 IPPS proposed rule (73 FR 23664), the results of the FY 2006 Occupational Mix Survey may be used for the volume decrease adjustment calculations for decreases in discharges occurring in cost reporting periods beginning in FYs 2006, 2007, and 2008. If the provider believes it would benefit from a recalculation of its volume decrease adjustment using the 2006 Occupational Mix Survey data rather than the HAS Monitrend data, it may submit a request for such a recalculation including the prior determination by the fiscal intermediary/MAC and the

documentation required to make a determination based on the Occupational Mix data, including staffing levels reported consistent with the Occupational Mix Survey instructions.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–49	25.47	20.60	20.61	24.42	20.30	25.96	22.22	24.01	20.99
50–99	21.17	18.60	20.61	23.16	18.58	22.40	20.58	21.89	19.14
100–199	18.28	16.25	17.24	19.04	17.08	19.77	16.90	18.22	16.50
200–399	16.91	13.87	16.02	17.89	15.55	18.94	14.88	17.06	16.57
400+	17.52	14.51	16.70	18.31	14.84	16.67	16.05	15.50	18.09

After consideration of the public comments received, we are finalizing our proposal to calculate the staff adjustment for the SCH and MDH low volume adjustment using the 2006 Occupational Mix Survey data based on the methodology described above.

b. AHA Annual Survey

In the FY 2007 IPPS final rule (71 FR 48058), we also allowed SCHs or MDHs that experienced a greater than 5 percent reduction in the number of discharges during a cost reporting period the option of using the AHA Annual Survey results, where available, to compare the number of hospital's core staff with other like-sized hospitals in its geographic area. Our methodology for calculating the nursing hours per patient day using the AHA Annual Survey data and the Medicare hospital cost report data was similar to the methodology using the Occupational Mix Survey data (eliminating outliers outside of three standard deviations from the mean). For this reason, as with the occupational mix data, both standard deviations and the mean could be influenced by extreme values. Therefore, in the FY 2009 IPPS proposed rule (73 FR 23664), we proposed to refine our methodology to calculate the core staffing factors using the AHA Annual Survey data as well. The AHA Annual Survey contains FTE counts for registered nurses, practical and vocational nurses, nursing assistive personnel, and other personnel in both inpatient and outpatient areas of the hospital. This is consistent with the Occupational Mix Survey data which includes data on both the inpatient and outpatient areas of the hospital.

In the FY 2007 IPPS final rule, we stated that we would calculate the nursing hours per patient day using the AHA Annual Survey data in a similar method to the Occupational Mix Survey. Consistent with the HAS/Monitrend Data book, we proposed to calculate the average number of nursing staff for a bed-size/census group if there are data available for three or more hospitals. First, we proposed to merge the AHA Annual Survey Data with the corresponding Medicare cost report data. We would then eliminate all observations for non-IPPS providers, providers with hospital-based SNFs, and the providers for which provider numbers, bed counts, and/or days counts were missing. We proposed to multiply the sum of nurse, licensed practical nurse, and nursing aide FTEs reported on the AHA Annual Survey by 2,080 hours to derive the number of nursing hours per year (based on a 40-hour work week). We would then divide this number by the total number of patient days reported on line 12 on Worksheet S–3, Part I, Column 6 of the Medicare cost report. In the FY 2007 IPPS final rule (71 FR 48060), we had stated that we would eliminate all providers with results beyond three standard deviations from the mean. However, to be consistent with our methodology with the Occupational Mix Survey data, in the FY 2009 IPPS proposed rule, we proposed to remove outliers from the AHA Annual Survey data by calculating the difference between the observations in the 75th percentile and the 25th percentile, which is the inter-quartile range. We then proposed to remove observations that are greater than the 75th percentile plus 1.5 times the inter-quartile range and less than the 25th percentile minus 1.5 times the inter-quartile range. After removing the outliers, we proposed to group the hospitals by bed size and census area to calculate the average number of nursing hours per patient day for each category. In this final rule, we also have updated our results of the nursing hours per patient day using the 2006 AHA Annual Survey data and the March 2008 Medicare cost report data, which is shown below. Using the 2006 AHA Annual Survey data, this would result in a pool of approximately 1,423 providers. We proposed to use the 2006 Survey for the volume decrease adjustment calculations for decreases in discharges occurring during cost reporting periods beginning in FY 2006. As we stated in the FY 2007 IPPS final rule, for other years, the corresponding AHA Annual Survey would be used for the year in which the decrease occurred.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–49	26.59	24.17	22.32	28.08	19.29	29.29	25.24	27.10	25.52
50–99	22.13	20.35	22.31	24.40	22.68	24.00	21.17	19.37	20.36
100–199	19.30	17.09	18.34	19.77	19.05	20.32	19.55	18.99	18.71

PAID NURSING HOURS PER PATIENT DAY—Continued

Number of beds	Census region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
200–399	18.84	15.04	15.67	17.10	15.62	20.35	16.17	18.96	18.43
400+	18.98	16.58	17.65	21.46	16.73	18.23	16.06	17.76	21.82

Comment: One commenter asked for clarification on which peer group of data a provider experiencing a volume decrease should use to determine whether it meets the allowable staffing requirement.

Response: Providers have been using HAS/Monitrend data to determine the staffing adjustment. The HAS/Monitrend data may be used as a source only for open adjustment requests. Beginning in FY 2007, only the AHA Annual Survey data and the Occupational Mix Survey data can be used to determine the amount of the volume decrease adjustment. Therefore, an SCH or MDH that has experienced a decrease in discharges in 2007 as compared to 2006 will no longer be permitted to use the HAS/Monitrend databook results to calculate the amount of the volume decrease adjustment. The staffing levels based on both data sources will be available on the CMS Web site.

The HAS/Monitrend data had separated staffing levels by intensive care unit and routine care. However, the data based on both the AHA Annual Survey and the Occupational Mix Survey provide only one number representing the average nursing hours per patient day aggregating the intensive care area and the routine care area. For an SCH or MDH seeking a volume decrease adjustment, the fiscal intermediary/MAC will determine the SCH or MDH's total hospital nursing staff per inpatient day for the year of the volume decrease and compare that figure to the number published for the hospital's census area and bed-size division in either the Occupational Mix Survey or AHA Annual Survey.

Comment: Several commenters encouraged CMS to clarify which data should be used for which fiscal year. In addition, the commenters requested that CMS explain what data source should be used for MDHs and SCHs seeking a volume decrease adjustment for years prior to FY 2006. Some commenters wanted to be able to use 2006 Occupational Mix Survey data or AHA Annual Survey data for open volume adjustment requests prior to FY 2006.

Response: In the FY 2007 IPPS final rule, we stated that open adjustment requests prior to FY 2007 would allow SCHs and MDHs the option of using the results of any of three sources: (1) The 2006 Occupational Mix Survey for cost reporting period beginning during FY 2006 through 2008; (2) the AHA Annual Survey (where available); or (3) the HAS/Monitrend Databook. The FY 2006 Occupational Mix Survey data and the 2006 AHA Annual Survey data cannot be used for open volume adjustment requests prior to FY 2006.

The Occupational Mix Survey data is updated every 3 years. The results of the FY 2006 Occupational Mix Survey can be used for volume decrease adjustment calculations for decreases in discharges occurring during the FY 2006, FY 2007, and FY 2008 cost reporting periods. The results of the FY 2009 Occupational Mix Survey will be used to update the data for volume decrease adjustment calculations for decreases in discharges occurring during the FY 2009, FY 2010, and FY 2011 cost reporting periods.

MDHs and SCHs will also have the option to use the AHA Annual Survey data. The AHA Annual Survey data is updated annually. The core staffing levels based on the FY 2006 AHA Annual Survey data are published in this final rule and will also be available on the CMS Web site. The fiscal intermediary/MAC will use the survey results from the year in which the decrease occurred. For example, if a hospital experiences a decrease between its 2006 and 2007 cost reporting periods, the fiscal intermediary/MAC will compare the hospital's 2007 staffing with the results of the FY 2007 AHA Annual Survey.

Comment: Commenters urged CMS to release the FY 2006 core staff data based on the Occupational Mix Survey and the AHA Annual Survey as soon as possible. The commenters asked if CMS does not publish the finalized core staff data with the final rule, that CMS allow interim volume adjustment payments to be made based on the data published in the FY 2009 IPPS proposed rule.

Response: This FY 2009 IPPS final rule includes two charts of core staffing levels by bed-size and census region for FY 2006 based on the Occupational Mix Survey and the AHA Annual Survey. These data will also be posted on the CMS Web site. The data can be used to determine if a volume decrease adjustment is necessary. The FY 2006 AHA Annual Survey data can be used for FY 2006 adjustments, and the FY 2006 Occupational Mix Survey data can be used for adjustments for FY 2006, FY 2007, and FY 2008. Currently, the AHA Annual Survey data for 2007 is not available. Core staff levels for FY 2007 will be available later this year on the CMS Web site.

Comment: A few commenters believed that a hospital's capital costs should be included in the determination of a qualifying hospital's additional payment.

Response: Sections 1886(d)(5)(D)(ii) and 1886(d)(5)(G)(iii) of the Act provide that ''the Secretary shall provide for such an adjustment to the payment amounts *under this subsection* [* * *]'' (emphasis added). Section 1886(d) of the Act governs the amount of payment for the operating costs of inpatient hospital services under the Medicare program, that is, payments under the operating IPPS. The authority for the development and implementation of a PPS for the capital-related costs of inpatient acute hospital services under the Medicare program (that is, the capital IPPS) is provided for in section 1886(g) of the Act. Because the respective statutory authority for the additional payment to SCHs and MDHs that experience a significant volume decrease specify that an adjustment will be made under section 1886(d) of the Act, which governs payments for operating costs, we believe it would be inconsistent with the statute to include a hospital's capital costs in the determination of a qualifying SCH's or MDH's additional payment under 1886(d)(5)(D)(ii) and 1886(d)(5)(G)(iii) of the Act. Therefore, we are not adopting the commenters' suggestions.

Comment: One commenter stated that updated data from the Occupational Mix Survey and the AHA Annual Survey are acceptable starting points, but that two additional factors are required to make the updated staffing factors meaningful. The two factors named were a case-mix measurement factor to recognize the differences in case-mix between the volume adjustment applicant versus the average case-mix score of the peer group hospitals, and a factor to recognize the variance in inpatient versus outpatient mix between the volume adjustment applicant and the peer group average.

Response: The current volume decrease adjustment calculation, using the HAS Monitrend data, does not include a factor to account for differences in the case-mix of the applicant provider and its peer group. We did not propose any changes to the methodology for the adjustment calculation. The only issue addressed in our proposal was the database to be used to determine staffing levels, given the fact that the HAS/Monitrend data are no longer a viable source. We believe that the staffing factors based on the more current Occupational Mix Survey and AHA Annual Survey data are a useful update. Regarding an adjustment for a case-mix index factor or for variance in inpatient and outpatient mix, we did not propose any changes to the methodology and we believe that additional adjustments would add complexity without necessarily providing a benefit. However, we may consider these recommendations in future rulemakings.

Comment: Several commenters supported the proposed changes. Other commenters who supported the proposed changes noted that, compared to the previously used Monitrend data, both the Occupational Mix Survey and the AHA Survey include information on nurses in other areas of the hospital besides the inpatient nursing units and requested that CMS clarify that the use of these data for future payment adjustment requests will require hospitals to analyze their nurse-staffing levels in the current and previous year using the same instructions used to complete the Occupational Mix Survey or the AHA Survey, or both.

The commenters also noted that the AHA Survey changed in 2006, and the same nursing data are not necessarily available from AHA for years prior to 2006. Likewise, the Occupational Mix Survey data are based on 2006 data. The commenters requested that CMS authorize the use of the 2006 Occupational Mix Survey data and AHA Survey data for payment adjustments for volume decreases in years prior to 2006, at the hospital's option. They also requested clarification as to when the 2007 and 2008 AHA survey data would be made available.

Response: We understand the 2007 AHA Annual Survey data will be made available to CMS sometime between September and November 2008. We expect to have the staffing factors based on the 2007 survey calculated and posted on the CMS Web site during the first quarter of FY 2009. We expect the 2008 AHA Annual Survey data to become available a year later, in autumn 2009, and to be posted on the CMS Web site the first quarter of FY 2010.

Regarding the application of the staffing factors based on the 2006 AHA Annual Survey data, those staffing factors should only be applied to hospital cost reporting periods beginning in FY 2006. It is not appropriate to use that data for periods prior to 2006. For example, if a hospital believes it experienced, in its cost reporting period beginning in FY 2008, a decrease of more than 5 percent in its number of inpatient discharges, compared to its immediately preceding cost reporting period (its cost reporting period beginning in FY 2007), the hospital would request a volume decrease adjustment for its FY 2008 cost reporting period, and include its FY 2007 and FY 2008 cost report information.

The 2007 AHA Annual Survey data will be available to CMS by the first quarter of FY 2009 and the staffing factors based on that data will also be posted on the CMS Web site in the first quarter of FY 2009. If the hospital opts to use the staffing factors based on the Occupational Mix Survey for its volume decrease adjustment, it would apply the staffing factors based on the 2006 Occupational Mix Survey to its FY 2007 cost report data.

After consideration of the public comments received, we are finalizing our methodology to calculate the average nursing hours per patient day using AHA Annual Survey data and the Medicare Cost Report as described above.

E. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges occurring before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and RRCs. Other rural hospitals with less than 500 beds are subject to a 12-percent cap on DSH payments. RRCs are not subject to the 12-percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). RRCs are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed the average hourly wage of the labor market area where the hospital is located by a certain percentage (106/108 percent in FY 2008).

Section 4202(b) of Public Law 105–33 states, in part, ''[a]ny hospital classified as an RRC by the Secretary * * * for fiscal year 1991 shall be classified as such an RRC for fiscal year 1998 and each subsequent year.'' In the August 29, 1997 final rule with comment period (62 FR 45999), we reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but did not reinstate the status of hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. However, subsequently, in the August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy the applicable criteria. We used the definitions of ''urban'' and ''rural'' specified in Subpart D of 42 CFR Part 412.

One of the criteria under which a hospital may qualify as a RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5) and the

September 30, 1988 **Federal Register** (53 FR 38513)). With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The national median CMI value for FY 2009 includes all urban hospitals nationwide, and the regional values for FY 2009 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). These values are based on discharges occurring during FY 2007 (October 1, 2006 through September 30, 2007), and include bills posted to CMS' records through March 2008.

In the FY 2009 IPPS proposed rule (73 FR 23665), we proposed that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, they must have a CMI value for FY 2007 that is at least—

- 1.4285; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

Based on the latest available data (FY 2007 bills received through March 2008), in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, they must have a CMI value for FY 2007 that is at least—

- 1.4270; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The final median CMI values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2532
2. Middle Atlantic (PA, NJ, NY)	1.2661
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3588
4. East North Central (IL, IN, MI, OH, WI)	1.3579
5. East South Central (AL, KY, MS, TN)	1.3051
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.3571
7. West South Central (AR, LA, OK, TX)	1.4208
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4669
9. Pacific (AK, CA, HI, OR, WA)	1.3945

Hospitals seeking to qualify as RRCs or those wishing to know how their CMI value compares to the criteria should obtain hospital-specific CMI values (not transfer-adjusted) from their fiscal intermediaries/MACs. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these CMI values are computed based on all Medicare patient discharges subject to the IPPS DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2009 IPPS proposed rule (73 FR 23666), we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2006 (that is, October 1, 2005 through September 30, 2006), which was the latest cost report data available at that time.

Therefore, in the FY 2009 IPPS proposed rule (73 FR 23666), we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, must have as the number of discharges for its cost reporting period that began during FY 2006 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (We refer readers to the table set forth in the FY 2009 IPPS proposed rule at 73 FR 23666.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that began during FY 2006, the final median number of discharges for urban hospitals by census region are set forth in the following table.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,158
2. Middle Atlantic (PA, NJ, NY)	10,659
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,982
4. East North Central (IL, IN, MI, OH, WI)	9,290
5. East South Central (AL, KY, MS, TN)	7,927
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,206
7. West South Central (AR, LA, OK, TX)	6,589
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,738
9. Pacific (AK, CA, HI, OR, WA)	8,620

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2008, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2006.

F. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical

education (IME) adjustment, are located at § 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2009

The IME adjustment to the MS–DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as *r*, and a formula multiplier, which is represented as *c*, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Public Law 108–173 modified the formula multiplier (*c*) to be used in the calculation of the IME adjustment. Prior to the enactment of Public Law 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. In the FY 2005 IPPS final rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). Section 502(a) modifies the formula multiplier beginning midway through FY 2004 and provides for a new schedule of formula multipliers for FYs 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2009, the formula multiplier is 1.35. We estimate that application of this formula multiplier for FY 2009 IME adjustment will result in an increase in IME payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

G. Payments for Direct Graduate Medical Education (GME) (§§ 413.75 and 413.79)

1. Background

Section 1886(h) of the Act, as implemented in regulations at § 413.75 through § 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated annually for inflation.

Section 1886(h)(4)(F) of the Act established caps on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the caps were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Section 422 of Public Law 108–173 added section 1886(h)(7) of the Act, which provided for a reduction to the resident caps of teaching hospitals that were training a number of FTE residents below their cap in a reference period, and authorized a ''redistribution'' of those FTE resident slots to hospitals that could demonstrate a likelihood of using the additional resident slots within the first three cost reporting periods beginning on or after July 1, 2005.

2. Medicare GME Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations

a. Legislative Authority

The stated purposes of section 1135 of the Act are (1) ''to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period, * * * that sufficient health care items and services are available to meet the needs of individuals enrolled in the programs under titles XVIII, XIX, and XXI [that is, Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)]; and (2) that health care providers * * * that furnish such items and services in good faith, but that are unable to comply with one or more requirements * * * may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.'' Specifically, section 1135 of the Act authorizes the Secretary, to the extent necessary to accomplish the statutory purpose, to temporarily waive or modify the application of certain types of statutory and regulatory provisions (such as conditions of participation or other certification requirements, program participation or similar requirements, or preapproval requirements) with respect to health care items and services furnished by health care provider(s) in an emergency area during an emergency period.

The Secretary's authority under section 1135 of the Act arises in the event there is an ''emergency area'' and continues during an ''emergency period'' as those terms are defined in the statute. Under section 1135(g) of the Act, an emergency area is a geographic area in which there exists an emergency or disaster that is declared by the President according to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act, and a public health emergency declared by the Secretary according to section 319 of the Public Health Service Act. (Section 319 of the Public Health Service Act authorizes the Secretary to declare a public health emergency and take the appropriate action to respond to the emergency, consistent with existing authorities.) Throughout the remainder of this discussion, we will refer to such emergency areas and emergency periods as ''section 1135'' emergency areas and emergency periods.

Furthermore, under section 1135 of the Act, ''a waiver or modification of requirements pursuant to this section may, at the Secretary's discretion, be

made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.'' Section 1135 of the Act further states that ''a waiver or modification of requirements pursuant to this section terminates upon—(A) the termination of the applicable declaration of emergency or disaster * * *; (B) the termination of the applicable declaration of public health emergency * * *; or (C) * * * the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification. * * *)''

As noted previously, sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment, respectively, establishing hospital-specific direct GME and IME FTE resident caps. Under the authority of section 1886(h)(4)(H)(ii) of the Act, the Secretary issued rules to allow institutions that are members of the same affiliated group to apply their direct GME and IME FTE resident caps on an aggregate basis through a Medicare GME affiliation agreement. The Medicare regulations at §§ 413.75 and 413.79 permit hospitals, through a Medicare GME affiliation agreement, to adjust IME and direct GME FTE resident caps to reflect the rotation of residents among affiliated hospitals.

Section 1886(d)(5)(B)(vi) of the Act specifies the application of an intern and resident-to-bed (IRB) ratio cap, stating that the IRB ratio ''may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds * * * during that cost reporting period.'' As specified under the regulations at § 412.105(a)(1)(i), an IRB ratio is calculated for a hospital based generally on the ratio of FTE residents (as limited by the regulation at § 412.105(f)) in the numerator to the number of available beds (which is described at § 412.105(1)(b)) in the denominator. Furthermore, section 1886(d)(5)(B)(viii) of the Act specifies that rules similar to the rules under section 1886(h)(4)(H) of the Act (special rules for new teaching programs and affiliations) shall apply for purposes of the IME FTE cap and the IRB ratio.

b. Regulatory Changes Issued in 2006 To Address Certain Emergency Situations

As explained above, the Secretary's authority under section 1135 of the Act is prompted by the occurrence of an emergency or disaster that leads to designation of a section 1135 emergency area, and continues throughout a section 1135 emergency period. For example, when Hurricane Katrina occurred on August 29, 2005, disrupting health care operations and medical residency training programs at teaching hospitals in New Orleans and the surrounding area, the conditions were met for the Secretary to establish an emergency area and emergency period under section 1135(g) of the Act, which he did for the Gulf Coast region on August 31, 2005. Shortly after Hurricane Katrina occurred, CMS was informed by hospitals in New Orleans that the training programs at many teaching hospitals in the city were closed as a result of the disaster and that the displaced residents were being transferred to training programs at hospitals in other parts of the country. At the time, the existing regulations did not adequately address the Medicare GME payment issues faced by hospitals located in a section 1135 emergency area that were affected by the disaster, and by hospitals that trained displaced residents from a section 1135 emergency area.

Specifically, the medical residency training programs at many teaching hospitals in New Orleans and surrounding areas were temporarily closed (either partially or completely) in the aftermath of Hurricane Katrina. Hurricane Rita, which followed Katrina by less than a month, further exacerbated the disaster conditions along the Gulf Coast. As a result, the displaced residents from the section 1135 emergency area were transferred to other hospitals (which included hospitals located in States outside of the emergency area) to continue their medical residency training. Hospitals in the section 1135 emergency area also informed CMS that, while many residents would be able to return to their original programs to complete residency training as these hospitals gradually rebuild their programs after the hurricanes, some residents may need to remain at other hospitals for an extended period of time.

In developing a policy to provide hospitals flexibility in responding to a disaster, we have stated that we must balance two priorities. First, we believe that in disaster situations, to the extent permitted under the statute, the policy should facilitate the continuity of GME, minimizing the disruption of residency training. Second, the policy should take into account that the training programs at certain hospitals located in a section 1135 emergency area may have been severely disrupted by a disaster and that these hospitals will usually want to rebuild their GME programs as soon as possible. Accordingly, we amended the Medicare regulations on April 12, 2006, in an interim final rule with comment period published in the **Federal Register** (71 FR 18654). Specifically, we revised § 413.75(b) to include definitions of home hospital, host hospital, section 1135 emergency area, section 1135 emergency period, and emergency Medicare GME affiliated group. We also revised § 413.79(f) to set forth the requirements of an emergency Medicare GME affiliation agreement. The existing regulation at § 413.75(b) specifies that hospitals may only form a Medicare GME affiliated group (that is, a regular, not an emergency, Medicare GME affiliated group) with other hospitals if they are in the same or contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. The provisions for a regular Medicare GME affiliation at § 413.79(f) permit participating teaching hospitals to aggregate and ''share'' FTE caps during a specified academic year. The Medicare GME affiliation regulations allow hospitals that need to either decrease or increase their FTE resident counts to reflect the normal movement of residents among affiliated hospitals to do so for the agreed-upon training years. Hospitals that affiliate must submit a Medicare GME affiliation agreement, as specified at § 413.75(b), to their CMS fiscal intermediary or MAC and to CMS no later than July 1 of the relevant academic year. Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of shared rotational arrangements. The net effect of the adjustments to hospitals' FTE resident caps, whether positive or negative on a hospital-specific basis, in the aggregate must not exceed zero. While additional hospitals may not be added to the Medicare GME affiliated group after July 1 of a year, amendments to the affiliation agreement to adjust the distribution of the number of FTE residents in the original Medicare GME affiliation among the hospitals that are part of the Medicare GME affiliated group can be made through June 30 of the academic year for which they are effective.

The April 12, 2006 interim final rule with comment period (70 FR 18654

through 18667) modified the regulations at § 413.75(b) and § 413.79(f) and provided the flexibility for hospitals whose medical residency programs have been disrupted in a section 1135 emergency area to enter into emergency Medicare GME affiliation agreements with other hospitals where the hospitals may not meet the regulatory requirements for regular Medicare GME affiliations. Under an emergency affiliation, hospitals training displaced residents from a section 1135 emergency area can specify temporary adjustments to their FTE resident caps to permit them to receive Medicare direct and indirect GME payments relating to the displaced residents, even as the hospitals affected by the emergency event are rebuilding their training programs. The April 12, 2006 interim final rule with comment period (70 FR 18654 through 18667) defined the hospitals that would be permitted to enter into emergency Medicare GME affiliation agreements. First, we defined a home hospital as a hospital that meets all of the following: (1) Is located in a section 1135 emergency area; (2) had its inpatient bed occupancy decreased by 20 percent or more as the result of a section 1135 emergency period so that it is unable to train the number of residents it originally intended to train in that academic year; and (3) needs to send the displaced residents to train at a host hospital. Second, we defined a host hospital as a hospital training residents displaced from a home hospital.

In the April 12, 2006 interim final rule with comment period (70 FR 18654 through 18667), we specified that the emergency Medicare GME affiliation agreement must be written, signed, and dated by responsible representatives of each participating hospital and must: (1) List each participating hospital and its provider number, and specify whether the hospital is a home or host hospital; (2) specify the effective period of the emergency Medicare GME affiliation agreement (which must, in any event, terminate no later than at the conclusion of 2 academic years following the academic year in which the section 1135 emergency period began); (3) list each participating hospital's IME and direct GME FTE caps in effect for the current academic year before the emergency Medicare GME affiliation (that is, if the hospital was already a member of a regular Medicare GME affiliated group before entering into the emergency Medicare GME affiliation, the emergency Medicare GME affiliation must be premised on the FTE caps of the hospital as adjusted per the regular Medicare GME affiliation agreement, and not include any slots gained under section 422 of the MMA); and (4) specify the total adjustment to each hospital's FTE caps in each year that the emergency Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to the host hospital's (or hospitals') direct and/or indirect FTE caps that is offset by a negative adjustment to the home hospital's (or hospitals') direct and/or indirect FTE caps of at least the same amount. The sum total of participating hospitals' FTE caps under the emergency Medicare GME affiliation agreement may not exceed the aggregate adjusted caps of the hospitals participating in the emergency Medicare GME affiliated group before entering into an emergency affiliation. A home hospital's IME and direct GME FTE cap reduction under an emergency Medicare GME affiliation agreement is limited to the home hospital's IME and direct GME FTE resident caps in effect for the academic year, in accordance with regulations at § 413.79(c) or § 413.79(f)(1) through (f)(5), that is, the hospital's base year FTE resident caps as adjusted by any and all existing regular Medicare GME affiliation agreements. Finally, as we stated in the April 12, 2006 interim final rule with comment period, amendments to the emergency Medicare GME affiliation agreement to adjust the distribution of the number of FTE residents in the original emergency Medicare GME affiliation among the hospitals that are part of the emergency Medicare GME affiliated group can be made through June 30 of the academic year for which it is effective (71 FR 18662).

In summary, the April 12, 2006 interim final rule with comment period made changes as follows:

- To allow host hospitals to count displaced residents for IME and direct GME payment purposes, host hospitals and home hospitals were permitted to enter into emergency Medicare GME affiliation agreements effective retroactive to the date of the first day of the section 1135 emergency period.
- Through emergency Medicare GME affiliation agreements, home hospitals were permitted to affiliate with host hospitals anywhere in the country. That is, a host hospital may be located in any State and may receive a temporary adjustment to its FTE caps to reflect displaced residents (subject to the aggregate home and host hospitals' FTE resident caps).
- Emergency Medicare GME affiliation agreements were required to be submitted to CMS with a copy to the CMS fiscal intermediary or MAC by the later of 180 days after the section 1135 emergency period begins or by July 1 of the academic year in which the emergency Medicare GME affiliation agreement is effective. However, for hospitals affected by Hurricanes Katrina and Rita, the deadline was subsequently extended to October 9, 2006. (We refer readers to the final rule published in the **Federal Register** on July 6, 2006, for a detailed discussion (71 FR 38264 through 38266)).
- The effective period of the emergency Medicare GME affiliation agreement was permitted to begin on or after the first day of a section 1135 emergency period, and must terminate no later than at the conclusion of 2 academic years following the academic year during which the section 1135 emergency period began. (We note that in a subsequent interim final rule with comment period, published in the **Federal Register** on November 27, 2007, the effective period was subsequently extended by 2 additional years (72 FR 66893 through 66898).) We summarize the changes addressed in the November 27, 2007 interim final rule with comment period in the section that follows.
- During the effective period of the emergency Medicare GME affiliation agreement, hospitals in the emergency Medicare GME affiliated group were not required to participate in a shared rotational arrangement (as they would be under a regular Medicare GME affiliation agreement).
- Host hospitals were allowed an exception from the otherwise applicable rolling average resident count for FTE residents added as a result of an emergency Medicare GME affiliation agreement, but only during the period from August 29, 2005 to June 30, 2006.
- Due to the infrastructure damage and continued disruption of operations experienced by medical facilities, and the consequent disruption in residency training caused by Hurricanes Katrina and Rita in 2005, there was an urgent need for emergency Medicare GME affiliation agreements to be effective retroactive to the date of the hurricanes. Section 1871(e)(1)(A) of the Act, as amended by section 903(a)(1) of the MMA, generally prohibits the Secretary from making retroactive substantive changes in policy unless retroactive application of the change is necessary to comply with statutory requirements, or failure to apply the change retroactively would be contrary to the public interest. Because existing regulations did not adequately address the issues faced by hospitals that are located in the section 1135 emergency area, or hospitals that

assisted by training displaced residents from the section 1135 emergency area, and because we believed hospitals affected by Hurricanes Katrina and Rita would otherwise have faced dramatic financial hardship and the recovery of graduate medical education programs in the emergency area would have been impeded, we found that failure to apply retroactively the regulatory changes contained in the April 12, 2006 interim final rule with comment period would be contrary to the public interest. Thus, the provisions of the April 12, 2006 interim final rule with comment period were made effective retroactively as of August 29, 2005.

For a detailed discussion on each of the above emergency Medicare GME affiliation provisions, we refer readers to the April 12, 2006 interim final rule with comment period (71 FR 18654 through 18667).

c. Additional Regulatory Changes Issued in 2007 To Address GME Issues in Emergency Situations

After the establishment of the emergency Medicare GME affiliation provisions in the April 12, 2006 interim final rule with comment period, we monitored the application of the emergency Medicare GME affiliation agreement rules in order to assess whether those regulatory changes appropriately addressed the needs of hospitals located in the section 1135 emergency area in the aftermath of Hurricanes Katrina and Rita. We understand that GME programs in the affected area were finding it necessary to continue to adjust the location of resident training, both within the emergency area and in other States, as hospitals located within the section 1135 emergency area continued to reopen beds at different rates, and as feedback from accreditation surveys warranted educational adjustments. Furthermore, stakeholders in Louisiana informed CMS that they believed fluidity in GME programs would continue for several more years, and the training of residents in the area is not likely to reach stability until permanent replacement facilities are established and functioning in the emergency area. As a result, we believed the provisions first established in the April 12, 2006 interim final rule with comment period needed to be further modified to meet the two priorities stated earlier. That is, we believed that the policy should facilitate the continuity of GME by minimizing the disruption of residency training and also enable home hospitals to rebuild their GME programs as soon as possible.

Therefore, we issued a second interim final rule with comment period in the **Federal Register** on November 27, 2007 (72 FR 66893). In that second interim final rule with comment period, we modified the regulations for emergency Medicare GME affiliated groups at § 413.79(f)(6) to extend relief to home and host hospitals affected by disruptions in residency programs in the section 1135 emergency area declared after Hurricanes Katrina and Rita, as well as to provide relief for similar challenges in any future emergency situation. We noted that we had received a number of comments on the interim final rule with comment period issued on April 12, 2006. However, we believed it was beneficial to provide the public with the opportunity to submit formal comments on these latest changes in the context of the current training situation in the area affected by Hurricanes Katrina and Rita, and to respond to all comments in a subsequent final rule.

In summary, the November 27, 2007 interim final rule with comment period made changes as follows:

(1) Extension of the Effective Period of Emergency Medicare GME Affiliation Agreements

In the November 27, 2007 interim final rule with comment period (72 FR 66893 through 66898), we further modified the regulations at § 413.75(b) and § 413.79(f) to allow hospitals to enter into emergency Medicare GME affiliation agreements with increased flexibility. First, for emergency Medicare GME affiliation agreements involving a host hospital located in a different State from the home hospital (hereinafter, an ''out-of-State host hospital''), the permissible effective period for such agreements was extended from up to 3 years (that is, the year in which the section 1135 emergency period began plus 2 subsequent academic years) to up to 5 years (that is, the year in which the section 1135 emergency period began plus 4 subsequent academic years). However, emergency Medicare GME affiliation agreements involving out-of-State host hospitals during these two additional periods may only apply with respect to the actual residents that were displaced from training in a hospital located in the section 1135 emergency area. By ''actual residents that were displaced from training in a hospital located in the section 1135 emergency area,'' we indicated that we meant residents in an approved medical residency training program at a home hospital at the time of the disaster that were either actually training at the home hospital or were scheduled to rotate to the home hospital during the training program. For emergency Medicare GME affiliation agreements involving a host hospital located in the same State as the home hospital (hereinafter, an ''in-State host hospital''), the permissible effective period for such agreements was extended from up to 3 years to up to 5 years for any resident (even those not displaced from training in a hospital located in the 1135 emergency area). We provided that emergency Medicare GME affiliation agreements involving in-State host hospitals during these additional 2 academic years need not be limited to only the actual residents that were displaced immediately following the disaster. In other words, such agreements may apply with respect to residents that were actually displaced as a result of the disaster, as well as to new residents that were not training in the program at the time the disaster occurred. With the 2-year extension described above, the effective period of an emergency Medicare GME affiliation agreement may begin with the first day of a section 1135 emergency period, and must terminate no later than at the end of the fourth academic year following the academic year during which the section 1135 emergency period began (for Hurricanes Katrina and Rita, this would be June 30, 2010). As home hospitals recover the ability to train residents after a disaster, the effective period for emergency Medicare GME affiliation agreements is intended to allow home hospitals to balance their desire to return residents to their original training sites, with their need to be given the opportunity to rebuild their programs incrementally. We believed extending the applicability of emergency affiliations for out-of-State host hospitals for 2 years (for a total of up to 5 years) only for the actual residents displaced from home hospitals allows such displaced residents to complete their training outside the affected area while providing an incentive for home hospitals to begin training new incoming residents locally (or closer to the home hospital), increasing the likelihood for the residents to stay and practice in the area after their training is completed. Affected hospitals in the New Orleans area have informed CMS that the majority of residents will tend to remain in the same State to practice where they had trained. We believe this makes intuitive sense and the policy established in the November 27, 2007 interim final rule with comment period provides additional impetus for residents to return to the State where

their ''home hospital'' is located, increasing the likelihood that the physicians will stay and practice there, and encouraging rebuilding of the health care infrastructure affected by the section 1135 emergency. In the interim final rule with comment period, we noted that this is consistent with needs expressed by affected hospitals in the New Orleans area for more physicians to replace the large numbers that left immediately after the hurricanes. Furthermore, after the expiration of the initial 3 years of the emergency Medicare GME affiliation agreement effective period, we believe it would be appropriate to begin bringing emergency Medicare GME affiliation rules into accord with regular Medicare GME affiliation rules which specify geographical limits. That is, regular Medicare GME affiliation rules limit hospitals geographically to affiliations with other hospitals that are located in the same urban or rural area (as those terms are defined under § 412.62(f)) or in a contiguous area.

(2) Provisions To Allow Hospitals To Count Displaced Residents Training in Nonhospital Sites

In the November 27, 2007 interim final rule with comment period, we noted that it had come to our attention that in the wake of Hurricanes Katrina and Rita, host hospitals, many of which received large numbers of displaced residents, were hard pressed to find training sites for these unanticipated residents (72 FR 66893 through 66898). Many host hospitals called upon community physician practices, clinics, and other nonhospital settings to supplement existing training locations and accommodate the displaced residents. Some of the host hospitals that took in displaced residents had never before had any residency training programs, and therefore were new to Medicare rules regarding graduate medical education. In the haste and confusion surrounding this unprecedented displacement of residents, many host hospitals arranged for displaced residents to begin training in nonhospital sites without first establishing a written agreement, as specified in § 413.78(e), between the hospital and nonhospital site. Similarly, home hospitals that may have sent some of their residents away to train at host hospitals, while continuing to train a reduced number of residents in the home hospital program, may have found that the usual nonhospital sites for the residents in that program had also been negatively affected by the disaster. Consequently, home hospitals may have hastily arranged for displaced residents to begin training in alternative nonhospital sites and, due to the reduced administrative capability in the aftermath of the disaster, home hospitals may not have been able to establish a written agreement, as specified in § 413.78(e), with the nonhospital site before residents started training in the nonhospital site. Also, during the unusual circumstances following the disaster, many hospitals did not actually incur all or substantially all of the costs of the training program in the nonhospital site in accordance with our regulations at § 413.78(e)(3)(i) or (f)(3)(i).

The November 27, 2007 interim final rule with comment period provided hospitals that are participating in emergency Medicare GME affiliation agreements with increased flexibility in submitting written agreements relating to training that occurs in nonhospital sites (72 FR 66893 through 66898). Home or host hospitals with valid emergency Medicare GME affiliation agreements training displaced residents in a nonhospital site may submit a copy of the written agreement, as specified under § 413.78(e)(iii) and (f)(iii) as applicable, to the CMS contractor servicing the hospital by 180 days after the first day the resident began training at the nonhospital site. We noted that, as with the existing rules for written agreements specified at § 413.78(f), amendments to the written agreement can be made through June 30 of the academic year for which it is effective.

Furthermore, under current rules, hospitals that are training residents at nonhospital sites have two options as specified by the regulations at § 413.78(e) and § 413.78(f). That is, hospitals must either have a written agreement in place before the training occurs or they must pay ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred. In the November 27, 2007 interim final rule with comment period, we provided additional flexibility in the ''concurrent payment'' option for home or host hospitals that have emergency Medicare GME affiliation agreements and are training displaced residents in nonhospital sites by extending the time allowable for ''concurrent payment'' from 3 months to 6 months (72 FR 66893 through 66898). That is, we permitted a home or host hospital with a valid emergency Medicare GME affiliation agreement to incur ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred.

In the case of the section 1135 emergency resulting from Hurricanes Katrina and Rita, we noted that the time limit we adopted to submit written agreements or to meet the ''concurrent payment'' requirement may have already passed. Therefore, we provided that, for residents training in nonhospital sites during the period of August 29, 2005, to November 1, 2007, home or host hospitals with valid emergency Medicare GME affiliation agreements could submit written agreements or incur ''all or substantially all'' of the costs of the training program (that is, the ''concurrent payment'' option) to cover those specific residents by April 29, 2008.

For a detailed discussion of the emergency Medicare GME affiliation provisions addressed in this section, we refer readers to the November 27, 2007 interim final rule with comment period (72 FR 66893 through 66898).

d. Public Comments Received on the April 12, 2006 and November 27, 2007 Interim Final Rules With Comment Period

In the April 12, 2006 and November 27, 2007 interim final rules with comment period, we revised the regulations at § 413.79(f) to provide for more flexibility than would have been possible under regular Medicare GME affiliations to allow home hospitals to efficiently find training sites for displaced residents. Under the flexibility provided by the emergency Medicare GME affiliated group provisions as specified at § 413.79(f)(6), decisions regarding the temporary transfers of FTE resident cap slots, including how to distribute slots in situations where the home hospital was training a number of residents in excess of its cap before the disaster, as well as the tracking of those FTE resident slots, were left to the home and host hospitals to work out among themselves. However, the home and host hospitals were required to include much of this information in their emergency Medicare GME affiliation agreements submitted both to CMS and the CMS contractor, as specified under § 413.79(f)(6). Furthermore, because hospitals were permitted to amend their emergency Medicare GME affiliation agreements (on or before June 30 of the relevant academic year) to reflect the actual training situation among the hospitals participating in the emergency Medicare GME affiliated group, hospitals were provided with a great

degree of flexibility to accommodate any change in residency training circumstances within the emergency Medicare GME affiliated group. We note that the emergency Medicare GME affiliation provisions are intended to enable and facilitate the continued training of residents displaced from a section 1135 emergency area. These provisions are not intended to provide increased flexibility to shift FTE resident cap slots to other hospitals in the country simply to maximize Medicare IME and direct GME payments.

We received a number of comments on the interim final rules issued on April 12, 2006 and November 27, 2007 (71 FR 18654 through 18667 and 72 FR 66893 through 66898, respectively). We noted in the November 27, 2007 interim final rule with comment period that we believed it would be beneficial to provide the public with the opportunity to submit formal comments to the latest changes implemented in the November 27, 2007 interim final rule, in the context of the ongoing training situation in the area affected by Hurricanes Katrina and Rita, and that we would respond to comments submitted and finalize our policies relating to both the April 12, 2006 and the November 27, 2007 interim final rules in a subsequent final rule. A summary of those public comments and our responses follow.

Comment: Commenting on the April 12, 2006 interim final rule, one commenter noted that the interim final rule providing for emergency Medicare GME affiliation agreements would have been unnecessary if the Medicare FTE resident caps were lifted. The commenter expressed appreciation for CMS' efforts to use its regulatory authority to work within the statutory framework for GME. However, the commenter noted that the Medicare FTE resident caps, implemented a number of years ago by the BBA of 1997, have generated significant problems for teaching hospitals and medical schools that sponsor residency programs, and have been detrimental to their educational policies and decisions. Specifically, the commenter noted that, to the extent a home hospital is training residents in excess of its FTE resident caps at the time a disaster occurs, there would not be enough cap slots to distribute to host hospitals through an affiliation agreement after an emergency. Furthermore, the commenter stated that, ''In other areas, decisions to impose a 'freeze' are temporary in nature. In health care and in Medicare in particular, we are unaware of policies that have not factored in the need for modifications after a certain period of time.'' The commenter believed it is time to reconsider FTE resident caps and urged CMS to work with Congress to address this policy.

Response: The Conference Report for the BBA of 1997 indicated that ''the Secretary's flexibility is limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.'' (H. Conf. Rept. No. 105–217, p. 822.) That is, among the GME reforms included in the BBA of 1997 was a limit that was placed on the number of allopathic and osteopathic FTE residents that can be included in a hospital's direct GME and IME FTE resident counts for Medicare payment purposes. Because there was an implicit incentive for hospitals to train more FTE residents (the more FTEs, the greater the payment), the direct GME and IME resident caps were implemented to limit the potential for increases in GME spending. While the commenter asserted that the FTE resident caps adopted by the BBA of 1997 have been detrimental to hospitals' and medical schools' educational policies and decisions, the FTE cap policy was intended to address concerns that the system of payment to hospitals for GME was encouraging an oversupply of physicians, a maldistribution of physicians across the country (for example, not enough physicians in rural areas), and a narrow focus on training residents in inpatient settings. In general, the BBA of 1997 sought to limit the growth of training programs at existing teaching hospitals in urban areas, while providing flexibility in order to encourage residency training programs to grow in rural areas. Dental and podiatric residents were, and still are, exempt from the caps as the concerns about an oversupply of practitioners did not apply to dentistry and podiatry.

Although the commenter believed that other Medicare policies recognize the need for modifications over time and that the imposition of a permanent ''freeze'' on the number of resident slots that Medicare would recognize for purposes of direct and indirect GME payments was inconsistent with that general practice, language in the Conference Report for the BBA of 1997 indicated that Congress anticipated the need for proper flexibility to respond to changing needs, especially given the sizeable number of urban hospitals that were not teaching hospitals at the time the direct GME and IME FTE resident caps were implemented, and that might elect to initiate new training programs in the future (H. Conf. Rept. No. 105–217, pp. 821–822). Accordingly, the statute allows non-teaching hospitals to become teaching hospitals and to receive direct GME and IME FTE resident caps if these hospitals participate in training residents in new programs that are accredited for the first time on or after January 1, 1995. In addition, rural hospitals, even those with existing teaching programs, may receive increases to their IME and direct GME FTE resident caps for training residents in new programs that are accredited for the first time on or after January 1, 1999.

The BBA of 1997 also provided flexibility for hospitals that cross-train residents to share their respective FTE resident caps. The statute authorized the Secretary to adopt rules under which hospitals could apply the FTE resident caps in the aggregate, and the Secretary adopted such rules. By entering into ''Medicare GME affiliation agreements,'' hospitals may combine their individual FTE resident caps to create ''aggregate caps'' for direct GME and IME, respectively. In this situation, the number of FTE residents that a particular hospital is permitted to count for direct GME and IME payment purposes may vary from the individual hospital's original FTE resident caps. However, the aggregate total number of FTE residents counted by all the hospitals participating in a Medicare GME affiliation agreement cannot exceed the aggregate total of the hospitals' direct GME and IME FTE resident caps. Consistent with the statute, in emergency situations, the emergency Medicare GME affiliation agreement provisions allow home hospitals the flexibility to temporarily transfer a portion or all of their FTE resident caps to host hospitals that are training the home hospitals' displaced residents. In contrast to the regular Medicare GME affiliation rules, for emergency Medicare GME affiliations, there is no requirement that the hospitals are ''cross-training'' residents.

In recent years, members of the GME community have asserted that, in general and on a national basis, an oversupply of physicians is no longer a pressing issue, although concerns that there is a maldistribution of physicians across the country (for example, not enough physicians in rural areas) and a narrow focus on training residents in inpatient settings still continue. In 2005, Congress took action to provide some relief to hospitals that were in need of additional FTE resident cap slots. Section 422 of the MMA authorized the one-time redistribution of FTE resident cap slots from hospitals that were not fully utilizing those positions to hospitals that demonstrated the

likelihood that they could use the FTE resident slots in order to expand or create new programs or to permit them to count FTE residents they were already training in excess of their existing FTE resident caps, with priority given to rural hospitals. This redistribution of FTE resident slots to support new or existing programs facilitated a more effective use of Medicare GME funding. In addition, we are aware that, even though a number of hospitals currently are training a number of residents in excess of their FTE resident caps, and are not permitted to count those FTE residents for purposes of Medicare direct and indirect GME payments, the hospitals are nonetheless effectively training residents at levels above their BBA FTE resident caps either because alternative sources for GME funding have been identified to support the training or because the hospitals have determined that even without Medicare funding relating to those slots, the benefits the hospitals gain from training those additional residents exceed the cost to the hospitals. We note that if the statutory provisions adopted in the BBA of 1997 and the MMA of 2003 are revised, we would modify our policies accordingly.

Comment: A number of commenters expressed concern that the application of a 3-year rolling average FTE resident count is detrimental to home hospitals. Some commenters disagreed with CMS that a home hospital could benefit from the 3-year rolling average because, the commenters argued, when a hospital abruptly closes, it has no Medicare patient load and thus cannot receive GME reimbursement. The commenters suggested that CMS allow home hospitals to count FTE residents in a fashion similar to the way hospitals are permitted to count residents in a new program so that home hospitals would not be subject to the 3-year rolling average FTE resident count for a preset number of years while they rebuild their GME programs.

Response: Section 1886(d)(5)(B)(vi)(II) of the Act for IME and section 1886(h)(4)(G) of the Act for direct GME require that a hospital's count of FTE residents in the current year be based on a 3-year ''rolling average'' count of FTE residents, that is, the average of the number of residents in the current year and the 2 immediate prior years. This is a statutory requirement we believe is intended to distribute the impact of increasing or decreasing the number of residents at a hospital over a 3-year period. Thus, if a hospital increases or decreases the number of FTE residents in a given year, the hospital's FTE resident count and consequent direct or indirect GME payment is impacted by only one-third of the change in FTEs in that year, two-thirds in the second, and all of the change only in the third year. We note that the 3-year rolling average can work to home hospitals' advantage because the effect from the decrease in the number of FTE residents a home hospital is training after an emergency event is spread out over 3 years and the home hospitals will be paid based upon a higher number of FTE residents than they actually train for several years after the emergency event. However, we agree that, in order for the home hospital to benefit from the nature of the 3-year rolling average, the home hospital must be operating sufficiently to provide inpatient care for Medicare beneficiaries. We note that Medicare GME payments (both direct GME and IME) are dependent on a hospital's Medicare patient load because the payments are intended to reimburse the hospital for Medicare's share of GME costs. We note that even if a hospital receives little or no Medicare funding for its GME programs due to low or no Medicare inpatient utilization, a hospital typically supports its training programs though a number of funding sources which may include universities, schools of medicines, and other Federal, State, and local grant programs.

We appreciate the commenter's concern that after an emergency event, there is a critical need for home hospitals to continue to receive GME funding in order to engage in the rebuilding of their programs. However, the statutory provisions regarding the 3-year rolling average still apply. In response to the commenter that suggested we allow home hospitals to count FTE residents that return to the home hospital's program (whether they are the transferred residents returning home from host hospitals or ''new'' residents starting to train in the hospital's existing programs), without subjecting those FTE residents to the 3-year rolling average, the statute does not provide for such an exception to the 3-year rolling average for residents training in an existing program. However, we note that following an emergency event, home hospitals may be eligible for non-Medicare emergency relief funds that are specifically appropriated and intended to provide relief to hospitals for losses incurred due to the emergency event.

Comment: Commenters expressed appreciation for the exception from the otherwise applicable 3-year rolling average resident count for FTE residents added as a result of an emergency Medicare GME affiliation agreement during the period from August 29, 2005, to June 30, 2006. The commenters urged CMS to extend the exception to the 3-year rolling average in the final rule so that host hospitals training displaced residents could count and thus receive payments relating to those FTE residents in the same year, rather than incrementally over 3 years. The commenters believed that host hospitals should not be penalized for taking in displaced residents, nor should they be discouraged from accepting these residents because they will not receive timely payments. The commenters also noted that the current ''closed program'' regulations at § 413.79(h) provide for an exception to the 3-year rolling average for hospitals that take in residents from a closed program. The majority of commenters recommended that CMS should extend the 3-year rolling average exception, that is, permit host hospitals to count displaced residents in full for as long as the emergency Medicare GME affiliations are effective. Alternatively, another commenter suggested that CMS extend the exception to the 3-year rolling average but with an annual reevaluation for its necessity as a financial incentive for hospitals to keep training displaced residents.

Response: As we stated in the April 12, 2006 interim final rule (70 FR 18654 through 18667), CMS was aware that, based on initial guidance from Qs & As posted on the CMS Web site shortly after Hurricane Katrina, many host hospitals took in displaced residents under the belief that, under the ''closed program'' regulations, they would not be subject to the 3-year rolling average rule for training displaced residents after Hurricanes Katrina and Rita. In fact, because many of the training programs in the section 1135 emergency area were incrementally reopened in the aftermath of Hurricanes Katrina and Rita, the ''closed program'' regulations could no longer be used. In response, we developed the policy for emergency Medicare GME affiliation agreements and established the regulations in an interim final rule with comment period on April 12, 2006. Therefore, between August 29, 2005 (when Hurricane Katrina occurred) and April 12, 2006, it is understandable that hospitals might have assumed that, based on the ''closed program'' regulations, they would not be subject to the 3-year rolling average rule for training displaced residents. Because we recognized that, as a result of the limited options under existing regulations and our initial guidance immediately following the Gulf Coast hurricanes, many host hospitals would have expected the application of the

''closed program'' regulations, under which the 3-year rolling average rules do not apply, we provided for a narrow, time-limited exception to the 3-year rolling average rule for host hospitals that trained displaced residents from August 29, 2005, to June 30, 2006 (pursuant to a valid emergency Medicare GME affiliation agreement). The April 12, 2006 interim final rule with comment period allowed host hospitals with valid emergency Medicare GME affiliation agreements to initially exclude the displaced FTE residents training at the host hospital from August 29, 2005 to June 30, 2006, from their regular 3-year rolling average calculation, and instead, to immediately add those displaced FTE residents to the hospital's 3-year rolling average FTE resident count, with the effect that the host hospital could receive GME payments relating to the displaced FTE residents in the first year rather than having them spread over 3 years.

In response to the commenters who requested that the exception to the 3-year rolling average be extended past June 30, 2006, we note that CMS provided for the narrow, time-limited exception from the 3-year rolling average rules because we recognized that host hospitals may have taken on displaced residents with the reasonable expectation, based on our guidance, that the displaced residents would be counted pursuant to the ''closed program'' regulations, under which the 3-year rolling average rules do not apply. We do not believe it would be appropriate, consistent with the statute, to extend the exception beyond the period immediately following the disaster during which there was a change in the rules regarding the treatment of displaced residents. We note that, in the case of the host hospital, application of the 3-year rolling average rule for periods after June 30, 2006, will result in 2 years of residual increases in the hospitals' FTE resident counts, permitting them to continue to receive increased GME payments relating to displaced residents even after the residents leave the host hospital.

Comment: Some commenters requested that, in the event an emergency situation causes a hospital or program to close permanently, CMS should grant host hospitals an automatic increase in their FTE resident caps to allow the residents displaced from the closed hospital or program to complete their training without requiring additional documentation requirements. That is, the commenters believed that in cases of hospital or program closure due to an emergency event, any hospital training displaced residents from these closed hospitals or programs would not need to submit any further documentation as currently required by either the emergency Medicare GME affiliation agreement provisions at § 413.79(f) or the closed program regulations at § 413.79(h) in order to increase their FTE resident caps to be paid for the training of the displaced residents.

Response: In the case where a hospital or program is closed permanently, the existing ''closed program'' and ''closed hospital'' regulations apply. We originally established the existing regulations at § 413.79(h) because hospitals indicated a reluctance to accept additional residents from a closed hospital when they would not be permitted to count them for purposes of Medicare GME payments without a temporary adjustment to their caps. The regulations at § 413.79(h) allow a temporary adjustment to a hospital's FTE resident cap if the following criteria are met: (a) The hospital is training additional residents from a hospital that closed or from a program that closed on or after July 1, 1996 (if the hospital with the closed program agrees, in a written statement, to temporarily reduce its FTE resident cap to offset the displaced residents trained by the receiving hospital); and (b) the hospital that is training the additional residents from the closed hospital or closed program submits a request to its fiscal intermediary/MAC at least 60 days after the hospital begins to train the residents for a temporary adjustment to its FTE cap. The hospital must also document that it is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed hospital or closed program and have caused the hospital to exceed its cap, and specify the length of time that the adjustment is needed. After the displaced residents leave the hospital's training program or complete their residency program, the temporary cap adjustment expires for the hospital that received displaced residents, and the cap slots would either revert back to the original hospital with the closed program or, in the case of a closed hospital, the cap slots permanently expire. Accordingly, after an emergency event, in the case of a hospital closure as defined at § 413.79(h)(1)(i), any hospital that trains displaced residents from the closed hospital may be permitted to use the ''closed hospital'' regulations at § 413.79(h)(2) as described above. Moreover, in cases where a hospital's program is completely closed, as defined at § 413.79(h)(1)(ii), any hospital that trains displaced residents from the closed program may be permitted to use the ''closed program'' regulations at § 413.79(h)(3). Alternatively, if a section 1135 emergency area has been declared, then hospitals may be permitted to use emergency Medicare GME affiliation agreement regulations as specified at § 413.79(f). We believe it is necessary to require that hospitals training displaced residents from closed hospitals and closed programs provide documentation as specified in the above regulations in order to ensure that Medicare payments are being paid appropriately and not in excess of the FTE caps.

Comment: Several commenters noted that, in the month immediately following Hurricane Katrina, many residents were not training anywhere. That is, while home hospitals were incurring significant training costs associated with the residents, arrangements had not yet been made for residents to continue their training at any hospital. Therefore, neither home hospitals nor host hospitals were counting these residents for Medicare GME payment purposes during this timeframe. Several commenters requested that home hospitals be allowed to annualize their 11-month FTE resident counts to 12 months, or alternatively, to attribute the August 2005 FTE resident counts to September 2005 as well, so that home hospitals could be paid as if residents had been training at the home hospital in September.

Response: While we understand that resident salaries and other costs may continue to be incurred even when the residents are prevented from training, as is the case after an emergency event that closes down their training sites, the Medicare statute provides for direct and indirect GME payments to hospitals only based on the actual time (counted in FTEs) that residents spend training at hospitals or, under certain circumstances, at nonhospital sites. We note that, as a result of an emergency event, hospitals may receive grants and other non-Medicare types of relief payments from other authorities to address the hospitals' needs to cover losses due to a cessation of operations.

Comment: Following the April 12, 2006 interim final rule with comment period, commenters urged CMS to address the situation where, in the confusion after the emergency events, home and host hospitals may have hastily arranged for displaced residents to begin training in nonhospital sites without first establishing a written agreement, as specified in § 413.78(e), between the hospital and nonhospital

site. In addition, the commenters indicated that, in the confusion and haste under which arrangements were made for displaced residents to train in nonhospital sites, hospitals may not have actually incurred all or substantially all of the costs of the training program in the nonhospital site in a timely fashion in accordance with our regulations at § 413.78(e)(3)(i) or (f)(3)(i). The commenters suggested CMS make accommodations for this period of confusion and modify the regulations at § 413.78 to allow home and host hospitals additional time to comply with the written agreement and payment requirements required for hospitals to count residents training at nonhospital sites.

Response: We acknowledged the commenters' concerns regarding the training of displaced residents in nonhospital sites after an emergency event and addressed this issue in the November 27, 2007 interim final rule with comment period (72 FR 66893 through 66898). As we discussed above, the November 27, 2007 interim final rule with comment period provided hospitals that are participating in emergency Medicare GME affiliation agreements with increased flexibility in submitting written agreements relating to training that occurs in nonhospital sites. Home or host hospitals with valid emergency Medicare GME affiliation agreements training displaced residents in a nonhospital site may submit a copy of the written agreement, as specified under § 413.78(e)(3)(iii) and (f)(3)(iii) as applicable, to the CMS contractor servicing the hospital by 180 days after the first day the resident began training at the nonhospital site.

Furthermore, because the regulations at § 413.78(f) specify two options: (1) That hospitals must either have a written agreement in place before the training occurs or (2) they must pay ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred, we provided additional flexibility in the ''concurrent payment'' option for home or host hospitals that have emergency Medicare GME affiliation agreements and are training displaced residents in nonhospital sites by extending the time allowable for ''concurrent payment'' from 3 months to 6 months. That is, we permit a home or host hospital with a valid emergency Medicare GME affiliation agreement to incur ''all or substantially all'' of the costs for the training program in the nonhospital setting attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred.

Finally, in the case of Hurricanes Katrina and Rita, we noted that the time limit we adopted to submit written agreements or to meet the ''concurrent payment'' requirement may have already passed. Therefore, we extended the deadline so that for residents training in nonhospital sites during the period of August 29, 2005, to November 1, 2007, home or host hospitals with valid emergency Medicare GME affiliation agreements could submit written agreements or incur ''all or substantially all'' of the costs of the training program (that is, the ''concurrent payment'' option) to cover those specific residents by April 29, 2008.

We did not receive any comments in response to our modifications of the regulations at § 413.78(e) and (f) as specified in the November 27, 2007 interim final rule.

Comment: The majority of commenters also responded to the April 12, 2006 interim final rule with a strong recommendation that CMS allow emergency Medicare GME affiliation agreements to continue past the maximum of 3 academic years as we originally specified in the April 12, 2006 interim final rule with comment period. The commenters stated that a residency program can take up to 5 years to complete, that fluidity in GME programs in the emergency area could continue for more than 3 years, and that GME programs are not likely to reach stability until permanent replacement facilities are established and functioning in the emergency area. The commenters recommended that CMS extend the effective period of emergency Medicare GME affiliation agreements from up to 3 years to up to 5 years.

Response: We agreed with the commenters' reasons for the necessity of extending the effective period of emergency Medicare GME affiliation agreements from up to 3 years to up to 5 years, and have already addressed this issue in the November 27, 2007 interim final rule with comment period (72 FR 66893 through 66898). In the November 27, 2007 interim final rule with comment period, we extended the permissible effective period for emergency Medicare GME affiliations from up to 3 years to up to 5 years, beginning with the first day of a section 1135 emergency period, and terminating no later than at the end of the fourth academic year following the academic year during which the section 1135 emergency period began. However, we specified that for an out-of-State host hospital (that is, a host hospital located in a different state from the home hospital), FTE cap adjustments during the additional 2 years could apply only for the actual residents that were displaced immediately following the disaster. For host hospitals located in the same state as the home hospital, the FTE cap adjustments under the emergency Medicare GME affiliation agreement can apply to new residents that were not training in the home hospital's program at the time the disaster began. We stated that the extension of the permissible effective period for emergency Medicare GME affiliation agreements is intended to allow home hospitals to balance their desire to return residents to their original training sites as they recover the ability to train residents after a disaster, with their need to be given the opportunity to rebuild their programs incrementally. We explained that we believed extending the permissible effective period for emergency Medicare GME affiliation agreements with out-of-State host hospitals for 2 years (for a total of up to 5 years), but limiting such agreements to residents that were displaced from home hospitals immediately following a disaster, would allow the displaced residents to complete their training, while providing an incentive for home hospitals to begin training new incoming residents locally, increasing the likelihood that the residents would stay and practice in the area after their training is completed.

We did not receive any public comments in response to the modification of the effective period for emergency Medicare GME affiliation agreements as specified in the November 27, 2007 interim final rule with comment period.

Comment: The majority of commenters requested that CMS reconsider the deadline for submission of emergency Medicare GME affiliation agreements, stating that the deadline CMS originally required in the April 12, 2006 interim final rule with comment period was unmanageable.

Response: In the April 12, 2006 interim final rule with comment period (70 FR 18654 through 18667), we required emergency Medicare GME affiliation agreements to be submitted to CMS with a copy to the CMS fiscal intermediary or MAC by the later of 180 days after the section 1135 emergency period begins or by July 1 of the academic year in which the emergency Medicare GME affiliation agreement is effective. However, in response to commenters' immediate request for an extension, we issued a final rule on July

6, 2006, to address this concern and extended the deadline for hospitals affected by Hurricanes Katrina and Rita to October 9, 2006. Upon further reflection and in response to comments from hospitals affected by Hurricanes Katrina and Rita, we are further modifying the deadlines for the submission of emergency Medicare GME affiliation agreements to apply to all future emergency events that result in a declaration of an 1135 emergency area (§ 413.79(f)(6)(ii)). Effective for emergency Medicare GME affiliation agreements that would otherwise be required to be submitted on or after October 1, 2008, home and host hospitals are permitted to submit emergency Medicare GME affiliation agreements by 180 days after the end of the academic year in which the emergency event occurs; for the second academic year, by 180 days after the end of the next academic year following the academic year in which the section 1135 emergency was declared; and for subsequent academic years, by July 1 of each academic year. That is, for example, if a section 1135 emergency area is declared for an emergency event that occurred on March 1, 2009, hospitals are permitted to submit an emergency Medicare GME affiliation agreement for the period from March 1, 2009, to June 30, 2009 (the first relevant academic year) by August 28, 2009. Additionally, for an emergency Medicare GME affiliation agreement for the period from July 1, 2009, to June 30, 2010 (the second relevant academic year), hospitals are permitted to submit the emergency Medicare GME affiliation agreement by August 28, 2010. For the remaining 3 academic years in which home and host hospitals are permitted to execute emergency Medicare GME affiliation agreements, hospitals are required to submit emergency Medicare GME affiliation agreements on or before July 1 of the relevant academic year. That is, in this example, for an emergency Medicare GME affiliation agreement for the period from July 1, 2010, to June 30, 2011 (the third relevant academic year), hospitals must submit the emergency Medicare GME affiliation agreement on or before July 1, 2010. We believe these revised deadlines will permit home and host hospitals sufficient time to respond and make adjustments to their GME training plans in the immediate aftermath of a disaster, and to prepare and submit the necessary emergency GME affiliation agreements.

Comment: One commenter on the November 27, 2007 interim final rule with comment period expressed appreciation ''for the efforts made by the Agency to deal with the continuing situation of displaced residents as a result of Hurricanes Katrina and Rita, as well as any future emergency situations.'' However, the commenter believed strongly that neither the residents nor the host hospitals that take them on should be penalized by not receiving direct GME or IME payments because the home hospitals may have been training a number of FTE residents in excess of their caps prior to the emergency event. The commenter urged CMS to work with Congress to address this issue if CMS could not resolve it administratively.

Response: Emergency Medicare GME affiliation agreements provide home hospitals with the flexibility to temporarily transfer their FTE cap slots to other hospitals around the country in order to allow host hospitals to receive direct GME and IME payments relating to training displaced residents from the home hospital. However, even though Congress granted the Secretary authority to provide for rules allowing hospital groups to affiliate and apply their FTE resident caps on an aggregate basis, the BBA of 1997 established a fixed limit on the number of allopathic and osteopathic FTE residents that can be included in the hospitals' direct GME and IME FTE resident counts for Medicare payment purposes. Therefore, hospitals, even under the permissible affiliation rules, are not permitted to receive direct GME or IME payments in excess of the FTE resident caps.

Comment: Several commenters expressed concern with the definition of a home hospital. Specifically, the commenters were concerned with the requirement that a home hospital experience a decrease in inpatient bed occupancy of 20 percent. One commenter stated it is not appropriate to ''test'' whether a hospital located in the section 1135 emergency area qualifies as a home hospital. Several commenters noted it would not be appropriate to review occupancy rates because the hospital may actually experience an increase in inpatient occupancy. One commenter stated that despite an increase in occupancy, a hospital may determine ''* * * that its physician residents are better served in being placed in another teaching hospital for a period of time or the duration of the residents' training.'' The commenter stated that the complexity associated in dealing with an emergency situation should not be encumbered by such administrative rules which are inappropriate in extraordinary circumstances. The commenter recommended CMS clearly state that any teaching hospital located in a section 1135 emergency area can be considered a home hospital under the regulations. Another commenter noted a hospital that remains open may consider it appropriate to relocate its residents due to a variety of reasons including structural damage or lack of other local services. Some commenters noted that adding the additional requirement that a home hospital see a decrease in inpatient volume of 20 percent ''* * * is unnecessary and could be detrimental.'' Several commenters noted it should be sufficient to use a nationally declared emergency as a trigger for the Medicare GME emergency affiliation agreement regulations. The commenters further stated that a volume reduction requirement would contradict the flexibility that CMS is trying to provide through the regulations. One commenter stated the timeframe provided in the April 12, 2006 interim final rule with comment period (71 FR 18658) is not a sufficient amount of time because hospitals may have difficulty obtaining documentation to support their occupancy rates. The commenter recommended that CMS be flexible in terms of the time periods used to calculate a decrease in inpatient occupancy. For example, the commenter suggested that if records had been lost, the provider could use its last cost report submitted to the fiscal intermediary/MAC as evidence of the occupancy rate prior to the disaster.

Response: In the April 12, 2006 interim final rule with comment period (71 FR 18658), we stated that, in determining whether a hospital in a section 1135 emergency area qualifies as a home hospital, we believe it is appropriate to compare the inpatient bed occupancy of the hospital 1 week before the earlier of the date the section 1135 emergency period begins, or the date on which the hospital began any evacuation efforts in anticipation of an event that results in the declaration of a section 1135 emergency area, as compared to the inpatient bed occupancy of the hospital 1 week after the section 1135 emergency period begins. If the inpatient bed occupancy decreases by 20 percent or more between these two comparison timeframes, we believe that the significant drop in occupancy can be assumed to be the result of the event that led to the declaration of a section 1135 emergency period. We stated that in order to be considered a home hospital, a hospital would be required to experience a decrease in inpatient bed occupancy of 20 percent or more as a

result of a section 1135 emergency period so that it is unable to train the number of residents it originally intended to train in that academic year. We did consider instituting a higher threshold to determine whether a hospital can be considered a home hospital. However, in consideration of hospitals that had not been as severely damaged but still needed to move residents, we determined that a decrease in inpatient occupancy of 20 percent would be an appropriate threshold. Furthermore, we believe that if we had allowed any hospital in the section 1135 area to be a home hospital, such a policy could have been detrimental to the attempts to preserve residency training within the emergency area. If there was no damage threshold established for a hospital to be considered a home hospital, a higher number of ''displaced residents'' would have been permitted to relocate their residency training out of state. Furthermore, we note that not all hospitals in the section 1135 emergency area experienced physical and structural interruptions necessitating the relocation of residency training to other facilities. We note that the increased flexibility provided by emergency Medicare GME affiliation agreements is intended to specifically help home hospitals that are experiencing extraordinary and dire conditions that necessitate the relocation of residency training.

In response to the comment that hospitals may not have the documentation available to calculate occupancy rates before and after the disaster, if hospitals do not have this information available, we will work the hospitals on an individual basis so that a determination can be made.

Comment: One commenter proposed that CMS assign sponsoring organizations the responsibility of coordinating between home and host hospitals, and require that hospitals participating in a Medicare GME emergency affiliation agreement obtain approval from the sponsoring organization before any cap transfers are made. The commenter noted that involving sponsoring institutions ''* * * will help ensure that the GME funds provided by CMS will be used for their intended use—to make certain medical residents receive high-quality training and are, therefore, able to provide high-quality care to program beneficiaries.'' The commenter stated that although hospitals affected by Hurricanes Katrina and Rita are making efforts at rebuilding, there is no guarantee that qualified personnel are available to mentor and teach the residents. The commenter further noted that although a hospital may be ready to resume residency training, the resident may not be adequately prepared to return to his or her training at that specific hospital. The commenter stated medical residencies are very structured and rigorous and that residents learn and master skills in a specific order. The commenter asserted that the resident's sponsoring program director is the only individual in a position to evaluate a resident's specific skills and needs and must participate in the decision to transfer residents between facilities.

Response: We appreciate the commenter's dedication towards ensuring that residents are prepared and able to receive a quality education both during a disaster and the rebuilding process. Although we agree that it is important for the various individuals involved in a resident's GME training program to be fully aware of the resident's prior and current training and skill level, we do not believe it would be appropriate for CMS to require that sponsoring institutions serve as the formal coordinator between the home and host hospitals that are involved in the organization of a resident's residency training program. By statute, CMS only reimburses hospitals for GME and therefore the regulations can only address hospitals' requirements. However, we encourage sponsoring institutions to work closely with hospitals to provide the residents with the most appropriate training experience both during and after a disaster.

Comment: Several commenters had questions concerning new teaching hospitals created after the date of onset of the emergency/disaster, that is, teaching hospitals that were nonteaching hospitals prior to training displaced residents. Two commenters stated they appreciated CMS' recognition that, during emergency periods, it may be necessary for a home hospital to send its residents to nonteaching hospitals to continue their training. The commenters stated that because the nonteaching hospitals do not have caps, they are reimbursed for direct GME and IME based on a temporary cap which they receive from the home hospital through an emergency Medicare GME affiliation agreement. The commenters requested CMS confirm ''* * * that, like nonteaching hospitals that enter into affiliation agreements in nonemergency situations, nonteaching hospitals that participate in emergency GME affiliation agreements do not lose their ''nonteaching'' status for purposes of obtaining their own, permanent resident cap at some point in the future if they choose to start new residency training programs.'' One commenter asked CMS to clarify the impact on a nonteaching hospital's base year calculation for direct GME payment purposes for a nonteaching hospital which is part of an emergency Medicare GME affiliation agreement. Another commenter expressed concern about several sections of the interim final rule with comment period and current GME regulations which have a direct impact on a specific hospital that became a teaching hospital effective July 1, 2006. The commenter stated that CMS' discussion in the interim final rule with comment period on the necessity for new teaching hospitals to incur teaching costs for purposes of establishing their PRAs was helpful. However, the commenter noted that new teaching hospitals have additional responsibilities of which they may be unaware. The commenter emphasized teaching hospitals that become new teaching hospitals once they begin to train displaced residents may be particularly uninformed on the rules relating to training at nonhospital sites. The commenter provided a review of the regulations addressing training at nonhospital sites and noted that if a hospital wishes to count residents training at a nonhospital site, the hospital and nonhospital site(s) must enter into a written agreement prior to the training taking place. The commenter asserted that hospitals failed to enter into written agreements prior to the training at the nonhospital site taking place. The commenter stated that the hospital was unaware of the requirements and even if the hospital had been aware, circumstances were such that it would not have been possible to secure written agreement prior to services being provided. The commenter requested that CMS make a special exception for the requirements at § 413.78 (regulations relating to the training at a nonhospital site). The commenter requested the regulations be modified to allow new teaching hospitals to enter into written agreements with nonhospital sites retroactive to the time when the services were provided, if the agreements are entered into within one year of the provision of services. The commenter believed that making theses changes to the regulations would not unfairly penalize new teaching hospitals for their unfamiliarity with the GME rules particularly during the ''confusing state of affairs.'' One commenter asked CMS to add a regulatory definition of ''new host teaching hospital.'' The commenter noted that, as discussed on page 18661

of the April 12, 2006 interim final rule with comment period (71 FR 18661), new host teaching hospitals were previously nonteaching hospitals that will become new teaching hospitals once they begin to train displaced residents from home hospitals as part of an approved medical residency program.

Response: We agree with the commenters that it is essential for hospitals to be aware of applicable regulations pertaining to GME if they are becoming or plan to become a new teaching hospital. In the April 12, 2006 interim final rule with comment period (71 FR 18661), we discussed policies pertaining to new teaching hospitals. We stated that when displaced residents are sent to train at hospitals that were not previously teaching hospitals, these hospitals will become new teaching hospitals once they begin to train residents from the home hospital as part of an approved medical resident training program. The following text is an excerpt from CMS' discussion on provisions effecting new teaching hospitals found on page 18661 of the April 12, 2006 interim final rule with comment period (71 FR 18661):

''As a new teaching hospital, such a hospital initially will have IME and direct GME FTE resident caps of zero (based on the number of residents training in the 1996 base year for FTE resident caps). However, the new teaching hospital, by participating in an emergency Medicare GME affiliation agreement, can receive a temporary cap increase in order to count the displaced FTE residents for purposes of IME and direct GME payments.

As a new teaching hospital, the hospital will not have an existing per resident amount for direct GME payment purposes. The per resident amounts for these hospitals will be established as specified at § 413.77(e) (just as any other new teaching hospital would have its per resident amount established). The new teaching hospital's per resident amount is established based on the lower of the hospital's direct GME costs per resident in its base year, or the updated weighted mean value of the per resident amounts of all hospitals located in the same geographic wage area as specified in the regulations at § 413.77. Therefore, it is very important for a new teaching host hospital to incur direct GME costs in its base year and to document all of the direct GME costs it incurs (for example, the residents' salaries, fringe benefits, any portion of the teaching physician salaries attributable to GME, and other direct GME costs) for the displaced residents it is training; otherwise the host hospital risks being assigned a very low permanent per resident amount in accordance with our regulations. If the host, new teaching hospital incurs no GME costs in the relevant base year, its per resident amount would be zero dollars. We advise hospitals to refer to the regulations at § 413.77(e) for the rules concerning the establishment of a new teaching hospital's per resident amount. In accordance with section 1886(h) of the Act and our regulations, once the base year per resident amount is established, it is fixed and not subject to adjustment to reflect costs incurred in years subsequent to the base year that might be associated with new programs or additional residents.''

The commenters are not entirely correct in stating that ''nonteaching hospitals that participate in emergency GME affiliation agreements do not lose their 'nonteaching' status for purposes of obtaining their own, permanent resident cap at some point in the future if they choose to start new residency training programs.'' Once a hospital begins training residents, even if it is training residents as part of a Medicare GME affiliation agreement, that hospital will become a teaching hospital and it will have a PRA established based on the costs it incurs in training those residents. Therefore, as we stated in the proposed rule, it is important that a new teaching hospital incur costs in training residents so the hospital is not assigned a very low or zero PRA. The commenters are correct that host hospitals that were not previously teaching hospitals, which become new teaching hospitals by virtue of training displaced residents, receive a temporary cap adjustment based upon the displaced FTE residents they are training. The cap adjustment is temporary because it is obtained by virtue of the fact that the host hospital is participating in a Medicare GME emergency affiliation agreement. A new teaching hospital could receive a permanent adjustment to the hospital's FTE resident caps only if it begins training residents in a newly approved program. The regulations pertaining to the establishment of a permanent cap adjustment can be found at § 413.79(e). A hospital's cap is adjusted for new programs based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the minimum number of years in which residents are expected to complete the program based on the accredited length for the type of program. A hospital's adjusted cap is applied beginning with the fourth year of its first new residency training program. We also note that direct GME payment is based on a rolling average which is calculated based on a hospital's FTE resident counts from the current year, and the prior two years. However, FTE residents training in new teaching hospitals and in new residency training programs at existing teaching hospitals are excluded from the rolling average for the minimum accredited length of the program (dental and podiatry residents are always exempt from the rolling average).

Regarding the commenter's concerns about the regulations governing residency training at nonhospital sites, we addressed these concerns, providing greater flexibility for hospitals to meet the written agreement or concurrent payment requirements, in the November 27, 2007 interim final rule with comment period (72 FR 66898). In response to the commenter who requested CMS to add a regulatory definition of ''new host teaching hospital,'' we do not believe that a regulatory definition is necessary because the regulations at § 413.75(b) already contain a definition of host hospital, which as defined ''means a hospital training residents displaced from a home hospital.'' Our policy has always been that once a hospital begins training residents, the hospital is considered a teaching hospital. We urge hospitals to contact their fiscal intermediary/MAC and CMS if they have questions as to how GME regulations are applied to hospitals that become teaching hospitals as a result of training displaced residents.

Comment: A number of commenters were concerned about the effects of the decreased number of FTE residents training after an emergency event, on the potential for a home hospital to reopen and receive adequate payments. Specifically, some commenters were concerned that when a home hospital has trained a substantially reduced number of FTE residents following a disaster, the cap on the interns and residents-to-beds (IRB ratio cap), which limits the IRB ratio used to calculate a hospital's IME payment calculation to the lesser of either the current year's IRB ratio based on the 3-year rolling average FTE count subject to the cap or the previous year's IRB ratio, would be either zero or very low. This could adversely affect a home hospital when it reopens operations. One commenter presented an example in which the IRB ratio cap for a home hospital that has no FTEs in FYs 2006 or 2007 would prevent the hospital from receiving any IME reimbursement in FYs 2006, 2007,

or 2008 because the current year IRB ratio is always limited to the lesser of the current year or the prior year. The commenters suggested that CMS allow home hospitals to use the higher IRB ratio from a year previous to the emergency event in order to prevent the situation where home hospitals would not be paid for IME due to an IRB ratio cap of zero. One commenter also indicated that host hospitals would be negatively impacted by the application of the IRB ratio cap which would result in a delay in receiving IME payments for the training of displaced residents in any given year.

Response: As specified under the regulations at § 412.105(1)(a)(i), an IRB ratio is calculated for a hospital based generally on the ratio of FTE residents in the numerator to the number of available beds (as described at § 412.105(1)(b)) in the denominator. Section 1886(d)(5)(B)(vi)(I) of the Act specifies the application of an IRB ratio cap, stating that the IRB ratio ''may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds * * * during that cost reporting period * * *''. Following an emergency event, a home hospital's IRB ratio could be affected by a decrease in the numerator or denominator, or both. We would expect that home hospitals that experience a decrease in their patient load or close completely could document the number of ''available'' beds (as described at § 412.105(b)) to reflect the actual circumstances of the home hospital. Depending on the actual number of FTE residents that remain and the number of beds (if any) available for inpatient use, decreases in the number of beds in the denominator could counterbalance decreases in the FTE resident count in the numerator in calculating the IRB ratio, producing an IRB ratio and an IRB ratio cap that are not out of line with the previous years.

From the comments that we received regarding the application of the IRB ratio cap, we believe some of the commenters may have been confused about the difference between the IRB ratio calculations for the current and prior years and the application of the IRB ratio cap based on the comparison of the current and prior years' IRB ratios. In accordance with section 1886(d)(5)(B)(vi)(II) of the Act, for the current year's IRB ratio, the numerator is based on the 3-year rolling average FTE resident count. In contrast, in accordance with section 1886(d)(5)(B)(vi)(I) of the Act, to determine the numerator of the prior year's ratio for purposes of the IRB ratio cap, the prior year's actual FTE resident count (subject to the FTE resident limit) is used (that is, the rolling average is not used to determine the numerator of the prior year's ratio for purposes of establishing the IRB ratio cap). The IRB ratio cap prescribes that the IRB ratio used for to calculate IME payments in the current year is the lesser of either the current year IRB ratio or the prior year IRB ratio as calculated in the manner described above. Accordingly, in the example presented by the commenter in which the home hospital is training no residents in FYs 2006 and 2007, although the commenter stated that IME payments would not be possible in FY 2006, in fact the hospital could receive IME payment in FY 2006 (assuming the hospital was training residents in FY 2005). That is, the numerator of the FY 2006 IRB ratio would be based on a rolling average count of the zero FTEs in FY 2006, and the number of FTEs training in FYs 2005 and 2004. For purposes of applying the IRB ratio cap, the numerator of the FY 2005 IRB ratio would be based on the actual number of FTE residents training in FY 2005 (subject to the FTE resident limit). Therefore, the hospital would receive IME payment in FY 2006.

The commenter also expressed concern that when home hospitals reopen or rebuild their GME programs after several years of training no or relatively few residents would be adversely affected by the IRB ratio cap. To continue the example discussed previously, if in FY 2008, the home hospital trains residents again after 2 years (2006 and 2007) in which there were no residents training at the hospital (that is, zero FTEs in the numerator of the IRB ratio of the prior year), the application of the IRB ratio cap would prevent the home hospital from receiving IME payment in FY 2008. We note that because the IRB ratio for the current year is based on a rolling average FTE count, while the IRB ratio for the prior year is based on the actual FTE count (subject to the FTE resident limit) for that year, the adverse effect of the application of the IRB ratio cap is limited to 1 year, assuming the hospital continues to train residents in the following years. We appreciate the commenter's concern that as home hospitals resume their training of FTE residents, they may be severely disadvantaged because of the 1-year lag in IME payments produced by application of the IRB ratio cap. We agree that after an emergency event, home hospitals could face a significant barrier in reopening or resuming previous levels of training in their GME programs due to the application of the IRB ratio cap, at a time when the home hospitals can least afford to have Medicare payments reduced. We also acknowledge that a host hospital that trains displaced residents through an emergency Medicare GME affiliation agreement could also be adversely affected by the application of the IRB ratio cap. Since the statute allows for an exception in the application of the IRB ratio cap for the special circumstances for Medicare GME affiliated groups and new programs, we are providing for home and host hospitals with valid emergency Medicare GME affiliation agreements an exemption from the application of the IRB ratio cap. Specifically, we are revising § 412.105(f)(1)(vi) of the regulations to specify that effective October 1, 2008, IME payments for home and host hospitals with valid emergency Medicare GME affiliation agreements will be calculated using the current year's IRB ratio without application of the IRB ratio cap. For example, a home hospital that has a valid emergency Medicare GME affiliation agreement and trains 60 FTE residents in FY 2008 after training no residents in FYs 2007 and 2006. If the IRB ratio cap is applied, the IRB ratio cap for FY 2008 would be zero (because the hospital trained no residents in FY 2007 so the IRB ratio for the prior year is zero). However, because of this exception to the application of the IRB ratio cap, the home hospital's FY 2008 IRB ratio would be based on 20 FTEs in the numerator ((60+0+0)/3=20). Accordingly, the IME payment for the home hospital would be based on 20 FTEs in the numerator of the 2008 IRB ratio rather than zero. We note that this provision is meant to allow home and host hospitals additional flexibility in the application of the IRB ratio cap, as provided for under section 1886(d)(5)(B)(viii) of the Act. However, we note that the 3-year rolling average FTE resident count (used in the numerator of the current year's IRB ratio) would still apply. We also note that, in accordance with section 1886(d)(5)((B)(vi)(I) of the Act, no adjustment to the IRB ratio is made for an increase in dental or podiatry residents during the cost reporting period in which an increase occurs because dental and podiatry residents are not included for purposes of calculating the IRB ratio.

Finally, we note that it has been several years since the section 1135 emergency areas were declared due to Hurricanes Katrina and Rita. While

some hospitals in these section 1135 emergency areas are still using emergency Medicare GME affiliation agreements in order to facilitate training of residents in programs that were affected by the hurricanes, other hospitals may have decided that they could meet the shared rotational arrangement and other requirements for regular Medicare GME affiliation agreements and have consequently elected enter into regular Medicare GME affiliation agreements rather than emergency Medicare GME affiliation agreements even though CMS has permitted the use of emergency Medicare GME affiliation agreements for up to 5 academic years (in this case, until June 30, 2010). In other cases, hospitals have informed us that they are waiting for the April 12, 2005 and the November 27, 2007 interim final rules with comment period to be finalized and, in order to preserve their ability to respond to any changes we make to the emergency Medicare GME affiliation or other provisions in the final rule, these hospitals have elected to have in place both a regular Medicare GME affiliation agreement and an emergency Medicare GME affiliation agreement. Because we recognize that home and host hospitals (both previous and current) will want to structure their Medicare GME affiliations in order to make best use of our final rules, we are permitting hospitals, for the remaining academic years for which emergency Medicare GME affiliations are authorized as a result of the section 1135 emergency relating to Hurricanes Katrina and Rita (that is, until June 30, 2010), to amend an existing regular Medicare GME affiliation agreement by June 30 of the relevant academic year in order to convert it into an emergency Medicare GME affiliation agreement if the hospitals submit the amended agreements to CMS and their fiscal intermediary/MAC by June 30 of the relevant academic year. For example, if hospitals have a regular Medicare GME affiliation agreement in effect for the current academic year, July 1, 2008, through June 30, 2009, they may amend the agreement to convert it to an emergency Medicare GME affiliation agreement by June 30, 2009.

e. Provisions of the Final Rule

Except for the modifications as noted below, we are adopting as final the policies included in the April 12, 2006 and November 27, 2007 interim final rules with comment period without further changes. The modifications to the April 12, 2006 and November 27, 2007 interim final rules that we are adopting as final policies include the following:

We are further modifying the deadline for the submission of emergency Medicare GME affiliation agreements in § 413.79(f)(6)(ii) to apply to all future emergency events that result in a declaration of an 1135 emergency area. Effective for emergency Medicare GME affiliation agreements required to be submitted on or after October 1, 2008, home and host hospitals must submit emergency Medicare GME affiliation agreements by 180 days after the end of the academic year in which the emergency event occurs and for the next academic year following the emergency event. For the remaining 3 academic years in which home and host hospitals are permitted to execute emergency Medicare GME affiliation agreements, hospitals are required to submit emergency Medicare GME affiliation agreements on or before July 1 of the relevant academic year.

We note that we had previously modified the submission deadline in the July 6, 2006 final rule (71 FR 38264 through 38266). The July 6, 2006 final rule permitted an extension in the submission deadlines only for home and host hospitals affected by Hurricanes Katrina and Rita. For emergency Medicare GME affiliation agreements that would otherwise be due on or before July 1, 2006, the deadline was subsequently extended to October 9, 2006.

For home and host hospitals with valid emergency Medicare GME affiliation agreements, we are providing for an exemption from application of the IRB ratio cap. Specifically, IME payments for home and host hospitals with valid emergency Medicare GME affiliation agreements are calculated based on the current year's IRB ratio (subject to the 3-year rolling average FTE resident provision and the hospital's Medicare IME cap.

f. Technical Correction

In the April 12, 2006 interim final rule with comment period (70 FR 18654 through 18667), we revised § 413.79(f) by adding a paragraph (6) to provide more flexibility in emergency Medicare GME affiliations for home hospitals located in section 1135 emergency areas to allow the home hospital to efficiently find training sites for displaced residents. We have discovered that, under § 413.79(f)(6)(iv), in our provision on the host hospital exception from the rolling average for the period from August 29, 2005, to June 30, 2006, we included an incorrect cross-reference to the rolling average requirements for direct GME as ''§ 413.75(d)''. The correct cross-reference to the rolling average requirement for direct GME is § 413.79(d). As we proposed in the FY 2009 IPPS proposed rule (73 FR 23667), we are correcting the cross-reference under § 413.79(f)(6)(iv) to read ''paragraph (d) of this section''.

H. Payments to Medicare Advantage Organizations: Collection of Risk Adjustment Data (§ 422.310)

Section 1853 of the Act requires CMS to make advance monthly payments to a Medicare Advantage (MA) organization for each beneficiary enrolled in an MA plan offered by the organization for coverage of Medicare Part A and Part B benefits. Section 1853(a)(1)(C) of the Act requires CMS to adjust the monthly payment amount for each enrollee to take into account the health status of the MA plan's enrollees. Under the CMS-Hierarchical Condition Category (HCC) risk adjustment payment methodology, CMS determines risk scores for MA enrollees for a year and adjusts the monthly payment amount using the appropriate enrollee risk score.

Under section 1853(a)(3)(B) of the Act, MA organizations are required to ''submit data regarding inpatient hospital services * * * and data regarding other services and other information as the Secretary deems necessary'' in order to implement a methodology for ''risk adjusting'' payments made to MA organizations. Risk adjustments to payments are made in order to take into account ''variations in per capita costs based on [the] health status'' of the Medicare beneficiaries enrolled in an MA plan offered by the organization. Submission of data on inpatient hospital services has been required with respect to services beginning on or after July 1, 1997. Submission of data on other services has been required since July 1, 1998.

While we initially required the submission of comprehensive data regarding services provided by MA organizations, including comprehensive inpatient hospital encounter data, we subsequently permitted MA organizations to submit an ''abbreviated'' set of data. Our regulations at 42 CFR 422.310(d)(1) currently explicitly provide MA organizations with the option of submitting an abbreviated data set. Under this provision, we currently collect limited risk adjustment data from MA organizations, primarily diagnosis data.

From calendar years 2000 through 2006, application of risk adjustment to MA payments was ''phased in'' with an increasing percentage of the monthly

capitation payment subjected to risk adjustment. Beginning with calendar year 2007, 100 percent of payments to MA organizations are risk-adjusted. Given the increased importance of the accuracy of our risk adjustment methodology, in the FY 2009 IPPS proposed rule (73 FR 23667), we proposed to amend § 422.310 to provide that CMS will collect data from MA organizations regarding each item and service provided to an MA plan enrollee. This will allow us to include utilization data and other factors that CMS can use in developing the CMS–HCC risk adjustment models in order to reflect patterns of diagnoses and expenditures in the MA program.

Specifically, we proposed to revise § 422.310(a) to clarify that risk adjustment data are data used not only in the application of risk adjustment to MA payments, but also in the development of risk adjustment models. For example, once encounter data for MA enrollees are available, CMS would have beneficiary-specific information on the utilization of services by MA plan enrollees. These data could be used to calibrate the CMS–HCC risk adjustment models using MA patterns of diagnoses and expenditures.

We proposed to revise §§ 422.310(b), (c), (d)(3), and (g) to clarify that the term ''services'' includes items and services.

We proposed to revise § 422.310(d) to clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee. The proposed revision also would clarify that CMS will determine the formats for submitting encounter data, which may be more abbreviated than those used for the fee-for-service claims data submission process.

We proposed to revise § 422.310(f) to clarify that one of the ''other'' purposes for which CMS may use risk adjustment data collected under this section would be to update risk adjustment models with data from MA enrollees. In addition, when providing that CMS may use risk adjustment data for purposes other than adjusting payments as described at §§ 422.304(a) and (c), we proposed to delete the phrase ''except for medical records data'' from paragraph (f). Any use of medical records data collected under paragraph (e) of § 422.310 is governed by the Privacy Act and the privacy provisions in the HIPAA. Furthermore, there may be occasions when we learn from analysis of medical record review data that some organizations have misunderstood our guidance on how to implement an operational instruction. We want to be able to provide improved guidance to MA organizations based on any insights that may emerge during analysis of the medical record review data.

In addition, we proposed a technical correction to § 422.310(f) to clarify that risk adjustment data are used not only to adjust payments to plans described at §§ 422.301(a)(1), (a)(2), and (a)(3) (which refer to coordinated care plans and private fee-for-service plans), but also to adjust payments for ESRD enrollees and payments to MSA plans and Religious Fraternal Benefit society plans, as described at § 422.301(c).

Under § 422.310(g), we would continue to provide that data that CMS receives after the final deadline for a payment year will not be accepted for purposes of the reconciliation. However, we proposed to revise paragraph (g)(2) of § 422.310 to change the deadline from ''December 31'' of the payment year to ''January 31'' of the year following the payment year. We also proposed to add language to provide that CMS may adjust deadlines as appropriate.

Comment: One commenter recognized CMS' interest in modifying the types of data collected from MA organization, and another commenter supported CMS' efforts to increase payment accuracy. Two commenters were pleased with CMS' plan to collect data on each item and service provided to MA plan enrollees, and supported the goal of more accurately paying MA organizations, monitoring the quality of care provided by MA organizations, and the benefits actually received by Medicare beneficiaries in these plans.

Response: We appreciate the commenters' support for our efforts to collect encounter data for services and items provided to MA enrollees.

Comment: Several commenters acknowledged CMS' interest in modifying the types of data collected from MA organizations in order to refine and improve the risk adjustment model and risk-adjusted payment, supported in principle the goal of improving the risk adjustment models to reflect patterns of diagnoses and expenditures in the MA program, supported CMS' efforts to increase payment accuracy, and understood CMS' need to be able to respond to Congressional inquiries, especially with respect to use of supplemental benefits.

Response: We appreciate the understanding of commenters regarding the advantages of our collection of encounter data.

Comment: Commenters expressed concern that collection of encounter data would have significant administrative and resources costs for plans and providers, even in an abbreviated form, because of the time and information technology investments needed to modify existing MA organization and CMS systems. The commenters cited challenges that they identified as being inherent in the collection of encounter data, including systems design, testing, and implementation, training for staff and providers, and sustained initiatives to collect, submit, correct, and resubmit data, which have been highly labor intensive. One commenter contended that reporting supplemental services, durable medical equipment, and home health services to comply with § 422.310(b) ''each item and service provided * * *'' would significantly increase the data reporting burden on both providers and plans. Another commenter argued that, if CMS required the submission of data elements such as dental services, vision services, optical services, fitness benefits, reporting on these items and services would be a challenge and would result in extensive new data collection that might not now exist with providers of some of these services. One commenter believed that the rule would impose a particular burden on prepaid delivery systems that have historically operated on a capitated payment model, to the extent that this proposed requirement effectively requires these plans to code every service as if they were preparing a bill, and argued that this could fundamentally alter the way they deliver care. One commenter believed that renegotiations of provider contracts may have downstream implications in terms of the MA organizations ability to maintain premium levels. Another commenter reported that, while the commenter might have utilization data on services rendered, it did not have it in an encounter data or claim format.

Response: We understand that reporting encounter data will be an expansion of MA organizations current effort to report diagnoses as part of their Risk Adjustment Processing System (RAPS) submissions and that this expanded effort may increase the administrative resources and costs that MA organizations need to commit to their reporting efforts. As we develop our plans for the fields to be collected, the submission process, and how we will use the data, we are committed to having discussions with MA organizations and other stakeholders to obtain feedback regarding the effort involved in implementation of encounter data collection.

Comment: Commenters cited problems from earlier CMS efforts to collect encounter data, including the adaptation of the claims submission

platform to accommodate MA risk adjustment data, which required numerous complex changes; some data elements, such as Medicare hospital provider numbers, that proved extremely difficult to submit successfully; and errors that do not exist in RAPS.

Response: We will take into account the concerns of industry, including those based on previous experience, when planning our collection efforts.

Comment: One commenter suggested that the burden of reporting was undoubtedly taken into account by Congress in the process of considering, and ultimately adopting, the statutory language giving CMS broad authority to require reporting of both inpatient and outpatient encounter data. Because information about the numbers and costs of items and services provided is already collected by MA organizations in the course of their internal accounting, reporting such information to CMS cannot be a significant additional burden on them.

Response: While we understand that plans will need to allocate additional resources to collect and report encounter data, we agree with the commenter that Congress recognized the advantages of having these data.

Comment: Commenters contended that the value provided by encounter data reporting would be significantly outweighed by the burden the new requirements would impose and that, without a compelling reason, managed care organizations should not need to produce data at the level of detail called for by the proposed regulation.

Response: We recognize that MA organizations will need to devote additional resources to the effort of reporting encounter data. Because we have not yet identified the scope of data to be submitted or the process for collecting encounter data, we have not yet determined how much additional effort will be required. In determining the scope of encounter data to be submitted, we will work closely with external stakeholders to ensure that administrative costs are minimized to the extent possible.

Comment: One commenter stated that providers have experienced burdensome disruptions in its practices as a result of MA plans or its contractors reviewing medical records in its offices and recommended that CMS clarify in the final rule and any relevant guidance that, if an MA plan must review patient records, CMS should require the MA organization to reimburse the physician for the time and expense involved in any such review.

Response: Under the MA program, payment arrangements between MA organizations and physicians in their provider network are governed by the contracts negotiated between the parties. To the extent providers believe such payments are appropriate, they can seek to have them provided for under their contract. In the case of nonnetwork providers, they are entitled to the same payment from an MA organization that they would receive from Original Medicare for a beneficiary not enrolled in an MA plan. To the extent that a provider already submits claims under Original Medicare, we do not see a requirement to submit encounter data as necessarily burdensome to providers, because they would be submitting similar data to MA organizations as they do to fiscal intermediaries/MAC.

Comment: Commenters were concerned that the collection of encounter data would have the potential to create significant administrative burden and costs for CMS, and such a process is likely to be difficult for CMS to replicate concurrently with the ongoing work to refine the systems infrastructure for the Medicare Part D Prescription Drug Benefit Program without a major new investment in staffing and systems development.

Response: We appreciate the concerns expressed by the commenters regarding the administrative burden of implementing the collection and use of encounter data. As we develop the schedule for developing and implementing the collection of encounter data, we will take into account the resources of both the MA organizations and CMS.

Comment: Commenters requested that CMS allow for sufficient lead time for plan implementation of any needed changes, including time to analyze detailed specifications for any new requirements, plan for systems modifications, allocate sufficient resources to support the resulting changes, thoroughly test all of the changes, and make appropriate staff adjustments, including training and hiring before changes are fully implemented. The commenters requested that CMS coordinate the implementation of encounter data collection with other major initiatives, such as the transition from ICD–9–CM to ICD–10, so that organizations can incorporate planning for infrastructure changes into a comprehensive plan. One commenter estimated that, given the implementation of UB04, the implementation of encounter data reporting could take months for its IS department to develop and recode the current programs followed by a further period of months for a testing phase. Based on its past experience, the commenter offered that the revamping of encounter data to RAPS implementation took about 4 months. Another commenter noted that plans will need time to renegotiate provider contracts. Another commenter requested that CMS consider a phased-in approach to implementing changes.

Response: We recognize that MA organizations will need sufficient time to schedule system changes needed to collect and report encounter data, and may need to coordinate the implementation of encounter data reporting with other initiatives. We will consider the scheduling needs of MA organizations in our implementation timeline for encounter data.

Comment: Many commenters requested that CMS clarify how operational and methodological guidance will be released. The commenters asked that detailed information regarding analyses, use of data, and collection requirements for encounter data be shared and discussed early and not just through the annual ''Advance Notice of Methodological Changes'' process.

Response: We have not determined how we will conduct ongoing written communication with health plans, although we do not plan to rely solely on the annual Advance Notices of Methodological Change and annual Announcements. We anticipate that we will develop a method of regular written communication with stakeholders, in addition to discussion, in order to share and discuss details of our plans for data collection requirements and uses of the encounter data.

Comment: Many commenters asked CMS to clarify for what ''other purposes'' it might use the data. One commenter believed that CMS' proposal to use the data for ''other purposes'' is inappropriately broad. Some commenters requested that CMS modify the regulatory language in order to limit the use of the data to the calculation of the risk adjustment factors and the updating of risk adjustment models. One commenter believed that it would be inappropriate for CMS to compare plan bid submissions and resulting payment rates against actual experience in order to assess the legitimacy of bid submissions. Other commenters supported the use of encounter data to conduct analyses, either by CMS itself or by external entities, comparing MA organizations to each other and to traditional Medicare. These commenters noted that the collection of beneficiary-specific information on the utilization of services within MA plans has the

potential to provide valuable insight to the needs and health of MA plan enrollees.

Response: In response to industry concern regarding the use of the encounter data that will be collected under this regulatory authority, and specifically to the suggestion that CMS clarify for what ''other purposes'' data would be used, in this final rule, we are revising the proposed regulatory text at § 422.310(f) to clarify that we will use the data for the calculation of risk scores, updating risk adjustment models, calculating Medicare DSH percentages (the DSH percentage methodology incorporates hospital days for MA plan enrollees), Medicare coverage purposes (that is, the determination of whether day limits have been exhausted and, if so, how many such days), and quality review and improvement activities. As part of the design of our data collection efforts, we will clarify how we will use the encounter data that we collect for these purposes.

Comment: One commenter argued that the Social Security Act only authorizes CMS to collect of risk adjustment data for risk adjustment purposes. Other commenters also questioned CMS' authority to use encounter data for purposes other than the establishment or maintenance of the risk adjustment model.

Response: Section 1853(a)(3)(B) of the Act obligates MA organizations to submit inpatient and outpatient encounter data for purposes of use in implementing a risk adjustment methodology. We fully intend to use the data collected for these purposes. Unlike the case of information collected under section 1860D–15 of the Act, however, which the statute restricts to being used solely for purposes of implementing that section (see section 1860D–15(d)(2)(B) and (f)(2) of the Act), section 1853(a)(3)(B) of the Act does not impose any restrictions on other legitimate uses of the encounter data collected. We believe that uses of such data to determine the proper amount of payments to MA plans to improve the calculation of Medicare DSH percentages, to determine what benefits are covered for a Medicare beneficiary, and to monitor and improve the quality of services provided to Medicare beneficiaries are all legitimate uses of encounter data that are collected for purposes of risk adjustment. As noted above, in response to comments, we are revising the regulation text to expressly limit the use of encounter data to these purposes.

Comment: Many commenters asked which items and services CMS was planning to collect encounter data on; the commenters noted that the proposed rule does not clarify whether encounter data for supplemental services, DME, and home health services would be collected pursuant to § 422.310(b), which refers to data on ''each item and service provided.'' The commenters asked if CMS planned to collect encounter data for non-Medicare services, certain supplemental services, or for services offered by providers from whom CMS does not currently collect data. Another commenter urged that, because CMS does not currently collect encounter data for services furnished by providers and suppliers such as SNFs, DME suppliers, and HHAs, CMS should explain whether or how the agency proposes to utilize these data for risk adjustment purposes, if CMS requires their submission. The commenters noted that requiring encounter data for some items would potentially require data submissions from providers who are not currently required to submit detailed encounter data, such as ancillary providers, facilities, DME providers.

Response: The intent of the proposed regulatory change was to restore CMS' previous authority to collect comprehensive encounter data; CMS has not yet determined for which items and services it will collect such data.

Comment: Some commenters asked CMS to define a core data set that would be collected and limit any new required data elements to only those needed for development of the CMS–HCC risk adjustment model. One commenter stated that data pertaining to rewards and incentives, optional supplemental benefits, or over-the-counter benefits have no bearing on health status and were not useful for calibrating the risk adjustment model, and therefore are beyond the scope of the authority provided by section 1853(a) of the Act. The commenters urged that these benefits be specifically carved out of the definition at § 422.310(d). Another commenter contended that the collection of encounter data for every item and service provided to Medicare beneficiaries is unnecessary for maintaining and updating the risk adjustment model and is redundant insofar as it covers data that CMS already gathers under the traditional fee-for-service program.

Response: We are still in the process of determining which items and services we need in order to calibrate the risk adjustment model. In designing our data collection efforts, we also will be sharing with stakeholders how we will use the encounter data for the other purposes that are now stated in regulation: Calculating Medicare DSH percentages, conducting quality review and improvement activities, and for Medicare coverage purposes.

Comment: Many industry commenters objected entirely to changing the regulations to restore CMS' previous authority to collect encounter data, and a number of them offered alternatives to the collection of encounter data or suggested further dialog with the industry in order to identify and evaluate alternative approaches. One commenter urged CMS to work with the industry to find a mutually acceptable reporting mechanism outside of the risk adjustment operational framework in order to find ways of collecting information on benefits that are not needed for risk adjustment, but that CMS needs for responding to inquiries from Congress. Some commenters indicated that they could support a requirement to submit aggregate utilization data on a plan-wide basis at the time when bids are due. Two commenters suggested a probe study and another commenter proposed that each MA organization submit a 5 percent to 10 percent sample of certain encounter data to CMS and/or an outside contractor who would aggregate the data for purposes of reflecting MA utilization data for adjustments to the MA payment methodology. Another commenter suggested that CMS consider a pilot project, rather than an immediate implementation, in order to develop a functioning operational framework for the collection and utilization of these data. One commenter stated that data from traditional Medicare should be an adequate reflection of the diagnosis, procedures, and services provided in the MA program.

Response: While we appreciate the suggestions offered by commenters regarding alternatives to the collection of beneficiary-level encounter data, we note that aggregate level data would not be useful in calibrating the risk adjustment model. Having the MA program's relative cost patterns is essential to CMS in order to improve the accuracy of payment to MA plans: these program-specific cost patterns will allow CMS to reflect appropriate relative costs in the risk adjustment model by calculating MA-specific risk adjustment factors. Regarding the sample approach to the reporting of encounter data, submission of a subset of data would restrict CMS' use of the data for other purposes, particularly calculation of Medicare DSH percentages. Claims from fee-for-service Medicare, which CMS currently uses to calibrate the risk adjustment model, are inadequate to the extent that MA cost

and coding patterns differ from fee-for-service cost patterns.

Comment: Commenters expressed concern that CMS has not adequately addressed the issue of protecting proprietary data in the proposed rule and urged CMS to build regulatory and procedural protections prohibiting the release of MA encounter data that could undermine the competitive nature of the MA program. One commenter stated that the commercially sensitive nature of MA encounter data is similar to that of Medicare Part D claims data.

Response: We appreciate the commenters' concerns regarding data privacy. To the extent that encounter data submissions contain any proprietary information, this information would be protected from disclosure under the Trade Secrets Act. Beneficiary specific information is also protected under the Privacy Act, and HIPAA, as well as the Federal Information Security Management Act (FISMA). As we develop our policies regarding data usage, we will provide opportunity for stakeholder feedback.

Comment: Many commenters asked for additional information regarding operational and methodological issues, such as what formats CMS plans to use to collect encounter data, whether CMS will modify RAPS or replace it with a new encounter data submission format, and how encounter data would be used to calibrate the CMS–HCC risk adjustment model.

Response: The purpose of the proposed regulatory changes was to affirm CMS' authority to collect encounter data only and was not intended to address operational or methodological issues. Further, we have not yet developed the requirements for collecting encounter data. As part of our discussions and requests for feedback from stakeholders, we will be presenting details of how we propose to collect the data and how we will incorporate encounter data into the calibration of the risk model.

Comment: One commenter requested clarification that the retention of the already existing regulatory language regarding ''functional limitations'' is not indicative of a change in how we collect such data. The commenter asked if CMS planned to continue to collect data pertinent to ''functional limitations'' through the Health Outcomes Survey (HOS). Another commenter asked if it was CMS' intent to implement the existing provisions under § 422.310(b) regarding the characterization of functional limitations. The commenter believed that the retention of this language seems contrary to the phase out of the frailty adjustor as it is applied to PACE organizations.

Response: The extant regulatory language at § 422.310(b) is intended support CMS authority to collect various data for use in developing and implementing the risk model used in the MA program in order to calculate as accurate payments as possible. Any changes that we would propose to make to data collection and methodology regarding functional limitations would be, at minimum, described in an annual Advance Notice of Methodological Change in order to provide stakeholders with an opportunity for comment.

Comment: A number of commenters were concerned about the impact of encounter data collection on PACE organizations. The commenters were concerned about the administrative impact of encounter data reporting on PACE programs, as few PACE centers code the procedures provided to enrollees since payment is made to salaried providers and is not based on the specific type or number of procedures provided and the delivery of medical care at a PACE facility does not comprise discrete visits or units of care. The commenters were concerned about the impact of encounter data reporting on our PACE programs' processes of care and requested that CMS exempt PACE organizations from reporting procedure codes for services provided by PACE organization staff.

Response: We appreciate the input of PACE organizations regarding the implementation of encounter data reporting. We will work with PACE organizations, as with all stakeholders, to obtain their feedback and understand better how we can design the encounter data collection requirements in a way that minimizes the administrative costs and operational changes required by plans.

Comment: Some commenters were concerned that encounter data reporting will not capture the full level of scope of services provided by PACE organizations because of differences between PACE and MA in terms of their statutory authorization, size, population served, care delivery model, the requirement to provide non-Medicare services. The commenters stated that there were services that were not reimbursed by Medicare, although the provision of these services substantially reduces participants' utilization of Medicare-covered services. The commenters were concerned that PACE programs will be disadvantaged if payment is based on the utilization of MA patterns of diagnoses and expenditures that do not take into account consideration the differences between MA and PACE organizations.

Response: We understand that PACE organizations operate under separate statutory authority and have a different model of care and provide a varied range of benefits to its enrolled population. However, we also recognize that PACE programs are paid for Medicare Part A and Part B services under section 1853 of the Act, along with MA plans, and we are required under section 1853(a)(3)(D) of the Act to apply risk adjustment uniformly. We are committed to working with all stakeholders to discuss and clarify how any changes in the methodology for calibrating the risk adjustment model will affect their organization.

After consideration of the public comments received, we are finalizing the proposed changes in policies under § 422.310, with one modification. Under § 422.310(f), we are identifying the uses of the encounter data that we will collect. Specifically, we will use the encounter data for calculating risk factors, updating risk adjustment models, calculating Medicare DSH percentages, conducting quality review and improvement activities, and for Medicare coverage purposes.

I. Hospital Emergency Services Under EMTALA (§ 489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this final rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for a medical condition, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272. Congress incorporated these antidumping provisions within the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services. Under section 1866(a)(1)(I)(i) of the Act,

a hospital that fails to fulfill its EMTALA obligations under these provisions may be subject to termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual. The regulations implementing section 1867 of the Act are found at 42 CFR 489.24. The regulations at 42 CFR 489.20(l), (m), (q), and (r) also refer to certain EMTALA requirements outlined in section 1866 of the Act. The Interpretive Guidelines concerning EMTALA are found at Appendix V of the CMS State Operations Manual.

2. EMTALA Technical Advisory Group (TAG) Recommendations

Section 945 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, required the Secretary to establish a Technical Advisory Group (TAG) to advise the Secretary on issues related to the regulations and implementation of EMTALA. The MMA specified that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing specific specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG's functions, as identified in the charter for the EMTALA TAG, were as follows: (1) Review EMTALA regulations; (2) provide advice and recommendations to the Secretary concerning these regulations and their application to hospitals and physicians; (3) solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and (4) disseminate information concerning the application of these regulations to hospitals, physicians, and the public. The TAG met 7 times during its 30-month term, which ended on September 30, 2007. At its meetings, the TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. During each meeting, the three subcommittees established by the TAG (the On-Call Subcommittee, the Action Subcommittee, and the Framework Subcommittee) developed recommendations, which were then discussed and voted on by members of the TAG. In total, the TAG submitted 55 recommendations to the Secretary. If implemented, some of the recommendations would require regulatory changes. Of the 55 recommendations developed by the TAG, 5 have already been implemented by CMS. A complete list of TAG recommendations is available in the Emergency Medical Treatment and Labor Act Technical Advisory Group final report available at the Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp*. The following recommendations have already been implemented by CMS:

- That CMS revise, in the EMTALA regulations [42 CFR 489.24(b)], the following sentence contained in the definition of ''labor'': ''A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.''

We revised the definition of ''labor'' in the regulations at § 489.24(b) to permit a physician, certified nurse-midwife, or other qualified medical person, acting within his or her scope of practice in accordance with State law and hospital bylaws, to certify that a woman is experiencing false labor. This recommendation was adopted with modification in the FY 2007 IPPS final rule (71 FR 48143). We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

- That hospitals with specialized capabilities (as defined in the EMTALA regulations) that do not have a dedicated emergency department be bound by the same responsibilities under EMTALA to accept appropriate transfers as hospitals with specialized capabilities that do have a dedicated emergency department.

This recommendation was adopted in the FY 2007 IPPS final rule (71 FR 48143). We added language at § 489.24(f) that makes explicit the current policy that all Medicare-participating providers with specialized capabilities are required to accept an appropriate transfer if they have the capacity to treat an individual in need of specialized care. We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to further clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

- That CMS clarify the intent of regulations regarding hospital obligations under EMTALA to receive individuals who arrive by ambulance. Specifically, the TAG recommended that CMS revise a letter of guidance that had been issued by the agency to clarify its position on the practice of delaying the transfer of an individual from an emergency medical service provider's stretcher to a bed in a hospital's emergency department.

This recommendation was adopted with modification by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*.)

- That CMS clarify that a hospital may not refuse to accept an individual appropriately transferred under EMTALA on the grounds that it (the receiving hospital) does not approve the method of transfer arranged by the attending physician at the sending hospital (for example, a receiving hospital may not require the sending hospital to use an ambulance transport designated by the receiving hospital). In addition, CMS should improve its communication of such clarifications with its regional offices.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*.)

- That CMS strike the language in the Interpretive Guidelines (CMS State

Operations Manual, Appendix V) that addresses telehealth/telemedicine (relating to the regulations at § 489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether an on-call physician should come to the emergency department and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the emergency department and the on-call physician refuses.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–23, which was released on June 22, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*.)

We are considering the remaining recommendations of the EMTALA TAG and may address them through future changes to or clarifications of the existing regulations or the Interpretive Guidelines, or both.

At the end of its term, the EMTALA TAG compiled a final report to the Secretary. This report includes, among other materials, minutes from each TAG meeting as well as a comprehensive list of all of the TAG's recommendations. The final report is available at the following Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp.*

3. Changes Relating to Applicability of EMTALA Requirements to Hospital Inpatients

While many issues pertaining to EMTALA involve individuals presenting to a hospital's dedicated emergency department, questions have been raised regarding the applicability of the EMTALA requirements to inpatients. We have previously discussed the applicability of the EMTALA requirements to hospital inpatients in both the May 9, 2002 IPPS proposed rule (67 FR 31475) and the September 9, 2003 stand alone final rule on EMTALA (68 FR 53243). As we stated in both of the aforementioned rules, in 1999, the United States Supreme Court considered a case (*Roberts* v. *Galen of Virginia*, 525 U.S. 249 (1999)) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Court that HHS would develop a regulation clarifying its position on that issue. In the 2003 final rule, CMS took the position that a hospital's obligation under EMTALA ends when that hospital, in good faith, admits an individual with an unstable emergency medical condition as an inpatient to that hospital. In that rule, CMS noted that other patient safeguards protected inpatients, including the CoPs as well as State malpractice law. However, in the 2003 final rule, CMS did not directly address the question of whether EMTALA's ''specialized care'' requirements (section 1867(g) of the Act) applied to inpatients.

As noted in section IV.I.2. of this preamble, the EMTALA TAG has developed a set of recommendations to the Secretary. One of those recommendations calls for CMS to revise its regulations to address the situation of an individual who: (1) Presents to a hospital that has a dedicated emergency department and is determined to have an unstabilized emergency medical condition; (2) is admitted to the hospital as an inpatient; and (3) the hospital subsequently determines that stabilizing the individual's emergency medical condition requires specialized care only available at another hospital.

We stated in the proposed rule that we believed that the obligation of EMTALA did not end for all hospitals once an individual had been admitted as an inpatient to the hospital where the individual first presented with a medical condition that was determined to be an emergency medical condition. Rather, once the individual was admitted, admission only impacted the EMTALA obligation of the hospital where the individual first presented. (Throughout this section of the preamble of this final rule, we refer to the hospital where the individual first presented as the ''admitting hospital.'') Section 1867(g) of the Act states: ''Nondiscrimination—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.'' In the proposed rule we suggested that section 1867(g) of the Act requires a receiving hospital with specialized capabilities to accept a request to transfer an individual with an unstable emergency medical condition as long as the hospital has the capacity to treat that individual, regardless of whether the individual had been an inpatient at the admitting hospital. Our suggestion was supported by the September 9, 2003 final rule (68 FR 53263), in which we amended the regulations at § 489.24(d)(2)(i) to state that: ''If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual in good faith in order to stabilize the emergency medical condition, *the* hospital has satisfied *its* special responsibilities under this section with respect to that individual'' (emphasis added). In the proposed rule we stated that we believed that permitting inpatient admission at the *admitting* hospital to end EMTALA obligations for *another* hospital to which an unstabilized individual was being appropriately transferred to receive specialized care would seemingly contradict the intent of section 1867(g) of the Act to ensure that hospitals with specialized capabilities provide medical treatment to individuals with emergency medical conditions in order to stabilize those conditions.

We also noted in the proposed rule that, as discussed in the preamble of the September 9, 2003 stand-alone final rule, notwithstanding any EMTALA protections, a hospital inpatient is protected under the Medicare CoPs and may also have additional protections under State law. A hospital that fails to provide necessary treatment to such individuals could face termination of its Medicare provider agreement for a violation of the CoPs. We stated in the proposed rule that we believe it is consistent with the intent of EMTALA to limit its protections to individuals who need them most; for example, individuals who present to a hospital but may not have been formally admitted as patients and thus are not covered by other protections applicable to patients of the hospital. We believe that, in the case of inpatients, there is no need or requirement to also supplement the hospital's obligation to its patients under the CoPs in order to further the objectives of EMTALA. However, the obligations of a hospital under the CoPs apply only to that hospital's patients; they do not apply to individuals who are not patients. Further, there is no CoP that requires a hospital to accept the transfer of a patient from another facility. Thus, a hospital with specialized capabilities has no obligations under the CoPs to any nonpatients. On the other hand, the EMTALA statute, in section 1867(g) of the Act, does create an obligation for such hospitals to accept appropriate transfers of nonpatient individuals if it

has the capacity to treat the individuals. Therefore, in our proposal, in order to ensure an individual the protections intended by the EMTALA statute, we indicated in the FY 2009 IPPS proposed rule (73 FR 23669) that we believed it was appropriate to propose to clarify that section 1867(g) of the Act (obligating a hospital with specialized capabilities to accept an appropriate transferred individual if it has the capacity to treat the individual) continues to apply so as to protect even an individual who has been admitted as an inpatient to an admitting hospital despite not being stabilized since becoming an inpatient. We stated that we believed that this clarification was necessary to ensure that EMTALA protections are continued for individuals who were not otherwise protected by the hospital CoPs (with respect to the obligation of other hospitals to those individuals). (We noted that this proposed clarification was consistent with the EMTALA TAG's recommendation that EMTALA does not apply when an individual is admitted to the hospital for an elective procedure and subsequently develops an emergency medical condition.)

We recognized that the proposed clarification that the obligation to accept an appropriate transfer under EMTALA applied to a hospital with specialized capabilities when an inpatient (who presented to the admitting hospital under EMTALA) was in need of specialized care to stabilize his or her emergency medical condition may have raised concerns among the provider community that such a clarification in policy could hypothetically result in an increase in the number of transfers. However, we stated that the intention of this proposed clarification was not to encourage patient dumping to hospitals with specialized capabilities. Rather, even if the hospital with specialized capabilities had an EMTALA obligation to accept an individual who was an inpatient at the admitting hospital, the admitting hospital transferring the individual should take all steps necessary to ensure that it has provided needed treatment within its capabilities prior to transferring the individual. This meant that an individual with an unstabilized emergency medical condition should only be transferred when the capabilities of the admitting hospital were exceeded.

Accordingly, we proposed to revise § 489.24(f) by adding to the existing text a provision that specifies that paragraph (f) also applies to an individual who has been admitted under paragraph (d)(2)(i) of the section and who has not been stabilized.

While we did not include the following in our proposed clarification, we sought public comments on whether the EMTALA obligation imposed on hospitals with specialized capabilities to accept appropriate transfers should apply to a hospital with specialized capabilities in the case of an individual who had a period of stability during his or her stay at the admitting hospital and is in need of specialized care available at the hospital with specialized capabilities. CMS takes seriously its duty to protect patients with emergency medical conditions as required by EMTALA. Thus, we sought public comments as to whether, with respect to the EMTALA obligation on the hospital with specialized capabilities, it should or should not matter if an individual who currently has an unstabilized emergency medical condition (which is beyond the capability of the admitting hospital) (1) remained unstable after coming to the hospital emergency department or (2) subsequently had a period of stability after coming to the hospital emergency department.

In summary, to implement the recommendation by the EMTALA TAG and clarify our policy regarding the applicability of EMTALA to hospital inpatients, we proposed to amend § 489.24(f) to add a provision to state that when an individual covered by EMTALA was admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual.

Comment: Numerous commenters opposed the proposal in the FY 2009 proposed rule regarding the applicability of EMTALA to hospital inpatients. Many commenters asserted that, rather than being a clarification of current regulations, CMS' proposal represents a significant change in policy which runs counter to CMS' policy expressed in the September 9, 2003 **Federal Register** (68 FR 53222). Commenters stated that the current regulations at § 489.24(d)(2)(i) provide a ''bright-line'' test for EMTALA, which ''* * * clearly states that once an individual presenting to the hospital's emergency department has been screened and admitted as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its EMTALA obligations for that individual, and EMTALA no longer applies to a subsequent transfer.'' Commenters stated they believe the proposed rule re-opens EMTALA for the admitting hospital. They noted the admitting hospital, after it has admitted the individual, would then be required to abide by the regulations governing an appropriate transfer when it transfers the inpatient to the hospital with specialized capabilities.

Many commenters questioned whether such a change in policy was necessary since it is unlikely that a hospital would knowingly admit an individual with an unstabilized emergency medical condition who they did not have the capability or capacity to stabilize. One commenter noted that all hospitals which have emergency departments should be capable of evaluating an individual who presents to the emergency department and if the hospital does not have the capability to appropriately care for the individual, the hospital should transfer, rather than admit the individual. Another commenter stated it was not the intent of EMTALA for a hospital to be able to transfer any individual whose condition worsens after admission. Commenters asserted that the proposed rule is unnecessary because current statutory and regulatory requirements provide extensive legal protections separate and apart from EMTALA. One commenter stated that, in addition to hospital CoPs, the Arkansas Rules and Regulations for Hospitals and Related Institutions as well as the Rules and Regulations for Critical Access Hospitals contain hundreds of pages of requirements concerning hospitals' care and treatment for all patients.

Commenters asserted that CMS is relying on a recommendation of the EMTALA TAG to make its policy change and the actions of the TAG do not justify a need for a change in policy. One commenter noted that the TAG vote in favor of the recommendation to apply EMTALA to hospital inpatients was 10 to 8 and that 5 of the votes in favor of the recommendation came from the U.S. Department of Health and Human Services. The commenter also noted that the vote was taken twice and that the recommendation was voted as a ''low'' priority by the TAG. Commenters stated that a discussion of the contentious nature of the TAG's recommendation was not included in the preamble to the proposed rule. Specifically, the commenters noted that CMS failed to state that the recommendation was only passed by a slim majority with most of the physician and hospital representatives opposing the recommendation. Commenters noted that after the TAG meeting, members of

the TAG sent the TAG chairman letters indicating their concern that if implemented, the recommendation would adversely affect patient care and could increase the number of unnecessary patient transfers. Furthermore, the commenters stated that two physicians who had voted in favor of the recommendation subsequently sent a letter expressing their concern that the recommendation could have a potential for abuse, namely patient dumping, and that they ''* * * fear that the potentially unintended consequence may be the transfer of EMTALA patients for reasons other than those related to emergency care of the problem for which the patient was originally admitted when these services could have been provided at the sending hospital.''

Many commenters were concerned that the proposed rule would facilitate patient dumping at hospitals with specialized capabilities. Commenters were concerned the admitting hospital would not initially pay sufficient attention to the EMTALA requirements by not adequately assessing whether it actually has the capabilities necessary to treat an individual who presents under EMTALA. The commenter stated that there is no clear mechanism outlined in the proposed rule for reporting a hospital that fails to treat individuals adequately or fails to utilize all available resources before transferring an individual. One commenter suggested that CMS require admitting hospitals, which are part of a larger hospital system, to look to other system hospitals within the geographic area for specialized capabilities before transferring an individual to a hospital located outside of the system (assuming it is in the best interests for the patient to be transferred). The commenter stated such a policy would dissuade hospitals from making transfers for financial rather than patient care reasons. One commenter asked CMS to clarify whether it intends for the proposed rule to apply to any individual with an emergency medical condition, regardless of whether or not the individual actually goes to the emergency department. The commenter stated, ''Some patients with an emergency medical condition may have been a direct admission to the hospital by a local physician but never cared for initially by the ER; the patient simply came through the ER as a direct admission. We request CMS clarify whether these patients also will be covered by EMTALA.'' Another commenter stated that in addition to being overwhelmed by transfer requests, a receiving hospital will have to determine: (1) Whether the inpatient originally presented to the requesting hospital's emergency department; (2) whether the patient has ever been stable; and (3) whether the patient requires specialized services not offered at the requesting hospital.

Commenters expressed their concern that tertiary care hospitals, urban safety net, and teaching hospitals that are already providing care to the indigent and uninsured patients, may become further overburdened by the proposed rule. Commenters stated that a sending hospital, acting in bad faith, could choose to only transfer medically complex patients requiring extensive lengths of stay, patients who are uninsured, and patients who have been subject to a medical error. One commenter stated that physicians expect that transfer requests of unresolved emergency medical conditions will come on weekends and holidays as a convenience measure and not a necessity. Another commenter stated that it treats more than 80,000 patients annually at its facility, which is the region's only Level I trauma center. The commenter stated it will always accept critically ill patients who are unable to be stabilized at another facility. The commenter stated that, under the proposed rule, it would now be obligated to accept the patient even though it has no ability to weigh in on the appropriateness of the transfer, which may not be in the best interest of the patient.

Commenters also expressed their concern on how the proposed rule would affect the care and treatment of patients. Commenters were especially concerned about the consequences to patient health (both physical and psychological) and safety due to a potential increase in inappropriate/unnecessary transfers and over-triaging. One commenter asserted that the proposed policy will worsen the increase of inappropriate transfers and that already too few seriously ill patients are receiving appropriate initial evaluations at Level I and II trauma centers, while too many patients with non serious injuries, are presenting to or being transferred to those centers. One commenter noted that if the policy is finalized as proposed, the referring hospital may transfer patients who deteriorate following admission, thereby risking the life of the patient. The commenter further noted that patients without health insurance may be given an incentive to bypass their closest emergency department and go to larger medical centers offering indigent care. The commenter noted that the proposed rule would discourage ''savvy'' patients from seeking care at the nearest available emergency department and encourage them to go to the most sophisticated emergency department to avoid the possibility of being admitted to a hospital lacking the necessary capabilities and the possibility of eventually being transferred. The commenter noted ''Unless and until CMS recognizes the magnitude of the problem of some hospitals avoiding their EMTALA obligations, no EMTALA policy can ever be adequate to the task of protecting the interests of patients.''

Commenters expressed their concern with the definition of ''stable'' and ''unstable'' and how the interpretation of these terms could be affected by the proposed rule. One commenter highlighted the applicability of the proposed rule to the state of Idaho, stating that Idaho contains many small hospitals that may only employ one general surgeon or orthopedic surgeon. The commenter noted that, when individuals require transfer, often what makes the receiving hospital ''the hospital with specialized capabilities'' is that it has an on-call specialist. One commenter stated that hospitals will have the incentive to stretch the definition of ''specialized'' to make the determination that some component of care for a particular patient is beyond its capability.

One commenter stated that CMS lacks the legal authority to apply EMTALA to an inpatient who presented to the admitting hospital under EMTALA. The commenter stated that the 2003 rule established a ''bright line'' for EMTALA, which also made a distinction between ''individuals'' and ''patients,'' (the primary distinction being that individuals, not patients, are protected by EMTALA.) The commenter recommended CMS withdraw the proposed rule as not authorized under the limited scope of the EMTALA statute. Additionally, the commenter stated that the preamble to the proposed rule does not provide sufficient reason as to why EMTALA should be expanded to apply to inpatients. The commenter stated that both the EMTALA interpretive guidelines and judicial decisions emphasize that EMTALA is anti-discrimination and designed to ensure that all patients with similar signs and symptoms are treated the same as recipients of emergency care services. The commenter argued that the proposed rule is the antithesis of the intent of the EMTALA statute and creates a dual standard of care for patients who require the same level of care by permitting inpatients who present to the hospital under EMTALA

special privileges. The commenter stated it would be difficult for a hospital to determine what type of inpatient it is dealing with, one with or without residual EMTALA rights. The commenter noted that hospitals and physicians are already puzzled by the inexact language of EMTALA, including the terms ''stabilization,'' ''resolved'' (as used in the IGs), ''stable,'' and what is meant by a higher level of care. The commenter recommended CMS provide greater ''specificity'' and ''clarity'' as to when a patient's condition is considered stabilized. The commenter further stated '' * * * there is no guidance as to what is an 'appropriate transfer' of an inpatient with residual EMTALA rights that triggers the obligation of a receiving hospital to accept the inpatient transfer.'' The commenter stated EMTALA is only triggered for the accepting hospital, if the transferring hospital participates in an ''appropriate transfer'' of an individual.

Another commenter recommended that the rule address requirements for the admitting hospital to take all steps necessary to ensure that it is providing required treatment within its capabilities prior to engaging in a transfer. The commenter stated that the proposed rule treats hospitals unequally because it does not impose sanctions on the transferring hospital for making an inappropriate transfer of an individual with residual EMTALA rights. The commenter stated that ''If receiving hospitals are subject to EMTALA sanctions for refusing an appropriate transfer of an inpatient with residual EMTALA rights, then sending hospitals and physicians should have the equivalent exposure to sanctions for making an improper transfer of an inpatient with residual EMTALA rights.''

Response: We thank the commenters for expressing their concerns regarding our proposal. We agree with the commenters that finalizing the proposed rule may result in hospitals with specialized capabilities experiencing an increase in inappropriate transfers. We understand that medical institutions such as academic medical centers, tertiary care centers, and public safety net hospitals are already facing significant and growing challenges in providing emergency services. After consideration of the comments, we believe that finalizing the policy as proposed may negatively impact patient care, due to an increase in inappropriate transfers which could be detrimental to the physical and psychological health and well-being of patients. We are concerned that finalizing our proposed rule could further burden the emergency services system and may force hospitals providing emergency care to limit their services or close, reducing access to emergency care.

We agree with the commenters' concerns that some hospitals might abuse the proposed policy by not providing patients with the necessary screening examination required under EMTALA to determine the nature and extent of their emergency medical condition. We believe that, in the case where an individual is admitted and later found to be in need of specialized care not available at the admitting hospital, hospitals with specialized capabilities generally do accept the transfer, even in the absence of a legal requirement to do so. Furthermore, as one commenter pointed out by referencing the Arkansas Rules and Regulations for Hospitals and Related Institutions as well as the Rules and Regulations for Critical Access Hospitals, some States have requirements in addition to the hospital CoPs that provide for further protections for patients.

We are very concerned about the possible disparate treatment of inpatients under the proposed policy. Specifically, under the proposed policy, an individual who presented to the hospital under EMTALA may have different transfer rights than an inpatient who was admitted for an elective procedure. This situation also creates operational challenges for hospital staff to differentiate which inpatient is afforded which transfer rights. Determining which individuals are covered by transfer rights under EMTALA may tie up a hospital's already strained resources. Furthermore, we believe that if we finalized the proposed rule, the admitting hospital may encounter challenges in determining whether or not an individual has ever been stable, as that term is defined in the EMTALA statute, because if the individual had any period of stability, EMTALA would not require acceptance of the transfer by the hospital with specialized capabilities. We recognize that the EMTALA definition of ''stable'' differs from clinical usage of this term.

We support in principle the commenter's suggestion that hospitals that are part of a larger hospital system should transfer an individual to a system hospital with the required specialized capabilities within the same geographic area, so long as doing so would not result in a significantly longer transport for the individual than would transfer to a nonsystem hospital. However, we cannot mandate that individuals only be transferred to certain hospitals within a specific geographic region. In response to the commenter who asked that we clarify (in the context of the proposed rule) whether EMTALA would apply to an individual with an emergency medical condition, regardless of whether or not the individual went to the emergency department, we would like to clarify when EMTALA applies. In addition to EMTALA applying when an individual presents to a hospital emergency department and requests examination or treatment for a medical condition, or has a request made on his or her behalf, EMTALA applies when an individual presents on hospital property (as defined at § 489.24(b)) and requests examination or treatment for an emergency medical condition, or has a request made on his or her behalf.

We recognize the concern of the commenters that the recommendation provided by the TAG to apply EMTALA to hospital inpatients was accepted by the TAG on the narrowest of margins and that the majority of hospital representatives serving on the TAG were opposed to the recommendation. The discussion of the TAG's recommendation is provided on the CMS Web site under the meeting reports link, or link to the EMTALA TAG final report at : *http://www.cms.hhs.gov/FACA/07_emtalatag.asp*. Therefore, in this final rule, due to the concerns noted above, we are clarifying our policy on the EMTALA obligation of a hospital with specialized capabilities, by stating that if an individual presents to the admitting hospital that has a dedicated emergency department, is provided an appropriate medical screening examination and is found to have an emergency medical condition, and is admitted as an inpatient in good faith for stabilizing treatment of an emergency medical condition, then the admitting hospital has met its EMTALA obligation to that individual, even if the individual remains unstable. Furthermore, in such a case, a hospital with specialized capabilities does not have an obligation under EMTALA to accept a transfer of that individual from the referring hospital. Accordingly, we have revised the regulation at § 489.24(f) to state that it does not apply to an individual who has been admitted under § 489.24 (d)(2)(i).

Due to the many concerns that the commenters raised which are noted above, we believe it is appropriate to finalize a policy to state that if an individual with an unstable emergency medical condition is admitted, the EMTALA obligation has ended for the admitting hospital and even if the individual's emergency medical

condition remains unstabilized and the individual requires special services only available at another hospital, the hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual. However, we would like to emphasize that if an individual presents to a hospital with a dedicated emergency department and is found to have an emergency medical condition that requires stabilizing treatment which requires specialized treatment not available at the hospital where the individual presented, and has not been admitted as an inpatient, then another Medicare-participating hospital with the requisite specialized capabilities is obligated under EMTALA to accept the appropriate transfer of this individual so long as it has the capacity to treat the individual.

Comment: Several commenters supported the proposal to apply EMTALA to hospital inpatients who present under EMTALA, continue to have an unstable emergency medical condition, and are found to require treatment or services only available at another hospital with specialized capabilities. Commenters stated the proposed policy is necessary to protect individuals who are not otherwise protected by hospital CoPs. One commenter stated that hospitals with specialized capabilities should not be exempt from accepting the transfer of an unstable patient from a hospital that lacks the specialized capabilities to treat that patient. However, the commenter stated that the regulation needs to be specific in order to minimize the potential for multiple interpretations and the actual process should be monitored for abuse, for example, excessive transfers from a hospital. One commenter believed hospitals are already routinely following the policy expressed in the proposed rule. Therefore, the commenter believed the proposed requirement will only formalize existing practice. Another commenter stated that the proposal was especially important for individuals living in rural areas because those individuals are routinely denied transfer to a regional facility for definitive care based on the conclusion that the individuals are already at a ''hospital.'' The commenter noted this scenario has been experienced multiple times by CAHs.

Commenters stated that the proposal would effectively treat the hospitalized inpatient as an individual who comes to the hospital with specialized capabilities seeking emergency care, when the hospital with specialized capabilities falls within the conditions described under section 1867(g) of the Act. The commenter took issue with CMS' 2003 final rule and stated that the proposed policy corrects the problem introduced by CMS' 2003 final rule, when the agency decided that inpatient admission would end EMTALA unless a subterfuge can be proven. One commenter asserted that the fact of whether or not an individual was admitted is irrelevant in determining whether the individual has an emergency medical condition or whether the admitting hospital has the capability to provide the necessary care. Instead, the commenter mentioned the aforementioned criteria are ''* * * the only operative criteria to whether the transfer is justified under EMTALA.'' The commenter stated that EMTALA was conceived because Congress recognized that patients needing transfers were being denied access to higher levels of care. The commenter urged CMS to go forward with the proposed changes and requested that clarifying language be included to establish that ''* * * CMS recognizes no provisions in paragraph G anti-discrimination provisions that would allow a receiving hospital to deny any patient on the basis of their admission status or physical location at the sending facility.''

Another commenter stated that CMS' proposal is in the best interests of patient care and should be implemented. The commenter claimed that without clarification, a hospital with specialized capabilities could legitimately decline a transfer, asserting that hospitals' EMTALA obligations and rights end upon admission of an individual to a hospital. The commenter stated that ''CMS should monitor closely the actual experience of inpatient emergency transfer to specialized care facilities for the first two years and then, if warranted, consider an appropriate DRG reimbursement adjustment for the initial admitting hospital's abbreviated admission that resulted in an emergent transfer to a specialized acute care facility.''

Response: We appreciate the commenters' emphasis on patient care and would like to reinforce that the intent of EMTALA was not to provide hospitals with a clear indication of the point at which their legal responsibility towards an individual ends, but rather the intent of EMTALA was to provide access to emergency care to all individuals who present to an emergency department and are determined to have an emergency medical condition, including the uninsured. In response to the commenter who believed that the policy expressed in the proposed rule is already routine practice, we also agree, as stated previously, that generally hospitals with specialized capabilities would accept the transfer of an inpatient with an unstable emergency medical condition, even if there was no legal requirement under EMTALA to do so. In response to the commenter who suggested that CMS monitor inpatient transfers to hospitals with specialized capabilities for the first 2 years and consider appropriate DRG reimbursement for the initial hospital's admission, EMTALA requirements are separate from Medicare payment policy for covered services provided to Medicare beneficiaries. Existing policy already addresses payment in cases of transfer of a beneficiary who is an inpatient to another hospital. In addition, although commenters expressed concerns regarding hospitals experiencing difficulties transferring patients (which we believe may exist), we are concerned with the potential for overcrowding that could result at academic medical centers, tertiary care centers, and public safety net hospitals if we were to finalize the proposed policy. Furthermore, we would like to emphasize that it is essential that the hospital to which the individual originally presents employ all available resources in its attempts to either stabilize the individual or transfer him/her, under an appropriate transfer. Not only is it a potential EMTALA violation for a hospital to provide an individual with insufficient medical screening or an inappropriate transfer when the hospital actually has the capability to treat the individual a potential EMTALA violation, it may prove to be more costly to society because the individual's emergency medical condition was not initially treated to the extent that it could have been, potentially risking the life of the individual. We would also like to make sure that individuals are aware of their resources if they believe they have been witness to an EMTALA violation. In addition to the investigation of EMTALA complaints conducted by CMS, individuals should be aware that the OIG also enforces EMTALA and may levy civil and monetary penalties against a physician and/or hospital for an EMTALA violation. The law also permits individuals to file a private right of action. Furthermore, the Act provides for whistleblower protection for hospital personnel. Section 1867(i) of the Act states ''A participating hospital may not penalize or take adverse action against a qualified

medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of the requirement of this section.''

Finally, as stated previously, due to the concerns that commenters raised, we are not finalizing the proposed policy. Rather, we are finalizing a policy that a hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital inpatient. Although we believe that the language of section 1867(g) of the Act can be interpreted as either applying or not applying to inpatients, after reviewing the comments raised by many commenters, we have serious concerns about the impact the proposed policy would have had on patient care and the possibility that it may overburden many hospitals that are currently having difficulties providing sufficient emergency care.

Comment: We did not receive any public comments in support of our request in the proposed rule for comment on whether the EMTALA obligation imposed on hospitals with specialized capabilities to accept appropriate transfers should apply to a hospital with specialized capabilities in the case of an individual who had a period of stability during his or her stay at the admitting hospital and is in need of specialized care available at the hospital with specialized capabilities. Commenters were concerned that such an application would provide for further potential for abuse. One commenter stated that a period of stability followed by instability should not be a reason to impose EMTALA obligations on a hospital with specialized capabilities. Another commenter stated that CMS' request for comment was based on a concept not even contemplated by the TAG's controversial comment. One commenter stated that such a policy may encourage hospitals to dump patients when they receive an especially difficult case study.

Response: We thank the commenters for their responses to our question on whether EMTALA should apply when an individual had a period of stability.

Comment: Commenters included information regarding recent publications which communicate the dire circumstances facing emergency care. Several commenters mentioned the 2006 Institute of Medicine (IOM) reports focused on the future of emergency care. One commenter mentioned a report recently issued by the House Oversight and Government Reform Committee titled: ''Hospital Emergency Surge Capacity: Not Ready for the Predictable Surprise.'' The commenter also cited a testimony made before the Committee by J. Wayne Meredith, MD, Professor and Chairman of General Surgery, Wake Forest University Baptist Hospital. One commenter stated that it wished to commend the work of the EMTALA TAG and stated that most of the TAG's recommendations will help clarify current interpretations of EMTALA and help improve the delivery of emergency medical services. The commenter wished to take the opportunity to highlight several of the TAG's recommendations, and urged CMS to adopt the following recommendations as soon as possible: 1, 8, 9, 11, 13, 14, 19, 27, 52, and 53. (Note: the number of the recommendation refers to the corresponding number found in final report of the EMTALA TAG. The final report can be found at the following Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp*). The commenter also discussed a survey of neurosurgeons conducted by the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) in 2004, which concluded that 45 percent of neurosurgeons practicing at either an academic health center or Level I or II trauma center, experienced an increase in the number of neurosurgical emergency cases in the previous 2 years. Another commenter stated that it supported number 53 of the TAG's recommendation, which recommends the statute be modified to create a funding mechanism for EMTALA.

Response: We thank the commenters for the information on the IOM reports and testimony which address the current crisis in emergency care as well as their support of the TAG and several of its recommendations. Although these comments pertain to EMTALA, they do not directly address the proposed rule. Therefore, we are not responding to them at this time.

As stated previously, in this final rule, rather than adopting the proposed regulation language, we are clarifying the EMTALA regulations at § 489.24(f) with respect to hospital inpatients by stating that once an individual is admitted in good faith by the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual even if the individual remains unstabilized and a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual. We encourage the public to make CMS aware if this interpretation of section 1867(g) of the Act should result in harmful refusals by hospitals with specialized capabilities to accept the transfer of inpatients whose emergency medical condition remains unstabilized, or any other unintended consequences.

4. Changes to the EMTALA Physician On-Call Requirements

a. Relocation of Regulatory Provisions

During its term, the EMTALA TAG dedicated a significant portion of its discussion to a hospital's physician on-call obligations under EMTALA and made several recommendations to the Secretary regarding physician on-call requirements that are included in its final report (available at the Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp*). As one recommendation, the TAG recommended that CMS move the regulation discussing the obligation to maintain an on-call list from the EMTALA regulations at § 489.24(j)(1) to the regulations implementing provider agreements at § 489.20(r)(2). As we stated in the proposed rule, we agree with the TAG's recommendation. The requirement to maintain an on-call list is found at section 1866(a)(1)(I)(iii) of the Act, the section of the Act that refers to provider agreements. Section 1867 of the Act, which outlines the EMTALA requirements, makes no mention of the requirement to maintain an on-call list.

To implement the EMTALA TAG's recommendation, in the FY 2009 IPPS proposed rule, we proposed to delete the provision relating to maintaining a list of on-call physicians from § 489.24(j)(1). We noted that a provision for an on-call physician list is already included in the regulations as a hospital provider agreement requirement at § 489.20(r)(2). We proposed to incorporate the language of § 489.24(j)(1) as replacement language for the existing § 489.20(r)(2) and amend the regulatory language to make it more consistent with the statutory language found at section 1866(a)(1)(I)(iii) of the Act. We proposed that revised § 489.20(r)(2) would read: ''An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital.''

The EMTALA TAG made additional recommendations regarding how a hospital would satisfy its on-call list obligations, including calling for an annual plan by the hospital and medical staff for on-call coverage that would

include an assessment of factors such as the hospital's capabilities and services, community need for emergency department services as indicated by emergency department visits, emergent transfers, physician resources, and past performance of previous on-call plans. The TAG also recommended that a hospital have a backup plan for viable patient care options when an on-call physician is not available, including such factors as telemedicine, other staff physicians, transfer agreements, and regional or community call arrangements. While community call arrangements are discussed below, we intend to address the remainder of the TAG recommendations at a later date.

Comment: Several commenters supported our proposal to move and amend the regulations text relating to maintaining a list of on-call physicians. However, the commenters requested that CMS explain why the language ''in a manner that best meets the needs of the hospital's patients'' was deleted. The commenters stated that this explanation is important so that ''* * * the change is not misconstrued as undermining the ability of hospitals to set expectations for physicians agreeing to serve on-call to the hospital emergency department.'' Two commenters suggested that the entire language of § 489.24(j) be moved to § 489.20(r) of the regulations. One commenter stated that moving the entire language of § 489.24(j) would conform the regulations to the statute and that consolidating all of the on-call requirements under a single regulation, would help hospitals more easily identify and comply with all applicable EMTALA on-call requirements.

Response: We proposed moving the regulatory text because we believe the change would make the regulations consistent with the statutory language. Furthermore, we deleted the ''best meets the needs'' language because we believe that the phrase has caused confusion among the provider community as to its meaning. We believe the language ''in accordance with the resources available to the hospital'' provides clarification that the hospital should provide on-call services based on the resources it has available, including the availability of specialists. We did not intend to suggest that removing the ''best meets the needs'' language would limit, in any way, a hospital's ability to set expectations that physicians be on call. It is crucial that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to meet the needs of their community in accordance with the resources they have available. A hospital should strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. We are aware that providing specialty on-call coverage can be challenging for a hospital because of the limited availability of specialty physicians who are willing or able to take call. Physicians should not perceive the change in regulations text as confirmation that they should limit their on-call availability. In addition, we believe the community call provision discussed below will help hospitals diversify their on-call coverage and ease the burden on those physicians who are providing continuous on-call coverage. Finally, we note that the TAG made additional recommendations related to on-call coverage that remain under consideration by CMS. We may, in the future, in response to these recommendations, engage in additional rulemaking or revise our interpretative guidelines to the EMTALA and related regulations in 42 CFR part 489.

In response to the commenters who suggested moving all of the language currently at § 489.24(j) to § 489.20(r), the proposed regulations regarding community call and the existing regulations that permit on-call physicians to serve simultaneous call and schedule elective surgery while on-call provide hospitals and physicians flexibility in meeting the requirement that when an emergency room physician requests the appearance of an on-call physician, that on-call physician is required to appear under EMTALA. We believe that the provisions included under § 489.24(j) should continue to be included under the EMTALA regulations and should not be moved to the provider agreement regulations at § 489.20(r).

We are adding the phrase ''who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan in accordance with § 489.24(j)(2)(iii)'' to the regulation text to make the regulation text consistent with our policy on community call plans. The finalized regulation text at § 489.20(r)(2) reads: ''An on-call list of physicians who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan in accordance with § 489.24(j)(2)(iii) available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital.''

b. Shared/Community Call

As noted in the previous section, section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that a hospital must keep a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If a physician on the list is called by a hospital to provide stabilizing treatment and either fails or refuses to appear within a reasonable period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Act. Thus, hospitals are required to maintain a list of on-call physicians, and physicians or hospitals, or both, may be held responsible under the EMTALA statute if a physician who is on call fails or refuses to appear within a reasonable period of time.

In the May 9, 2002 proposed rule (67 FR 31471), we stated that we were aware of hospitals' increasing concerns regarding their physician on-call requirements. Specifically, we noted that we were aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals because of on-call obligations, especially when those physicians belong to more than one hospital medical staff. We further noted that physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. In the September 9, 2003 final rule (68 FR 53264), we clarified the regulations at § 489.24(j) to permit on-call physicians to schedule elective surgery during the time that they are on call and to permit on-call physicians to have simultaneous on-call duties. We also specified that physicians, including specialists and subspecialists, are not required to be on call at all times, and that the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. We expected these clarifications to help improve access to physician services for all hospital patients by permitting hospitals flexibility to determine how best to maximize their available physician resources. Furthermore, we expected that these clarifications would permit hospitals to continue to attract physicians to serve on their medical staffs, thereby continuing to provide services to all patients, including those

individuals who are covered by EMTALA.

As part of its recommendations concerning physician on-call requirements, the EMTALA TAG recommended that hospitals be permitted to participate in ''community call.'' Specifically, the language of the recommendation states: ''The TAG recommends that CMS clarify its position regarding shared or community call: That such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform an MSE [medical screening examination].'' The TAG also recommended in a subsequent recommendation that ''A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program (CMS to determine appropriate approval process).''

We believe that community call (as described below) would afford additional flexibility to hospitals providing on-call services and improve access to specialty physician services for individuals in an emergency department. Therefore, in the FY 2009 IPPS proposed rule, we proposed to amend our regulations at § 489.24(j) to provide that hospitals may comply with the on-call list requirement specified at § 489.20(r)(2) (under our proposed revision), by participating in a formal community call plan so long as the plan meets the elements outlined below. We further proposed to revise the regulations to state that, notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to provide for transfer when appropriate.

We proposed ''community call'' to be a formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of each month and Hospital B could be designated as the on-call facility for the remaining days of each month. Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases. Based on the proposal, we anticipated that hospitals and their communities would have the flexibility to develop a plan that reflects their local resources and needs. Such a community on-call plan would allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week), without putting a continuous call obligation on any one physician. We note that, generally, if an individual arrives at a hospital other than the designated on-call facility, is determined to have an unstabilized emergency medical condition, and requires the services of an on-call specialist, the individual would be transferred to the designated on-call facility in accordance with the community call plan.

As noted above, we proposed that a community call plan must be a formal plan among the participating hospitals. While we do not believe it is necessary for the formal community call plan to be subject to preapproval by CMS, if an EMTALA complaint investigation is initiated, the plan will be subject to review by CMS. We proposed that, at a minimum, hospitals must include the following elements when devising a formal community call plan:

- The community call plan would include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
- The community call plan would define the specific geographic area to which the plan applies.
- The community call plan would be signed by an appropriate representative of each hospital participating in the plan.
- The community call plan would ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.
- Hospitals participating in the community call plan would engage in an analysis of the specialty on-call needs of the community for which the plan is effective.
- The community call plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
- There would be an annual reassessment of the community call plan by the participating hospitals.

We proposed that revised § 489.24(j) would read ''*Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—(i) Permit on-call physicians to schedule elective surgery during the time that they are on call; (ii) Permit on-call physicians to have simultaneous on-call duties; and (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements: [proposed elements noted above in the bullets are included in regulations text].''

We welcomed public comments on the proposed elements of the formal community call plan noted above. We also solicited public comments on whether individuals believe it is important that, in situations where there is a governing State or local agency that would have authority over the development of a formal community call plan, the plan be approved by that agency. In summary, we proposed that, as part of the obligation to have an on-call list, hospitals may choose to participate in community call, provided that the formal community call plan includes, at a minimum, the elements noted in bullets above. In addition, we proposed that each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control. We further proposed that a hospital would still be responsible for performing medical screening examinations on individuals who present to the hospital seeking treatment and conducting appropriate transfers, regardless of which hospital has on-call responsibilities on a particular day.

Comment: The majority of commenters supported our proposal to permit hospitals to use participation in a community call plan as a means of meeting their on-call obligation. The commenters stated that such an

approach would allow communities to provide for access to specialty care in a more reasoned, expedited and efficient manner as well as relieve specialists from on-call 24 hours a day, 7 days a week, eliminate the need for duplicative coverage of nearby hospitals, increase physician retention of specialists, and regionalize scarce resources. Another commenter stated that community call, along with telemedicine, is one of the few ways limited resources can be used efficiently. The commenter noted that participation in community call is a necessary response to the workforce crisis in the emergency department.

In addition, some commenters stated that the community call proposal would be particularly important to rural areas where physicians are in short supply. One commenter specifically addressed concerns about on-call coverage for the field of neurosurgery. The commenter stated that there are approximately 3,100 board certified neurosurgeons actively practicing in the country and about 5,000 hospitals with emergency departments. The commenter stated it is, therefore, impossible to have neurosurgical on-call coverage for every emergency department 24 hours a day, 7 days a week, 365 days a year. The commenter noted that, in an effort to provide as much on-call coverage as possible, more than half of the country's neurosurgeons take simultaneous call at more than 1 hospital, 28 percent of neurosurgeons cover 2 hospitals, 13 percent cover 3 hospitals, and 10 percent cover 4 or more hospitals. The commenter stated that the Institute of Medicine's (IOM's) series of reports on the future of emergency care addressed the shortage of on-call specialists. The commenter noted that an IOM committee studying the issue of on-call specialists identified regionalization of specialty services as an approach that warrants special consideration. The commenter included in its comment some language from the IOM committee and stated that while not exactly the same as regionalization, the idea of community call addresses a number of the same challenges that hospitals and on-call specialists face in their attempt to provide on-call coverage. The commenter stated that the IOM committee also noted that current EMTALA rules may be hampering the adoption of regional or community call; the commenter included language from the IOM committee which stated ''uncertainty surrounding the interpretation and enforcement of EMTALA remains a damper to the development of coordinated, integrated emergency care systems.'' The commenter noted that the IOM recommended ''that the Department of Health and Human Services adopt regulatory changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) * * * so that the original goals of the law are preserved but integrated systems may further develop.'' The commenter stated that [they] are hopeful that because CMS has embraced the concept of community call and in essence removed the EMTALA barrier to organize such plans, patient access to timely emergency neurosurgical care will improve.

The commenters cautioned CMS against being too prescriptive in the requirements imposed on hospitals that choose to participate in a community call arrangement. In particular, the commenters recommended that CMS delete the requirement in the proposed § 489.24(j)(2)(iii)(E) requiring ''evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective.'' One commenter encouraged CMS to work with other Federal agencies to remove legal and financial barriers to facilitate the proposed rule. The commenter noted that recent efforts to develop a community call plan in one county in Florida have been promising, although complex. The commenter urged CMS to provide for as much flexibility as possible to ''* * * support models for other communities to emulate.''

Several commenters stated that CMS should not require approval of community call plans by public agencies. Another commenter stated that while the development of a community call plan is a worthwhile goal, developing that plan may be challenging, especially in communities where there is competition between hospitals and hospital systems. The commenter supported the proposal that the community call remain voluntary. Another commenter believed that the use of community call plans will provide relief to hospitals that are struggling to meet their EMTALA obligations. The commenter suggested CMS consider requiring medical staff to take call as a condition of holding privileges at a hospital. The commenter stated that legally requiring hospitals to maintain a call schedule, but placing no legal obligation on medical staff to participate in on-call, has led to staff members refusing to participate, participating only if paid, or changing their status from ''active'' to ''courtesy'' or ''consulting'' (categories which the commenter noted, traditionally, do not require a physician to take call).

One commenter supported the proposal to formalize in regulation previous subregulatory guidance related to unavailability of certain specialists, scheduling elective surgery while taking call, and simultaneous on-call duties. In addition, the commenter ''* * * enthusiastically supports any initiative that fosters communication and cooperation among the hospitals in a community.'' The commenter stated that while the proposed regulations on community call fall under the EMTALA regulations, they are in line with The Joint Commission standards for emergency management that involve community partners in the development of emergency management plans as well as communication with community emergency response agencies and directives for timely communication with other hospitals during an emergency.

One commenter stated the preamble indicated that a community call plan, which would qualify under the proposed rule, should have in the aggregate physicians on continuous call (24 hours a day, 7 days a week) and that this requirement is too restrictive and should be made more flexible. The commenter stated that this requirement does not appear to be consistent with the current regulatory standard that allows hospitals to maintain an on-call list in accordance with the hospital's resources.

Response: We appreciate the commenters' support of the proposal to allow hospitals to participate in community call arrangements in order to meet their on-call obligations. We believe that providing hospitals with flexibility in maintaining on-call will allow for, as well as encourage, more specialists to participate in on-call for hospitals. We agree with the commenters that this proposal is especially important to rural hospitals that may have previously had difficulty obtaining specialty coverage for their emergency departments. We also appreciate the commenter's shared concerns regarding the field of neurosurgery and believe that community call plans will provide individuals with greater access to many specialties, such as neurosurgery.

In response to the commenter who requested CMS provide models of community call plans for other communities to emulate, we stated in the proposed rule that we do not believe a community call plan needs preapproval from CMS. We continue to believe that a community call plan does not require authorization from CMS prior to taking effect. However, we encourage hospitals that believe they

have an effective community call plan to communicate such a plan to other hospitals that are interested in developing such a plan. We also emphasize that participation in a community call plan is strictly voluntary because the proposed regulations at § 489.24(j)(2)(iii) do not require hospitals to participate in a community call arrangement. Rather, our proposal was intended to provide hospitals with a tool to use to promote an increase in the availability of specialty on-call physicians.

In response to the commenter who suggested CMS require medical staff to take call as a condition of holding privileges at a hospital, we believe that would be an overly broad and inflexible approach to developing specific on-call arrangements for each hospital. Hospitals can, if they choose, make taking a call a requirement for physicians granted privileges at their hospital. In response to the commenter who supported ''the proposal'' to formalize the subregulatory guidance permitting simultaneous call and scheduling of elective surgery while on-call, we are clarifying that CMS previously finalized these regulations in the September 9, 2003 final rule (68 FR 53264). We did not propose any changes to those provisions in the FY 2009 IPPS proposed rule. We stated in the proposed rule that we believe a community call plan will allow various physicians in a certain specialty, in the aggregate, to be on continuous call (24 hours a day, 7 days a week) without putting a continuous call obligation on any one physician. While we are not at this time mandating that hospitals maintain 24/7 on-call coverage, hospitals should carefully consider whether they are providing sufficient on-call services in line with their available resources. In the event of an investigation related to the compliance of a hospital with regard to an on-call list, whether accomplished through a community call plan or not, the determination, as at present, will be based on the specific circumstances of that hospital and, if applicable, the community call plan. We also note that the TAG made additional recommendations on the topic of on-call requirements which remain under consideration by CMS, and which may be the subject of future rulemaking or revisions of interpretative guidelines.

With regard to the elements that we proposed that must be included in a formal community call plan, we agree with the commenters that it is not necessary for a community call plan to include the following proposed requirement in proposed § 489.24(j)(2)(iii)(E): ''Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective.'' We believe this requirement is covered under proposed paragraph (G) of § 489.24(j)(2)(iii), which requires: ''An annual reassessment of the community call plan by the participating hospitals.'' Therefore, we are finalizing the community call regulation as proposed, with one modification. We are deleting the requirement under paragraph (E) of the proposed § 489.24(j)(2)(iii).

Comment: Several commenters were concerned with potential liabilities under the Sherman Anti-Trust Act if they were to engage in a multihospital community call plan. Two commenters stated ''If a group of hospitals were to jointly formulate a community call plan, it is conceivable that the hospitals may, as a group, choose to contract with a physician group for coverage of certain emergency services. This could be regarded as collusion under certain interpretations of Sherman.'' One commenter stated that hospitals are presently reluctant to establish community call arrangements due to ''* * * potential Federal or State antitrust liability related to unlawful market division.'' The commenter recommended CMS support efforts to establish antitrust exemptions for community call arrangements. Another commenter expressed concern that, without an arrangement that is approved by the Antitrust Division of the Department of Justice, competitor hospitals could be investigated for anticompetitive activities related to the division of markets, resulting from either a timeframe or service-line division of responsibility. The commenter recommended that CMS obtain guidance from Justice on the additional checks and balances that might be needed to ensure hospitals can safely avail themselves of this added flexibility.

Another commenter requested clarification of the application of the HIPAA to the proposed policy. The commenter asked whether, because protected health information of patients who may need the services of on-call physicians would not be in existence at the time of the community call agreement, the community call agreement would be classified under health care operations, an organized health care organization, or a business relationship. The commenters also requested clarification of the proposed policy if one or several hospitals that were part of a proposed community call plan decided not to participate in the plan. The commenters requested that CMS respond to the following questions regarding hospital participation: (1) Does nonparticipation of all providers invalidate the plans? (2) Is there a threshold for participation that must be met? (3) Does the presence of a community call plan in an area with nonparticipating providers partially or fully meet the nonparticipating hospital's EMTALA obligation?

Response: In response to commenters' concerns pertaining to potential antitrust liabilities, we suggest that antitrust concerns be directed to the U.S. Department of Justice Antitrust Division for further review under the business review process. As mentioned previously, participation in a community call plan is strictly voluntary. Therefore, there is no threshold for participation in a community call plan, nor does nonparticipation of one or more hospitals invalidate the plan. In the event of an investigation related to the compliance of a hospital with the on-call requirements outlined in § 489.20(r)(2), the determination, as at present, will be based on a review of the specific circumstances of that hospital, including, as applicable, the provisions of any community call plan in which it participates.

In response to the commenter who expressed concerns about the applicability of the HIPAA Privacy Rule to the proposed community call provisions, the Office for Civil Rights (OCR) in the U.S. Department of Health and Human Services provides technical guidance and enforces the HIPAA Privacy Rule. OCR has explained that hospitals and other covered health care providers with a direct treatment relationship with individuals are not required to provide their notices to patients at the time they are providing emergency treatment. In these situations, the HIPAA Privacy Rule requires only that providers give patients a notice when it is practical to do so after the emergency situation has ended. In addition, where notice is delayed by an emergency treatment situation, the Privacy Rule does not require that providers make a good faith effort to obtain the patient's written acknowledgment of receipt of the notice. Any questions concerning the application of the HIPAA Privacy Rule to patients with emergency medical conditions should be directed to OCR.

Comment: Several commenters expressed specific concerns regarding CMS's community call proposal. A few commenters were concerned that a community call plan could actually

reduce the amount of specialty services provided by a hospital, if hospitals were to contract with each other and transfer the burden of providing specialty on-call services to public safety net hospitals. One commenter urged CMS to closely monitor the implementation of community call plans as well as changes in patterns of on-call coverage. The commenter expressed concern that ''* * * groups of hospitals may misuse community call by improperly decreasing their community's access to specialty on-call coverage.'' The commenter provided an example in which two private hospitals that currently provide specialty on-call services would enter into a community call plan and decrease the amount of coverage so that the amount of coverage they provide together to the community is less than the coverage that was provided prior to the plan being in effect. The commenter stated that, in this case, the community call plan would become a tool whereby private and other nonprofit hospitals coordinate decreasing their on-call coverage at the expense of safety net hospitals.

One commenter requested further research on the impact of the proposed rule and suggested pilot testing in representative communities to determine the impact. Another commenter stated that while it does appear that community call arrangements would encourage physicians to take call at specific hospitals, in most cases there are not enough tertiary care hospitals with specialized capabilities to manage all of the transfer requests. The commenter stated that from her experience, a community call plan does not stop abuse of EMTALA and stated ''It should not surprise CMS, and it is an unspoken truth, that specialty physicians prefer insured patients.'' The commenter noted a difference in the treatment of individuals who are uninsured versus those who are insured and stated that if an individual is uninsured a specialty physician may refuse to see that individual. The commenter asserted that, in such a case, the hospital would need to transfer the individual because no physician will see him or her and the hospital would not be paid for admitting the individual. The commenter stated that it is very difficult for a receiving hospital to charge the transferring hospital with an EMTALA violation because ''* * * we must take them at their professional word that the hospital does not have a physician on call for the needs of the patient.'' The commenter provided several examples that illustrate abuse of EMTALA requirements and recommended that, to avoid abuse of the community call plan, hospitals be ''* * * required to report the results of the on-call annual plan and the patients that the on-call physician accepts on subsequent days, but was not on call or available for the day the patient came to the ER.'' In addition, the commenter requested that CMS address that commenter's suggestion that local emergency rooms should make every effort to arrange the transportation of an individual to a nearby facility before turning to tertiary and quaternary care centers. One commenter stated that hospitals' annual on-call plans should be made available to the public and should include an assessment of whether the plan was adequate. The commenter also suggested the hospitals' backup plans be made available.

Another commenter stated that the proposed policies would have a negative impact on patients. The commenter stated that a community call arrangement, such as the one outlined in the proposed rule could ''* * * erode an emergency department physician's ability to consult a specialist and may require a patient transfer to the hospital that the on-call specialist is covering.'' The commenter stated that it is unfair and unsafe to transport an individual only for the convenience of the on-call specialist. The commenter also noted that moving the individual to the on-call specialist could delay treatment and increase the staffing burden on an already-taxed emergency care system because it is likely that advanced life support as well as a registered nurse would be required to accompany the individual. Instead of the proposal, the commenter urged CMS to adopt the recommendation provided by the IOM (included in *Hospital-Based Emergency Care at the Breaking Point* 2006), which reads: ''The Department of Health and Human Services and the National Highway Traffic Safety Administration, in partnership with professional organizations, convene a panel of individuals with multidisciplinary expertise to develop evidence-based categorization systems for emergency medical services, emergency departments, and trauma centers based on adult and pediatric services capabilities.''

Response: We agree with the commenters that a community call plan should improve patient care by providing greater access to specialists rather than potentially risking an individual's life by engaging in an unnecessary transfer. Furthermore, we agree that a hospital that makes an appropriate transfer in accordance with EMTALA requirements should attempt to avoid transporting individuals long distances when a shorter transport to a hospital with the appropriate specialized capabilities and capacity is possible. We also remind hospitals and medical staff that EMTALA requires a hospital to treat an individual regardless of his or her insurance status. Therefore, if there is evidence of disparate treatment based on an individual's insurance coverage, the hospital or physician, or both, may be subject to penalties for an EMTALA violation. Moreover, a hospital that believes it has been the recipient of an inappropriate transfer of an individual with an unstable emergency medical condition who is protected under EMTALA is obligated to report this to CMS. In response to the commenters who suggested the effect of community call will be to allow certain hospitals to get together to reduce their on-call capacity and in effect dump individuals on other hospitals in their area, we remind hospitals that CMS will continue to investigate complaints about hospitals' compliance with EMTALA and related requirements, including compliance with on-call requirements.

In response to the commenter who suggested that hospitals be ''* * * required to report the results of the on-call annual plan and the patients that the on-call physician accepts on subsequent days, but was not on call or available for the day the patient came to the ER,'' we stated in the regulations proposed at § 489.24(j)(2)(iii)(G) that there must be an ''Annual assessment of the community call plan by the participating hospitals.'' However, we believe that a requirement for hospitals to report the results of their community call plans on an annual basis to CMS may be too burdensome. Therefore, we are not instituting a mandatory reporting requirement at this time.

In response to the commenters who suggested further research and adoption of the IOM recommendation, we anticipate that we will continue to present proposals concerning various on-call issues in future rulemaking and will consider the commenters' suggestions at that time.

Comment: One commenter stated that the health care district of its county has been working for several years with the hospital and physician community to address the shortage of specialty physicians providing on-call coverage in the county's hospital emergency departments. The commenter requested that CMS consider the following comments and questions:

(1) Will the final regulation address whether the shared/community call

plan can contain a financial arrangement to address how participating physicians and/or hospitals can be compensated for serving as the designated on-call facility during an established period of time?

(2) What parameters will be allowed to define the specific geographic area? For example, does it have to be set up to include an entire county, or could it be as small as a city or sub-county region?

(3) Do all hospitals within the defined geographic area have to participate in the community call plan?

(4) Will CMS place any safeguards into the regulation to prevent hospitals from other counties or areas outside the defined geographic area from taking advantage of the new community call plan by transporting patients to the designated on-call facility absent a transfer agreement?

(5) Will any entity grant authority to community call plans?

(6) Will the community call plan regulation provide any guidance on the financial/payer arrangements for patients outside the Medicare and Medicaid system and the implication of patients being transferred to a hospital that may not accept their insurance?

(7) The development of community call plans should not impose a disproportionate and uncompensated obligation on tertiary hospitals that have a broader representation of medical specialties in limited supply on their medical staffs.

Response: We appreciate the commenter's questions and comments regarding the community call plan. In response to the question regarding compensation for serving as the designated on-call facility during an established period of time, the financial arrangements made between an on-call physician and a hospital are between that physician and that hospital. CMS is not in a position to participate in any sort of contractual relationship between a physician and a hospital. We do not believe any sort of financial agreement needs to be included in the community call plan. However, if hospitals choose to, they are welcome to include this information in their community call plans.

In response to the commenters request for clarification on defining the geographic boundaries of a community call plan, we did not specify in the proposed rule any geographic parameters that a community call plan must adhere to; that is, we did not specify whether a community call plan must cover a city, region, or State, or other area because we intended to promote flexibility for hospitals in the development of community call plans. Therefore, we would like to clarify that there are no geographic rules that hospitals must follow as participants of a community call plan. Similarly, not all hospitals within a defined geographic area need to participate in the community call plan. For example, if four hospitals are located in a specific county and only three of those hospitals choose to participate in the community call plan, the plan will not be invalidated due to lack of participation of the fourth hospital in the community call plan.

In response to the commenter's question as to whether CMS will place any safeguards into the regulation to prevent hospitals not participating in the plan from transporting individuals to the on-call facility without a transfer agreement, we specified in the proposed regulation text at § 489.24(j)(2)(iii) that: ''Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and *to conduct appropriate transfers*'' (emphasis added). Therefore, if an individual presents to a hospital and requests treatment for a medical condition and it is determined the individual has an emergency medical condition, the hospital must provide stabilizing treatment within its capability and capacity, and may make an appropriate transfer, consistent with the EMTALA regulations governing transfer. This obligation remains, regardless of whether or not the hospital to which the individual presented is either participating in the community call plan or is designated as the on-call facility. If CMS determines through an investigation that a hospital, whether or not it is participating in a community call plan, engaged in an inappropriate transfer of an individual with an unstable emergency medical condition who was protected under EMTALA, that hospital would be in violation of EMTALA and subject to enforcement action. All Medicare-participating hospitals with dedicated emergency departments, including hospitals that are outside a particular geographic region or not participating in a formal community call plan, can still seek to transfer individuals to hospitals that are participating in a formal community call plan, via an appropriate transfer, notwithstanding the absence or presence of a transfer agreement and regardless of whether the transferring hospital is participating in a formal community call plan. Neither the current EMTALA regulations nor the proposed regulations require a hospital to have a transfer agreement in place prior to seeking to transfer an individual to another hospital that is capable of providing stabilizing care.

In the proposed rule, we did not propose, but solicited comment, on whether community call plans should be approved by State or local agencies. We did not receive any comments supporting preapproval of a community call plan by a local or State agency, or both. Therefore, at this time, we are not requiring local, State, or Federal agencies to approve a community call plan.

In response to the commenter's request for guidance as to whether the regulations would give guidance on financial/payer arrangements to provide for individuals not covered by Medicare or Medicaid and the implication of individuals being transferred to a hospital that may not accept their insurance, we note that the intent of EMTALA is to ensure that an individual presenting to a hospital with a dedicated emergency department receives an appropriate medical screening examination to determine whether the individual has an emergency medical condition and, if necessary, receives stabilizing treatment or providing for an appropriate transfer to another facility, regardless of the individual's method of payment or insurance status. Thus, we do not see the relevance of providing any guidance on financial/payer arrangements outside of the EMTALA context. Together with the OIG, we issued a Special Advisory Bulletin on the Patient Anti-Dumping Statute that addresses hospital obligations toward individuals under EMTALA, including individuals covered under managed care plans (64 FR 61353). We continue to stand by that guidance.

In summary, after consideration of the public comments we received, we are finalizing the community call provision at § 489.24(j)(2)(iii) as proposed, with one modification. We are deleting the requirement at proposed paragraph (j)(2)(iii)(E) ''Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective.''

5. Technical Change to Regulations

In the FY 2008 IPPS final rule with comment period (72 FR 47413), we revised § 489.24(a)(2) (which refers to the nonapplicability of certain EMTALA provisions in an emergency area during an emergency period) to conform it to the changes made to section 1135 of the

Act by the Pandemic and All-Hazards Preparedness Act. When we made the change to the regulations, we inadvertently left out language consistent with the following statutory language found in section 1135: ''pursuant to an appropriate State emergency preparedness plan; or in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State.'' We also inadvertently left out the phrase in section 1135 ''during an emergency period'' when we state the nonapplicability of the sanctions in an emergency area. As we proposed, we are revising the language at § 489.24(a)(2) to include the aforementioned language to conform the regulation text to the statutory language. Proposed revised § 489.24(a)(2) would read as follows: ''*Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.''

Comment: Several commenters addressed our proposal to amend the regulations at § 489.24(r)(2) so that the regulations conform to the statute and to the changes made to section 1135 of the Act by the Pandemic and All-Hazards Preparedness Act. The commenters supported the change because it makes the regulations consistent with the requirements of the statute and allows hospitals to provide appropriate care in a timely manner during a disaster without fear of EMTALA sanctions.

Response: We appreciate the commenters' support of our proposed technical change. We are finalizing the technical change to § 489.24(a)(2) as proposed.

J. Application of Incentives To Reduce Avoidable Readmissions to Hospitals

1. Overview

In the FY 2009 IPPS proposed rule (73 FR 23673), we discussed the development and application of evidence-based best practices meant to reduce the incidence of avoidable hospital readmissions. We note that we are not adopting policy in this final rule. Rather, we are providing a summary of the public comments received on this topic.

A significant portion of Medicare spending—$15 billion each year—is related to hospital readmissions. According to a 2005 MedPAC report,[24] nearly 18 percent of beneficiaries who are discharged from the hospital are readmitted within 30 days, resulting in approximately 2 million readmissions each year. MedPAC's analysis concluded that over 13 percent of 30-day hospital readmissions and an associated $12 billion in spending (4/5 of all Medicare spending for readmissions) are potentially avoidable through the application of evidence-based best practices.

The FY 2009 IPPS proposed rule (73 FR 23673) did not propose any specific policy regarding readmissions but instead highlighted issues related to measurement, accountability, and value-based purchasing (VBP) incentives. Specifically, we presented three VBP options to reduce costs and improve quality related to readmissions: (1) Direct adjustments to hospital payments; (2) adjustments to hospital payments through a performance-based payment methodology; and (3) public reporting of readmission rates.

Of the approximately 1,150 comments received on the FY 2009 IPPS proposed rule, 65 (5.6 percent) addressed readmissions to hospitals. Hospital associations and hospitals submitted over 70 percent of the relevant public comments, with medical specialty societies comprising the next largest group of commenters. A summary of these public comments are included under the subject topics.

2. Measurement

In the FY 2009 IPPS proposed rule, we noted certain prerequisites for initiatives intended to reduce hospital readmission rates, including the recognition that routine, valid, and reliable measurements are important to encourage trust and to engage stakeholders. Moreover, measurement data should be meaningful and actionable for hospitals.

Risk adjustment is one method for achieving more accurate measurement of preventable readmissions. The proposed rule stated that a zero percent readmission rate may not be an appropriate goal, as extremely low readmission rates could indicate restricted access to necessary medical services rather than quality health care delivery. However, risk adjustment could help define expected readmission rates for a given patient or patient population.

Informative readmission measurement also requires an appropriate timeframe between discharge and readmission on which to base measures of avoidable readmissions. For example, a 30-day window is used for readmission measures in the RHQDAPU program and the 9th Scope of Work for Medicare Quality Improvement Organizations (QIOs).

One commenter suggested that CMS use QIO data to conduct research and develop a knowledge base to help answer readmission measure specification questions of this type. However, the commenter did not specifically address the appropriateness of the 30-day window.

In the proposed rule, we also solicited comments concerning the appropriate scope of readmissions measures, querying whether to focus on all readmissions or to spotlight higher cost, more easily preventable, or most frequently occurring readmissions.

Most commenters urged CMS to exclude certain categories of readmissions when measuring and calculating rates. One commenter stated that CMS should not penalize hospitals for readmissions that occur if a patient returns from a postacute care setting or if a readmission is not clearly related to the initial admission. Other commenters described cases in which readmissions are not only foreseeable but planned occurrences. For example, if a patient has an acute episode just prior to elective surgery, the attending physician may discharge a patient for a few days to ensure that the patient is hydrated and infection free before surgery.

3. Shared Accountability

In the FY 2009 IPPS proposed rule (73 FR 23673), we discussed that hospitals are accountable for the quality of care delivered during hospitalization, which may also affect health care quality post-discharges. However, hospitals are not the only providers that affect the occurrence of readmissions. Other

[24] Medicare Payment Advisory Commission: Report to Congress: Promoting Greater Efficiency in Medicare. June 2007, Chapter 5, p. 103.

health care entities (such as SNFs, IRFs, HHAs, ESRD facilities, and health care providers), as well as Medicare beneficiaries and their caregivers share responsibility for quality health care delivery and play important roles in preventing readmissions.

To improve accountability, many commenters recommended expanding financial accountability to additional stakeholders. For example, one commenter advocated increasing accountability by holding physicians financially responsible for high rates of risk-adjusted readmissions. In addition, many commenters advocated for the development of accurate methods to attribute accountability.

Shared accountability makes accurate measurement difficult without alignment of quality measures across care settings. Commenters addressed how health care alignment and infrastructure impact readmission rates. Citing a MedPAC report, one commenter noted that hospitals rarely follow up with patients after hospital discharge and that other health care providers have not adequately invested in their responsibility to provide effective transitional care.

4. VBP Incentives

CMS is increasingly promoting quality and efficiency of care through the application of VBP tools. The VBP methodology is meant to promote adherence to evidence-based best practices by rewarding high-achievement. In the context of readmissions, we presented in the FY 2009 IPPS proposed rule three potential uses of incentives to encourage prevention of avoidable hospital readmissions.

All of the commenters supported efforts to reduce avoidable readmissions. However, their comments were mixed about the appropriateness of payment-focused interventions. Commenters representing hospital associations asked CMS to answer the following three questions before advancing any particular readmission policy:

- To what extent is it possible to identify avoidable readmissions?
- Are there effective strategies for reducing or eliminating these avoidable readmissions?
- What is the likelihood that each approach will promote and encourage the use of those effective strategies while avoiding undesirable consequences?

One commenter urged CMS to focus on auditing 30-day readmission outlier facilities rather than pursuing payment incentive policies to determine if clinical interventions and targeted readmission denials improve readmission rates.

Other commenters also emphasized that reducing readmission rates requires more than simple payment incentive strategies because of structural limitations inherent to the U.S. health care system, including the lack of coordinated chronic care services and the use of hospitals as primary care providers. One commenter questioned whether readmission data would be meaningful or actionable to either CMS or hospitals. This commenter asserted that readmission rates should not be tied to hospital reimbursement because such rates more accurately measure physician resource use.

5. Direct Payment Adjustment

As stated in the FY 2009 IPPS proposed rule (73 FR 23674), direct payment adjustment for readmissions could range from total denial to incremental adjustment. The magnitude of the payment adjustment could be based on patient-specific risk factors or on the shared accountability among the involved entities. A variation of this approach could be adjustment of all hospital payments for readmissions, nationwide or by some regional designation, based on aggregate information about avoidable readmissions for the relevant Medicare population (national or regional) under typical circumstances. Under this approach, hospitals would receive less Medicare payment for readmissions for conditions with lower than expected rates of readmission and less shared responsibility.

Many commenters favored various forms of direct payment adjustment to reduce avoidable hospital readmissions. Given the number of care settings and patient-specific factors that affect hospital readmission rates, many commenters favored direct payment adjustments based on degrees of accountability and foreseeable risk. Numerous commenters suggested that direct payment adjustments should account for patient-specific risk factors, including age, disease severity, and the presence of comorbidities. Commenters also noted that a lack of prescription drug coverage can reduce patient compliance, raising the risk of readmission.

Not all of the public comments that addressed direct payment adjustments were favorable. None of the commenters supported using an all-or-nothing approach like the current HAC payment provision. The commenters stated that this strategy unfairly punishes hospitals for readmissions that will occur despite strict adherence to best practices. Commenters noted that direct payment adjustments cannot adequately correct for all contributing factors to readmission rates. One commenter also argued against direct payment adjustments in cases where hospitals already receive reduced payments for transfer patients.

6. Performance-Based Payment Adjustment

Performance-based adjustments could be based on a payment methodology such as the Medicare Hospital VBP Plan discussed in section IV.C. of the proposed rule and this final rule. The payment adjustment could reflect a comparison between an individual hospital's actual and expected readmission rates.

Many commenters supported some form of performance-based payment adjustment for readmissions. A number of commenters stated that readmission quality and cost reduction measures should be part of the broader picture of value-based purchasing. In contrast, one commenter suggested that CMS continue to work through QIOs on education-based reduction strategies before adopting performance-based payment adjustments for readmissions.

7. Public Reporting of Readmission Rates

The third VBP incentive that we presented for public comment in the FY 2009 IPPS proposed rule (73 FR 23675) was public reporting of hospital-specific, risk-adjusted readmission rates. The Administration's Value-Driven Health Care Initiative, which stems from the President's Executive Order Promoting Quality and Efficient Health Care in Federal Government Health Care Programs, instructed federal agencies to increase transparency of healthcare quality and costs. Using the Hospital Compare Web site explained in section IV.B. of the proposed rule and this final rule, patients can compare the quality of care provided by hospitals. The information supports improve consumer decision making through better access to healthcare information.

Many commenters supported public reporting of readmission data. All of the commenters who were in favor of public reporting supported using only the Hospital Compare Web site for postings. However, many commenters only supported public reporting of measures endorsed by the NQF and adopted by the HQA. Some commenters suggested that readmission data remain confidential for a period to allow health care providers to adjust to collecting and reporting readmission measures,

which would give hospitals time to analyze their data and develop programs to improve readmission rates.

8. Potential Unintended Consequences of VBP Incentives

Some commenters identified potential unintended consequences for readmission-related VBP incentives. A few commenters stated that payments tied to readmission rates might lead hospitals to direct previous patients to other institutions for follow-up care, frustrating continuity of care.

Other commenters addressed the potential for increased health care costs. One commenter expressed concern that linking readmission rates to payment would create an incentive for hospitals to lengthen costly inpatient stays to avoid related readmissions later and expose patients to increased hospital-related risks without improving quality of care. However, another commenter noted that Medicare IPPS gives hospitals a balancing incentive to not prolong length of stay.

We appreciate all of the public comments that we received in response to our solicitation. We will take them into consideration in any future rulemaking efforts that we determine may be necessary.

K. Rural Community Hospital Demonstration Program

In accordance with the requirements of section 410A(a) of Public Law 108–173, the Secretary has established a 5-year demonstration program (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

Section 410A(a)(4) of Public Law 108–173 states that no more than 15 such hospitals may participate in the demonstration program.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Public Law 108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming (Source: *U.S. Census Bureau Statistical Abstract of the United States: 2003*). Nine rural community hospitals located within these States are currently participating in the demonstration program. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have become CAHs and have withdrawn from the program.)

In a notice published in the **Federal Register** on February 6, 2008 (73 FR 6971 through 6973), we announced a solicitation for up to six additional hospitals to participate in the demonstration program. Four additional hospitals were selected to participate under this solicitation. We are planning for each of these hospitals to begin under the demonstration payment methodology with its first cost report year starting on or after July 1, 2008. The end date of participation for these hospitals is September 30, 2010. The February 6, 2008 notice specifies the eligibility requirements for the demonstration program.

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004 implementation date of the demonstration program (or the July 1, 2008 date for the newly selected hospitals). Payments to the participating hospitals will be the lesser amount of the reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services are inpatient hospital services (defined in section 1861(b) of the Act), and include extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Public Law 108–173 requires that, ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration program. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration program for FY 2009, as we proposed in the FY 2009 IPPS proposed rule, we are adjusting the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are applying budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, FY 2007 and FY 2008 IPPS final rules (69 FR 49183; 70 FR 47462; 71 FR 48100; and 72 FR 47392), we believe that the language of the

statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2009, using data from the cost reports from each of the nine currently participating hospitals' first year of participation in the demonstration program, that is, cost reports for years beginning in CY 2005, and estimating the cost of four additional hospitals selected based on cost report periods that include CY 2006, we estimate that the additional cost will be $22,790,388. This estimated adjusted amount reflects the estimated difference between the participating hospitals' costs and the IPPS payment based on data from the hospitals' cost reports. We discuss the payment rate adjustment that is required to ensure the budget neutrality of the demonstration program for FY 2009 in section II.A.4. of the Addendum to this final rule.

V. Changes to the IPPS for Capital-Related Costs

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312 of the regulations. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

Hospitals also may receive outlier payments for those cases that qualify under the threshold established for each fiscal year as specified in § 412.312(c) of the regulations.

1. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

2. New Hospitals

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. For more detailed information, we refer readers to the FY 1992 IPPS final rule (56 FR 43418). During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because, as discussed in the FY 2003 IPPS final rule (67 FR 50101), we believe that special protection to new hospitals is also appropriate even after the transition period, we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (We refer readers to the FY 2002 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

3. Hospitals Located in Puerto Rico

Section 412.374 of the regulations provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate that consisted of 75 percent of the capital IPPS Puerto Rico specific rate

and 25 percent of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating IPPS blend percentage for hospitals located in Puerto Rico required by section 4406 of Public Law 105–33, we revised the methodology for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS Federal rate. Similarly, in conjunction with the change in operating IPPS payments to hospitals located in Puerto Rico for FY 2005 required by section 504 of Public Law 108–173, we again revised the methodology for computing capital IPPS payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges occurring on or after October 1, 2004.

B. Revisions to the Capital IPPS Based on Data on Hospital Medicare Capital Margins

As noted above, under the Secretary's broad authority under the statute in establishing and implementing the IPPS for hospital inpatient capital-related costs, we have established a standard Federal payment rate for capital-related costs, as well as the mechanism for updating that rate each year. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. Section 412.308(c)(2) provides that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights, and changes in the geographic adjustment factor are budget neutral.

In the FY 2008 IPPS final rule with comment period (72 FR 47398 through 47401), based on our analysis of data on inpatient hospital Medicare capital margins that we obtained through our monitoring and comprehensive review of the adequacy of the standard Federal payment rate for capital-related costs and the updates provided under the existing regulations, we made changes in the payment structure under the capital IPPS beginning with FY 2008. We summarize these changes below. We refer readers to section V.B. of the preamble of the FY 2008 final rule with comment period (72 FR 47393 through 47401) for a detailed discussion of the data used as a basis for these changes. These data showed that hospital inpatient Medicare capital margins were very high across all hospitals during the period from FY 1996 through FY 2004.

In the FY 2008 IPPS final rule with comment period, as background, we noted that, in general, under a PPS, standard payment rates should reflect the costs that an average, efficient provider would bear to provide the services required for quality patient care. Payment rate updates should also account for the changes necessary to continue providing such services. Updates should reflect, for example, the increased costs that are necessary to provide for the introduction of new technology that improves patient care. Updates should also take into account the productivity gains that, over time, allow providers to realize the same, or even improved, quality outcomes with reduced inputs and lower costs. Hospital margins, the difference between the costs of actually providing services and the payments received under a particular system, thus provide some evidence concerning whether payment rates have been established and updated at an appropriate level over time for efficient providers to provide necessary services. All other factors being equal, sustained substantial positive margins demonstrate that payment rates and updates have exceeded what is required to provide those services. Under a PPS, it is expected that highly efficient providers might regularly realize positive margins, while less efficient providers might regularly realize negative margins. However, a PPS that is correctly calibrated should not necessarily experience sustained periods in which providers generally realize substantial positive Medicare margins. Under the capital IPPS in particular, it seems especially appropriate that there should not be sustained significant positive margins across the system as a whole. Prior to the implementation of the capital IPPS, Congress mandated that the Medicare program pay only 85 percent of hospitals' inpatient Medicare capital costs. During the first 5 years of the capital IPPS, Congress also mandated a budget neutrality adjustment, under which the standard Federal capital rate was set each year so that payments under the system as a whole equaled 90 percent of estimated hospitals' inpatient Medicare capital costs for the year. Finally, Congress has twice adjusted the standard Federal capital rate (a 7.4 percent reduction beginning in FY 1994, followed by a 17.78 percent reduction beginning in FY 1998). On the second occasion in particular, the specific congressional mandate was ''to apply the budget neutrality factor used to determine the Federal capital payment rate in effect on September 30, 1995 * * * to the unadjusted standard Federal capital payment rate'' for FY 1998 and beyond. (The designated budget neutrality factor constituted a 17.78 percent reduction.) This statutory language indicates that Congress considered the payment levels in effect during FYs 1992 through 1995, established under the budget neutrality provision to pay 90 percent of hospitals' inpatient Medicare capital costs in the aggregate, appropriate for the capital IPPS. The statutory history of the capital IPPS thus suggests that the system in the aggregate should not provide for continuous, large positive margins.

As we also discussed in the FY 2008 IPPS final rule with comment period, we believed that there could be a number of reasons for the relatively high margins that most IPPS hospitals have realized under the capital IPPS. One possibility is that the updates to the capital IPPS rates have been higher than the actual increases in Medicare inpatient capital costs that hospitals have experienced in recent years. Another possible reason for the relatively high margins of most capital IPPS hospitals may be that the payment adjustments provided under the system are too high, or perhaps even unnecessary. Specifically, the adjustments for teaching hospitals, disproportionate share hospitals, and large urban hospitals appear to be contributing to excessive payment levels for these classes of hospitals. Since the inception of the capital IPPS in FY 1992, the system has provided adjustments for teaching hospitals (the IME adjustment factor, under § 412.322 of the regulations), disproportionate share hospitals (the DSH adjustment factor, under § 412.320), and large urban hospitals (the large urban location adjustment factor, under § 412.316(b)). The classes of hospitals eligible for these adjustments have been realizing much higher margins than other

hospitals under the system. Specifically, at the time of the FY 2008 IPPS final rule with comment period, teaching hospitals (11.6 percent for FYs 1998 through 2004), disproportionate share hospitals (8.4 percent), and urban hospitals (8.3 percent) had significant positive margins. Other classes of hospitals had experienced much lower margins, especially rural hospitals (0.3 percent for FYs 1998 through 2004) and nonteaching hospitals (1.3 percent). The three groups of hospitals that had been realizing especially high margins under the capital IPPS are, therefore, classes of hospitals that are eligible to receive one or more specific payment adjustment under the system. We believed that the evidence indicates that these adjustments have been contributing to the significantly large positive margins experienced by the classes of hospitals eligible for these adjustments. (We discuss our updated margin analysis below.)

Therefore, in the FY 2008 IPPS final rule with comment period, we made two changes to the structure of payments under the capital IPPS, as discussed under items 1 and 2 below.

1. Elimination of the Large Add-On Payment Adjustment

In the FY 2008 IPPS final rule with comment period, we determined that the data we had gathered on inpatient hospital Medicare capital margins provided sufficient evidence to warrant elimination of the large urban add-on payment adjustment starting in FY 2008 under the capital IPPS. Therefore, for FYs 2008 and beyond, we discontinued the 3.0 percent additional payment that had been provided to hospitals located in large urban areas (72 FR 24822). This decision was supported by comments from MedPAC.

2. Changes to the Capital IME Adjustment

a. Background and Changes Made for FY 2008

In the FY 2008 IPPS proposed rule, we noted that margin analysis indicated that several classes of hospitals had experienced continuous, significant positive margins. The analysis indicated that the existing payment adjustments for teaching hospitals and disproportionate share hospitals were contributing to excessive payment levels for these classes of hospitals. Therefore, we stated that it may be appropriate to reduce these adjustments significantly, or even to eliminate them altogether, within the capital IPPS. These payment adjustments, unlike parallel adjustments under the operating IPPS, were not mandated by the Act. Rather, they were included within the original design of the capital IPPS under the Secretary's broad authority in section 1886(g)(1) of the Act to include appropriate adjustments and exceptions within a capital IPPS.

In the FY 2008 final rule with comment period, we also noted a MedPAC recommendation that we seriously reexamine the appropriateness of the existing capital IME adjustment, that the margin analysis indicated such adjustment may be too high, and that MedPAC's previous analysis also suggested the adjustment may be too high. In light of MedPAC's recommendation, we extended the margin analysis discussed in the FY 2008 IPPS proposed rule in order to distinguish the experience of teaching hospitals from the experience of urban and rural hospitals generally. Specifically, we isolated the margins of urban, large urban, and rural teaching hospitals, as opposed to urban, large urban, and rural nonteaching hospitals. In conducting this analysis, we employed updated cost report information, which allowed us to incorporate the margins for an additional year, FY 2005, into the analysis. The data on the experience of urban, large urban, and rural teaching hospitals as opposed to nonteaching hospitals provided significant new information. As the analysis demonstrated, teaching hospitals in each class (urban, large urban, and rural) performed significantly better than comparable nonteaching hospitals. For the period covering FYs 1998 through 2005, urban teaching hospitals realized aggregate positive margins of 11.9 percent, compared to a positive margin of 0.9 percent for urban nonteaching hospitals. Similarly, large urban teaching hospitals realized an aggregate positive margin of 12.8 percent during that period, while large urban nonteaching hospitals had an aggregate positive margin of only 2.9 percent. Finally, rural teaching hospitals experienced an aggregate positive margin of 4.5 percent, as compared to a negative 1.3 percent margin for nonteaching rural hospitals. We noted that the positive margins for teaching hospitals did not exhibit a decline to the same degree as the margins for all hospitals. For example, the positive margins for all IPPS hospitals declined from 8.7 percent in FY 2002 to 5.3 percent in FY 2004 and 3.7 percent in FY 2005. For urban hospitals, aggregate margins decreased from 10.3 percent in FY 2002 to 6.4 percent in FY 2004 and 4.8 percent in FY 2005. Rural hospitals experienced a decrease from 1.5 percent in FY 2001 to a negative margin of −4.2 percent in FY 2005. In comparison, the aggregate margin for teaching hospitals was 12.1 percent in FY 2001 and 10.6 percent in FY 2005. For urban teaching hospitals, margins were 12.5 percent in FY 2001, 14.0 percent in FY 2002, 13.6 percent in FY 2003, 11.9 percent in FY 2004, and 10.9 percent in FY 2005. Rural teaching hospital margins were more variable, but did not exhibit a pattern of significant decline. In FY 2001, rural teaching hospitals had a positive margin of 3.2 percent; in FY 2002, 8.2 percent; in FY 2003, 4.7 percent; in FY 2004, 5.7 percent; and in FY 2005, 4.0 percent. We are reprinting below the table found in the FY 2008 IPPS final rule with comment period showing our analysis (72 FR 47400).

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HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996-2005	Aggregate 1998-2005
U.S.	17.6	13.4	7.0	6.8	7.3	8.1	8.7	7.6	5.3	3.7	8.5	6.8
URBAN	17.7	13.8	7.8	7.5	8.4	9.2	10.3	9.0	6.4	4.8	9.4	7.9
RURAL	16.8	11.0	2.1	2.4	1.0	1.5	-1.7	-1.4	-2.3	-4.2	2.6	-0.4
No DSH Payments	16.2	11.7	4.2	4.3	5.6	5.5	4.7	4.4	-1.3	-4.7	5.9	3.2
Has DSH Payments	18.5	14.4	8.6	8.1	8.2	9.0	10.0	8.5	7.0	5.9	9.5	8.1
$1-$249,999	14.5	12.9	-0.4	3.1	1.6	4.1	3.2	1.4	-1.7	-4.8	3.2	1.9
$250,000-$999,999	15.5	9.0	2.3	1.6	2.8	2.7	-2.4	-1.5	-4.3	-7.3	1.5	-0.9
$1,000,000-$2,999,999	16.8	13.0	8.7	9.0	8.7	7.0	10.1	5.2	3.2	2.0	8.2	6.6
$3,000,000 or more	20.3	16.6	10.4	9.3	9.7	12.1	13.2	12.5	10.6	9.5	12.2	11.0
TEACHING	19.5	15.7	9.8	9.7	11.2	12.1	13.8	13.2	11.7	10.6	12.7	11.6
Urban	19.7	15.9	10.2	10.0	11.4	12.5	14.0	13.6	11.9	10.9	13.0	11.9
Large Urban	20.5	16.8	11.0	10.1	12.5	13.9	15.2	14.7	12.0	11.9	13.9	12.8
Rural	13.9	8.5	1.0	2.9	5.8	3.2	8.2	4.7	5.7	4.0	5.7	4.5
NONTEACHING	15.3	10.5	3.4	2.8	2.2	2.6	1.7	0.0	-3.2	-5.1	2.8	0.3
Urban	14.4	10.1	3.8	3.0	3.0	3.1	3.6	0.9	-2.9	-4.9	3.1	0.9
Large Urban	15.5	11.3	6.2	6.1	5.7	5.2	5.3	1.7	-0.9	-3.2	5.1	2.9
Rural	17.3	11.4	2.3	2.4	0.2	1.2	-3.7	-2.6	-3.9	-6.0	2.0	-1.3
Census Division												
New England (1)	27.9	25.9	17.1	15.1	18.2	20.7	21.3	21.1	20.5	20.3	21.0	19.5
Middle Atlantic (2)	19.1	15.5	11.1	11.6	14.1	16.5	18.7	18.0	14.7	16.0	15.6	15.2
South Atlantic (3)	18.1	13.9	5.9	4.0	6.0	5.0	6.6	6.9	5.8	2.8	7.4	5.4
East North Central (4)	18.2	12.7	6.4	7.1	8.8	8.5	6.1	7.1	6.6	3.2	8.4	6.7
East South Central (5)	14.9	11.1	3.3	4.1	3.8	3.8	3.8	-0.9	-3.4	-5.8	3.2	0.9
West North Central (6)	14.3	7.0	0.1	-0.3	-1.5	2.0	1.9	3.4	1.6	-0.4	2.8	0.9
West South Central (7)	13.2	8.3	3.3	2.6	-0.7	0.0	1.2	-2.0	-4.0	-6.5	1.2	-1.0
Mountain (8)	17.2	14.7	8.5	7.7	7.2	6.4	2.9	3.3	0.8	-4.7	5.8	3.6
Pacific (9)	20.4	16.1	12.3	11.3	11.9	13.3	14.7	12.1	9.8	8.8	13.0	11.7
Code 99	23.7	24.1	14.5	16.8	19.8	20.7	20.5	25.1	21.6	24.8	21.4	20.8

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996-2005	Aggregate 1998-2005
Bed Size												
< 100 beds	17.7	13.0	4.6	3.5	2.7	2.5	-1.8	-1.2	-6.1	-9.6	2.0	-0.9
100-249 beds	15.1	10.5	3.7	4.5	4.3	6.1	6.0	4.2	1.5	0.8	5.6	3.8
250-499 beds	18.9	14.1	8.9	8.3	10.6	10.7	12.1	11.6	10.3	7.7	11.4	10.1
500-999 beds	19.9	17.1	10.7	10.4	11.3	10.8	12.6	10.1	7.3	7.8	11.6	10.1
>= 1000 beds	8.2	14.0	2.2	-1.3	-6.6	-3.6	6.5	8.1	6.5	2.1	3.5	2.3

Notes:
Based on Medicare Cost Report hospital data updated as of the 1st quarter of 2007.
Medicare payments are from Worksheet E, Part A, Lines 9 and 10.
Expenses are from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8.
We apply the outlier trimming methodology developed with MedPAC.
Code 99 applies when census division information was not specified in the Medicare Cost Report hospital data.

As we indicated in the FY 2008 IPPS final rule with comment period (72 FR 47401), the statutory history of the capital IPPS suggests that the system in the aggregate should not provide for continuous, large positive margins. As we also indicated, a possible reason for the relatively high margins of many capital IPPS hospitals may be that the payment adjustments provided under the system are too high, or perhaps even unnecessary. We agreed with MedPAC's recommendation and reexamined the appropriateness of the teaching adjustment. We concluded that the record of relatively high and persistent positive margins for teaching hospitals under the capital IPPS indicated that the teaching adjustment is unnecessary, and that it was therefore appropriate to exercise our discretion under the capital IPPS to eliminate this adjustment. At the same time, we believed that we should mitigate abrupt changes in payment policy and that we should provide time for hospitals to adjust to changes in the payments that they can expect under the program.

Therefore, in the FY 2008 IPPS final rule with comment period, we adopted a policy to phase out the capital teaching adjustment over a 3-year period beginning in FY 2008. Specifically, we maintained the adjustment for FY 2008, in order to give teaching hospitals an opportunity to plan and make adjustments to the change. During the second year of the transition, FY 2009, the formula for determining the amount of the teaching adjustment was revised so that adjustment amounts will be half of the amounts provided under the current formula. For FY 2010 and after, hospitals will no longer receive an adjustment for teaching activity under the capital IPPS.

b. Public Comments Received on Phase Out of Capital IPPS Teaching Adjustment Provisions Included in the FY 2008 IPPS Final Rule With Comment Period and on the FY 2009 IPPS Proposed Rule

As indicated above, in the FY 2008 IPPS final rule with comment period, we formally adopted as final policy a phase out of the capital IPPS teaching adjustment over a 3-year period, maintaining the current adjustment for FY 2008, making a 50-percent reduction in FY 2009, and eliminating the adjustment for FY 2010 and subsequent years. However, because we concluded that this change to the structure of payments under the capital IPPS was significant, we provided the public with an opportunity for further comment on these provisions through a 90-day comment period after publication of the FY 2008 IPPS final rule with comment period (72 FR 47401). In addition, as we indicated in that final rule with comment period, to provide a more than adequate opportunity for hospitals, associations, and other interested parties to raise issues and concerns related to our policy, we would provide additional opportunity for public comment during the FY 2009 proposed rulemaking cycle for the IPPS (73 FR 23679).

We received numerous timely pieces of correspondence that commented on the policy of phasing out the capital IPPS teaching adjustment as described in the FY 2008 IPPS final rule with comment period. We also received a number of public comments on this policy during the comment period for the FY 2009 IPPS proposed rule. A summary of the public comments received on both documents and our responses follow.

Comment: A number of commenters objected that the proposed elimination of the capital IME adjustment would have an excessive financial impact on hospitals. Many commenters cited estimates of payment reductions that could be expected for individual hospitals or various groups of hospitals. Some of these commenters pointed out that teaching hospitals maintain high levels of advanced services and require adequate levels of payment to acquire and maintain the new technologies required to support these services. Some commenters also contended that operating and capital IME adjustments assist teaching hospitals in maintaining underfunded services such as inpatient services for the uninsured and other kinds of uncompensated care. In addition, some commenters contended that elimination of the IME adjustment would make it much more difficult for hospitals to undertake the capital improvements required by various state mandates, as well as the adoption of the information technologies encouraged by various Federal initiatives.

Response: Our margin analysis continues to show that teaching hospitals are realizing significant positive margins under the capital IPPS. As noted above, in the aggregate, teaching hospitals experienced capital IPPS margins of 12.1 percent in FY 2001, 13.8 percent in FY 2002, 13.2 percent in FY 2003, 11.5 percent in FY 2004, 10.8 percent in FY 2005, and 8.4 percent in FY 2006. For urban teaching hospitals, margins were 12.5 percent in FY 2001, 14.0 percent in FY 2002, 13.6 percent in FY 2003, 11.7 percent in FY 2004, 11.0 percent in FY 2005, and 8.6

percent in FY 2006. Rural teaching hospital margins were more variable, but did not exhibit a pattern of significant decline. In FY 2001, rural teaching hospitals had a positive margin of 3.2 percent. The margins for rural teaching hospitals were 8.2 percent in FY 2002, 4.7 percent in FY 2003, 6.4 percent in FY 2004, 4.9 percent in FY 2005, and 3.1 percent in FY 2006. In contrast, the margins for nonteaching hospitals were 2.6 percent in FY 2001, 1.7 percent in FY 2002, 0.0 percent in FY 2003, −3.1 percent in FY 2004, −5.5 percent in FY 2005, and −9.1 percent in FY 2006. The updated margin analysis continues to suggest that the capital IPPS has been providing more than adequate funding for the capital needs of teaching hospitals. We anticipate that teaching hospitals will continue to have adequate funding even in the absence of the IME adjustment. Our estimate is that, even if the teaching adjustment had been eliminated for FYs 2004, 2005, and 2006, teaching hospitals would continue to experience positive capital IPPS margins of 3.9 percent, 3.2 percent, and 0.4 percent, respectively. Our current margin analysis is reflected in the table below:

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Hospital Inpatient Medicare Capital Margins 1996 – 2006

	1996 Margin	1997 Margin	1998 Margin	1999 Margin	2000 Margin	2001 Margin	2002 Margin	2003 Margin	2004 Margin	2005 Margin	2006 Margin	1996-2006 Aggregate Margin	1998-2006 Aggregate Margin
All hospitals	17.6	13.4	7.0	6.8	7.3	8.1	8.7	7.6	5.3	3.9	0.9	7.7	6.1
Urban	17.7	13.8	7.8	7.5	8.4	9.2	10.3	9.0	6.3	5.0	2.3	8.7	7.2
Large Urban	18.7	15.0	9.4	8.8	10.4	11.1	12.1	10.5	7.6	7.0	4.5	10.3	9.0
Other Urban	16.3	11.6	4.4	4.5	4.1	4.8	4.9	4.4	2.6	0.3	-3.3	4.8	2.9
Rural	16.8	11.0	2.1	2.4	1.0	1.5	-1.7	-1.4	-2.0	-4.0	-9.3	1.6	-1.3
No DSH	16.2	11.7	4.2	4.3	5.6	5.5	4.7	4.4	-0.9	-3.8	-7.5	5.0	2.3
Has DSH	18.5	14.4	8.6	8.1	8.2	9.0	10.0	8.5	6.8	5.9	2.9	8.7	7.4
$1 - $249,000	14.5	12.9	-0.4	3.1	1.6	4.1	3.2	1.4	-2.3	-0.4	-7.9	3.0	1.6
$250,000 - $999,000	15.5	9.0	2.3	1.6	2.8	2.7	-2.4	-1.5	-4.1	-8.2	-12.3	0.2	-2.2
$1 million - $3 million	16.8	13.0	8.7	9.0	8.7	7.0	10.1	5.2	2.9	1.0	-2.6	7.1	5.4
> $3 million	20.3	16.6	10.4	9.3	9.7	12.1	13.2	12.5	10.3	9.8	7.0	11.5	10.4
Teaching	19.5	15.7	9.8	9.7	11.2	12.1	13.8	13.2	11.5	10.8	8.4	12.3	11.2
Urban	19.7	15.9	10.2	10.0	11.4	12.5	14.0	13.6	11.7	11.0	8.6	12.5	11.5
Large Urban	20.5	16.8	11.0	10.1	12.5	13.9	15.2	14.7	11.8	12.0	9.8	13.0	11.8
Other Urban	17.9	13.8	7.9	9.0	9.0	9.2	11.5	10.9	11.1	8.7	6.1	13.2	11.9
Rural	13.9	8.5	1.0	2.9	5.8	3.2	8.2	4.7	6.4	4.9	3.1	5.6	4.5
Non-teaching	15.3	10.5	3.4	2.8	2.2	2.6	1.7	0.0	-3.1	-5.5	-9.1	1.6	-0.8
Urban	14.4	10.1	3.8	3.0	3.0	3.1	3.6	0.9	-2.9	-5.3	-8.3	1.9	-0.3
Large Urban	15.5	11.3	6.2	6.1	5.7	5.2	5.3	1.7	-1.0	-3.3	-6.0	3.9	1.8
Other Urban	15.1	9.9	1.4	0.7	0.0	1.0	-0.6	-1.1	-4.6	-7.0	-11.4	0.1	-2.6
Rural	17.3	11.4	2.3	2.4	0.2	1.2	-3.7	-2.6	-3.7	-5.9	-11.9	0.8	-2.4
Census Division:													
New England	27.9	25.9	17.1	15.1	18.2	20.7	21.3	21.1	21.2	18.9	19.2	20.7	19.4
Middle Atlantic	19.1	15.5	11.1	11.6	14.1	16.5	18.7	18.0	14.4	15.6	13.7	15.4	15.0
South Atlantic	18.1	13.9	5.9	4.0	6.0	5.0	6.6	6.9	5.6	3.7	-0.9	6.7	4.7
East North Central	18.2	12.7	6.4	7.1	8.8	8.5	6.1	7.1	6.1	3.5	-1.3	7.5	5.8
East South Central	14.9	11.1	3.3	4.1	3.8	3.8	3.8	-0.9	-2.7	-4.0	-7.6	2.3	0.1
West North Central	14.3	7.0	0.1	-0.3	-1.5	2.0	1.9	3.4	2.0	-1.1	-3.5	2.2	0.4
West South Central	13.2	8.3	3.3	2.6	-0.7	0.0	1.2	-2.0	-4.4	-6.9	-9.4	0.0	-2.2
Mountain	17.2	14.7	8.5	7.7	7.2	6.4	2.9	3.3	0.5	-3.1	-6.9	4.5	2.3
Pacific	20.4	16.1	12.3	11.3	11.9	13.3	14.7	12.1	9.7	8.1	6.6	12.2	11.0

	1996 Margin	1997 Margin	1998 Margin	1999 Margin	2000 Margin	2001 Margin	2002 Margin	2003 Margin	2004 Margin	2005 Margin	2006 Margin	1996-2006 Aggregate Margin	1998-2006 Aggregate Margin
Unidentified	23.7	24.1	14.5	16.8	19.8	20.7	20.5	25.1	21.9	24.8	22.3	21.5	21.0
Bedsize:													
<100	17.7	13.0	4.6	3.5	2.7	2.5	-1.8	-1.2	-6.1	-9.7	-16.3	0.3	-2.6
100-249	15.1	10.5	3.7	4.5	4.3	6.1	6.0	4.2	1.6	0.3	-2.4	4.8	3.1
250-499	18.9	14.1	8.9	8.3	10.6	10.7	12.1	11.6	10.1	7.9	4.4	10.7	9.4
500-999	19.9	17.1	10.7	10.4	11.3	10.8	12.6	10.1	7.1	8.4	7.1	11.2	9.7
>=1000	8.2	14.0	2.2	-1.3	-6.6	-3.6	6.5	8.1	7.0	3.3	0.3	3.3	2.3

Note: The estimates for 2004 through 2006 are based on Medicare Cost Reports received as of March 31, 2008. The estimates for 1996 through 2003 are based on Medicare Cost Reports as of March 31, 2007.

Source: Office of the Actuary

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Finally, MedPAC's March 2007 report found little evidence to support the contention that the operating and capital IME adjustments help hospitals that have large shares of uncompensated care. Specifically, the report found that ''it appears that the hospitals most involved in teaching * * * are not, by and large, the ones that devote the most resources to treating patients who are unable to pay their bills'' (Report to the Congress: Medicare Payment Policy, March 2007, page 79). In any event, IME payments (operating and capital) were never intended to subsidize services for the uninsured and other uncompensated care.

Comment: Many commenters contended that total Medicare inpatient margins, rather than Medicare inpatient capital margins, should be employed as the basis for evaluating the appropriateness of the capital IPPS IME and other payment IPPS payment adjustments. Other commenters objected to employing of margin analysis at all as a basis for determining whether the payment adjustments are warranted. Some commenters noted that cost regression analysis was originally employed to determine whether an IME adjustment was warranted under the capital IPPS. Most of these commenters contended that revisions to the payment adjustments should not be considered without updating these original regression analyses. Furthermore, these commenters emphasized that it would only be appropriate to employ total cost regressions, as opposed to capital cost-only regressions, in these analyses. Commenters advocated using total cost regressions on the grounds that doing so would follow precedent (the analysis that supported the original establishment of the adjustments employed total cost regressions), and would be consistent with treating the capital IPPS as intrinsically part of a broader IPPS embracing both capital and operating payments. One commenter interpreted the proposal to eliminate the capital IPPS IME adjustment to represent an attempt to wring excess IME payments out of the operating PPS. The commenter indicated that CMS has no authority to change operating IPPS payment parameters. MedPAC noted that ''analysis over the past decade has consistently shown that capital and operating IME adjustments have been set substantially above what can be empirically justified, leading to large disparities in financial performance under Medicare between teaching and nonteaching hospitals. The Commission in its March 2007 and 2008 reports to the Congress recommended that the operating IME adjustment be reduced from 5.5 percent to 4.5 percent per 10 percent increment in teaching intensity and that the funds obtained from reducing the IME adjustment be used to fund a quality incentive payment program.''

Response: We do not agree with many of the criticisms of our analysis and the conclusions that we drew from that analysis. A basic principle of prospective payment systems is that efficient providers should be able to realize positive margins from the payment structure. However, prospective payment systems are generally designed to pay at rates reflecting the costs of hospitals at average levels of efficiency. Under such a system, hospitals of above average efficiency would be expected to realize positive margins, while hospitals of less than average efficiency would be expected to realize negative margins. Therefore, the continuation of significant positive margins across a prospective payment system (or across classes of hospitals that receive specific adjustments) is an indication that the payment rates (or the adjustments to the rates) may be set at a level higher than necessary to cover the costs of efficient operation. Under such circumstances, we believe that it is appropriate to revise basic payment rates or payment adjustments, or both, to account for such evidence.

We also do not agree that it is necessary either to base our determination at this time about the appropriateness of continuing the capital IPPS IME adjustment on updated regression analysis, or to employ a total cost regression analysis in doing so. We adopted approaches on several issues in the initial development of the capital IPPS that were based on the premise that the capital and operating IPPS might eventually be merged into one system. The two systems have now operated separately for 15 years without any apparent prospect of integration in the near future. Therefore, we believe that it is appropriate under the current design of the capital and operating IPPSs to base proposals for payment policies under the capital IPPS on analysis that is confined to the data regarding the capital IPPS alone, and that total IPPS margins should not be the controlling factor in the analysis that we are now conducting. For this same reason, we do not agree with commenters who urged us to employ updated versions of the total cost regressions that were originally used to establish the payment adjustments under the capital IPPS. In the long run, we believe that it makes sense to base capital payment adjustments on total cost variations only if similar adjustments under the operating IPPS are also based on total cost regression analysis. We do not agree that, in the context of the current payment system, the capital IPPS should be treated as a component of a larger system embracing both the capital and operating IPPSs.

Another reason that we do not believe it to be necessary to replicate the original total cost regression analysis is that MedPAC has, in fact, recently conducted such an analysis. Regression analyses conducted by MedPAC over the last decade have shown that capital and operating IME adjustments have been set substantially above what can be empirically justified, leading to large disparities in financial performance under Medicare between teaching and nonteaching hospitals. In its March 2007 and 2008 reports to the Congress, MedPAC recommended that the operating IME adjustment be reduced from 5.5 percent to 4.5 percent per 10 percent increment in teaching intensity. In developing our proposal to eliminate the capital IPPS IME adjustment over a 3-year transition period, we did not take into account total Medicare IPPS margins, Medicare operating IPPS margins, or the relationship between the statutory operating IPPS IME adjustment and the empirically justifiable level of operating IPPS IME adjustment. As we have previously stated, we believe that it is appropriate under the current design of the capital and operating IPPS to base proposals for payment policies under the capital IPPS on analysis that is confined to the data regarding the capital IPPS alone. However, we also believe that it is difficult, in the light of the MedPAC analysis, to argue on the basis of a total cost regression analysis for the continuation of a capital IPPS IME adjustment. As we have previously observed, MedPAC noted in its comment on the proposed rule that its ''analysis over the past decade has consistently shown that capital and operating IME adjustments have been set substantially above what can be empirically justified, leading to large disparities in financial performance under Medicare between teaching and nonteaching hospitals. MedPAC also observed in its comment on our proposal to eliminate the capital IPPS IME adjustment, ''the reduction in IME payments from eliminating the capital IME adjustment would be smaller than the effect of the Commission's recommendation'' to reduce the operating IPPS IME adjustment.

Comment: Some commenters contended that, if CMS proceeds with

the elimination of the IME adjustment, reductions in hospital capital payments for teaching hospitals should be implemented in a budget neutral fashion, returning the funds to all hospitals as a group. Most of these commenters cited the recent record of negative overall Medicare inpatient margins as evidence that the proposed elimination of the capital IME adjustment is unwarranted. Some commenters also noted that overall capital IPPS margins have been declining and that several classes of hospitals have had significant negative capital IPPS margins in recent years, including nonteaching hospitals and rural hospitals. One commenter wondered how low capital IPPS margins must go before CMS concludes that capital payments are marginally justified. This commenter opposed not only the elimination of the capital IME adjustment, but also eliminating the adjustment without restoring the IME costs to the base rate.

Response: We believe that the evidence continues to support eliminating the capital IPPS IME adjustment in a way that provides savings for the Medicare program. It is the case that overall capital IPPS margins have declined somewhat in recent years, from 7.6 percent in FY 2003 to 5.3 percent in FY 2004, 3.9 percent in FY 2005, and 0.9 percent in FY 2006. It is also true that rural hospitals (−4.0 percent in FY 2005 and −9.3 percent in FY 2006) and nonteaching hospitals (−5.5 percent in FY 2005 and −9.1 percent in FY 2006) have experienced negative margins in recent years. However, over the period from 1998 through 2006, overall hospital margins have been a healthy 6.1 percent. Over the same period, rural hospitals and nonteaching hospitals have experienced capital IPPS margins that are only slightly negative: −1.3 percent and −0.8 percent, respectively. We believe that this experience indicates that the capital IPPS will remain adequately funded without redistributing the payments made under the IME adjustment to all hospitals, especially in the light of the legislative history that we have previously cited. Prior to the implementation of the capital IPPS, Congress mandated that the Medicare program pay only 85 percent of hospitals' inpatient Medicare capital costs. During the first 5 years of the capital IPPS, Congress also mandated a budget neutrality adjustment, under which the standard Federal capital rate was set each year so that payments under the system as a whole equaled 90 percent of estimated hospitals' inpatient Medicare capital costs for the year. Finally, Congress has twice adjusted the standard Federal capital rate (a 7.4 percent reduction beginning in FY 1994, followed by a 17.78 percent reduction beginning in FY 1998). On the second occasion in particular, the specific congressional mandate was ''to apply the budget neutrality factor used to determine the Federal capital payment rate in effect on September 30, 1995 * * * to the unadjusted standard Federal capital payment rate'' for FY 1998 and beyond. (The designated budget neutrality factor constituted a 17.78 percent reduction.) This statutory language indicates that Congress considered the payment levels in effect during FYs 1992 through 1995, established under the budget neutrality provision to pay 90 percent of hospitals' inpatient Medicare capital costs in the aggregate, appropriate for the capital IPPS. This statutory history thus suggests that the reduced margins experienced in recent years under the capital IPPS are not unwarranted. Therefore, we are maintaining our policy of eliminating the capital IPPS IME adjustment without increasing the capital IPPS rate to account for this change.

Comment: Many of the commenters further contended that the proposals do not take sufficient account of the cyclical nature of capital spending. These commenters pointed out that, under the design of the capital IPPS, hospitals were expected to reserve capital funds in anticipation of future capital needs, similar to how funded depreciation reserves had been used under the prior cost reimbursement system. These funds would permit future capital investment to be funded in part with equity financing rather than borrowing. Thus, it is only to be expected that hospitals would run positive margins during one phase of the capital cycle. Some regional hospital associations provided evidence intended to demonstrate that their hospitals have been experiencing positive margins because they are in a low-spending phase of their capital cycles. For example, one association representing a major metropolitan area submitted an extensive analysis, including data on margins and changes in unit cost and price, suggesting that its member hospitals are in a lower-spending phase of their capital cycle than other hospitals may be. Other commenters contended that, in order to account adequately for the capital spending cycle, it would be necessary to conduct an analysis over a much longer period, such as 20 years.

Response: We agree with commenters that the capital spending of hospitals tends to occur in cycles, with periods of higher capital investment followed by periods in which capital spending tends to be lower. As some of the commenters noted, we devoted considerable attention to the potential implications of this capital cycle in developing the original design of the capital IPPS. At that time, we decided not to build any specific feature into the system to account for capital cycles, on the grounds that hospitals ought to be able to manage their spending on the basis of the predetermined rates and adjustments under the capital IPPS, conserving funds during lower spending portions of the cycle in order to prepare for necessary capital expenditures later. We do not agree with those commenters who suggested that the existence of a capital spending cycle accounts for the persistently high margins for some classes of hospitals that we have observed over the period 1996 through 2006 nationally. There is no reason to suppose that there would be uniformity or regularity among hospitals in the length of time between major capital expenditures or the overall pattern of capital spending. To the degree that a capital cycle exists, it reflects the pattern of spending in individual hospitals or, in some cases, groups of hospitals where the pattern of spending is determined by factors such as common ownership, local regulation, or other factors. There is no uniform or regular capital cycle across IPPS hospitals generally or large classes of hospitals (for example, teaching hospitals) nationally. In any given year, the margins of hospitals generally, and of large classes of hospitals defined nationally, would reflect the experience of many hospitals in the lower spending portions of their capital cycles, and many other hospitals in the higher spending portions of their capital cycles. Therefore, the existence of the persistent positive margins that we identified cannot be explained on the basis of a ''capital cycle.'' For the same reasons, we do not believe that it is necessary to conduct an analysis of a period of 20 or more years, as suggested by some commenters, in order to account fully for the existence of a capital cycle. Our analysis covers almost half the 20-year period cited by some commenters, and we have no reason to believe that it is not a representative period in which hospitals across the system are at various phases of their capital cycles.

Comment: One commenter contended that the elimination of the loss on

recapture amount by the BBA of 1997 is skewing the calculation of the capital margins, which therefore should not be the basis for our proposals.

Response: We also do not agree with the commenter who suggested that the margins are skewed by the elimination of the provision to recognize losses or gains on sales. Prior to the BBA of 1997, the Medicare program recognized losses or gains on sales of capital assets in relation to the depreciation that the program for which the program paid under the cost-based payment system. Depreciation payments for the years prior to a sale were accordingly adjusted in the cost report submitted for the year of the sale: an additional payment was made for Medicare's portion of the depreciation on the asset if the hospital experienced a loss on the sale (indicating that prior payments for depreciation had been too low). Conversely, a portion of Medicare's payments for the depreciation of the asset was recaptured (by means of reducing payments to the hospital) in case of a gain on the sale (indicating that prior payments for depreciation had been too high). The BBA of 1997 eliminated recognition of such gains and losses on sales under Medicare's cost accounting rules, effective December 1, 1997. In light of the congressional elimination of this provision, we do not believe that it would be appropriate (even if it were possible) to take any account of the possible effects of this provision on the margin data that we have analyzed. However, it is worth noting that elimination of the provision to account for gains and losses on sales does not necessarily ''skew'' the margin data in the manner suggested by the commenter. Because the provision operated both to increase payments to account for losses on sales, and to decrease payments to account for gains on sales, the overall effect of the provision would not necessarily be (as implied by the commenter) to reduce the positive margins that are evident in the data.

VI. Changes for Hospitals and Hospital Units Excluded From the IPPS

A. Payments to Excluded Hospitals and Hospital Units

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers, which included rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals.

Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

In the FY 2009 IPPS proposed rule, we proposed that the percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs would be the percentage increase in the FY 2009 IPPS operating market basket, which was estimated to be 3.0 percent. Consistent with our historical approach, we proposed that if more recent data was available for the final rule, we would use the most recent data to calculate the IPPS operating market basket for FY 2009. For cancer and children's hospitals and RNHCIs, the FY 2009 rate-of-increase percentage that is applied to FY 2008 target amounts in order to calculate FY 2009 target amounts is 3.6 percent, based on Global Insight, Inc.'s 2008 second quarter forecast of the IPPS operating market basket increase, in accordance with the applicable regulations in 42 CFR 413.40.

IRFs, IPFs, and LTCHs were paid previously under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provided transition periods of varying lengths during which time a portion of the prospective payment was based on cost-based reimbursement rules under Part 413 (certain providers do not receive a transition period or may elect to bypass the transition period as applicable under 42 CFR Part 412, Subparts N, O, and P). We note that the various transition periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to 42 CFR Part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to 42 CFR Part 413. Likewise, for cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem amount under the IPF PPS. Therefore, for cost reporting periods beginning on or after January 1, 2008, no portion of an IPF PPS payment is subject to 42 CFR Part 413.

B. IRF PPS

Section 1886(j) of the Act, as added by section 4421(a) of Public Law 105–33, provided for a phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by IRFs for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with payments based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Public Law 106–113 to require the Secretary to use a discharge as the payment unit for services furnished under the PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of hospitals (referred to as IRFs), and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow IRFs, subject to the blended methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for IRFs, effective for cost reporting periods beginning on or after January 1, 2002. There was a transition period for cost reporting periods beginning on or after January 1, 2002, and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the adjusted Federal prospective payment rate determined under the IRF PPS.

C. LTCH PPS

On August 30, 2002, we issued a final rule in the **Federal Register** (67 FR 55954) establishing the PPS for LTCHs, effective for cost reporting periods beginning on or after October 1, 2002. Except for a LTCH that made an election under § 412.533(c) or a LTCH that is defined as new under § 412.23(e)(4), there was a transition period under § 412.533(a) for LTCHs. For cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate.

D. IPF PPS

In accordance with section 124 of Public Law 106–113 and section 405(g)(2) of Public Law 108–173, we established a PPS for inpatient hospital services furnished in IPFs. On November 15, 2004, we issued in the **Federal Register** a final rule (69 FR 66922) that established the IPF PPS, effective for IPF cost reporting periods beginning on or after January 1, 2005. Under the requirements of that final rule, we computed a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, days of the stay, and certain facility characteristics, including a wage index adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and COLAs for IPFs located in Alaska and Hawaii.

We established a 3-year transition period during which IPFs whose cost reporting periods began on or after January 1, 2005, and before January 1, 2008, would be paid a PPS payment, a portion of which was based on reasonable cost principles and a portion of which was the Federal per diem payment amount. For cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem payment amount.

E. Determining LTCH Cost-to-Charge Ratios (CCRs) Under the LTCH PPS

In general, we use a LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(c)(4)(iv)(B) for high cost outliers and short-stay outliers, respectively. (We note that, in some instances, we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(c)(4)(iv)(C), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(c)(4)(iv)(A).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single ''overall'' or ''total'' LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, generally, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2008 IPPS final rule with comment period, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and § 412.529(c)(4)(iv)(C)(*2*) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2007 update to the Provider-Specific File (PSF), we established a total CCR ceiling of 1.284 under the LTCH PPS effective October 1, 2007, through September 30, 2008. (For further detail on our methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48117 through 48121) and the FY 2008 IPPS final rule with comment period (72 FR 47403 through 47404).)

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on ''total'' IPPS CCR data. Under the LTCH PPS high-cost outlier policy at § 412.525(a)(4)(iv)(C) and the short-stay outlier policy at § 412.529(c)(4)(iv)(C), the fiscal intermediary (or MAC) may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) A new LTCH that has not yet submitted its first Medicare cost report (for this purpose, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) a LTCH whose CCR is in excess of the LTCH CCR ceiling (as discussed above); and (3) any other LTCH for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary (or MAC) may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In the FY 2009 IPPS proposed rule (73 FR 23681), in accordance with § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and § 412.529(c)(4)(iv)(C)(*2*) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the December 2007 update to the PSF, we proposed establishing a total CCR ceiling of 1.262 under the LTCH PPS, effective for discharges occurring on or after October 1, 2008, and before October 1, 2009. In Table 8C of that same proposed rule, we presented the proposed LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2008, and before October 1, 2009. In the proposed rule, we stated that if more data became available before publication of the final rule, we would use such data to determine the final statewide average total CCRs for urban and rural hospitals under the LTCH PPS for FY 2009 using our established methodology described above.

In this final rule, in accordance with § 412.525(a)(4)(iv)(C)(2) for high-cost outliers and § 412.529(c)(4)(iv)(C)(2) for short-stay outliers, we are finalizing our proposal to use our established methodology to determine the LTCH total CCR ceiling (described above), based on the most recent complete IPPS total CCR data. Specifically, using data from the March 2008 update of the PSF, we are establishing a total CCR ceiling of 1.242 under the LTCH PPS, effective for discharges occurring on or after October 1, 2008, and before October 1, 2009.

In addition, in this FY 2009 IPPS final rule, in accordance with § 412.525(a)(4)(iv)(C) for high-cost outliers and § 412.529(c)(4)(iv)(C) for short-stay outliers, using our established methodology for determining the LTCH statewide average CCRs (described above), based on the most recent complete IPPS total CCR data from the March 2008 update of the PSF, we are establishing the LTCH PPS statewide average total CCRs for urban and rural hospitals that are effective for discharges occurring on or after October 1, 2008, and before October 1, 2009, presented in Table 8C of the Addendum to this final rule.

We note that, for this final rule, as we proposed and as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121), and as is the case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban, and, therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this final rule. In addition, as we proposed and as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in that same final rule, and as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there were no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2008. Therefore, for this final rule, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum to this final rule. As we also proposed and as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through 48121), in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, we use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We use this proxy because we believe that the CCR data on the PSF for Maryland hospitals may not be accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

F. Change to the Regulations Governing Hospitals-Within-Hospitals

On September 1, 1994, we published hospital-within-hospital (HwH) regulations to address inappropriate Medicare payments to LTCHs that were effectively units of other hospitals (59 FR 45330). There was concern that the LTCH HwH model was being used by some acute care hospitals paid under the IPPS as a way of inappropriately receiving higher payments for a subset of their cases. Moreover, IPPS-exclusion of long-term care ''units'' was and remains inconsistent with the statute.

Therefore, we codified the HwH regulations at 42 CFR 412.23 (currently at § 412.22(e)) for a LTCH HwH that is co-located with another hospital. A co-located hospital is a hospital that occupies space in a building also used by another hospital or in one or more separate buildings located on the same campus as buildings used by another hospital. The regulations at § 412.23(e) required that, to be excluded from the IPPS, long-term care HwHs must have a separate governing body, chief medical officer, medical staff, and chief executive officer from that of the hospital with which it is co-located. In addition, the HwH must meet either of the following two criteria: the HwH must perform certain specified basic hospital functions on its own and not receive them from the host hospital or a third entity that controls both hospitals; or the HwH must receive at least 75 percent of its inpatients from sources other than the co-located hospital. A third option was added to the regulations on September 1, 1995 (60 FR 45778) that allowed HwHs to demonstrate their separateness by showing that the cost of the services that the hospital obtains under contracts or other agreements with the co-located hospital or a third entity that controls both hospitals is no more than 15 percent of the hospital's total inpatient operating cost. In 1997, we extended application of the HwH rules at § 412.22 to all classes of IPPS excluded hospitals. Therefore, effective for cost reporting periods beginning on or after October 1, 1997, psychiatric, rehabilitation, cancer, and children's hospitals that are co-located with another hospital are also required to meet the ''separateness'' criteria at § 412.22(e). Various other changes to the HwH regulations have been made over the years.

In addition, a ''grandfathering'' provision was added to the regulations at § 412.22(f), as provided for under section 4417 of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33). This provision of the regulations allowed a LTCH that was excluded from the IPPS on or before September 30, 1995, and was a HwH, to retain its IPPS-excluded status even if the HwH criteria at § 412.22(e) could not be met, as long as the hospital continued to operate under the same terms and conditions as were in effect on September 30, 1995. Consistent with the grandfathering provision under the BBA, which applied to LTCHs, we extended the application of the grandfathering rule to the other classes of IPPS-excluded hospitals that are HwHs but did not meet the criteria at § 412.22(e). (We subsequently expanded this provision to allow for a grandfathered hospital to make specified changes during particular timeframes.)

As we explained in the FY 2009 IPPS proposed rule (73 FR 23682), despite extending the grandfathering provision to all classes of IPPS-excluded hospitals and allowing other changes within that provision, it appears that there may be a gap in our regulations. There remain certain HwHs that may be unnecessarily restricted from expanding their bed size under current rules. These HwHs were IPPS-excluded State-owned hospitals that were co-located with a State-owned hospital and were both under the same State governance at the time the criteria at § 412.22(e) were implemented. These HwHs remain State-owned hospitals operating within a State-owned hospital and because of State law requirements, both hospitals remain under State governance. The HwH has retained the IPPS-excluded status by virtue of the grandfathering provision at § 412.22(f) that precludes changes in the terms and conditions under which they operate except under specific circumstances.

Where a State law defines the structure and authority of the State's agencies and institutions, and the State hospital is co-located with another hospital that is under State governance, each hospital may have control over the day-to-day operations of its respective facility and have separate management, patient intake, and billing systems and medical staff, as well as a governing board. However, State law may require that the legal accountability for the budgets and activities of entities operating within a State-run institution rests with the State. Therefore, the co-located State hospitals may also be governed by a common governing body.

Because of State law requirements, these HwHs cannot meet the existing HwH criteria at § 412.22(e)(1)(i) that requires the governing body of a co-located hospital to be separate from the governing body of the hospital with which it shares space. Under the HwH rules, a HwH's governing body may not be under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

Currently, there are State HwHs in these types of arrangements that have been able to retain their IPPS-excluded status solely because of the grandfathering provision in § 412.22(f). These HwHs were IPPS-excluded even before the HwH criteria were implemented and remain IPPS-excluded HwHs only as long as they continue to meet the requirements specified under § 412.22(f)(1), (f)(2), and (f)(3), which means that these HwHs cannot increase their bed size without losing their IPPS-excluded status under the grandfathering provisions (§ 412.22(f)). Moreover, if a grandfathered State-run HwH increased its bed size, it would be unable to qualify as an IPPS-excluded HwH under § 412.22(e) because it cannot meet the HwH criteria at § 412.22(e)(1)(i) as a result of State law requirements regarding its organizational structure and governance. These HwHs are precluded from the flexibility to expand their bed size, which is available to other HwHs whose organizational structure is not bound by State law.

As stated above, the organizational arrangements for these HwHs were in place even before the HwH regulations were adopted. To the extent the arrangements are required by State law, we believe they do not reflect attempts by entities to establish a nominal hospital and, in turn, seek inappropriate exclusions. As explained in the FY 2009 proposed rule, we also believe it is unnecessary to prevent State hospitals that were created before the HwH requirements, and that because of State statutory requirements cannot meet the subsequently issued separate governing body requirements, from being excluded from the IPPS if they exercised the same flexibility available to other IPPS-excluded HwHs to increase their bed capacity. Accordingly, as stated in the FY 2009 IPPS proposed rule, we proposed adding a provision to the regulations that would apply only to State hospitals that were already in existence when the HwH regulations were established. This provision would not apply to other State hospitals that would like to open as a HwH subsequent to the establishment of the HwH regulations in FY 1994, under an organizational structure the same as or similar to the one described in this section because these hospitals know, in advance of becoming a HwH, the requirements that must be met in order to be an IPPS-excluded HwH, unlike those hospitals that existed before the HwH regulations were established. Instead of opening the IPPS-excluded hospital co-located with another State hospital, it can open at another site in a manner that is consistent with the HwH regulations.

Accordingly, as proposed, we are adding a new paragraph (e)(1)(vi) to § 412.22 to provide that if a hospital cannot meet the criteria in § 412.22(e)(1)(i) solely because it is a State hospital occupying space with another State hospital, the HwH can nevertheless qualify for an exclusion from the IPPS if that hospital meets the other applicable criteria in § 412.22(e) and–

- Both State hospitals share the same building or same campus and have been continuously owned and operated by the State since October 1, 1995;
- Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and
- Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the IPPS through September 30, 2008.

We believe the criteria capture the segment of State-operated HwHs that were in existence prior to the HwH regulations and that are unable to meet the current HwH rules because of State law regarding governance. These HwHs were therefore in existence prior to the HwH regulations. We emphasize that we proposed allowing an exception to the criteria in § 412.22(e)(1)(i) only if the hospital that meets the criteria above cannot meet the separate governing body requirement because of State law. We are not providing similar treatment for hospitals that are not subject to State statutory requirements regarding governance but instead chose to organize in a manner that would not allow them to be an IPPS-excluded hospital that meets the HwH criteria at § 412.22(e)(1)(i) but were co-located prior to October 1, 1995, because these hospitals can revise the way they are organized to ensure that they meet the governance regulations at § 412.22(e).

Comment: All commenters, with the exception of one organization, strongly supported our proposal to allow HwHs that meet specific criteria to obtain their IPPS-excluded status if they are precluded from meeting the separate governing body criteria of the HwH regulations because of State law, but meet all other HwH requirements at § 412.22(e). However, two commenters requested that CMS also revise the rules governing satellite facilities of IPPS-excluded cancer hospitals that preclude bed-size expansion. The commenters believed that the same rationale that CMS provided for exempting children's hospitals from the expansion limitation for satellite facilities could be applied to cancer hospitals, and viewed the time it took for CMS to explain its rationale for not including cancer hospitals as evidence that belies the soundness of this decision. The commenters also contended that the provider-based rules that apply to satellite facilities would protect against inappropriate utilization, and that any financial effect on Medicare costs from removing the expansion restrictions for IPPS-excluded cancer hospitals would be negligible because there are only 11 IPPS-excluded cancer hospitals.

Response: We appreciate the support of the commenters for the HwH proposal. Regarding their request that we remove the expansion restrictions for satellite facilities of IPPS-excluded cancer hospitals, we thank the commenters for bringing their concerns to our attention. However, we did not propose any changes to the regulations for satellite facilities at § .22(h) and these comments are beyond the scope of our rule. Therefore, we are not addressing those particular comments. We refer the commenters to our FY 2007 IPPS final rule, appearing in the August 18, 2006 **Federal Register** (71 FR 48106 through 48115), that provides detailed comments and responses regarding our policy with respect to satellite facilities.

Comment: One commenter suggested an alternative approach to our proposal that would permanently grandfather IPPS-excluded cancer HwHs, allowing them to increase their bed size regardless of ownership and still retain their IPPS-excluded status. The commenter believed this would be more reflective of congressional intent regarding payment to IPPS-excluded cancer hospitals because Congress did not impose bed size limitations on these hospitals and that it would represent sound Medicare policy. The commenter also believed this approach would level the playing field for all IPPS-excluded cancer hospitals.

Response: Our proposal is only with respect to the HwH regulations at § 412.22(e) and not to the grandfathered provision at § 412.22(f). This comment is beyond the scope of our proposal.

Therefore, we are not responding to the comment in this rule.

Comment: One commenter had numerous objections to our proposal for State-operated HwHs. The commenter believed CMS was providing special treatment to a subset of grandfathered HwHs by allowing them to retain their grandfathered status, yet increase their bed size, which is contrary to its past actions regarding grandfathered HwHs; that there is no basis for our proposal; and that it is inconsistent with the legislative intent of the grandfathering provisions. The commenter also pointed out that all grandfathered HwHs could experience the need to add beds, not just State-owned HwHs. Furthermore, the commenter contended that States have the ability to create or change ownership arrangements in order to meet the HwH criteria.

Response: The commenter has misunderstood our proposal. A grandfathered State-owned HwH that is precluded from meeting the separate governance criteria in § 412.22(e) of the regulations because of State statutory requirements would lose its grandfathered status (in other words, it would no longer be exempt from the ''separateness and control'' criteria in § 412.22(e) if it added beds). However, under the proposal and our final policy, such a hospital could remain an HwH if it met all of the applicable HwH criteria in § 412.22(e) except for the separate governance requirement in § 412.22(e)(1)(i). This policy is consistent with our longstanding policy that grandfathered HwHs cannot add beds and remain grandfathered. However, HwHs have always remained, and continue to remain, free to add beds if they meet the applicable HwH criteria in § 412.22(e). Furthermore, we are not singling out a particular type of HwH such as an LTCH HwH. Rather, we proposed to allow any type of HwH that was in existence prior to the HwH regulations and that is precluded by State law from meeting the separate governance criteria if it is State-owned along with the hospital with which it is co-located, to be an HwH so long as it meets the remaining applicable HwH criteria in § 412.22(e). With respect to the commenter's point that all grandfathered HwHs, not just State-owned HwHs, could experience the need to add beds, as discussed above, we believe the commenter has misunderstood our proposed (and thus final policy) to mean that a State-owned grandfathered HwH is being given special treatment under our regulations to add beds and remain grandfathered. As explained previously, this is not the case, as these hospitals will lose their grandfathered status to the extent they add beds. In general, under our final policy, we are merely providing a very narrow exception so that hospitals that were in existence prior to the HwH regulations and that are operating under specific arrangements required by State law that prevent the hospitals from complying with the separate governance requirement in § 412.22(e) can continue to be HwHs so long as they meet the other ''separateness and control'' policies set forth in the regulations. Under this particular circumstance, we do not believe the hospitals are acting as nominal hospitals and therefore IPPS exclusion remains appropriate. Furthermore, just as we have broad authority under sections 1102 and 1871 of the Act to create the HwH regulations, we equally have broad authority under those provisions of the statute to create exceptions within those regulations as appropriate.

Comment: One commenter contended that being a State-owned provider is not an insurmountable obstacle to the separate governance criteria because States have the latitude to create or change governance rules to conform to the HwH criteria and that this is no more burdensome than promulgating regulations is to CMS. The commenter also stated that compliance with the HwH rules would be impossible for grandfathered HwHs and the hospital with which it shares space if they are commonly owned by religious organizations. The commenter indicated that these HwHs would not be able to change their organizational and governance structures to comply with the HwH provision because they would not be able to change the religion of the organizations of which they are a part.

Response: We disagree that religious organizations are precluded from complying with the separate governance criteria. In this type of situation, separate financial control could be created without changing religious control.

While not unequivocally disputing the commenter's assertion that States have the ability to change governance arrangements in order to comply with the HwH separateness criteria, we do know that the processes required to do so could involve a lengthy legislative process at the State level and be far more onerous than making an exception to one of the HwH criteria for a handful of HwHs through the rulemaking process. We believe that the time required for a State to make the changes that would allow State-owned facilities to meet the HwH criteria could be measured in terms of years rather than months. Furthermore, there are clearly situations, such as a State-run HwH co-located with a State-run university hospital, where it is to the benefit of all affected parties, including Medicare beneficiaries, to continue the relationship as it exists. This kind of co-located status provides a venue for training medical students and residents, as well as attracting physician scientists and promoting research efforts. Unlike the scenarios that prompted CMS to develop the HwH regulations, we see no deleterious effects occurring to the Medicare program from the adoption of our proposal. Therefore, after consideration of the public comments received and for the reasons explained previously throughout this section, we are adopting as final our proposal without change.

G. Report of Adjustment (Exceptions) Payment

Section 4419(b) of Public Law 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, generally, an excluded hospital or excluded unit of a hospital must file its cost report for a fiscal year in accordance with § 413.24(f)(2). The fiscal intermediary reviews the cost report and issues a Notice of Program Reimbursement (NPR). Once the hospital receives the NPR, if its operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment. After the fiscal intermediary receives the hospital's request in accordance with applicable regulations, the fiscal intermediary or CMS, depending on the type of adjustment requested, reviews the request and determines if an adjustment payment is warranted. This determination is sometimes not made until more than 6 months after the date the request is filed because there are times when the applications are incomplete and additional information must be requested in order to have a completed application. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustment payments that were processed by the fiscal intermediary or CMS during FY 2007.

The table below includes the most recent data available from the fiscal

intermediaries and CMS on adjustment payments that were adjudicated during FY 2007. As indicated above, the adjustments made during FY 2007 only pertain to cost reporting periods ending in years prior to FY 2006. Total adjustment payments given to excluded hospitals and units during FY 2007 are $9,862,685. The table depicts for each class of hospitals, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payments.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Psychiatric	13	$8,223,003	$3,756,831
Long-Term Care	1	4,962,747	584,150
Children's	2	1,082,666	824,308
Cancer	2	7,168,945	3,186,072
Religious Nonmedical Health			
Care Institution	11	3,619,026	1,511,324
Total			9,862,685

VII. Disclosure Required of Certain Hospitals and Critical Access Hospitals (CAHs) Regarding Physician Ownership (§ 489.2(u) and (v))

Section 1866 of the Act states that any provider of services (except a fund designated for purposes of sections 1814(g) and 1835(e) of the Act) shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files with the Secretary a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated into our regulations in 42 CFR part 489, subparts A and B.

In the FY 2008 IPPS final rule with comment period, we revised our regulations governing Medicare provider agreements, specifically § 489.20(u), to require a hospital to disclose to all patients whether it is physician-owned and, if so, the names of its physician owners (72 FR 47385 through 47387). In addition, we added a definition of physician-owned hospital at § 489.3. (Because the definition of physician-owned hospital at § 489.3 includes a critical access hospital, for ease of reference and readability, the term ''hospital,'' when used in the context of a physician-owned hospital, is intended to include a CAH.) The disclosure requirement in current § 489.20(u), as amended by the FY 2008 IPPS final rule with comment period, is applicable only to those hospitals with physician ownership; we neglected to include those hospitals in which no physician held an ownership or investment interest, but in which an immediate family member of a referring physician held an ownership or investment interest. However, it was always our intent to have consistency between the disclosure requirements and the physician self-referral statute and regulations. The physician self-referral statute and regulations, which recognize the potential for program and patient abuse where a financial relationship exists, are applicable to both a physician and the immediate family member of the physician. Therefore, in the FY 2009 IPPS proposed rule, we proposed to revise the language in § 489.3 to define a ''physician-owned hospital'' as a participating hospital in which a physician, or an immediate family member of a physician (as defined at § 411.351), has an ownership or investment interest in the hospital (73 FR 23683). In this final rule, we are finalizing our proposal. We believe that it is necessary to revise our definition of physician-owned hospital because a physician's potential conflict of interest occurs not only in those instances where he or she has a financial relationship in the form of an ownership or investment interest, but also where his or her immediate family member has a similar interest, and patients should be informed of this as part of making an informed decision concerning treatment.

Following publication of the FY 2008 IPPS final rule with comment period, we became aware that some physician-owned hospitals have no physician owners who refer patients to the hospital (for example, in the case of a hospital whose physician-owners have retired from the practice of medicine). In the FY 2009 IPPS proposed rule, we proposed to include in § 489.20(v) new language to provide for an exception to the disclosure requirements for a physician-owned hospital (as defined at § 489.3) that does not have any physician owners who refer patients to the hospital (and that has no referring physicians (as defined at § 411.351) who have an immediate family member with an ownership or investment interest in the hospital), provided that the hospital attests, in writing, to that effect and maintains such attestation in its files for review by State and Federal surveyors or other government officials (73 FR 23683). In this final rule, we are finalizing our proposal. We believe that requiring a hospital with no referring physician owners to disclose to all patients that it is physician-owned and to provide the patients with a list of the (nonreferring) physician owners would be an unnecessary burden on the hospital and of no value in assisting a patient in making an informed decision as to where to seek treatment. Similarly, we do not believe that it is useful to require a hospital to make such disclosures when no referring physician has an immediate family member who has an ownership or investment interest in the hospital.

In the FY 2009 IPPS proposed rule, we proposed to revise § 489.20(u) to specify that a physician-owned hospital must furnish to patients the list of owners and investors who are physicians (or immediate family members of physicians) at the time the list is requested by or on behalf of the patient (73 FR 23683). (Currently, § 489.20(u) provides that a physician-owned hospital must provide a list of its owners and investors to patients but does not specify when the list must be provided.) In this final rule, we are finalizing our proposal. We believe that it is critical that the patient receives the list of names of the relevant owners or investors at the time the request is made by or on behalf of the patient so that the patient may make a determination as to whether his or her admitting or referring physician has a potential conflict of interest. Also, furnishing the list at the time the request is made by the patient or on behalf of the patient is crucial to affording the patient an opportunity to make an informed decision before treatment is furnished at the physician-owned hospital.

In addition, we proposed to add new § 489.20(u)(2) to require a physician-owned hospital to require all physicians who are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients whom they refer to the hospital any ownership or investment interest in the hospital held by themselves or by an immediate family member (73 FR 23684). We proposed to require that physicians agree to make such disclosures at the time they refer patients to the hospital. In this final rule, we are finalizing our proposal. We believe that early notification of physician ownership or investment in the hospital is beneficial to the patient's decision-making concerning his or her treatment. Requiring a physician to notify patients of his or her ownership or investment interest at the time of the referral will afford patients the opportunity to discuss the physician's ownership or investment interest in the hospital and make a more informed decision.

In the FY 2009 IPPS proposed rule, we also proposed to revise § 489.53 to permit CMS to terminate the Medicare provider agreement if a physician-owned hospital fails to comply with the provisions of proposed § 489.20(u), discussed above, or if a hospital or CAH fails to comply with the requirements set forth in § 489.20(v) (which we proposed to redesignate as § 489.20(w) (73 FR 23684 through 23685). (In the FY 2008 IPPS final rule with comment period, we added a new provision at § 489.20(v) to require that hospitals and CAHs: (1) Furnish all patients written notice at the beginning of their inpatient hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week; and (2) describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital or CAH (72 FR 47387).) In this final rule, we are finalizing these proposals. We believe that these revisions are necessary to enforce the disclosure requirements set forth in § 489.20(v) and redesignated § 489.20(w).

We received approximately 20 public comments, most of which were supportive of our proposals. After consideration of the public comments received, we are adopting, with some modification, our proposals as final. The new provisions are codified in revised §§ 489.3, 489.20(u), (v), and (w), and 489.53. We stated in our proposal with respect to redesignated § 489.20(w), that we were proposing to revise § 489.53 to permit CMS to terminate the Medicare provider agreement of any hospital or CAH that fails to comply with the requirements set forth in proposed redesignated § 489.20(w) (73 FR 23684). This proposal was consistent with the current rule's application to all hospitals and CAHs that do not have a physician on-site 24 hours per day, 7 days per week. However, our proposed revisions to the regulatory text inadvertently were worded so as to imply that this enforcement action could be taken only in the case of a violation by a physician-owned hospital. In this final rule, we are amending the proposed regulatory text of § 489.53(c) by adding language so that the provision of paragraph (c) applies to all hospitals and CAHs (and not just physician-owned hospitals and CAHs) covered by redesignated § 489.20(w). In response to our solicitation of comments regarding whether hospitals and CAHs should educate patients about the availability of information regarding physician ownership under the proposed disclosure requirements, we are not adopting any such requirement at this time.

Comment: Most commenters strongly supported our proposals to: (1) Revise the definition of a physician-owned hospital to include hospitals in which an ownership interest is held by a physician or his or her immediate family member; (2) require hospitals to provide to the patient at the time the list is requested, by or on behalf of the patient, the names of each physician and immediate family member with an ownership interest in the hospital; (3) create an exception to the disclosure requirements for a physician-owned hospital (as defined at revised § 489.3) that does not have any physician owners who refer patients to the hospital (and that has no referring physicians (as defined at § 411.351) who have an immediate family member with an ownership or investment interest in the hospital); and (4) terminate the Medicare provider agreement of a hospital that does not comply with the disclosure requirements set forth in revised §§ 489.20(u)(1) and (u)(2), and redesignated § 489.20(w). One commenter contended that receiving the list of physician owners after admission occurs or even at the point of registration is too late to provide a meaningful period of discussion and reflection, and an opportunity for the patient to make a choice. The commenter asserted that the amendments and enhancements in the proposed rule will enable informed patient decisions and strengthen transparency in physician financial relationships that may conflict with a patient's best interest.

Response: We are adopting our proposals as final for the reasons stated above (see §§ 489.3, 489.20(u)(1) and (u)(2), (v), and (w), and 489.53).

Comment: One commenter, supportive of the proposed revisions regarding disclosure of a physician's, or his or her immediate family member's, ownership or investment interest in a hospital, recommended that we state in the final rule that physician financial interests in hospitals to which they refer patients is viewed positively by patients and that such interests should not be presumed to be improper or inappropriate.

Response: We are not adopting the language suggested by the commenter because we do not want to take any position as to whether or not patients are generally satisfied with physician ownership. With respect to the commenter's suggestion that we state affirmatively that physician ownership should not be presumed to be improper or inappropriate, we cannot adopt such language. As we stated in the FY 2008 IPPS final rule with comment period (72 FR 47388), we believe that the physician ownership disclosure requirement would permit an individual to make more informed decisions regarding his or her treatment and to evaluate whether the existence of a financial relationship, in the form of an ownership interest, suggests a conflict of interest that is not in the patient's best interest. We believe that our preamble language is consistent with the statute and there is no basis for incorporating the language recommended by the commenter. We believe patients will be able to make appropriate use of information disclosed by hospitals regarding ownership by physicians or their immediate family members. However, disclosure to patients, standing alone, does not adequately protect against inappropriate referrals by health care providers and practitioners.

Comment: Several commenters requested that we revisit our requirement in § 489.20(v) (now redesignated as § 489.20(w)) that a hospital that does not have a physician on the hospital premises 24 hours per day, 7 days per week, disclose this fact to all patients and describe how the hospital would treat patients with an emergency medical condition. The commenters suggested that the requirement be limited to inpatient admissions only and those outpatient visits that include surgery, other

invasive procedures, use of general anesthesia or other high-risk treatment. In addition, the commenters recommended that emergency department services be excluded. One commenter contended that the intended focus of the requirement was on physician-owned specialty hospitals, arguing that full-service community hospitals are part of a network of care and that there is no need for them to be subject to this requirement. Two commenters objected to the patient notification requirements on the basis that they are particularly burdensome to CAHs and small rural hospitals.

Response: The issues raised, and the suggestions made, by the commenters are outside the scope of the provisions of the proposed rule, as we did not propose to make any changes to the patient notification requirements in redesignated § 489.20(w). We will take into consideration, for purposes of possible future rulemaking, the comments that the notification requirements be limited to inpatient admissions only and certain outpatient visits, and that emergency department services be excluded. We note that we do not agree with the commenters who asserted that this requirement should be applied only to physician-owned specialty hospitals, for the reasons that we stated in the FY 2008 IPPS final rule with comment period (72 FR 47388), nor do we agree with the commenter that suggested the notification requirements should not apply to CAHs and small rural hospitals. It is important for consumers to be informed whether or not a physician is always on site, and how emergency medical conditions will be handled when no physician is available. In this regard, we note that there are no restrictions on the types of services CAHs and small rural hospitals may provide, as compared to other types of hospitals. Moreover, we do not believe the patient notification requirements are onerous for any type or size of hospital.

Comment: One commenter concurred that proposed enforcement through the possibility of termination of the individual physician's Medicare provider agreement for noncompliance is appropriate. A second commenter recommended that we provide clarification of what form of investigative and administrative procedures CMS will follow in order to provide hospitals and CAHs ''due process'' prior to terminating a Medicare provider agreement. A third commenter requested clarification of CMS' enforcement mechanism, and urged CMS to implement a progressive discipline system with termination of the Medicare provider agreement as the final, rather than the only, step.

Response: We believe that the commenters misunderstood either our proposal or our procedures for terminating Medicare provider agreements. We did not propose to take action against individual physicians as a result of violations of § 489.20(u) and redesignated § 489.20(w). (We note that physicians do not enter into Medicare provider agreements.) The requirements in § 489.20(u) and redesignated § 489.20 (w) apply to hospitals and CAHs and, thus, the termination action provided for in § 489.53(c) also applies to hospitals and CAHs. When CMS takes enforcement action pursuant to § 489.53, it follows the procedures described in section 3030 of the State Operations Manual. In brief, the CMS Regional Office will base its termination action on documentation that supports a finding that the hospital or CAH is not complying with the terms of the Medicare provider agreement, in this case § 489.20(u)(1) or (u)(2), or § 489.20(w). The CMS Regional Office provides a preliminary notice of termination to the hospital or CAH by letter, giving it time to correct the deficiency and come into compliance. If the hospital or CAH provides credible evidence in a timely manner that the cause for termination has been removed, CMS does not proceed with formal termination action. CMS may or may not require a survey of the hospital or CAH to confirm the correction of the deficient practice. If the hospital or CAH fails to come into compliance within the allotted timeframe, the CMS Regional Office issues a formal termination notice to the provider. The public is also provided advance notice of CMS' intent to terminate the Medicare provider agreement. The notice to the provider includes details of the hospital or CAH's appeal rights and information about where to file an appeal. This process is generally the same one used when CMS determines that a hospital or CAH fails to comply with a Medicare CoP, or with the requirements of the EMTALA.

Comment: Several commenters responded to our solicitation of comments regarding whether hospitals and CAHs should educate patients about the availability of information regarding physician ownership under the proposed disclosure requirements. One commenter questioned the utility of mandating additional signage or other educational materials. The commenter asserted that patients are already confronted with visual ''clutter'' in waiting/admitting rooms, and stated that any additional requirements to educate patients on ownership interests are redundant in light of the other disclosure proposals included in the FY 2009 IPPS proposed rule. A second commenter also expressed opposition to the proposal that hospitals educate patients about the availability of information regarding physician ownership. The commenter opposed the education requirement ''due to the lack of research that a patient's knowledge of physician ownership of a hospital affects a patient's choice of hospital,'' and asserted that the proposal would represent an unnecessary burden.

Response: At this time, we are not adopting a requirement that hospitals educate patients regarding physician ownership in hospitals. We believe that the provisions in §§ 489.20(u)(1) and (u)(2) will provide patients with prompt and sufficient notification of a physician's or immediate family member's ownership or investment interest in the hospital.

VIII. Physician Self-Referral Provisions (§§ 411.351, 411.352, and 411.354)

A. General Overview

1. Statutory Framework and Regulatory History

Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain ''designated health services'' (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS rendered as a result of a prohibited referral. The statute establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse. The current version of section 1877 of the Act, which applies to referrals for 11 DHS, has been in effect and subject to enforcement since January 1, 1995. The following is a chronology of relevant physician self-referral rules published in the **Federal Register**.

- January 9, 1998—*Proposed rule* (63 FR 1659)
- January 4, 2001—*Phase I of the final rulemaking*—(Phase I)—Final rule with comment period; effective January 4, 2002 (66 FR 856)
- March 26, 2004—*Phase II of the final rulemaking*—(Phase II)—Interim final rule with comment period; effective July 26, 2004 (69 FR 16054)

- July 12, 2007—*CY 2008 Physician Fee Schedule (PFS)*—Proposed rule (72 FR 38122, 38179). This proposed rule included the proposals regarding the following issues, which are finalized in this FY 2009 IPPS final rule:
  - Alternative Criteria for Satisfying Certain Exceptions
  - Percentage-Based Compensation Formulae
  - Unit-of-Service (Per-Click) Payments in Space and Equipment Leases
  - Services Furnished ''Under Arrangements''
  - Obstetrical Malpractice Insurance Subsidies
  - Burden of Proof
  - Ownership or Investment Interest in Retirement Plans
- September 5, 2007—*Phase III of the final rulemaking*—(Phase III)—Final rule; effective December 4, 2007 (72 FR 51012)
- November 15, 2007—*Final Rule delaying effective date* of ''stand in the shoes'' provisions for certain compensation arrangements (72 FR 64161)
- April 30, 2008—*FY 2009 Inpatient Prospective Payment System*—Proposed rule (73 FR 23683). Proposals regarding the following issues were included in the FY 2009 IPPS proposed rule and are finalized in this FY 2009 IPPS final rule:
  - ''Stand in the Shoes'' Provisions (physician ''stand in the shoes'' provisions were proposed for the first time in the FY 2009 IPPS proposed rule; entity ''stand in the shoes'' provisions were re-proposed from the CY 2008 PFS proposed rule)
  - Period of Disallowance
  - Disclosure of Financial Relationships Report (DFRR)

2. Physician Self-Referral Provisions Finalized in This FY 2009 IPPS Final Rule

In this final rule, we make various revisions to the physician self-referral regulations. Some of the revisions were proposed in the CY 2008 PFS proposed rule (72 FR 38122, 38179) and some of the revisions were proposed in the FY 2009 IPPS proposed rule (73 FR 23528, 23683). (We note that one of the proposals from the CY 2008 PFS proposed rule, our proposal to consider a DHS entity to stand in the shoes of an entity that it wholly owns or controls, was re-proposed in the FY 2009 IPPS proposed rule to require a DHS entity to stand in the shoes of an organization in which it holds a 100 percent ownership interest. We are not finalizing either proposal regarding the DHS entity ''stand in the shoes'' provisions, as discussed below in section VIII.B. of this preamble.) We are finalizing the proposals from the CY 2008 PFS proposed rule in this FY 2009 IPPS final rule. Many of the proposals from the two proposed rules are related, and finalizing them in one rulemaking will assist the public in understanding the final revisions to the regulations and analyzing their integrated application to financial relationships between DHS entities and referring physicians. For example, in the CY 2008 PFS proposed rule, we proposed an alternative method for compliance with certain provisions of certain exceptions. In the FY 2009 IPPS proposed rule, we proposed to specify an outside limit on the period of disallowance for certain noncompliant financial relationships. Together, as finalized, these regulations provide guidance to parties to a financial arrangement who have failed to obtain a required signature on a written agreement. (See sections VIII.C. and VIII.D. of this preamble.)

In response to our proposals in the CY 2008 PFS proposed rule, several commenters asserted that we should further contemplate the issues with which we noted concern and propose revised regulatory provisions in the CY 2009 PFS proposed rule if we continue to believe that such revisions are necessary. We responded in the CY 2008 PFS final rule that we were not inclined to follow the commenters' suggestion regarding reproposal of the physician self-referral provisions in the CY 2009 PFS proposed rule. We expressed confidence that we have sufficient information, both from the commenters and our independent research, to finalize revisions to the physician self-referral regulations without the need for new proposals and additional public comment. However, given the number of physician self-referral proposals, the significance of the provisions both individually and in concert with each other, and the volume of public comments, in the interest of prudence, we did not finalize any of the proposals in the CY 2008 PFS final rule with comment period (except for the proposal for anti-markup provisions for diagnostic tests). We stated our intent to publish a final rule that addresses the following proposals: (1) Burden of proof; (2) obstetrical malpractice insurance subsidies; (3) unit-of-service (per-click) payments in lease arrangements; (4) the period of disallowance for noncompliant financial relationships; (5) ownership or investment interests in retirement plans; (6) ''set in advance'' and percentage-based compensation arrangements; (7) DHS entity ''stand in the shoes'' provisions; (8) alternative criteria for satisfying certain exceptions; and (9) services furnished ''under arrangements.'' We stated further that a measured, thoughtful approach to the final physician self-referral rules is critical, and that the future rulemaking would address the public comments and present a coordinated, comprehensive approach to accomplishing the goals described in the proposed rule, namely, minimizing the threat of program and patient abuse while providing sufficient flexibility to enable those who are parties to financial relationships to satisfy the requirements of, and remain in compliance with, the physician self-referral law and the exceptions thereto. Finalizing together the proposals from the CY 2008 PFS and the FY 2009 IPPS proposed rules is consistent with our outlined approach.

The following chart identifies the revisions to the physician self-referral regulations included in this final rule and indicates the rule in which the revisions were proposed.

FY 2009 IPPS final rule section	Issue/final rule	Rulemaking where proposed
VIII.B	''Stand in the Shoes'' Provisions	Physician ''stand in the shoes'' provisions—FY 2009 IPPS proposed rule DHS Entity ''stand in the shoes'' provisions—CY 2008 PFS proposed rule; re-proposed in FY 2009 IPPS proposed rule.
VIII.C	Period of Disallowance	Solicitation of comments in CY 2008 PFS proposed rule; Proposal in FY 2009 IPPS proposed rule.
VIII.D	Alternative Method for Compliance with Certain Exceptions.	CY 2008 PFS proposed rule.
VIII.E	Percentage-based Compensation Formulae	CY 2008 PFS proposed rule.

FY 2009 IPPS final rule section	Issue/final rule	Rulemaking where proposed
VIII.F	Unit-of-service ("Per-click") Payments in Lease Arrangements.	CY 2008 PFS proposed rule.
VIII.G	Services Provided "Under Arrangements"	CY 2008 PFS proposed rule.
VIII.H	Exception for Obstetrical Malpractice Insurance Subsidies.	CY 2008 PFS proposed rule.
VIII.I	Ownership or Investment Interest in Retirement Plans.	CY 2008 PFS proposed rule.
VIII.J	Burden of Proof	CY 2008 PFS proposed rule.

In reviewing and analyzing public comments, and revising the physician self-referral rules, we carefully consider the history and structure of section 1877 of the Act. We address in this final rule many of the industry's primary concerns, and believe that the regulatory revisions finalized here are consistent with the statute's goals and directives, and protect beneficiaries of Federal health care programs. We have endeavored to simplify the rules where possible and provide additional guidance in response to comments, as well as to reduce the burden on the regulated community by modifying exceptions created using the Secretary's authority under section 1877(b)(4) of the Act. Detailed descriptions of the proposals and regulatory revisions included in this final rule are found in sections VIII.B. through VIII.J. of this preamble and are not repeated in this general overview. However, we note the following issues of significance that are included in this final rule:

- The provisions regarding ownership or investment interests in retirement plans, burden of proof, and period of disallowance are finalized and effective October 1, 2008.
- Revisions to the physician ''stand in the shoes'' provisions require owners (other than titular owners) and permit non-owner physicians (and titular owners) to stand in the shoes of their physician organizations and address the application of the rules to the AMC exception. These regulations are effective October 1, 2008.
- We are not finalizing the DHS entity ''stand in the shoes'' provisions at this time.
- The proposal for an alternative method for compliance is finalized with a modified, narrow scope of application for missing signature requirements only, effective October 1, 2008.
- Percentage-based compensation formulae prohibitions are finalized with a narrower scope, specifically addressing the exceptions applicable to office space and equipment lease arrangements, with a delayed effective date of October 1, 2009.
- We are finalizing the proposal prohibiting certain unit-of-service (''per-click'') payments in lease agreements with a delayed effective date of October 1, 2009.
- Revisions to the definition of ''entity'' are finalized with a delayed effective date of October 1, 2009 (this proposal was referred to as ''services provided 'under arrangements' '').
- Revisions to the exception for obstetrical malpractice insurance subsidies permit parties to either comply with the anti-kickback statute safe harbor, or comply with revised requirements of § 411.357(r). The effective date of the revised exception is October 1, 2008.

3. Solicitations of Comments in the CY 2008 PFS and FY 2009 IPPS Proposed Rules

In the CY 2008 PFS proposed rule, we solicited comments regarding the necessity or appropriateness of revisions to the exception in § 411.355(b) for in-office ancillary services. We received hundreds of comments in response. We made no proposals regarding revisions to this exception in either the CY 2008 PFS or FY 2009 IPPS proposed rules; therefore, we are not finalizing revisions to the exception in this final rule. In the CY 2008 PFS proposed rule, we solicited public comments regarding the period of disallowance for noncompliant financial relationships and noted in the CY 2008 PFS final rule with comment period our intent to finalize it in a future rulemaking. We included a proposal on this issue in the FY 2009 IPPS proposed rule. We also included two solicitations of comments in the FY 2009 IPPS proposed rule—one requesting comments regarding the need for and possible structures for an exception to the physician self-referral prohibition for gainsharing arrangements, and one requesting comments regarding the applicability of the physician self-referral rules to physician-owned medical device and other companies and any revisions to the rules that might be necessary to address program integrity concerns. Because these were only solicitations of comments, we are not finalizing revisions to the physician self-referral regulations related to these solicitations, nor do we discuss here the comments that we received in response to the solicitations. We note that, following the close of the comment period for the FY 2009 IPPS proposed rule, in the CY 2009 PFS proposed rule, we proposed to establish an exception to the physician self-referral law for incentive payment and shared savings programs. We refer the reader to 73 FR 38548 for more information regarding the proposed exception.

B. ''Stand in the Shoes'' Provisions

1. Background

In the FY 2009 IPPS proposed rule, we proposed to revisit the ''stand in the shoes'' provisions issued in Phase III due to the potential widespread impact of the provisions, as well as the considerable industry interest in their application (73 FR 23685). As we stated there, we believe that a more refined approach to the ''stand in the shoes'' provisions would simplify the analysis of many financial arrangements and reduce program abuse by bringing more financial relationships within the scope of the physician self-referral law (such as certain potentially abusive arrangements between DHS entities and physician organizations that may not have met the definition of an ''indirect compensation arrangement''). In addition, we proposed to take a global approach to the ''stand in the shoes'' provisions, and considered whether to establish rules that deem a DHS entity to stand in the shoes of an organization in which it has an ownership interest or over which it exerts control.

a. Regulatory History of the Physician ''Stand in the Shoes'' Rules

The Phase III ''stand in the shoes'' rules included provisions under which referring physicians are treated as standing in the shoes of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements in

§ 411.354 (72 FR 51026 through 51030). In Phase III, a ''physician organization'' was defined at § 411.351 as ''a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352.'' Therefore, under this definition, when determining whether a direct or indirect compensation arrangement exists between a physician and an entity to which the physician refers Medicare patients for DHS under the Phase III provisions, the referring physician stands in the shoes of: (1) Another physician who employs the referring physician; (2) his or her wholly-owned professional corporation (''PC''); (3) a physician practice (that is, a medical practice) that employs or contracts with the referring physician or in which the physician has an ownership interest; or (4) a group practice of which the referring physician is a member or independent contractor. The referring physician is considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands.

The industry responded to the ''stand in the shoes'' provisions of Phase III with concern as to how the provisions would apply to certain stakeholders. Academic medical centers (''AMCs''), integrated tax-exempt health care delivery systems, and their representatives, expressed concern about compensation arrangements involving ''mission support payments'' and ''similar payments'' (''support payments''). The stakeholders asserted their view that certain payments did not previously trigger application of the physician self-referral law but, after Phase III, needed to satisfy the requirements of an exception. According to these stakeholders, support payments previously were analyzed under the rules regarding indirect compensation arrangements and, in their view, would have been permitted. After Phase III, in their view, it is unlikely that support payments could satisfy the requirements of an available exception, given the nature of support payments; that is, support payments usually are not tied to specific items or services provided by the faculty practice plan (FPP) (or group practice within an integrated health care delivery system), but rather are intended to support the overall mission of the AMC or maintain operations in an integrated health care delivery system. For this reason, they asserted that support payments likely would not satisfy the requirement, present in many exceptions, that the compensation be fair market value for items or services provided. Similarly, some stakeholders raised concerns about support payments made from FPPs to AMC components. We noted that, although AMCs are free to use the exception for services provided by an AMC in § 411.355(e) (which would protect support payments made among AMC components if all of the conditions of the exception are met), industry stakeholders explained that many AMCs do not use the exception, preferring instead to rely on other available exceptions and the rules regarding indirect compensation arrangements (especially prior to Phase III).

Following publication of the Phase III final rule, in order to have time to consider these concerns and develop a comprehensive response, we issued a final rule entitled ''Medicare Program; Delay of the Date of Applicability for Certain Provisions of Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III)'' (72 FR 64164) (''November 15, 2007 final rule'') that delayed the effective date of the provisions in § 411.354(c)(1)(ii), § 411.354(c)(2)(iv), and § 411.354(c)(3) for 12 months after the effective date of Phase III (that is, until December 4, 2008). That final rule was applicable only to certain compensation arrangements between physician organizations and entities. These arrangements included: (1) With respect to an AMC as described in § 411.355(e)(2), compensation arrangements between a faculty practice plan and another component of the same AMC; and (2) with respect to an integrated section 501(c)(3) health care system, compensation arrangements between an affiliated DHS entity and an affiliated physician practice in the same integrated section 501(c)(3) health care system. Shortly after the publication of the November 15, 2007 final rule, other industry stakeholders asserted that, in addition to section 501(c)(3) health care systems, most integrated health care delivery systems, including ones involving for-profit entities, make support payments. These stakeholders urged that any approach to addressing the impact of the Phase III ''stand in the shoes'' provisions on support payments and other monetary transfers within integrated health care delivery systems should have universal applicability that is not dependent on whether the system meets the definition of an AMC or has a particular status under the rules of the Internal Revenue Service.

In the FY 2009 IPPS proposed rule, we proposed two alternative ways to address the ''stand in the shoes'' issues described above. The first proposal offered a multi-faceted approach for revising the existing physician ''stand in the shoes'' rules in § 411.354(c), and provided two options for certain proposed elements. The second proposal involved leaving the Phase III ''stand in the shoes'' provisions as promulgated and creating a new exception using our authority under section 1877(b)(4) of the Act for nonabusive arrangements that warrant protection not available under existing exceptions. In this final rule, we are finalizing one of our physician ''stand in the shoes'' proposals with modification, but are not finalizing our proposals regarding the DHS entity ''stand in the shoes'' provisions or the conventions for applying the physician ''stand in the shoes'' provisions in concert with the DHS entity ''stand in the shoes'' provisions.

b. Summary of Proposed Revisions to the Physician ''Stand in the Shoes'' Rules

(1). Alternative 1: Amend the Phase III Physician ''Stand in the Shoes'' Provisions

Our first proposal included two options for revising the physicians ''stand in the shoes'' provisions. The first option under this proposal would have revised § 411.354(c)(2)(iv) to provide that a physician would be deemed not to stand in the shoes of his or physician organization if the compensation arrangement between the physician organization and the physician satisfies the requirements of the exception in § 411.357(c) (for *bona fide* employment relationships), the exception in § 411.357(d) (for personal service arrangements), or the exception in § 411.357(l) (for fair market value compensation). The first step in the analysis focused on the compensation that a referring physician receives from his or her physician organization. If the compensation arrangement satisfied the requirements of § 411.357(c), (d), or (l), the referring physician would be deemed not to stand in the shoes of the physician organization for purposes of applying the definitions of and provisions related to direct and indirect compensation arrangements in § 411.354(c). Arrangements between DHS entities and physician organizations whose physicians do not stand in their shoes could still create indirect compensation arrangements that would need to satisfy the requirements of the exception for

indirect compensation arrangements in § 411.357(p).

The second option under the proposal to revise the physician ''stand in the shoes'' provisions would have deemed physician owners of a physician organization to stand in the shoes of the physician organization. We solicited public comments on whether considering all physician owners of (or physician investors in) a physician organization to stand in the shoes of the physician organization, as they currently do under the Phase III ''stand in the shoes'' provisions, might be over-inclusive. We were concerned that a physician owner of a captive or ''friendly'' PC who has no right to the distribution of profits and similarly situated physician owners would have to stand in the shoes of their physician organizations even when their ownership interest is merely nominal (or titular) in nature and their compensation arrangement with the physician organization satisfies the requirements of one of the exceptions in § 411.357(c), (d), or (l). We also solicited comments on an approach under which only owners of a physician organization would stand in the shoes of that physician organization (in which case, a physician would not stand in the shoes of a physician organization unless he or she holds an ownership or investment interest; under this approach, whether a physician ''stands in the shoes'' would not depend on whether the physician's compensation arrangement with the physician organization satisfies the requirements of § 411.357(c), (d), or (l)).

Under the first proposal, we also proposed to revise § 411.354(c)(3)(ii) to clarify that the provisions of §§ 411.354(c)(1)(ii) and (c)(2)(iv) do not apply when the requirements of § 411.355(e) are satisfied; that is, a physician would not stand in the shoes of his or her physician organization (for example, a faculty practice plan) when his or her referral for DHS is protected under the exception in § 411.355(e) for services provided by an AMC. We also proposed a specific revision to the regulation in § 411.354(c)(2)(iv) (when a physician is deemed to ''stand in the shoes'') and sought public comment as to whether this policy related to AMCs is better achieved by revising § 411.354(c)(3) to delete the reference to applying the exceptions in § 411.355, and thereby providing that the ''stand in the shoes'' provisions do not apply where the prohibition on referrals is not applicable because all of the requirements of any of the exceptions in § 411.355 are satisfied. Finally, we proposed to revise § 411.354(c)(3)(ii) to provide that the provisions of § 411.354(c)(1)(ii) and (c)(2)(iv) do not apply when compensation is provided by a component of an AMC to a physician organization affiliated with that AMC through a written contract to provide services required to satisfy the AMC's obligations under the Medicare GME rules where the contract is limited to services necessary to fulfill the GME obligations as set forth in 42 CFR Part 413, Subpart F. We stated in the proposed rule that we may provide additional guidance on the application of the three elements of the definition of ''indirect compensation arrangement'' in the FY 2009 IPPS final rule. We solicited comments regarding ways in which we could ensure that the full range of potentially abusive arrangements between DHS entities and physician organizations are appropriately addressed in situations where physicians do not stand in the shoes of their physician organizations.

(2). Alternative 2: New Exception for ''Mission Support'' Payments; No Change to Phase III Physician ''Stand in the Shoes'' Provisions

The alternative proposal in the FY 2009 IPPS proposed rule that addressed the Phase III physician ''stand in the shoes'' provisions was to make no revisions to existing §§ 411.354(c)(1)(ii), (c)(2)(iv), and (c)(3) and, to the extent necessary to protect nonabusive arrangements, promulgate a separate exception using our authority under section 1877(b)(4) of the Act to create exceptions for arrangements that do not pose a risk of program or patient abuse. We solicited comments about this proposal, including whether such an exception should be limited to ''mission support'' payments, whether other specific types of payments or compensation arrangements should be eligible for such an exception, the types of parties that should be permitted to use the exception (for example, AMC components, physician practices), and the conditions that should apply to such an exception to ensure that a protected compensation arrangement poses no risk of program or patient abuse. We recognized that the term ''integrated health care delivery system'' is loosely used in the industry to describe a wide variety of systems, with varying degrees of actual integration, and that it may prove infeasible to craft a sufficiently bounded definition. Due to our concern that, in many circumstances, payment arrangements between components of ''integrated health care delivery systems,'' as well as payments from ''integrated health care delivery systems'' to physicians affiliated with those systems are susceptible to fraud and abuse, we sought public comment about defining a fully integrated health care delivery system, what types of compensation arrangements should be protected (for example, support payments), and what conditions should be included in an exception that would ensure no risk of program or patient abuse.

c. Summary of Proposed DHS Entity ''Stand in the Shoes'' Rules

In the CY 2008 PFS proposed rule (72 FR 38122), we proposed a corollary provision to the Phase III physician ''stand in the shoes'' provisions that addressed the DHS entity side of physician-DHS entity financial relationships. Specifically, we proposed to amend § 411.354(c) to provide that, where a DHS entity owns or controls an entity to which a physician refers Medicare patients for DHS, the DHS entity would stand in the shoes of the entity that it owns or controls and would be deemed to have the same compensation arrangements with the same parties and on the same terms as does the entity that it owns or controls. We solicited public comments as to whether and how we would employ a ''stand in the shoes'' approach for these types of relationships, as well as for other types of financial relationships. We did not finalize the DHS entity ''stand in the shoes'' provisions in the CY 2008 PFS final rule published in the **Federal Register** on November 27, 2007 (72 FR 66222, 66306). Ultimately, as explained in the FY 2009 IPPS proposed rule, we wanted to undertake a comprehensive approach to the ''stand in the shoes'' provisions that addresses both physicians and physician organizations, as well as DHS entities and other entities that they own or control.

In the FY 2009 IPPS proposed rule, we proposed a revision to § 411.354(a) to provide that an entity that furnishes DHS would be deemed to stand in the shoes of an organization in which it has a 100 percent ownership interest and would be deemed to have the same compensation arrangements with the same parties and on the same terms as does the organization that it owns. We sought public comments specifically as to whether we should consider a DHS entity to stand in the shoes of another organization in which the DHS entity holds less than a 100 percent ownership interest and, if so, what amount of ownership should trigger application of the DHS entity ''stand in the shoes'' provisions. We also sought comments as to whether we should deem a DHS entity to stand in the shoes of an organization that it controls (for

example, an entity would stand in the shoes of a nonprofit organization of which it is the sole member), noting that we would consider a DHS entity to control an organization if the DHS entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of the organization. Finally, we solicited comment as to what level of control should trigger the application of the entity ''stand in the shoes'' provisions.

We also proposed provisions outlining the conventions to use when applying both the physician ''stand in the shoes'' provisions and the DHS entity ''stand in the shoes'' provisions to a chain of financial relationships between a physician and a DHS entity. The proposed conventions were intended to ensure that at least one compensation arrangement remains between the DHS entity and the referring physician for purposes of analyzing the chain of relationships under the physician self-referral rules. No regulation text was proposed at the time regarding application of the physician and DHS entity ''stand in the shoes'' provisions.

2. Physician ''Stand in the Shoes'' Provisions

Although we received a few comment letters suggesting that we not finalize any of our proposals related to the physician ''stand in the shoes'' provisions, the majority of commenters supported our proposal to revise the existing provisions in § 411.354(c), which were finalized in Phase III (72 FR 51012). Some commenters supported finalizing both our proposed revisions to § 411.354(c) and a new exception to the physician self-referral prohibition for mission support payments. A few commenters urged us to abandon the Phase III ''stand in the shoes'' provisions and instead revise the definition of ''indirect compensation arrangement'' and the exception for indirect compensation arrangements in § 411.357(p) to address the concerns noted in Phase III and the FY 2009 IPPS proposed rule (72 FR 51028; 73 FR 23686 through 23687). In this final rule, we are finalizing revisions to the physician ''stand in the shoes'' provisions to deem a physician who has an ownership or investment interest in a physician organization to stand in the shoes of that physician organization. Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment) are not required to stand in the shoes of their physician organizations. In addition, we are permitting non-owner physicians (and titular owners) to stand in the shoes of their physician organizations and we are also clarifying that the physician ''stand in the shoes'' provisions in § 411.354(c) do not apply to an arrangement that satisfies the requirements of the exception in § 411.355(e) for AMCs. We are not finalizing our proposal regarding compensation arrangements between physician organizations and AMC components for the provision of services required to satisfy the AMC's obligations under the Medicare GME rules in 42 CFR Part 413, Subpart F. We address below the specific comments that we received in response to our proposals in the FY 2009 IPPS proposed rule.

Comment: The majority of commenters urged us to finalize simple, bright line rules for analyzing financial relationships involving DHS entities, physician organizations and the physicians that comprise those physician organizations. Although a large hospital association and those commenters adopting that association's comments asserted that the proposals were inconsistent with our stated goal of simplification, all of the commenters agreed that any final physician ''stand in the shoes'' rule should be guided by simplicity.

Response: We are finalizing revisions to the physician ''stand in the shoes'' provisions in § 411.354(c) that require only physician owners of a physician organization to stand in the shoes of that physician organization. Physicians with an ownership or investment interest that is titular in nature would not be deemed to stand in the shoes of their physician organizations. (We describe what we mean by ''titular'' ownership below.) We believe that this approach offers the best option for achieving our goal in this rulemaking of simplifying the analysis of many financial arrangements. We are also permitting, but not requiring, non-owner physicians (including titular owners) to stand in the shoes of their physician organizations. We discuss in more detail below the application of the physician ''stand in the shoes'' provisions included in this final rule.

Comment: One commenter suggested that we withdraw its proposals regarding the physician and DHS entity ''stand in the shoes'' provisions and issue a separate proposed rule that provides greater clarity and detail regarding appropriate financial arrangements between physicians and academic medical centers (AMCs) and integrated health care delivery systems regarding mission services that benefit all patients. Several other commenters submitted identical comments urging us to review all of our outstanding proposals and develop one integrated package of proposals in the future.

Response: We are not, as the first commenter suggested, withdrawing the proposals contained in the FY 2009 IPPS proposed rule and issuing a separate proposed rule regarding the application of the ''stand in the shoes'' rules with respect to mission support payments. As we stated in the FY 2009 IPPS proposed rule, we proposed and solicited comments regarding revisions to the physician ''stand in the shoes'' rules in order to revisit, with public input, the physician ''stand in the shoes'' regulatory scheme (73 FR 23685). Our intent was not merely to address the alleged problems that result from the application of the physician ''stand in the shoes'' rules to mission support payments. Further, it is not our intention, now or in the future, to regulate financial relationships between DHS entities and referring physicians by making exceptions to rules or exceptions within existing exceptions simply in response to the complaints or concerns of the industry. With respect to the other commenters' suggestions, we note that, with the exception of our proposal in the CY 2009 PFS proposed rule for a new exception for incentive payment and shared savings programs (73 FR 38548), we have considered all of the outstanding proposals for this final rule, both standing alone and in concert with each other, and we are finalizing a set of rules that are well-integrated and designed to be consistent.

Comment: Some commenters urged us not to finalize any of the proposals and, instead, ''plot out a more comprehensive approach to the larger issue of compliant physician relationships.''

Response: As noted above, we are finalizing with modification our proposal regarding the physician ''stand in the shoes'' provisions in § 411.354(c). We continually review our regulations to ensure that they serve to protect the Medicare program and its beneficiaries from program or patient abuse, and may, in a future rulemaking subject to notice and public comment, propose further revisions to our regulations to address program integrity concerns as they arise.

Comment: Many commenters supported the proposal to revise the physician ''stand in the shoes'' provisions to deem only physician owners of a physician organization to stand in the shoes of the physician organization. Most of these commenters

also urged us to not deem a physician to stand in the shoes of his or her physician organization if the physician's ownership interest is titular only. Commenters asserted that: (1) This approach is the most straightforward, least intrusive approach, and provides the clearest standard for analysis; (2) because non-owners generally have no control over the financial relationships between their employers and providers of DHS, it would be inappropriate to hold them accountable for financial relationships that may violate the physician self-referral prohibition; and (3) an ownership interest that is truly titular only will not result in any of the financial risks or rewards to the physician (for example, dividends, tax benefits, proceeds of sale, and other returns on investment) typically associated with ownership and investment interests. One commenter contended that a physician organization's non-owner physician employees and contractors are likely to have compensation arrangements based on fair market value and are highly unlikely, if ever, to benefit from the infusion of capital into (or a mission support payment to) the physician organization.

Response: We agree that the best approach for our physician ''stand in the shoes'' rules is to require a physician with an ownership or investment interest in his or her physician organization to stand in the shoes of the physician organization, excluding from the application of the rule any physician whose ownership interest is merely titular in nature. (We describe in the response to the next comment what we mean by a ''titular'' ownership interest.) We are permitting non-owner physicians (and titular owners) to stand in the shoes of their physician organizations. We do not agree with the last commenter's assertions that a physician organization's non-owner (and titular-owner) physician employees and contractors necessarily are likely to have compensation arrangements based on fair market value and that they are highly unlikely, if ever, to benefit from the infusion of capital into (or a mission support payment to) the physician organization. To the contrary, we are aware of situations where non-owner physician employees and contractors have compensation arrangements that are not based on fair market value and benefit from payments made to their physician organizations from entities to which the physician employees and contractors refer patients for DHS. We remain concerned about such compensation arrangements. (We note that the rules regarding indirect compensation arrangements would apply to these arrangements.) In addition, depending on the circumstances, non-fair market value compensation arrangements potentially implicate the Federal anti-kickback statute (section 1128B(b) of the Act) (the ''anti-kickback statute'') and False Claims Act.

Comment: Most commenters asserted that a physician whose ownership or investment interest in a physician organization is merely titular in nature should not be deemed to stand in the shoes of his or her physician organization. Some of these commenters added the caveat that the titular owner should not stand in the shoes of his or her physician organization only where his or her compensation arrangements with the physician organization satisfy the requirements of an applicable exception. One commenter suggested that nominal, or titular, ownership would include any situation in which a physician's ownership interest does not afford the physician any ''material'' right to receive profits from the physician organization's compensation arrangement with the DHS entity.

Response: We are revising § 411.354(c)(1)(ii) and (c)(2)(iv) to specify that we do not deem a physician to stand in the shoes of his or her physician organization if the physician's ownership interest in that physician organization is titular in nature, as described in § 411.354(c)(3)(ii)(C). We consider an ownership or investment interest to be titular where the physician is not able or entitled to receive any of the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment. We do not believe that ''nominal'' or ''titular'' ownership should be decided based on whether a physician has a ''material'' right to receive profits from the physician organization's compensation arrangement with the DHS entity, but rather any right to the financial benefits through ownership or investment. In the interest of establishing a bright-line rule regarding when a physician stands in the shoes of a physician organization, we are not finalizing, as some commenters suggested, a requirement that the compensation from a physician organization to a titular owner of that physician organization must satisfy the requirements of an applicable exception to avoid application of the physician ''stand in the shoes'' rules in § 411.354(c). Titular owners are not required to stand in the shoes of their physician organizations.

Comment: Many commenters expressed concern regarding the application, if finalized, of our proposal that all physicians would stand in the shoes of their physician organizations except a physician whose total compensation from his or her physician organization for the provision of professional physician services satisfied the requirements of the exceptions in § 411.357(c), (d) or (l). Commenters noted that it is difficult for DHS entities to know of ''downstream'' financial relationships between physician organizations and physicians. Moreover, hospitals and other DHS entities have no control over such relationships. To address these concerns, one commenter urged us to permit a DHS entity to rely on information provided by the physician organization or physician regarding the status of physicians as owners, titular owners, or employees or contractors. Another commenter urged us to not require the DHS entity to investigate the relationships between the physician organization and its physicians if the arrangement between the DHS entity and the physician organization satisfies the requirements of a direct exception.

One commenter argued that the final physician ''stand in the shoes'' provisions should permit DHS entities to assess the availability of an exception by considering the compensation payable by the DHS entity, rather than make the availability of an exception dependent on internal compensation decisions made by a physician group of which the DHS entity may have some knowledge, but over which the DHS entity has no control. This commenter suggested that we permit a DHS entity to assume that the physician organization has physician owners, essentially permitting a DHS entity to ''opt into'' the application of the physician ''stand in the shoes'' rules, even if the rules would not actually apply to the compensation arrangement between the DHS entity and the physician organization. A different commenter suggested that we make the direct exceptions applicable where a physician organization has a financial relationship with a DHS entity, similar to the manner in which direct exceptions are applicable where a physician's immediate family member has a financial relationship with a DHS entity.

Response: We recognize the limitations described by the commenters in regard to the proposed alternative approach. As discussed above, we are not finalizing this

approach. Rather, we are finalizing an approach in which physician owners stand in the shoes of their physician organizations (with a narrow exception for titular owners). We believe that this approach comports with the commonsense understanding of physician relationships and is easier to apply in practice. It furthers our goal of addressing potential abuses and offers a clear, bright line rule. To further our goal of simplifying the analysis of compensation arrangements, we are also finalizing a provision that permits a physician who is not an owner or investor in his or her physician organization to stand in the shoes of the physician organization for purposes of applying the compensation exceptions. In essence, we are modifying the Phase III ''stand in the shoes'' provisions to permit, but not require, such physicians to stand in the shoes of their physician organizations. Thus, for example, employees and contractors may stand in the shoes of their physician organizations for purposes of applying the rules regarding direct and indirect compensation arrangements. If parties treat a physician as standing in the shoes of the physician organization, they would be required to satisfy the requirements of one of the exceptions for direct compensation arrangements, which generally contain additional or stricter requirements, such as a minimum 1-year term and compensation that is ''set in advance.'' Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. Therefore, in order to satisfy the requirements of an exception in § 411.357 for direct compensation arrangements, the parties would consider whether the referrals between the DHS entity and the physician satisfy the applicable requirements of an exception. This approach is consistent with our longstanding view that parties are entitled to use any available exception of which they satisfy all of the applicable requirements. We believe that compliance with an exception for direct compensation arrangements, as opposed to compliance with the exception for indirect compensation arrangements or no exception at all if the arrangement did not meet the definition of ''indirect compensation arrangement,'' would safeguard against program and patient abuse. We have revised § 411.354(c)(3)(ii), accordingly.

Although not raised by this commenter, we recognize that many arrangements that, prior to Phase III, would have met the definition of ''indirect compensation arrangement'' and been required to satisfy the requirements of the exception in § 411.357(p) have been restructured (or initially structured) to comply with an exception for direct compensation arrangements in § 411.355 or § 411.357 as required under the Phase III ''stand in the shoes'' provisions that went into effect on December 4, 2007. Arrangements that were not direct compensation arrangements and that would not have been indirect compensation arrangements under the provisions in § 411.354(c) prior to Phase III have similarly been restructured to comply with an exception for direct compensation arrangements as required under Phase III. The revisions to § 411.354(c)(3)(iii) make it clear that such arrangements do not need to be restructured to comply with the revised physician ''stand in the shoes'' rules finalized in this rulemaking. In addition, the new ''stand in the shoes'' provisions in § 411.354(c)(1)(iii) and (c)(2)(iv)(B) that permit non-owners to stand in the shoes of their physician organizations should also address situations in which non-owner physicians have been standing in the shoes of their physician organizations pursuant to the Phase III ''stand in the shoes'' provisions. They may continue to do so.

Comment: A few commenters suggested that we adopt more than one of our proposals. One of these commenters suggested that doing so would permit the parties to a compensation arrangement to structure their arrangement to fit into the best option available under applicable State laws and existing corporate structures. Another commenter argued that, because, in its opinion, each proposal has its benefits, but also its limitations, we should adopt both and permit parties to choose their method for complying with the physician self-referral statute. We assume that, by stating ''each proposal,'' this commenter was urging us to revise § 411.354(c) and also issue a new exception for mission support payments.

Response: We believe that finalizing more than one proposal, or revising § 411.354(c) and issuing an exception for mission support payments, would add complexity and uncertainty, rather than simplify the physician ''stand in the shoes'' rules, and we decline to adopt these commenters' suggestions.

Comment: Three commenters suggested that, if we finalize revisions to § 411.354(c) to exempt a physician from standing in the shoes of his or her physician organization if his or her total compensation from that physician organization satisfies the requirements of § 4111.357(c), (d) or (l), we expand the list of exceptions to all compensation exceptions. Another commenter suggested that we include in this ''carveout'' (or list of exceptions, compliance with which would not require a physician to stand in the shoes of his or her physician organization) the exception for in-office ancillary services in § 411.355(b).

Response: We are not finalizing this proposal and, in light of our final rule, the commenters' concerns as we understand them are moot.

Comment: One commenter suggested an adjunct proposal to our proposal that a physician would not stand in the shoes of a physician organization if the physician's compensation arrangement satisfies the requirements of an exception in § 411.357(c), (d) or (l). Specifically, the commenter suggested that we not deem a physician to stand in the shoes of his or her physician organization if: (1) The physician is an employee or contractor of a group practice that satisfies the conditions of § 411.352 (the group practice rules) and the physician's referrals to the group practice are protected under the exception for in-office ancillary services in § 411.355(b); and (2) the physician's compensation from the group practice is fair market value for the services provided to the group practice.

Response: As discussed above, we are not finalizing the proposal on which the commenter's suggestions are based. We believe that this final rule addresses the commenter's concerns, albeit in a different manner than requested by the commenter.

Comment: One commenter urged us to revise the AMC rules in § 411.355(e) to allow faculty practice plans (FPPs) to share profits with their physicians in the same manner that group practices are permitted under § 411.352. The commenter asserted that, without such a revision, if a FPP shares profits, in addition to or in lieu of providing a productivity bonus to the physicians in the FPP (as could a group practice), the exception in § 411.355(e) for AMCs cannot be satisfied because the compensation to the FPP physicians would take into account the volume or value of referrals or other business generated by the referring physician within the AMC. The commenter asserted that an alternative under which a physician would stand in the shoes of his or her physician organization unless the physician's total compensation from that physician organization satisfies the requirements of § 411.357(c), (d) or (l)

would have the effect of prohibiting FPPs from compensating their physicians like group practices.

Response: The commenter's suggestion that we revise § 411.355(e) is outside the scope of this rulemaking. We do not believe that revisions to the exception in § 411.355(e) for AMCs are warranted or necessary, and we decline to adopt the commenter's recommendation. As discussed below, we are finalizing our proposal not to apply the physician ''stand in the shoes'' provisions within the context of the exception in § 411.355(e). Therefore, FPP physicians are not required to stand in the shoes of the FPP if the requirements of § 411.355(e) are satisfied. If a FPP elects to compensate its physicians in such a way as to preclude compliance with the exception for AMCs, the FPP should be treated like any other group practice under § 411.352 and would not be afforded the special protection for physician referrals within an AMC that is provided under § 411.355(e).

Comment: A few commenters suggested that we make permanent the current ''moratorium'' on the physician ''stand in the shoes'' rules included in the November 15, 2007 final rule. Some of these commenters suggested revisions or expansions to the scope of the ''moratorium.''

Response: Given our decision to finalize revisions to the physician ''stand in the shoes'' rules in this final rule, which will be effective October 1, 2008, it is unnecessary to continue or to make permanent the delay in effective date of the Phase III physician ''stand in the shoes'' provisions or to expand the delay in effective date to additional compensation arrangements. We believe that, taken in concert, the revisions we are finalizing address most, if not all, of the concerns brought to our attention by industry stakeholders and which the November 15, 2007 final rule was intended to address. This final rule does not affect the continued applicability of the November 15, 2007 final rule. The delay in effective date of the Phase III physician ''stand in the shoes'' provisions is through December 4, 2008. The provisions of this final rule are effective October 1, 2008 and, on that date, except as provided in § 411.354(c)(3)(iii), compensation arrangements must comply with the requirements of the revised regulations set forth in this final rule.

Comment: Two commenters asserted that a new exception for mission support payments holds the most promise for solving the problem of mission support payments. A few commenters provided specific suggestions for requirements that we should include in such an exception. Other commenters opposed the issuance of an exception for mission support payments, noting that establishing an accurate definition for ''mission support payments'' would be extremely challenging and may well result in complexities that will defeat the purpose of developing a simplified regulatory scheme, such an exception would be unworkable, and it is unlikely that an exception could be crafted to permit the appropriate range of nonabusive arrangements. Another commenter noted that an attempt to define the universe of nonabusive arrangements would be limiting and quickly obsolete.

Response: We agree with the commenters that opposed the issuance of an exception for mission support payments, as well as with the reasons stated by those commenters regarding the difficulty in crafting a useful exception that is easy to understand and apply and that does not pose a risk of program or patient abuse. We are not finalizing a separate exception for compensation arrangements involving ''mission support'' or similar payments.

Comment: A few commenters recommended that, instead of finalizing revisions to the physician ''stand in the shoes'' rules, we revise the rules regarding indirect compensation arrangements, as this would address perceived problems in States that enforce a prohibition on the corporate practice of medicine. One of these commenters suggested that we define ''indirect compensation arrangement'' to include arrangements between a DHS entity and an entity with which the physician has a direct financial relationship (the ''intervening entity'') that provide for a fixed amount of compensation in excess of fair market value compensation for the items and services provided by the intervening entity. Another commenter suggested that we revise the definition of ''indirect compensation arrangement'' to establish an objective test for whether compensation takes into account the volume or value of referrals or other business generated for a DHS entity; that is, the intent of the parties should not be used as a basis for finding that the arrangement took referrals into account.

Response: We decline to revise the definition of ''indirect compensation arrangement'' as suggested by these commenters. Specific proposals and regulatory text for revisions to our rules regarding indirect compensation arrangements (other than revisions to the physician ''stand in the shoes'' provisions proposed in the FY 2009 IPPS proposed rule and subject to public comment), were not included in the FY 2009 IPPS proposed rule, and we believe that any such revisions would benefit from appropriate vetting through notice and public comment. With respect to the specific comment regarding above-fair market value compensation arrangements, we note that the suggested approach does not resolve the perceived problems brought to our attention following the publication of Phase III and the original physician ''stand in the shoes'' rules. The last commenter's suggestion that we revise the definition of ''indirect compensation arrangement'' to incorporate a test for whether compensation takes into account the volume or value of referrals or other business generated for a DHS entity is outside the scope of this rulemaking.

Comment: One commenter urged us to repeal the physician ''stand in the shoes'' provisions made final in Phase III and, instead, revise the definition of ''indirect compensation arrangement'' to address program integrity concerns. (The commenter did not provide suggested regulatory text or language for a revised definition.) The commenter asserted that revisions to the definition of ''indirect compensation arrangement'' could bring within the coverage of the physician self-referral rules those compensation arrangements that do not qualify as direct compensation arrangements and that previously may not have met the definition of ''indirect compensation arrangement,'' yet would not force indirect relationships to satisfy the more rigid requirements of the personal service arrangements exception (or, presumably, other exceptions for direct compensation arrangements). According to the commenter, this would be beneficial because indirect compensation arrangements, including those covered under a revised definition of ''indirect compensation arrangement,'' would need to satisfy the requirements of the exception in § 411.357(p), but would not be subject to the strict 1-year term and ''set in advance'' requirements in the exceptions for direct compensation arrangements. The commenter contended that the 1-year term and ''set in advance'' requirements are unworkable for contracts between DHS entities and large physician groups because compensation formulae employed in such arrangements require adjustments that cannot be anticipated at the commencement of the arrangement due to evolving patient care and community needs. The commenter offered suggestions for

revising the definition of ''set in advance.'' A second commenter echoed the concern regarding the impact on financial arrangements between DHS entities and physician organizations of the requirement in the direct compensation arrangement exceptions that compensation be ''set in advance.'' The second commenter urged us to permit parties to modify a compensation arrangement between a DHS entity and a physician organization prospectively for the balance of the existing term of the arrangement to reflect a change in services provided by the physician organization and its physicians if the change in compensation is limited to the modified services, represents fair market value for the actual change in services, and does not take into account the volume or value of referrals or other business generated between the parties.

Response: We decline to adopt the first commenter's suggestions regarding revisions to the definition of ''set in advance'' at 411.354(d)(1). However, we have reconsidered the position we stated in the Phase III final rule regarding our interpretation of the ''set in advance'' rules with respect to modification of the rental charges in an agreement for the lease of office space or equipment (and the compensation terms in an agreement for a physician's personal services) (72 FR 51044). There, in response to a comment seeking clarification whether the parties to an agreement for the rental of office space or equipment may amend the agreement during the first year of its term, we stated that

> Because rental charges, including the methodology used to calculate rental charges, must be 'set in advance,' as defined at § 411.354(d)(1), parties may not change the rental charges at any time during the term of an agreement. Parties wishing to change the rental charges must terminate the agreement and enter into a new agreement with different rental charges and/or other terms; however, the new agreement may be entered into only after the first year of the original lease term (regardless of the length of the original term). In addition, the new lease must be for a term of at least 1 year and must comply with all other criteria in the relevant rental exception.

(We noted also that personal service agreements may be amended in the same manner as agreements for the rental of office space or equipment (72 FR 51047).) We agree with the commenter that requiring compliance with an exception for direct compensation arrangements (as would be the case where a compensation arrangement exists between a DHS entity and a physician who stands in the shoes of his or her physician organization) imposes upon parties requirements not present in the exception for indirect compensation arrangements, including the 1-year term and ''set in advance'' requirements. We are sympathetic to the concerns of the commenter with respect to arrangements between DHS entities and physician groups that may require modification during the term of the arrangement. Moreover, in light of the revisions we are finalizing with respect to the use of percentage-based and per-click compensation formulae for determining rental charges for office space and equipment leases (see sections VIII.E. and VIII.F. of this preamble), we believe that an interpretation that permits amendments to an agreement between a DHS entity and a physician (or physician organization) during the term of the agreement is consistent with our mandate to safeguard against program or patient abuse and is consistent with our rules regarding compensation that is ''set in advance,'' provided that: (1) All of the requirements of an applicable exception are satisfied; (2) the amended rental charges or other compensation (or the formula for the amended rental charges or other compensation) is determined before the amendment is implemented and the formula is sufficiently detailed so that it can be verified objectively; (3) the formula for the amended rental charges does not take into account the volume or value of referrals or other business generated by the referring physician; and (4) the amended rental charges or compensation (or the formula for the new rental charges or compensation) remain in place for at least 1 year from the date of the amendment. We are taking the opportunity here to clarify that the rule regarding the amendment of arrangements between DHS entities and physicians (or physician organizations) applies to all of the exceptions for compensation arrangements in 42 CFR, Subpart J that include a 1-year term requirement for satisfying the exception.

Comment: Several commenters suggested that we repeal the existing physician ''stand in the shoes'' provisions, arguing that they are unnecessary. One commenter argued that the exception in § 411.357(p) for indirect compensation arrangements is better designed than the direct compensation arrangements exceptions to handle the types of complex contractual and business relationships between DHS entities and physician organizations. One commenter suggested that we clarify the basic analysis under the indirect compensation arrangements definition and exception without resorting to the physician ''stand in the shoes'' provisions. Another commenter suggested that a more focused and coherent approach could be achieved by proposing changes to the existing exception for indirect compensation arrangements.

Response: We are not repealing the physician ''stand in the shoes'' provisions in § 411.354(c). For the reasons discussed in Phase III, we continue to believe that these provisions are both appropriate and necessary to safeguard against program and patient abuse (72 FR 51027 through 51029). We discussed above our determination not to revise, at this time, the definition of ''indirect compensation arrangement.''

Comment: One commenter suggested that, given the serious consequences of failing to satisfy the ''set in advance'' requirement in many of the exceptions for direct compensation arrangements (which would apply if the compensation arrangement between a DHS entity and a physician organization is deemed to be a direct compensation arrangement between the DHS entity a physician in the physician organization), we allow parties subject to § 411.354(c)(1)(ii) and (c)(2)(iv) a ''60-day grace period'' that would permit them to consider compensation to be ''set in advance,'' even if the written agreement embodying the compensation arrangement is not signed by the parties until 60 days after the commencement of the services agreement. The commenter asserted that, as long as the ''grace period'' is limited to no more than 60 days, the parties could not use it to recalibrate compensation in a way that reflects the volume or value of referrals or other business generated between the parties.

Response: We are not revising the ''stand in the shoes'' provisions as requested by the commenter. We believe that new § 411.353(g), discussed below in section VIII.D. of this preamble, which provides an alternative method for compliance when parties fail to satisfy a signature requirement, should address some of the commenter's concerns. We note that nothing in the rules regarding compensation that is ''set in advance'' in § 411.354(d)(1) requires that signatures be present.

Comment: One commenter contended that analyzing the remaining relationships after ''collapsing'' physicians into their physician organizations (or entities into organizations that they own) may not yield the correct result. According to the commenter, if the financial relationship

that disappears is the direct compensation arrangement closest to the referring physician (as a result of applying the physician ''stand in the shoes'' rules), the ''stand in the shoes'' rules may actually invite abuse.

Response: As we read the commenter's analysis, it appears that the commenter is not considering the direct financial relationship between the physician and his or her physician organization which, wholly separate from the physician ''stand in the shoes'' provisions, must be analyzed for compliance with an applicable exception to the physician self-referral prohibition if the physician is to make referrals for DHS to the physician organization. It appears that the commenter misunderstood the application of the proposed conventions for our ''stand in the shoes'' rules and assumed that relationships between ''collapsed'' parties disappear and need not be analyzed for compliance with the physician self-referral law. The ''stand in the shoes'' provisions are applied for purposes of evaluating the relationship between a DHS entity and a referring physician when a physician organization is an intervening link in that chain of relationships and linked to the physician with no other intervening links between. Because we are not finalizing the DHS entity ''stand in the shoes'' provisions or the conventions for applying those provisions in concert with the physician ''stand in the shoes'' provisions, the commenter's concerns should be resolved.

Comment: One commenter responded to the solicitation of comments regarding arrangements that would not fall within the ''stand in the shoes'' provisions but might fall outside of the scope of the definition of ''indirect compensation arrangement'' and, thus, outside the scope of the physician self-referral law. The commenter noted that such arrangements would be subject to the Federal anti-kickback statute. The commenter also asserted that the current rules regarding indirect compensation arrangements allow much-needed flexibility in establishing nonabusive financial relationships that foster the provision of necessary health care services. The commenter urged us to exercise caution in restricting the rules regarding indirect compensation arrangements. According to the commenter, further revisions to the definition of, and limitations of, the exception for indirect compensation arrangements would likely create unintended consequences that, in turn, would require additional exceptions—the very type of complexity, in the commenter's view, that makes compliance with the physician self-referral rules increasingly difficult.

Response: As discussed above, we are not making changes to the definition of ''indirect compensation arrangement'' beyond what was proposed in the FY 2009 IPPS proposed rule with respect to the physician ''stand in the shoes'' provisions in § 411.354(c), nor are we revising the exception in § 411.357(p) to address the applicability of the physician self-referral law to compensation arrangements between DHS entities and referring physicians that involve intervening entities. However, as discussed below in sections VIII.E. and F. of this preamble, in this final rule, we are revising the exception in § 411.357(p) to address our concerns regarding indirect compensation arrangements for the lease of office space or equipment.

Comment: One commenter supported our proposal to clarify that the physician ''stand in the shoes'' provisions do not apply where all of the requirements of the exception in § 411.355(e) for AMCs are satisfied. The commenter noted that, if the exception in § 411.355(e) is not considered sufficient protection against program and patient abuse so as to require the application of the physician ''stand in the shoes'' provisions, virtually all mission support payments would be in danger of violating the physician self-referral prohibition.

Response: We are finalizing revisions to § 411.354(c)(3)(ii)(B), clarifying that the provisions of § 411.354(c)(1)(ii) and (c)(2)(iv)(A) do not apply when the requirements of § 411.355(e) are satisfied.

Comment: Three commenters supported our proposal to not apply the physician ''stand in the shoes'' provisions to a compensation arrangement between a physician organization and a component of an AMC for the provision to that AMC of only services required to satisfy the AMC's obligations under the Medicare GME rules in 42 CFR part 413, subpart F. Commenters stated that analysis under the rules regarding indirect compensation arrangements would be more appropriate for such arrangements, including arrangements under which a community physician organization services as a teaching site for the AMC's residents.

Response: We are not finalizing our proposal. Upon further review, we believe that existing exceptions (including the exceptions for *bona fide* employment relationships, personal service arrangements, fair market value compensation arrangements, and indirect compensation arrangements) provide adequate protection for arrangements between physician organizations and AMCs for GME-related services, provided that the overall arrangement is fair market value (which could include the value to the physician organization of the placement of the medical resident at the training site or other valuable consideration from the AMC) for legitimate services that are actually performed, and provided that all other requirements of an exception are satisfied. Hospitals are also free to contract directly with individual physicians, rather than physician organizations, for the oversight and training required under the Medicare GME and IME rules in order to avoid perceived or actual obstacles caused by the physician ''stand in the shoes'' rules. We note also that the final physician ''stand in the shoes'' provisions in § 411.354(c) require only physicians with an ownership or investment interest (other than titular owners) in a physician organization to stand in the shoes of that physician organization. As stated previously, we are permitting non-owners (and titular owners) to stand in the shoes of their physician organizations. To the extent that a compensation arrangement between a hospital and a physician organization to serve as a teaching site for the hospital's residents does not implicate the physician ''stand in the shoes rules'' (because the physician organization has no, or only titular, physician owners or investors), the rules regarding indirect compensation arrangements would apply.

We recognize industry stakeholder concerns that compensation to a physician organization that is paid in accordance with Medicare rules that require a hospital to pay ''all or substantially all'' of the costs of training a resident and which may be determined following completion of a hospital's cost report (and, thus, may require a reconciliation payment between the parties) may not satisfy the ''set in advance'' requirement included in many of the exceptions to the physician self-referral prohibition. However, a properly structured formula for the compensation to the community physician organization could meet an applicable ''set in advance'' requirement if it is determined at the commencement of the compensation arrangement, does not take into account the volume or value of referrals or other business generated between the parties, and satisfies the other requirements in § 411.354(d)(1).

Comment: One commenter suggested that we also suspend the application of the physician ''stand in the shoes''

provisions to compensation arrangements for the provision of services required to satisfy an AMC's obligations under the Medicare rules regarding indirect medical education (IME) in 42 CFR 412.105. Other commenters suggested that we extend this protection to all hospitals and not limit it to compensation arrangements between community physician organizations and components of an AMC. The commenters noted that non-AMC hospitals provide training for medical residents and must comply with the Medicare GME (and IME) rules, and contended that it is unfair to treat similarly situated hospitals differently.

Response: As discussed in response to the previous comment, we are not finalizing the proposal regarding the application of the physician ''stand in the shoes'' provisions to compensation arrangements for the provision of services required to satisfy Medicare GME requirements; thus, we are not making the revision suggested by the commenters.

3. DHS Entity ''Stand in the Shoes'' Provisions

Nearly all of the commenters who addressed the proposal to deem a DHS entity to stand in the shoes of an organization in which it has a 100 percent ownership interest opposed the proposal. The few commenters who provided ''conditional'' comments (in the event that we finalize the proposal) urged us to confine the DHS entity ''stand in the shoes'' provisions to 100 percent ownership interests only. For the reasons described below in our responses to comments, we are not finalizing the DHS entity ''stand in the shoes'' proposal. One purpose for our proposal to require a DHS entity to stand in the shoes of an organization in which it has a 100 percent ownership interest was to safeguard further against abusive business structures that attempt to evade restrictions on payments for referrals by using shell organizations interposed between the DHS entity and referring physicians. We caution that such arrangements are highly suspect under the fraud and abuse laws and will be subject to close scrutiny. Depending on the circumstances, such arrangements could violate the physician self-referral law, constitute unlawful circumvention schemes, or violate the anti-kickback statute. Moreover, structuring an arrangement purposefully to evade restrictions on payments for referrals may be evidence of unlawful intent.

Comment: Two commenters suggested that we not finalize the DHS entity ''stand in the shoes'' proposal until the implications of the final physician ''stand in the shoes'' rules are fully understood by the affected health care providers and by physicians. One commenter contended that, although the proposal is clearer than the one presented in the CY 2008 PFS proposal (72 FR 38184), it may add a new level of complexity to an already complex regulatory scheme.

Response: We agree with the first set of commenters that a measured approach to the overall ''stand in the shoes'' regulatory scheme is warranted and appropriate. As suggested, we are not finalizing the entity ''stand in the shoes'' provisions. A key goal of our proposal in the FY 2009 IPPS proposed rule was to simplify the analysis of financial relationships between DHS entities and referring physicians. We believe that this final rule achieves that goal.

Comment: One commenter asserted that the DHS entity ''stand in the shoes'' provisions do not offer any real protections to the Medicare program relating to the elimination of potentially abusive arrangements. This commenter further asserted that, to the extent that a DHS entity forms a 100 percent owned subsidiary with the intent to indirectly secure referrals that are otherwise prohibited under the self-referral law, the arrangement would constitute a circumvention scheme prohibited under the physician self-referral statute (section 1877(g)(4) of the Act). According to the commenter, the arrangement could also be subject to prosecution under the Federal anti-kickback statute if the parties knowingly intended to induce referrals of services or the ordering of goods and services under Federal health programs. The commenter asserted that providers are well-aware of the legal risk these arrangements pose, and noted its belief that most arrangements involving DHS entities and subsidiaries are designed to treat the DHS entity and the subsidiary as the same and to satisfy an exception for direct compensation arrangements, where applicable, under the current physician self-referral rules. The commenter contended that, as a result, the DHS entity ''stand in the shoes'' rules would have little meaningful impact in limiting program abuse, while creating the need for complicated conventions for its application that could serve as a trap to even the most wary DHS entity attempting compliance with the physician self-referral law.

Response: As discussed above, arrangements that attempt to evade restrictions on payments for referrals by using interposed organizations are highly suspect under the fraud and abuse laws and will be subject to close scrutiny. Depending on the circumstances, such arrangements could violate the physician self-referral law, constitute unlawful circumvention schemes, or violate the anti-kickback statute. Moreover, structuring an arrangement purposefully to evade restrictions on payments for referrals may be evidence of unlawful intent.

Comment: One commenter contended that the proposal to deem a DHS entity to stand in the shoes of an organization in which it has a 100 percent ownership interest is outside the scope of our authority under section 1877 of the Act because the purpose of the statute is to prevent self-referrals involving the provision of DHS. According to the commenter, the proposal purports to regulate relationships between organizations that are not DHS entities and physicians. Another commenter noted its strong opposition to any proposal that would permit us to regulate non-DHS entities through an extension of the physician self-referral law.

Response: Our proposal, if finalized, would have governed the relationship between DHS entities and the physicians who refer to them, which is within the scope of our authority under section 1877 of the Act. The last commenters' concerns are moot, given that we are not finalizing the DHS entity ''stand in the shoes'' provisions proposed in the FY 2009 IPPS proposed rule.

Comment: A few commenters urged us to not finalize any rule that requires a DHS entity to stand in the shoes of an organization that it owns or controls, regardless of the ownership percentage or level of control. These commenters asserted that the proposed provisions are complicated and would result in very complex conventions for applying the physician ''stand in the shoes'' rules and the DHS entity ''stand in the shoes'' rules to a chain of financial relationships where both sets of provisions are implicated.

Response: We agree with the commenters that finalizing the DHS entity ''stand in the shoes'' provisions would require that we also issue formal rules regarding the application of the physician ''stand in the shoes'' provisions and the DHS entity ''stand in the shoes'' provisions in the event that both could apply to the same chain of financial relationships between a DHS entity and a referring physician. Given that we are not finalizing at this time the proposed DHS entity ''stand in the shoes'' provisions, there is no need for such conventions in this final rule.

4. Application of the Physician ''Stand in the Shoes'' and the DHS Entity ''Stand in the Shoes'' Provisions (''Conventions'')

As discussed above, we are not finalizing the DHS entity ''stand in the shoes'' provisions. Therefore, it is not necessary to finalize the proposed conventions for applying the physician ''stand in the shoes'' provisions and the DHS entity ''stand in the shoes'' provisions when both potentially would have applied. We received no comments regarding revisions to the conventions proposed in the FY 2009 IPPS proposed rule (73 FR 23689).

5. Definitions: ''Physician'' and ''Physician Organization''

We are finalizing the revisions to the definitions of ''physician'' and ''physician organization'' as proposed in the FY 2009 IPPS proposed rule (73 FR 23690) in order to clarify that (1) a physician and the PC of which he or she is the sole owner are always treated the same for purposes of applying the physician ''stand in the shoes'' rules; and (2) a physician who stands in the shoes of his or her wholly-owned PC also stands in the shoes of his or her physician organization in accordance with revised §§ 411.354(c)(1)(ii) and (c)(2)(iv). We received no comments regarding the proposed revisions to the definitions of ''physician'' and ''physician organization.''

C. Period of Disallowance

In the CY 2008 PFS proposed rule (72 FR 38183), we noted that several commenters responding to the Phase II interim final rule with comment period (69 FR 16054) questioned the period of time for which a physician could not refer DHS to an entity and for which the entity could not bill Medicare because the financial relationship between the referring physician and the entity failed to satisfy all of the requirements of an exception to the general prohibition on physician self-referral. (We refer to this period of time as the ''period of disallowance.'') We solicited comments addressing how we might, to a practical extent, set forth the period of disallowance for financial relationships that implicate, but fail to satisfy the requirements of one or more of the various exceptions. We noted that our interpretation of the physician self-referral statute is that the period of disallowance begins on the date that a financial relationship fails to comply with the statute and regulations and ends on the date the relationship came into compliance or ended. We requested comments about whether we should allow the period of disallowance to terminate where the value or consideration has been returned (72 FR 38183).

In the FY 2009 IPPS proposed rule (73 FR 23690, 23704) we discussed the comments that we received in response to the solicitation of comments in the CY 2008 PFS proposed rule, and we proposed to amend § 411.353(c) to provide that the period of disallowance begins at the time the financial relationship fails to satisfy the requirements of an applicable exception and ends no later than:

(1) Where the noncompliance is unrelated to compensation, the date that the financial relationship satisfies all of the requirements of an applicable exception;

(2) Where the noncompliance is due to the payment of excess compensation, the date on which the excess compensation is returned to the party that paid it and the financial relationship satisfies all of the requirements of an applicable exception;

(3) Where the noncompliance is due to the payment of compensation that is of an amount insufficient to satisfy the requirements of an applicable exception, the date on which the additional required compensation is paid to the party to which it is owed such that the financial relationship would satisfy all of the requirements of the exception as of its date of inception. We continue to believe that it is possible that a financial relationship may end prior to the arrangement being brought into compliance.

Our proposals were intended to place an outside limit on the period of disallowance in certain circumstances. That is, where the reason(s) for noncompliance does not relate to compensation, the latest the period of disallowance would end would be the date the arrangement was brought into compliance. Where the reason for noncompliance is the fact that excess compensation was provided or too little compensation was paid, the latest the period of disallowance would end would be the date that the party receiving the excess compensation returned it to the party that provided it or the party owing the shortfall in compensation paid it to the party to which it was owed (assuming the arrangement otherwise satisfies the requirements of an applicable exception).

After considering the public comments we received, we are finalizing the period of disallowance proposals, without modification in substance. We have revised the proposed regulatory text because we were concerned that the language ''the date on which the additional required compensation is paid to the party to which it is owed such that the financial relationship would satisfy all of the requirements of the exception as of its date of inception'' may not have been entirely clear. The purpose of the quoted language was to emphasize that where a party has underpaid compensation (such as where a party has paid rent in an amount below fair market value for each of the months 1–6 under a lease agreement), it is not sufficient for the parties to address the noncompliant compensation on a going forward basis (such as adjusting the compensation for month 7 of the rental agreement used in the example), or for some partial period (such as making up the shortfall for months 4–6 in the lease agreement), but rather all additional compensation must be paid (that is, in the example given, compensation required to bring the rental payments for months 1–6 up to fair market value must be paid). Similarly, under our proposal, and as finalized in this rule, it is not sufficient for the party receiving excess compensation under a financial relationship to repay some of the excess compensation, but rather the party receiving it must repay all of it to the party that paid it. Accordingly, we are revising the proposed text for language for § 411.353(c) to provide that the period of disallowance ends no later than the date on which all excess compensation is returned to the party that paid it, or the date on which all additional required compensation is paid to the party to which it is owed. We emphasize that, consistent with our proposals, this final rule only prescribes the outside period of disallowance for certain situations, that is, a date by which parties can be assured that referrals for DHS are not prohibited (provided that compensation on a going-forward basis fully complies with an exception). Revised § 411.353(c) does not prevent parties from arguing that the period of disallowance ended earlier than the prescribed outside period, on the theory that the financial relationship ended at an earlier time. This final rule does not purport to define when a financial relationship begins or ends. In every case, a financial relationship begins and ends according to the conduct of the parties and the specific facts of the case. We further emphasize that the beginning and end dates of a financial relationship do not necessarily coincide with the beginning and end dates of a written agreement.

We address specifically the comments received in response to the FY 2009 IPPS proposed rule below.

Comment: Several groups commented that, although the proposals attempt to offer greater clarity regarding making referrals and billing the Medicare program in the case of noncompliant financial relationships, the proposals rely on a ''pay back'' concept or otherwise resort to a specific facts and circumstances test in determining the period of disallowance. The commenters stated that both approaches reach beyond the duration of the relationship and create consequences far into the future in complex ways. According to the commenters, the proposals would have the effect of inhibiting self-reporting and self-correction of compliance violations rather than establishing the certainty to encourage them.

Response: We disagree in all respects with the commenters' characterization of the effects of the proposals, which we are adopting. Prior to this final rule, there was no express statement in the statute, or in our regulations or other guidance as to when the period of disallowance ends for noncompliant relationships. This final rule provides assurance that the period of disallowance will end no later than: (1) Where the noncompliance is not related to the payment of compensation, the date that the financial relationship satisfies all of the requirements of an applicable exception; or (2) where the noncompliance is related to the payment of compensation, as applicable, the date on which all excess compensation is returned to the party that paid it, or the date on which all required compensation is paid to the party to which it is owed, and the financial relationship satisfies all of the requirements of an applicable exception. As we pointed out in the proposed rule (73 FR 23692), and as we reiterate here, the proposals were not intended to prevent parties from attempting to establish that the financial relationship, and thus the period of disallowance, ended at some earlier point. (We recognized in the proposed rule that all the terms of an exception may never be met, such as where an entity discovers that a physician has failed to sign an agreement and is never successful in obtaining the signature, or where excess compensation may never be repaid.) We are merely prescribing an outside limit on the period of disallowance, that is, a means by which parties are assured that referrals made after a certain date, and claims made pursuant to such referrals, will not run afoul of the prohibitions in the statute. Thus, the proposal, as adopted in this final rule, did not reach beyond the duration of the financial relationship. Similarly, our approach of using a case-by-case analysis for noncompliant arrangements that do not satisfy the conditions of § 411.353(c)(1) or (c)(2), does not reach beyond the duration of the relationship. It has long been our policy that a financial relationship does not necessarily begin with, or end with, the opening or closing dates of a written agreement. As an example, where excess compensation is paid to a physician by an entity, the question is raised as to whether the excess was intended as a reward for referrals that took place prior to the beginning date of a written agreement and/or was intended as an inducement for referrals subsequent to the ending date of a written agreement. It is not possible for us to specify, through rules of general applicability, the end date of the period of disallowance for this type of situation; rather, the same case-by-case analysis approach that was in effect prior to the proposed rule continues to be in effect.

Finally, we do not agree that the proposals, as adopted, have the effect of inhibiting self-reporting and self-correction of compliance violations rather than establishing the certainty to encourage them. The proposals would not, and the final rule does not, require self-reporting to take advantage of the certainty afforded by revised § 411.353(c). Moreover, as explained above, the proposals as adopted do establish a point at which the parties may be certain that the period of disallowance has ended. Where an entity discovers that it is missing a signature on an agreement, for example, or that too much or too little compensation has been paid, it should take steps to bring its relationship(s) into compliance. By doing so, the entity and the referring physician at issue will have the assurance that the period of disallowance ended no later than a certain date; again, revised § 411.353(c) sets only an outer limit on the period of disallowance and does not prevent parties from attempting to demonstrate that the period of disallowance ended on some earlier date.

Comment: One commenter suggested that billing should be permitted to resume when the financial relationship between the physician and the DHS entity satisfies the requirements of an exception to the physician self-referral prohibition. This would not eliminate the violation for the time prior to the correction and other remedies would be applicable to that time period. Although the commenter acknowledged that the billing prohibition could last indefinitely or for some period after correction, it believes a better regulation to promote correction and compliance would be one that ends the billing prohibition upon correction of the noncompliance and establishment of a relationship within an exception.

Response: We are unsure of the exact position of the commenter. We understand the commenter as suggesting that, in all cases, the prohibition on billing should end when the parties bring an arrangement into compliance with an exception, irrespective of whether the parties account for any problems with too much or too little compensation that may have taken place prior to the correction. If that is the commenter's position, we do not agree. An example concerning a contract between a physician and a hospital for personal services should serve to illustrate the essential difference between the position we are taking in this final rule and the position we believe the commenter may be advocating. Suppose a physician is paid excess compensation under a personal service agreement for months 1–6 and, near the end of month 6, the parties discover the error, with the result that, on July 1, the physician repays the excess compensation for months 1–6 and the arrangement otherwise complies with all of the requirements of an applicable exception. The final rule provides for an outside period of disallowance that will end no later than the date a party repays excess compensation provided that the financial relationship otherwise meets all of the requirements of an applicable exception. Thus, under the facts of this example, the final rule provides that the period of disallowance would end no later than July 1. The commenter appears to agree, that if the excess compensation is not repaid, referrals from the physician to the hospital for DHS during months 1–6 are tainted so that claims for such referrals may not be paid (and that other penalties may attach), but to the extent that the commenter is suggesting that the period of disallowance should end no later than July 1, even if the excess compensation is not repaid, simply because the parties have brought the arrangement into compliance with an exception going forward, we do not agree. As we stated in the response to the immediately preceding comment, the beginning and end dates of an agreement do not necessarily correspond with the beginning and end dates of a financial relationship. Thus, for example, compensation that does not meet the requirements of any exception

may establish a financial relationship that began prior to, or ended later than, the period specified in a written agreement between the parties, and the fact that a new agreement is entered into (or an existing agreement is modified) at some point does not, by itself, remove the tainted effects of the nonconforming compensation. Thus, under the facts of the example above, payment of excess compensation for months 1–6 may have been intended as a reward for referrals prior to, during, or after the period specified in the agreement, or as incentive for referrals past month 6.

Comment: Commenters expressed concern regarding what they perceived as the ''seemingly piecemeal approach'' in addressing the issue of period of disallowance, raising doubts about the proposal's clarity and usefulness. To support this claim, the commenters cited the preamble discussion in the FY 2009 proposed rule that noted our consideration of a related proposed ''alternative method of compliance'' from the CY 2008 PFS proposed rule that remained under consideration. Also, commenters noted that we suggested we ''may propose rulemaking on [a period of disqualification during which the parties to a noncompliant financial relationship would be prohibited from using a particular exception due to that relationship] in the future,'' although this was not included in the FY 2009 proposed rule. Additionally, these commenters noted that the proposal did not address whether the anti-kickback statute is implicated and/or whether CMPs under the physician self-referral statute are potentially applicable due to the noncompliant financial relationship. The commenters urged us to consider developing and publishing a more comprehensive proposal that would allow organizations to consider the full impact of proposed changes. These commenters recommended that we work with OIG to coordinate efforts to address the full range of concerns raised regarding these arrangements.

Response: We believe that revised § 411.353(c), adopting the proposal, is clear, non-complex and useful to physicians and entities, as it sets forth bright line rules as to the outside limit of the period of disallowance for noncompliant financial relationships. Also appearing in this final rule is new § 411.353(g), which contains a special rule for certain arrangements involving noncompliance with signature requirements (adopting the ''alternative method of compliance'' proposal referred to by the commenters). These two rules pertain to missing signatures (although the revisions to § 411.353(c) address other reasons for noncompliance), but they operate independently of each other. To illustrate, suppose a referring physician and a DHS entity enter into a financial relationship on January 1, 2009 for the lease of office space, and the physician initially failed to sign the lease agreement, but subsequently signed it. Depending on the facts and circumstances, new § 411.353(g) may operate to keep the arrangement within the protection of the lease exception at § 411.357(a). If, however, the requirements of new § 411.353(g) are not met (because, for example, the agreement was signed more than 90 days after the financial relationship began), the arrangement would be noncompliant with the lease exception at § 411.357(a), and thus there would be a period of disallowance. Under revised § 411.353(c), the period of disallowance would run from the beginning of the financial relationship until no later than the date the physician signed the lease agreement. (This example assumes that the physician subsequently signed the lease agreement and the financial arrangement continued past the date of signing. We recognize that, in some cases parties may never bring the arrangement back into compliance, such as failing to ever get a missing signature. That is why we proposed, and we adopt as final, a rule that specifies an outside date for the period of disallowance.) Note that taking action that fixes the outside date of the period of disallowance under revised § 411.353(c) does not vitiate a DHS entity's overpayment for any claims submitted during the period of disallowance as a result of the prohibited referrals. Note also that the revisions to § 411.353(c) do not affect the operation of the statutory provision for CMPs for knowing violations of the physician self-referral statute, the anti-kickback statute, the False Claims Act, or any other applicable statute. That is, section 411.353(c) prescribes, for certain situations involving both knowing and inadvertent noncompliance, the outside period of disallowance. Section 411.353(c) does not purport to address the complete range of penalties or remedies that may be imposed for prohibited referrals for DHS during the period of disallowance and for the submission of claims to Medicare for such prohibited referrals. To illustrate, suppose an entity and a physician enter into a one-year personal service arrangement on January 1, and both parties are aware that the compensation called for under the contract is above fair market value and is therefore not compliant with any of our exceptions. On June 6, the physician repays the entity the excess compensation that he or she has received. Under revised § 411.353(c), the period of disallowance would last from January 1 until June 6. Under section 1877(g)(1) of the Act, claims submitted by the entity for referrals for DHS made during the period of disallowance are not payable. In addition, however, because the parties knowingly violated the provisions of the physician self-referral statute, CMPs, assessments and exclusions could be assessed under the authority of section 1877(g)(3) of the Act (incorporating by reference section 1128A of the Act), and liability under the False Claims Act could be imposed. Further, depending on the facts, one or both parties could be guilty of violating the anti-kickback statute, or may have violated some other criminal or civil statute.

Comment: A commenter recommended that we set a 90-day ''cure'' period for noncompliance not related to the compensation terms of an arrangement. If the noncompliance, such as a missing signature, is remedied within 90 days of when the services began, the commenter suggested a period of disallowance should not arise. The commenter believed that this ''cure'' period would encourage corrective action by hospitals in the case of an inadvertent technical noncompliance that is discovered and also would encourage diligent administrative monitoring to ensure that the required signatures are obtained in a timely fashion. The commenter expressed concern over the harsh effects of not obtaining a signature prior to the commencement of physician services under a valid medical services arrangement at fair market value. Ensuring that essential medical coverage is provided to the community, that is, emergency department, surgery, should be a higher priority to a hospital and us than is assurance that a compliant personal services contract is signed by the physician in advance of performing services. The proposal, if finalized, would require the hospital to refuse to provide services to Federal health program beneficiaries prior to bilateral execution of a valid contract. Hospitals may be forced to withhold services to avoid incurring fraud and abuse fines and/or CMPs for knowingly providing covered health services to federal health program beneficiaries for free which would violate OIG limits on allowable gratuities to beneficiaries. The commenter requested that we clarify that a ''valid written agreement'' is

defined by the requirements for an enforceable agreement under state law where the hospital is located. The commenter stated that, in many States, a legally enforceable agreement can exist even in the absence of every required signature.

The commenter also suggested that, when a compensation-related violation is detected and the amount of the overpayment is *de minimis* and immaterial to the contract as a whole, we should exempt such violations from a period of disallowance. Materiality, in the view of this commenter, should be defined as any amount that exceeds 5 percent of the total payment expected or reasonably projected by the parties at the outset of the arrangement. This would allow for the correction of minor payment errors when promptly detected and repaid by the party who received the overpayment without imposing complete disallowance of hospital reimbursement for an erroneous payment of even $1 above stated limits or fair market value. The commenter suggested that if we go forward with imposing a period of disallowance for compensation-related violations that are *de minimis*, the disallowance be limited to the amount that matches the unearned benefit retained or received by the physician.

Response: The commenter's suggestions are more closely related to our proposal in the CY 2008 PFS proposed rule for an alternative method of compliance than they are with respect to our proposal to specify the outside period of disallowance for certain situations. In this final rule, we are finalizing our proposal for an alternative method of compliance at new § 411.353(g), entitled ''Special rule for certain arrangements involving noncompliance with signature requirements.'' It provides that a financial relationship that otherwise would be out of compliance with an exception that has a signature requirement will remain in compliance with that exception (assuming all other requirements are satisfied), provided that certain conditions are met. Specifically, in the case of non-inadvertent failures to obtain a necessary signature, the parties must obtain the missing signature within 30 days of the beginning of the financial relationship. In the case of inadvertent failures to obtain a necessary signature, the parties must obtain the necessary signature within 90 days of the beginning of the financial relationship. In either case, new § 411.353(g) may be used only once every 3 years with respect to the same referring physician. We are not extending the protection afforded by new § 411.353(g) to failures to meet compensation requirements (such as the requirement that compensation be at fair market value or not take into account the volume or value of referrals), including failures that result in ''minor payment errors'' because we are not confident at this time that if we were to do so we would meet the requirement in section 1877(b)(4) of the Act that new exceptions, or modifications to existing exceptions, not create a risk of program or patient abuse. We also note a practical difficulty in defining what would constitute a ''minor'' payment error or a ''*de minimis*'' deviation from the compensation requirement. Finally, we note that the commenter may be referring to section 1128A(a)(5) of the Act, which provides for CMPs for certain prohibited inducements to beneficiaries; if so, it is not clear from the comment why the commenter believes that hospitals would be at risk for violating this section of the Act.

Comment: One commenter urged us to reconsider our ''technical'' and ''highly impractical'' interpretation of the physician self-referral prohibition as it relates to the period of disallowance proposal. The commenter addressed the examples we provided for application of the period of disallowance rules labeling them highly restrictive and unrealistic applications of the law. The commenter argued that a short delay in obtaining a signature should not trigger the physician self-referral law, as the risk of abuse resulting from a delayed signature is so low as to be nonexistent. According to the commenter, there is nothing in the statute requiring us to adopt this interpretation, and doing so would only multiply the number of potential technical non-abusive violations of the physician self-referral law. Another commenter requested that, in the event a potentially noncompliant arrangement is ''cured'' by repayment of money that was paid under an arrangement that did not comply with all elements of an exception, the ''cure'' ''relate back'' to the start date of the arrangement. That is, no repayment to Medicare would be required and no other penalties or assessments under 42 CFR part 411 would occur.

Response: Under the physician self-referral statute, a physician may not refer DHS to an entity, and the entity may not bill Medicare for such referred DHS, if the physician (or an immediate family member) has a financial relationship with the entity, unless an exception applies. For purposes of determining whether a referral for DHS (and the billing of such referred DHS) is protected by an exception, we believe that the most natural reading of the statute is that all of the requirements of the exception must be met at the time the referral is made. Further, we believe that the statute does not contemplate that parties have the right to back-date arrangements, return compensation, or otherwise attempt to turn back the clock so as to bring arrangements into compliance retroactively. Under section 1877(b)(4) of the Act, however, we have the authority to craft additional exceptions, or modify existing exceptions, if doing so would pose no risk of program or patient abuse. As noted above, in response to the immediately preceding comment, we have finalized our proposal for an alternative method of compliance, by providing, at new § 411.353(g), that, an arrangement that is otherwise compliant with an exception but for the fact that a signature is missing, nevertheless will remain in compliance with the exception if certain conditions are met. We do not believe that allowing parties to ''cure'' retroactively a noncompliant relationship by having one party repay another party excess compensation would satisfy the requirement in section 1877(b)(4) that new or modified exceptions pose no risk of program abuse.

Comment: A commenter offered support of our position that any period of disallowance begins when the violation of the physician self-referral regulation occurs and ends when the violation is corrected. However, the commenter stated that the provider should have the burden of proof to establish that a violation was inadvertent and resulted in no financial harm to the Medicare program. For ''those violations,'' a financial penalty should apply rather than a period of disallowance.

Response: We believe the proposal, which we are adopting without modification in this final rule, is fully consistent with the physician self-referral statute. We are unsure of the exact position taken by the commenter. First, to the extent that the commenter believes that it is necessary to require a provider or other DHS entity to establish that the violation was inadvertent in order to avail itself of the rules in § 411.353(c) setting the outside period of disallowance, we disagree. We note that, under section 1877(g)(3) of the Act, knowing violations of the physician self-referral statute, irrespective of whether harm is caused to the program, are punishable by CMPs. Moreover, as discussed below, knowing violations of the physician self-referral statute may also implicate the anti-kickback statute at section 1128B(b) of the Act, and/or

the False Claims Act, or other Federal statute.

To the extent that the commenter is suggesting that if the parties to a noncompliant arrangement are able to demonstrate to us that the compliance was inadvertent and that there was ''no financial harm'' to the Medicare program, the parties should be subject to some financial penalty rather than a period of disallowance, we also disagree. The statute provides at section 1887(a) of the Act that, where a physician and an entity have a financial relationship that does not comply with the requirements of any exception, the physician may not refer DHS to the entity during the period of the noncompliant financial relationship and that the entity may not bill Medicare for DHS referred to it by the physician during that period. Section 1877(g)(1) of the Act provides that no claim made pursuant to a prohibited referral may be paid by Medicare. No finding of financial harm to the Medicare program is necessary, or even authorized, by the statute, in order to trigger the prohibition in section 1877(g)(1) of the Act on making payment. Moreover, the statute does not authorize us to impose financial penalties for inadvertent violations in lieu of (or in addition to) the prohibition on making payment in section 1877(g)(1) of the Act.

Comment: Two commenters objected to the proposal on the basis that the physician may not have been aware that he or she was in violation of one or more physician self-referral prohibitions. For example, the physician may not have known that his or her compensation was greater than fair market value or exceeded limits for such services. The physician may have assumed that the entity that contracted with him or her had structured the relationship in accordance with appropriate restrictions and regulations. Additionally, according to the commenters, ''the typical physician'' would not know where to find the appropriate information that would clearly show the relevant values and/or limits. Similarly, the entity contracting with the physician may not have known the appropriate value or limits associated with the respective physician services. The entity may have difficulty determining whether or not the arrangement violated certain prohibitions, particularly if the entity is a small hospital without adequate resources or experience. Another commenter urged us to not impose defined periods of disallowance except for the most egregious violations, for which clear evidence of intent to defraud is found after examination of the individualized facts. The commenter also encouraged a stay of the period of disallowance if the arrangement's facts meet the temporary period of noncompliance exception authorized in § 411.353(f). According to this commenter, the proposed rule imposes potential penalties that are far in excess of either the value of the loss, if any, to the public fisc or the wrongfulness of the violation and also presents concerns of unintended consequences such as jeopardizing essential patient care for federal health program beneficiaries.

Response: The physician self-referral statute is a strict liability statute, meaning that a financial relationship that does not meet a relevant exception because the compensation was above or below fair market value (or because of any other reason) is noncompliant, regardless of whether one or both parties to the arrangement were unaware of the defect. (As noted above in response to another comment, however, certain penalties or remedies beyond claims denials are potentially applicable to knowing violations of the physician self-referral statute.) New § 411.353(g) allows parties to remain in compliance with an exception, under certain circumstances, despite a missing signature, if the parties later obtain the signature. Section 411.353(g) does not provide protection for arrangements in which too little or too much compensation is paid because we are concerned that there would a risk of program or patient abuse if we were to provide such protection. Section 411.353(f) provides relief for temporary noncompliance in certain situations, but one condition that must be met is that the noncompliance must be for reasons beyond the control of the entity. We believe that the payment of compensation below, or above fair market value would rarely, if ever, be beyond the control of the entity.

Comment: Two commenters objected that the period of disallowance as proposed could be extended unreasonably into the future, possibly beyond the relationship of the parties. The two commenters also objected that the same period of disallowance would apply to all compensation related violations regardless of the violation being the first such violation for the given entity or if it is an occurrence reflecting a pattern of violations for the entity. One of the commenters suggested that we apply a lighter period of disallowance to the first compensation-related violation than where the violation is not the first for either the physician or the entity.

Response: We disagree that, under the proposal, the period of disallowance could be extended unreasonably into the future, possibly beyond the relationship. Revised § 411.353(c), consistent with the statute (and with the proposal) does not attempt to set the period of disallowance beyond the end of the financial relationship. Rather, it provides clear guidance that, under certain circumstances, the period of disallowance ends no later than the date parties to a noncompliant financial relationship take certain, specified action.

We fail to see why one rule should apply for a first violation and a different rule should apply for a repeat violation. Revised § 411.353 sets forth what we believe is the natural reading of the statute, that is, the period of disallowance begins when a financial relationship becomes noncompliant and ends when the noncompliance is rectified. Our rule provides that the period of disallowance ends no later than a certain time, in order to provide assurance to parties that referrals after that time and claims submitted pursuant to those referrals will not be tainted by the previous noncompliance. We reiterate that parties are free, in any given case, to assert that the financial relationship (and, hence, the period of disallowance) ended at a time prior to the correction of a noncompliant condition, and such assertions will be evaluated on a case-by-case basis. As noted above, certain penalties or remedies beyond claims denials are reserved only for knowing violations of the physician self-referral statute, and if the same parties repeat the same types of noncompliance it may raise questions as to whether the noncompliance was deliberate.

Comment: A commenter expressed concern regarding whether the proposed period of disallowance was truly bilateral and applied to all parties in a multi-party agreement that is found to be in violation of the self-referral prohibition. The commenter requested that we state clearly in the final rule that any period of disallowance resulting from the final rule applies equally to all enrolled providers seeking federal health program reimbursement for DHS provided to Federal health program beneficiaries pursuant to an agreement found to be out of compliance with the physician self referral prohibition. The commenter stated that the physician involved in a noncompliant financial relationship should also be disallowed from billing federal health programs during the period of disallowance and should be required to refund any professional services reimbursement received from federal health programs during the same period that is

applicable to the improper agreement to which he or she is a party. To hold only the hospital liable during the period of disallowance would be arbitrary and capricious, whereas aligning compliance incentives for all parties to an agreement likely would be more effective than punishing the hospital only.

Response: The physician self-referral statute, at section 1877(a) of the Act, provides for two types of prohibitions with respect to unexcepted financial relationships between a physician (or the physician's immediate family member) and an entity. First, the physician is prohibited from making referrals for DHS to the entity, and second, the entity is prohibited from billing Medicare for DHS referred by the physician. We believe the proposal was, and revised § 411.353(c) is, clear that the period of disallowance refers to the period that the physician is prohibited from making referrals as well as the period the entity is prohibited from billing Medicare. We decline to adopt the commenter's suggestion that the physician party to a noncompliant financial relationship be disallowed from billing Federal health programs during the period of disallowance and to refund any professional services reimbursement received from federal health programs during that same period that is applicable to the improper agreement to which he or she is a party. We understand the commenter as alluding to the physician in the capacity of making prohibited referrals to a DHS entity such as a hospital and not in the capacity as a DHS entity (although sometimes physicians do act in the capacity of a DHS entity). Thus understood, we have no authority under the statute to impose such penalties as a matter of course on a physician who makes prohibited referrals. As noted above, where a physician or DHS entity knowingly violates the physician self-referral statute, under authority of section 1877(g)(3) of the Act, certain penalties and the remedy of exclusion may be imposed. If a physician is excluded, he or she is prohibited from participating in any Federal health care program. We refer readers to section 1128 of the Act.

Comment: One commenter requested clarification, with respect to the situation in which a physician receives excess compensation from an entity, as to whether the physician may repay the excess compensation by negotiating a promissory note to the hospital, at commercially reasonable interest rates and is current on all loan payments under that note; and if so, whether one missed loan payment by the physician under the terms of the promissory note commences a period of disallowance that continues until all overdue payments, including any interest on the missed payment(s) per the terms of the note, are made current.

Response: Revised § 411.353(c) is applicable where the party that has received excess compensation has, in fact, repaid the excess compensation. Revised § 411.353(c) places no restriction on the source of the funds that the physician uses to repay excess compensation (or to make up a shortfall in compensation), and thus, the physician may pay the funds out-of-pocket, or may obtain a loan from a commercial lender, private party or even from the entity itself, in order to repay the excess compensation (or make up the shortfall in compensation). However, where a physician receives excess compensation from an entity and then obtains a loan from the entity to repay the entity the excess compensation that he or she received, the question is raised whether the physician has in fact repaid the excess compensation through the use of a bona fide, commercially reasonable loan, or whether the loan transaction is a sham. We question the commercial reasonableness of any loan made to a referring physician by an entity to assist the physician in repaying funds owed to the entity, and we note that such a loan would be highly suspect under the anti-kickback statute. Entities, therefore, should be very cautious before offering to make such loans. Moreover, hospitals or other entities that do make loans to physicians (particularly for the purpose of allowing a physician to repay excess compensation or make up a shortfall in compensation following the discovery of a noncompliant financial relationship) would be well-advised to make reasonable efforts to enforce the terms of the loan agreement, lest the failure to do so raises questions as to whether the agreement was a sham arrangement. We also note that the granting of a loan by the entity to the physician would itself create a financial relationship, and thus the loan arrangement itself must meet an exception.

D. Alternative Method for Compliance With Signature Requirements in Certain Exceptions

In the CY 2008 PFS proposed rule, we stated that, although we do not have discretion to waive violations of the physician self-referral statute, we were considering whether to amend some of the exceptions that appear in §§ 411.355 through 411.357 to provide an alternate method for satisfying certain requirements of the exceptions (72 FR 38185). We cautioned that our proposal was intended to address only inadvertent violations in which a financial relationship fails to satisfy a procedural or ''form'' requirement of an exception in the statute or regulations. In addition, we stated that we did not intend to apply the alternative method for compliance to other requirements, such as compensation that must be fair market value, not related to the volume or value of referrals, or be set in advance. We cited the example of a situation in which parties are missing a signature but satisfy every other requirement of the exception for personal service arrangements in § 411.357(d). Section 1877(b)(4) of the Act provides that the Secretary may promulgate additional exceptions regarding financial relationships that pose no risk of program or patient abuse. We proposed to rely on our authority under this provision of the Act to implement this policy. We proposed eight criteria that, if satisfied, would allow a financial relationship that did not satisfy all of the existing ''prescribed'' criteria of an exception nevertheless to meet the exception. They were: (1) The facts and circumstances of the financial relationship are self-disclosed by the parties to us; (2) we determine that the financial relationship satisfied all but the prescribed procedural or ''form'' requirements of the exception at the time of the referral for the DHS at issue and at the time of the claim(s) for such DHS; (3) the failure to meet all of the prescribed criteria of the exception was inadvertent; (4) the referral for the DHS and the claim(s) for the DHS were not made with knowledge that one or more of the prescribed criteria of the exception were not met (consistent with other exceptions, we would apply the same knowledge standard as that applicable under the False Claims Act); (5) the parties have brought (or will bring as soon as possible) the financial relationship into complete compliance with the prescribed criteria of the exception or have terminated (or will terminate as soon as possible) the financial relationship between or among them; (6) the financial relationship did not pose a risk of program or patient abuse; (7) no more than a set amount of time had passed since the time of the original noncompliance with the prescribed criteria; and (8) the financial relationship at issue is not the subject of an ongoing Federal investigation or other proceeding (including, but not limited to, an enforcement matter). We proposed no regulatory text.

Commenters were generally supportive of the policies underlying the proposal, but most contended that the proposal was too restrictive. In particular, the commenters stated that we should not require parties to self-disclose that a procedural or ''form'' requirement was not met in order to be eligible for the alternative method for compliance.

We are adopting the proposal, with modification. Specifically, we are not adopting most of the proposed eight criteria, including the requirements that parties self-disclose a noncompliant financial relationship and that we determine that the financial relationship satisfied all but the prescribed procedural or ''form'' requirements of an exception. Under new paragraph (g) of § 411.353, payment may be made to an entity that submits a claim or bill for DHS if the financial relationship between the entity and the referring physician fully complied with an applicable exception under § 411.357, except with respect to a signature requirement, and the following conditions are met: (1) If the failure to comply with the signature requirement was inadvertent, the entity rectifies the failure to comply with the signature requirement within 90 days after the commencement of the financial relationship (without regard to whether any referrals have occurred or compensation has been paid during such 90-day period); or (2) if the failure to comply with the signature requirement was not inadvertent, the entity rectifies the failure to comply with the signature requirement within 30 days after the commencement of the financial relationship (without regard to whether any referrals have occurred or compensation has been paid during such 30-day period). In order to take advantage of the alternative method for compliance in § 411.353(g), the financial relationship at issue must, at the commencement of the financial relationship, satisfy all of the requirements (except the signature requirement) of an applicable exception. For example, if the applicable exception includes a requirement that the financial relationship not violate the Federal anti-kickback statute (section 1128B(b) of the Act), the alternative method for compliance with the exception would not be available to the parties unless this requirement was satisfied. New paragraph (g) of § 411.353 may be used by an entity only once every 3 years with respect to the same referring physician.

We decline, at this time, to extend the relief offered by the proposal to failures to meet other prescribed procedural or ''form'' criteria. Commenters have not identified other procedural or ''form'' criteria to which the final rule should apply. We are reluctant to expand the relief addressed in the proposed rule, particularly in light of the fact that we are not requiring entities to self-disclose the failure to meet the prescribed criteria, and are not requiring that we make a determination that alternative criteria are met.

We address below the specific comments that we received in response to our proposal in the CY 2008 PFS proposed rule.

Comment: One commenter stated that the proposed list of requirements that parties would need to satisfy in order to be eligible for the alternative method for compliance appeared reasonable and that we should not dilute the requirements if we finalize the proposal. Although the exception might have limited utility, it would provide flexibility when it is clear that the noncompliance with the substantive criteria was caused by an inadvertent error. One commenter stated that the proposal was cumbersome and ultimately would not benefit physicians because of the inordinate number of requirements that would have to be satisfied before an entity could take advantage of the alternative method for compliance. Another commenter expressed concern that the proposal was so burdened by cautions and reservations that it may be less viable than it otherwise could be. One commenter stated that requiring us to make individual determinations for each self-disclosure would provide an enormous administrative burden on both us and providers. The commenter suggested that, if providers meet the alternative criteria to comply with certain exceptions, they should be able to self-correct within 30 days of noncompliance and not be required to self-disclose. This structure, the commenter contended, would eliminate the administrative burden, yet provide ample protections against abuse, because the alternative criteria we set forth in the proposed rule are clear. Another commenter said that, in light of the potential tremendous penalties and the black-and-white nature of the prohibition, there should be a means specified in the regulations to rectify inadvertent violations internally, and for us or another agency to exercise discretion upon later review, without subjecting parties to the burden and expense of a self-disclosure. Another commenter stated that DHS entities would be unlikely to submit to (or be counseled to submit to) an ''uncertain'' process that exposes their mistakes. Two commenters complained that it was unfair to require a voluntary disclosure to use this method for compliance. Several commenters stated that the proposal for us to retain sole authority to determine whether a financial relationship failed to satisfy all of the prescribed procedural or ''form'' criteria of an exception would give the agency too much control. Several other commenters expressed dissatisfaction that the decision of whether the alternative criteria were met would not be subject to further administrative or judicial review. One of these commenters claimed that the proposed lack of administrative or judicial review, coupled with the proposed option of not making a decision, would be a perversion of due process.

Response: We recognize that our proposal contained a significant number of requirements. In order not to discourage providers and suppliers from taking advantage of the opportunity to remain in compliance with an exception through an alternative method for compliance, we have decided to eliminate the requirement that we must make a determination that alternative criteria are met, as well as the requirement that DHS entities must self-disclose the failure to meet the prescribed criteria. We are modifying § 411.353 to provide what is essentially an adjunct to the relief offered by the special rule in § 411.353(f) for temporary noncompliance. New paragraph (g) of § 411.353 provides that, notwithstanding that a financial relationship did not satisfy all of the requirements of an exception in § 411.357 due to a missing signature on a written agreement, payment may be made to an entity that submits a claim or bill for a designated health service if the financial relationship between the entity and the referring physician fully complied with an applicable exception under § 411.357, except with respect to the signature requirement (described below), and the following conditions are met: (1) The failure to comply with the signature requirement was inadvertent; and (2) the entity rectifies the noncompliance with the signature requirement within 90 days after the commencement of the financial relationship (without regard to whether any referrals have occurred or compensation has been paid during such 90-day period). (We describe in the next comment and response the provisions in this final rule for an alternative method for compliance where the failure to obtain a required signature was not inadvertent (that is, the failure was ''knowing'').) For

purposes of new paragraph (g) of § 411.353, the relevant signature requirements are found in § 411.357(a)(1), § 411.357(b)(1), § 411.357(d)(1)(i), § 411.357(e)(1)(i), § 411.357(e)(4)(i), § 411.357(l)(1), § 411.357(p)(2), § 411.357(q) (incorporating the requirement contained in § 1001.952(f)(4)), new § 411.357(r)(2)(ii), § 411.357(t)(1)(ii) and (t)(2)(iii) (both incorporating the requirement contained in § 411.357(e)(1)(i)), § 411.357(v)(7)(i), and § 411.357(w)(7)(i). New § 411.353(g) may be used by an entity only once every 3 years with respect to the same referring physician.

In this final rule, we have eliminated the proposed requirement of self-disclosure, as well as the proposed requirement that we make an advance determination that the alternative criteria were satisfied, but we emphasize that we have done so only for the purpose of encouraging entities to take advantage of the alternative method for compliance. Because the final rule is narrow in scope, applying to missing signatures only, we believe that we can eliminate these proposed requirements and still meet the statutory mandate under section 1877(b)(4) of the Act that any additional exception that we create by regulation under that authority, or any revisions to existing regulations created under such authority not pose a risk of program or patient abuse.

Comment: A few commenters suggested that a financial relationship should not be considered noncompliant for failure to get a signature on an agreement, even if the failure was not inadvertent. One commenter asserted that there is no risk of fraud or abuse with respect to a missing signature. Another commenter emphasized that it is difficult sometimes for parties to obtain all necessary signatures prior to the time that a physician must begin providing services to the hospital. A third commenter recommended a 60-day grace period for financial relationships that begin prior to the time that all necessary signatures are obtained. (These comments were submitted in response to our proposals on period of disallowance and the physician ''stand in the shoes'' provisions discussed in sections VIII.B and VIII.C of this preamble.)

Response: We are distinguishing between inadvertent and knowing failures to comply with a signature requirement by allowing 90 days to obtain the missing signature for inadvertent noncompliance and 30 days for noncompliance that is not inadvertent (that is, noncompliance that is ''knowing''). We understand that parties may not obtain all signatures and that referrals may be made despite the missing signature(s). We also recognize that, on occasion, a hospital or other entity may need to retain a physician's services on very short notice (such as obtaining emergency on-call coverage from a physician who is substituting for another physician) and that the entity is faced with choosing to begin a financial relationship without the physician's signature on the agreement or to forego using the physician's services, thus possibly adversely affecting patient care. However, we want to incent parties to exercise diligence with our rules, and we believe that 90 days after the beginning of an otherwise fully compliant financial relationship is sufficient time for parties to exercise diligence and discover whether a signature is missing, and, where an entity has knowingly entered into an otherwise fully compliant financial relationship despite a missing signature, 30 days after the beginning of the financial relationship is sufficient time for such entity to procure the signature.

Comment: One commenter asserted that our proposal was not an alternative method for compliance, but was instead a method for us or OIG to grant immunity in connection with a self-disclosure.

Response: We disagree that the proposal was a method to grant immunity. As we explained in the proposed rule, we do not have the authority to waive or grant immunity for a violation of the physician self-referral law or regulations (72 FR 38185). Using our authority under section 1877(b)(4) of the Act, we proposed to amend our physician self-referral rules in order to keep within the exceptions certain financial relationships that, but for the proposed change, would be out of compliance with the rules.

Comment: One commenter stated that the physician self-referral regulations are complex and that we should focus only on those parties that intentionally disregard the requirements, and not on those that missed a signature on a single document while attempting to comply with the rules. Another commenter stated that the proposal was a positive first step toward recognition that ''innocent and trivial'' violations of the statute should not be treated the same as those that involve intentional violations of the statute. The commenter believed, however, that the proposal was tailored far too narrowly and that it is unlikely that providers would submit, or be counseled to submit, to such an uncertain process that exposes them for ''innocent'' mistakes. The commenter urged us to focus only on those parties that intentionally disregard the physician self-referral law.

Response: As we stated in the proposed rule, we do not have the authority to waive violations of the physician self-referral law, regardless of their nature. We have the authority under section 1877(b)(4) of the Act to create (or modify) regulatory exceptions only to the extent that there is no risk of program or patient abuse. We do not believe that providing an alternative method for compliance that permits parties that inadvertently failed to obtain a required signature to correct this failure at any time during the term of the arrangement, as recommended by the commenter, would meet the ''no risk of program or patient abuse'' standard. Thus, we are proceeding in a cautious manner in order to guard against the possibility of abuse and, as discussed above, are permitting parties to use the alternative method for compliance for up to 90 days when the failure to obtain a required signature was inadvertent and up to 30 days when such failure was not inadvertent. We will evaluate our experience with new § 411.353(g) and may propose modifications, either less or more restrictive in nature, at a later date.

Comment: One commenter suggested that an alternative to ''formal compliance'' should be permitted if: (1) The provider can identify contemporaneous written documentation that provides evidence that the key terms of the financial relationship complied with the substantive elements of the applicable exception; and (2) the provider brings the financial relationship into compliance with the procedural and substantive requirements of the exception. The commenter further stated that, if the provider is unable to identify contemporaneous written documentation, it should terminate the financial relationship and seek repayment of compensation from the physician of the amount that was paid to the physician in excess of that permitted or required under the physician self-referral law. If the physician will not repay the compensation, the commenter suggested that the provider should be required to submit an amount of money to us equal to the payment made in excess of the amount of money permitted or required by the physician self-referral law and regulations.

Response: We decline to adopt the suggestions of the commenter. We do not believe that it is appropriate to protect the failure to comply with the substantive requirements of an

exception, as the commenter suggests. The commenter's suggestion that the entity be allowed to terminate a financial relationship and either collect from the physician the amount of excess compensation paid to the physician or pay such excess amount to the program does not address our concerns. Payment of excess compensation, even if ultimately repaid by the party that received it, could induce or reward referrals for at least the period of time before repayment is made. Without additional restrictions, the commenter's suggested approach is subject to abuse. The commenter's suggestion regarding repayment to the program by the provider that made the excess payment is not authorized by, or consistent with, the statute.

Comment: One commenter stated that it was generally supportive of the proposal, but was concerned that hospitals will be hesitant to self-report violations unless we clarify certain issues. First, the commenter was concerned that, if a hospital were to have multiple ''technical violations'' or have such violations over a sustained period of time, it could be subject to civil monetary penalties. Therefore, the commenter requested additional guidance regarding the specific circumstances in which the hospital could make an allowed correction. Second, the commenter requested guidance as to what hospitals would be permitted to do during three time intervals: (1) The time period between when the violation is discovered and when it is reported to us; (2) the time period between when the violation is reported to us and when we issue a determination; and (3) the time period between when the determination is issued and when the financial relationship is brought back into compliance. Without this guidance, the commenter contended, many hospitals will not self-report.

Response: We believe that the commenter's concerns are addressed by the fact that the final rule does not require hospitals or other entities to self-report in order to take advantage of the relief offered under new § 411.353(g). In order to encourage entities to monitor vigilantly their financial relationships with physicians, this final rule provides that entities must rectify inadvertent noncompliance with a signature requirement within 90 days after the commencement of the financial relationship (without regard to whether any referrals have occurred or compensation has been paid during such 90-day period), and must rectify knowing noncompliance with a signature requirement within 30 days after the commencement of the financial relationship (without regard to whether any referrals have occurred or compensation has been paid during such 30-day period). New § 411.353(g) may be used by an entity only once every 3 years with respect to the same referring physician. A civil monetary penalty may be issued only for a knowing violation of the statute. By definition, an arrangement that complies fully with new § 411.353(g) is not in violation of the statute.

Comment: One commenter offered a number of criticisms and recommendations in response to the proposed alternative compliance criteria. First, requiring a provider to disclose to us the ''facts and circumstances'' of the inadvertent failure to satisfy procedural or ''form'' requirements of an exception will require resources to be allocated to this process by both the providers and us. The commenter expressed concern that we would be flooded with disclosures of ''technical'' violations, which may make us unable to respond in a timely fashion. The commenter suggested that we establish reasonable timeframes for our response so that providers are not awaiting a decision for a long period of time. Second, the commenter requested additional guidance regarding what constitutes an ''innocent or unintentional mistake,'' noting that this could be confusing for providers who seek to make a disclosure. Third, the commenter asserted that determining whether a provider complied with all requirements of an exception other than procedural or ''form'' requirements appears to be outside of the Department's normal course of business and would require significant resources and may require the use of outside experts. Fourth, the commenter claimed that it is not clear how we would evaluate whether the referral for DHS was made without knowledge that one or more of the exception's prescribed criteria were not met. The commenter contended that, if any knowledge requirement is used by us, it should be actual knowledge. Fifth, the commenter suggested that we remove the condition that no more than a set amount of time could pass following the time of the original noncompliance with the prescribed criteria, because this would exclude many financial relationships that otherwise would satisfy the alternative criteria (as many physician self-referral violations are unintentional and not discovered immediately).

Response: We believe that the final rule, which does not contain most of the conditions specified in the proposed rule, will satisfy some, but not all, of the commenter's concerns. With respect to the commenter's first and second criticisms, the final rule does not require that the entity self-disclose the facts and circumstances of the financial relationship in order to use the alternative method for compliance. We note also that the final rule provides for protection both in the situation in which the failure to comply with the signature requirement is inadvertent (for which there is a 90-day period to rectify the noncompliance) as well as the situation in which the failure to comply with the signature requirement was not inadvertent or ''knowing'' (for which there is a 30-day period to rectify the noncompliance). We do not believe that it is necessary to define ''inadvertent;'' parties should attach the ordinary meaning to ''inadvertent.'' We provide the following example of what we consider a knowing failure to comply with the signature requirement: A compensation arrangement under which a hospital contracts with a physician to provide medical directorship of a service at the hospital beginning January 1; the physician begins providing services on January 1 and refers patients to the hospital for DHS; the physician does not sign the written agreement until January 15, when it is returned from the physician's attorney following legal review; and, at all times up to January 15, both the physician and the hospital are aware that the physician had not signed the agreement. In regard to the commenter's third and fourth criticisms, the final rule does not require an advance determination from us that the financial relationship satisfied all but the signature requirement of the exception at the time of the referral for the DHS at issue and at the time of the claim for such DHS. However, we note that a financial relationship that an entity believes complied with all criteria except the signature requirement, like all financial relationships that implicate the statute, is still subject to scrutiny; that is, nothing absolves the entity from otherwise having to satisfy the remaining requirements of the exception. As for the commenter's fifth criticism, the final rule requires that the entity rectify the noncompliance with the signature requirement within 90 days after the beginning of the financial relationship in the case of an inadvertent failure to comply with the signature requirement, or within 30 days after the beginning of the financial relationship in the case of knowing failure to comply with the signature requirement (without regard to whether any referrals have occurred or

compensation has been paid during such 90-day or 30-day period). The condition that the entity promptly rectify the noncompliance is similar to that contained in existing § 411.353(f)(2), as our approach in this final rule is to pattern the alternative method for compliance after the exception for certain arrangements involving temporary noncompliance in § 411.353(f). We believe that it is appropriate to put a limit on the period during which parties may take advantage of the alternative method for compliance in order to encourage them to monitor diligently financial relationships for compliance with the prescribed criteria. The alternative method for compliance is designed to alleviate, under certain circumstances, the consequences that would otherwise result from the failure to obtain a signature as required by an exception; it is not intended to become the default means by which parties comply with the conditions of exceptions. For this reason, we have also placed a limit on the use of the alternative method for compliance. The final rule provides that new § 411.353(g) may be used by an entity only once every 3 years with respect to the same referring physician, similar to the limit in existing § 411.353(f)(3).

E. Percentage-Based Compensation Formulae

In the CY 2008 PFS proposed rule, we proposed clarifications to our regulations regarding compensation that is ''set in advance'' (72 FR 38184). As discussed in the CY 2008 PFS proposed rule, our proposal would have affected numerous compensation arrangements, as the requirement that compensation be ''set in advance'' (or ''fixed in advance'') appears throughout our regulations—in both regulations implementing the statutory exceptions and in exceptions issued using our authority under section 1877(b)(4) of the Act. Specifically, we proposed to clarify that compensation determined using a percentage-based formula: (1) May be used only for paying for personally performed physician services; and (2) must be based on the revenues directly resulting from the physician services rather than based on some other factor such as a percentage of the savings by a hospital department (which is not directly or indirectly related to the physician services provided).

Under our regulations in § 411.354(d), compensation is considered ''set in advance'' if the aggregate compensation, a time-based or per-unit amount, or a specific formula for calculating the compensation, is set forth in an agreement between the parties before the furnishing of the items or services for which the compensation is to be paid. In Phase I, the regulation in § 411.354(d)(1) read: ''[p]ercentage compensation arrangements do not constitute compensation that is 'set in advance' in which the percentage compensation is based on fluctuating or indeterminate measures or in which the arrangement results in the seller receiving different payment amounts for the same service from the same purchaser'' (66 FR 959). Following publication of Phase I, we received anecdotal accounts about contracts for physician services pursuant to which payment is calculated based on a percentage of the revenue billed or collected as a result of the physician's own professional services. We delayed the effective date of the final sentence of § 411.354(d)(1) through five **Federal Register** notices to allow us to reconsider the provision (66 FR 60154; 67 FR 70322; 68 FR 20347; 68 FR 74491; and 69 FR 35529). Ultimately, we did not finalize the last sentence of § 411.354(d)(1), explaining in Phase II that we were persuaded that our original position was overly restrictive and that, as a result of us not finalizing this language, independent contractor physicians, like their group practice and employee counterparts, may receive certain limited forms of percentage compensation under section 1877 of the Act (69 FR 16068). We noted also that the same is true for academic physicians under the exception for academic medical centers, which also contains the ''set in advance'' requirement (69 FR 16068). In explaining our action, we stated that ''[w]e considered maintaining the Phase I definition of 'set in advance,' but realized that hospitals, academic medical centers, and other entities would have to renegotiate numerous legitimate contracts *for physician services,* potentially causing significant disruption within the health care industry without a corresponding program integrity benefit'' (69 FR 16124 through 16125, *emphasis added*). We also noted our concern that such disruption might unnecessarily inconvenience beneficiaries.

In Phase II, we also addressed the concerns of commenters to Phase I that pointed out that, under section 1877 of the Act, group practices are not subject to the ''set in advance'' restriction when paying profit shares or productivity bonuses to group practice physicians, nor are employers so restricted in their payments to employed physicians under the exception for *bona fide* employment relationships. We discussed percentage-based compensation formulae in the context of contrasting the rules regarding compensation to physicians within a group practice (which evidence a statutory preference) and compensation outside of the group practice context, noting that we attempted to equalize the most important requirements in the other main physician compensation exceptions (that is, the exceptions for *bona fide* employment relationships, personal service arrangements, fair market value compensation arrangements, and academic medical centers) (69 FR 16066). We stated that, under these exceptions, physicians can be paid a percentage of revenues or collections *for personally performed services,* receive a productivity bonus on any personally performed services, and participate in a physician incentive plan related to health plan enrollees (69 FR 16066, emphasis added).

We noted in the CY 2008 PFS proposed rule that, despite our stated intent that percentage-based compensation formulae be used only for compensating physicians for the physician services they personally perform, it had come to our attention that arrangements involving percentage-based compensation formulae are being used for the rental of office space or for the provision of items and services, such as the rental of equipment (72 FR 38184). With respect to arrangements for the rental of office space or equipment, the rental charges for the office space or equipment are determined as a percentage of the revenues raised in the office space or by the equipment. With respect to billing agent or management agreements, the compensation is often set as a percentage of collections or revenues of the party for whom the services are provided.

Although we proposed to revise § 411.354(d) to specify that compensation determined using a percentage-based formula may be used for paying for personally performed physician services only, at this time, we are finalizing a targeted approach for addressing our primary concerns regarding percentage-based compensation formulae that are used to determine compensation outside the context of personally performed physician services. Specifically, relying on our authority in sections 1877(e)(1)(A)(vi), 1877(e)(1)(B)(vi), and 1877(b)(4) of the Act, we are revising § 411.357(a), § 411.357(b), § 411.357(l) and § 411.357(p) to prohibit the use of percentage-based compensation formulae in the determination of rental charges for the lease of office space or equipment. We continue to believe that

the use of percentage-based compensation formulae to determine rental charges for office space or equipment poses a heightened risk of program and patient abuse. For example, lease payments based on a percentage of revenues earned by the lessee provide incentive for the lessor to increase DHS referrals to the lessee so as to increase potentially the rental payment under the lease. In addition, fluctuating rental payments determined using a percentage-based formula may not result in fair market value payments (even if the formula itself is arguably reasonable), which also poses an increased risk of program or patient abuse. In Phase III, we discussed this concern in connection with compliance with the exception for indirect compensation arrangements in § 411.357(p), which requires that compensation received by the referring physician (or immediate family member) is fair market value for the services and items provided. There, we noted that a compensation arrangement based on a percentage of collections may not, depending on how the actual collections progress, result in fair market value received by the referring physician (or immediate family member) (72 FR 51063). With respect to an indirect compensation arrangement involving, for example, the rental of equipment between a physician lessor and a DHS entity lessee, compensation based on a percentage of collections for the services performed on the equipment may not result in fair market value, depending on how the collections actually materialize.

For a more detailed description of our concerns, we refer the reader to sections VIII.F and VIII.G of this preamble. We intend to continue to monitor compensation formulae in arrangements between DHS entities and referring physicians and, if appropriate, may further restrict percentage-based formulae in a future rulemaking. We refer the reader to section VIII.B of this preamble for a discussion of our interpretation of compensation that is ''set in advance'' as it applies to the modification of rental charges in office space or equipment leases. We address below the specific comments that we received in response to our proposal in the CY 2008 PFS proposed rule.

Comment: One commenter expressed its support of the proposal to continue to allow percentage-based compensation for personally performed physician services. The commenter asserted that finalizing the proposal would curtail potentially abusive percentage compensation arrangements to physicians for non-professional services. Another commenter supported the elimination of percentage-based lease arrangements for office space and imaging equipment. The commenter asserted that such arrangements are prone to abuse and should be eliminated. The commenter further asserted that lease arrangements featuring flat-rate payments that are not tied to volume are less susceptible to abuse. Two other commenters suggested that, if our most significant concern is with the use of percentage-based compensation formulae for determining rental charges for office space and equipment rentals, a more effective solution would be to prohibit such formulae under the specific exceptions applicable to the rental of office space and equipment.

Response: As discussed above, we are finalizing our proposal with the modifications suggested by the third and fourth commenters, which also reflect generally the second commenter's recommendation. Specifically, we are amending the exceptions for the rental of office space (§ 411.357(a)), the rental of equipment (§ 411.357(b)), fair market value compensation arrangements (§ 411.357(l)), and indirect compensation arrangements (§ 411.357(p)) to prohibit the use of compensation formulae based on a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the leased office space or to the services performed on or business generated by the use of the leased equipment. We are finalizing a narrow, targeted approach to address our most significant concerns with percentage-based compensation formulae. We are revising § 411.357(a), § 411.357(b), § 411.357(l) and § 411.357(p) to prohibit the use of percentage-based compensation formulae in the determination of rental charges for the lease of office space or equipment. Although we are not extending, at this time, the prohibition on the use of percentage-based compensation formulae to arrangements for any non-professional service (such as management or billing services), we reiterate our intention to continue to monitor arrangements for non-professional services that are based on a percentage of revenue raised, earned, billed, collected, or otherwise attributable to a physician's (or physician organization's) professional services.

Comment: One commenter urged that we continue to permit percentage-based fee arrangements for billing and collection services, even if this causes some variability in physician compensation. According to the commenter, percentage-based fee arrangements are the most common method of compensation for billing and collections services, and provide appropriate incentives for quality and accuracy. The commenter asserted that these fees should be set at fair market value. Two other commenters expressed similar concerns, arguing that practice management agreements (in which a manager provides administrative and other management services to physicians, typically in exchange for a percentage of the physician's revenues or collections, which could include ancillary revenue) and billing services agreements that are negotiated using percentage-based compensation formulae promote positive management or administrative practices without a risk of program or patient abuse. Another commenter asserted that the proposal would call into question a whole host of percentage-based compensation arrangements (for example, lease agreements, practice management agreements, and pay-for-performance incentives) that have little or no risk of abuse.

Response: We disagree with the last commenter's assertion that all of the percentage-based compensation arrangements it cited pose little or no risk of program or patient abuse. As described above, due to our concerns regarding the use of percentage-based compensation formulae to determine rental charges for office space and equipment lease arrangements, the final rule prohibits such compensation formulae. We note that our determination to limit the prohibition to arrangements for the rental of office space and equipment only should not be construed as agreement with any of the commenters' other assertions, and we intend to continue to monitor compensation formulae in financial relationships between DHS entities and referring physicians. We may further restrict percentage-based formulae in a future rulemaking if appropriate to safeguard against program or patient abuse.

Comment: Several commenters expressed concern that the proposal, if finalized, would prohibit a hospital (or other DHS entity) that leases office space in its medical office building from charging the physician tenants a *pro rata* share of real estate taxes and other costs associated with common areas of the property.

Response: It appears that the commenters assume that charging a tenant a *pro rata* share of expenses related to the office space leased by a

tenant is equivalent to utilizing a percentage-based compensation formula for rental charges. We believe that there is a difference between determining rental charges using a percentage-based formula and assessing a tenant (lessee) for the expenses incurred that are related to the space leased by the tenant (lessee). The revised regulation text prohibits determining rental charges using a formula based on a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space. We do not consider a percentage of expenses imposed or levied by a third party, such as property taxes or utilities, to be prohibited percentage compensation. Moreover, we do not interpret the revisions to § 411.357(a) (or to § 411.357(b), § 411.357(l) and § 411.357(p)) as prohibiting a lessor from charging a lessee a *pro rata* share of expenses incurred that are attributable to that portion of the medical office building or other space (or the equipment) that is leased by the lessee.

Comment: One commenter asserted that percentage compensation lease arrangements are used by parties to circumvent the physician self-referral law. The commenter argued that our proposal does not go far enough to meet our objective because it permits percentage-based compensation lease arrangements through indirect compensation arrangements, the exception for which does not require that compensation be set in advance. According to the commenter, parties simply could structure an equipment lease as an indirect compensation arrangement that qualifies for the exception for indirect compensation arrangements. The commenter asserted that physicians often do not directly lease equipment; therefore, most equipment leasing arrangements are indirect compensation arrangements. The commenter recommended that we revise the exception for indirect compensation arrangements in § 411.357(p) to require that compensation be set in advance.

Response: As noted above, we proposed to prohibit the use of percentage-based compensation formulae for any arrangement other than an arrangement for personally performed physician services. However, in this final rule, we are prohibiting the use of such compensation formulae with respect to office space and equipment lease arrangements only. We agree with the commenter that our concerns regarding potentially abusive percentage-based compensation arrangements for office space or equipment are not fully addressed if parties could restructure an (office space or) equipment lease arrangement as an indirect compensation arrangement that would qualify for the exception in § 411.357(p). Accordingly, we are making corresponding changes to the exception in § 411.357(p) to prohibit the use of percentage-based compensation formulae in the determination of rental charges for office space and equipment lease arrangements. We are also making corresponding changes to § 411.357(l), the fair market value exception, to prohibit the use of percentage-based compensation formulae in the determination of rental charges for equipment lease arrangements (which is potentially applicable for equipment leases of less than a year.)

We note also that our proposal in the CY 2008 PFS proposed rule and this commenter's letter pre-dated the publication of the Phase III ''stand in the shoes'' provisions in § 411.354(c) (72 FR 51012). To the extent that a physician organization, rather than an individual referring physician or joint venture, leases office space or equipment to or from a DHS entity, the physician may stand in the shoes of the physician organization, and the arrangement between the DHS entity and the referring physician is analyzed as if it were a lease arrangement between the DHS entity and the referring physician.

Comment: A large number of commenters expressed concern that the proposal, if finalized, would have a chilling effect on, or prohibit outright, various gainsharing arrangements and other incentive payment (or pay-for-performance) programs. These commenters urged us not to finalize our proposal to clarify that compensation determined using a percentage-based formula must be based on the revenues directly resulting from physician services rather than based on some other factor such as a percentage of the savings by a hospital department.

Several commenters, in similar or identical letters, stated that prohibiting percentage-based compensation (unless for personally performed physician services) fails to recognize the important role that financial incentives play in achieving the goals that the Institute of Medicine (IOM) has set for all of health care, including payments based on achieving quality measures, patient satisfaction, or efficiencies. Some of the commenters also asserted that the proposal, if finalized, would work against achieving clinical integration and coordination. According to several commenters, the proposed changes are out of sync with the relationships that are developing and need to evolve to meet the public policy goals for health care delivery. The commenters noted that, the financial model for integrated care delivery, through recognizing the challenges set by the IOM and responding to the use of financial incentives by the government and other payers, has come to rely on sharing revenue in appropriate ways as a mechanism to incent appropriate behavior. The commenters argued that these efforts will be frustrated if percentage-based compensation formulae can be used only for personally performed physician services. Many of these commenters recommended that we should permit certain types of percentage-based compensation arrangements such as: (1) Sharing of cost savings from efficiencies; (2) incentives to meet quality indicators, even when cost savings do not accrue to the hospital; (3) incentives to clinically integrate services and coordinate care across settings; (4) sharing of pay-for-performance bonuses from payers; (5) service contracts to build new service capacities; and (6) management contracts.

Response: We have addressed the commenters' concerns by finalizing a narrow, targeted approach that does not require percentage-based formula used to determine physician compensation for personally performed services to be based on the revenues directly resulting from the physician's services rather than based on some other factor, such as a percentage of the savings by a hospital department. We share the commenters' interest in the permissibility of properly structured, nonabusive incentive payment and shared savings programs. We refer the reader to the CY 2009 PFS proposed rule (73 FR 38502) in which we proposed a new exception for certain incentive payment and shared savings programs (which may include gainsharing arrangements) (73 FR 38548). We also note that, although we are not, at this time, prohibiting percentage-based compensation for personally performed physician services that is calculated based on a percentage of the savings of a hospital department, we refer the reader specifically to our discussion at 73 FR 38551 regarding whether such payments would meet necessarily the fair market value requirement present in the various exceptions that may be applicable to gainsharing and similar arrangements.

Comment: A commenter representing academic medical centers (AMCs) and faculty practice plans (FPPs) expressed concern that the proposed changes, if finalized, would cause compensation

models within an AMC to fail to meet the requirements of the AMC exception. According to the commenter, some formulae compensate FPP physicians in a way in which some of the compensation is attributable to services performed by other physicians within the same FPP. The commenter asserted that stripping AMCs of the availability of such compensation formulae would have severe consequences with respect to an AMC's ability to achieve its teaching, research and community service mission.

Response: The narrow, targeted approach we take in this final rule prohibits the use of percentage-based compensation formulae in the determination of rental charges for the lease of office space or equipment. The commenter discussed the compensation of FPP physicians in describing its concerns, but did not specify whether such compensation is related solely to physician services or includes other compensation to the FPP physicians, such as compensation for the rental of office space or equipment by the AMC (where the FPP physicians are or the FPP is the lessor). To the extent that the commenter's concerns relate to the use of percentage-based compensation formulae in the determination of compensation to physicians for physician services, rather than for the rental of office space or equipment, this commenter's concerns are moot. In this final rule, we are not finalizing any new prohibitions or limitations on the use of percentage-based compensation formulae to pay physicians for their physician services. If a compensation formula for physician compensation for items or services—other than the rental of office space or equipment—was permissible prior to October 1, 2009 (the effective date of the prohibition on the use of percentage-based compensation formulae for determining rental charges in arrangements for the lease of office space or equipment), that formula would not be made impermissible by this final rule.

Comment: Several commenters asserted that percentage-based fee arrangements facilitate access to costly treatment modalities, often with predicted low volume, by allowing for the apportionment of risk of low or no volume for new or costly therapeutic modalities. According to two other commenters, prohibiting percentage-based compensation formulae would make new technology and equipment beyond the reach of all but the largest hospitals or government-sponsored hospitals. A number of commenters argued that beneficiary access will be impacted negatively if compensation arrangements cannot be structured with percentage-based compensation formulae. One commenter asserted that percentage fee arrangements are fair and the best option for vendors and for hospitals. Several other commenters agreed generally with this assertion, stating that percentage-based compensation formulae are used to spread risk, allowing hospitals and equipment vendors to share in market risks. Other commenters advocated that percentage-based compensation formulae can encourage the proper use of resources, sharing financial risk among the physicians in a group practice. According to some of these commenters, hospitals are able to avoid large financial risk by paying compensation as a percentage of reimbursement for a certain procedure. Several commenters argued that permitting percentage-based compensation formulae would ensure that a hospital never makes an equipment rental payment in an amount greater than what it collects for the services, from even the lowest paying insurer. One commenter questioned whether there are any distinct advantages inherent in flat-fee arrangements to reduce the potential for abuse that are not also apparent in other variable-fee arrangements.

Response: Parties are free to structure arrangements using other permissible compensation methodologies, including flat-fee payments set at fair market value and, unless otherwise prohibited as described in section VIII.F. of this preamble, per-procedure compensation. We do not believe that prohibiting percentage-based compensation formulae for determining the rental charges for office space and equipment lease arrangements should limit beneficiary access to needed services because other compensation structures for office space and equipment leases remain available to contracting parties.

Sharing of financial risk among parties does not eliminate necessarily the risk of program or patient abuse. As we described above, we believe that the use of percentage-based compensation formulae to determine rental charges for office space and equipment may provide significant incentive for parties to increase referrals in order to increase the rental payments that are based on revenues generated by those referrals. With respect to the comments regarding the ability of a hospital to ensure that it does not make a rental payment that is greater than the reimbursement it receives for the particular service for the particular patient, we note that rental charges must be set at fair market value. Reimbursement from an insurer does not correlate necessarily to fair market value, and rental charges based on a percentage of the amount reimbursed for a particular service may not result in fair market value rental charges for the equipment leased.

As explained in section VIII.F. of this preamble, we are concerned that entities may enter into per-use equipment lease arrangements, even though they may have sufficient volume to justify purchasing the equipment, because they are afraid of losing the referral stream from the physician lessor. Similarly, we are concerned that entity lessees may enter into percentage-based office space or equipment leases instead of flat-rate compensation lease arrangements because they are afraid of losing the referral stream from the physician lessor. We note that, although these commenters (which are either physicians or representatives of physicians) emphasized the benefits of percentage-based compensation arrangements for hospitals, no hospital or hospital association commented in support of this view.

Comment: One commenter explained that requiring a flat-fee compensation methodology may result in a DHS entity paying more for services than such services are worth (that is, if the assumptions on which the fair market value assessment obtained at the commencement of the compensations arrangement was based do not bear out, the physicians may get paid more than their effort merits or more than the value of the service to the DHS entity). The commenter gave the example of a hospital that pays physicians to help develop a spine center and, despite their best efforts, the spine center is not utilized by patients.

Response: This final rule does not prohibit the use of percentage-based compensation formulae outside of the context of determining the rental charges for the lease of office space and equipment. The commenter appears to be concerned about the use of a percentage-based compensation formula for paying physicians for their personal services, which would not be prohibited under this final rule, provided that all of the requirements of an applicable exception to the physician self-referral law are satisfied.

Comment: According to one commenter, we would be adopting a superfluous provision if we limit the definition of ''set in advance'' to allow percentage compensation arrangements in connection with the services ''personally performed'' by the physician. The commenter asserted that it would never be necessary for a physician who receives compensation

related to services that he or she is personally performing even to need to take advantage of an exception that includes a ''set in advance'' requirement, as personally performed services are not referrals.

Response: It is true that no exception is required for a financial relationship between a DHS entity and a physician if the physician is not making any ''referrals'' (as defined at § 411.351) to the entity. However, if a physician who is compensated for his or her personally performed physician services on a percentage basis by a DHS entity makes DHS referrals to the entity, the financial relationship would need to satisfy an exception. Moreover, we note that the proposal would have restricted percentage-based compensation formulae to personally performed physician services. Physicians personally perform services other than physician services, such as medical directorship, management and other administrative services.

Comment: One commenter asserted that continually changing the scope of permissible arrangements is very disruptive to established, long-term arrangements.

Response: In finalizing our proposal regarding percentage-based compensation formulae, as well as the other proposals finalized in this final rule, we have balanced the need for regulatory certainty to foster compliance against the risk of program and patient abuse from potential overutilization. The fact that a financial relationship is ''established'' or long-term does not guarantee that it presents no risk of program or patient abuse. The restrictions on the use of percentage-based compensation formulae finalized here are necessary to address our concerns regarding the risks of overutilization and program or patient abuse when such formulae are used to determine rental charges for the lease of office space or equipment.

Comment: One commenter suggested that we delay the effective date of the final rule. Another commenter asserted that the proposed change to the regulations would have complex and significant implications for sleep medicine as many specialists and hospitals have joint venture and lease management agreements that would require complete restructuring or possible termination.

Response: For the reasons discussed above, the final restrictions regarding the use of percentage-based compensation formulae for determining rental charges for the lease of office space and equipment are effective October 1, 2009. We recognize that the revisions to § 411.357(a), § 411.357(b), § 411.357(l) and § 411.357(p) in this final rule may require restructuring or termination of arrangements for the rental of office space and equipment. We expect that the delayed effective date of the revisions will provide parties with sufficient time to review existing arrangements and restructure them as necessary.

F. Unit of Service (Per Click) Payments in Lease Arrangements

In the CY 2008 PFS proposed rule, we stated that arrangements involving a physician lessor to an entity lessee under which the physician lessor receives unit-of-service (also known as per-click or per-use) payments are inherently susceptible to abuse because the physician lessor has an incentive to profit from referring a higher volume of patients to the lessee. Therefore, we proposed that such arrangements would not qualify for the exceptions at § 411.357(a) and (b) for space and equipment leases. We also solicited comments on the question of whether we should prevent per-click payments in situations in which the physician is the lessee and a DHS entity is the lessor. We received a few comments on the latter issue, all of which were in favor of answering the question in the affirmative.

We received many comments in favor of the proposals that such per click arrangements do not qualify for the exceptions at § 411.357(a) and (b) for space and equipment leases. Some of these commenters asserted that per-click leases with physicians for lithotripters are abusive, and that hospitals are effectively coerced into leases with physicians for fear that if they contract with non-physicians, their referral stream will dry up. We also received many comments opposed to our proposals, the great majority of which came from urologists, and from associations and law firms that represent urologists. Many of these commenters stated that lithotripsy is not a DHS, and that in any event there is no risk of overutilization because lithotripters and other equipment leased by urologists are for therapeutic, and not diagnostic, procedures. These commenters also emphasized that hospitals are either unwilling or unable to purchase lithotripters, lasers and other equipment, and that if it were not for physicians, including joint ventures among urology groups, patients would not have the benefit of advanced technology at all, or at best would have to travel longer distances to obtain it. These commenters also stated that instead of encouraging abuse, the per-click payment methodology was the fairest way to compensate the physician lessors. Many of these commenters also stated that the Congress intended that per-click leases be allowed.

Many of the commenters in favor of, or in opposition to, the proposal also commented on the proposal to amend the definition of ''entity'' at § 411.351 to clarify that a person or entity is considered to be ''furnishing'' DHS if the person or entity is performing services that are billed as DHS, notwithstanding that another person or entity actually billed the services as DHS (see section VIII.G. of this final rule for a discussion of that proposal) and, in many cases, the comments made specifically with respect to one proposal were applicable to the other. In some cases, it was not clear on which proposal the commenters were commenting. Because we believe that the issues are intertwined, in finalizing the ''per-click'' proposal, we considered the comments to both the ''per-click'' and ''under arrangements'' proposals, and considered also some of the comments submitted in response to the CY 2008 PFS proposed rule solicitation of comments on possible changes to the in-office ancillary services exception (72 FR 38181). We read carefully and considered each comment. Space limitations prevent us from summarizing each comment; however, we discuss below all of the significant points raised by commenters in favor of, or in opposition to, our proposal. A discussion of specific comments is presented below.

At this time we are adopting our proposal to prohibit per-click payments to physician lessors for services rendered to patients who were referred by the physician lessor. We continue to have concerns that such arrangements are susceptible to abuse, and we also rely on our authority under sections 1877(e)(1)(A)(vi) and 1877(e)(l)(B)(vi) of the Act to disallow them. Because physicians themselves may bill for DHS, we have the same concerns with respect to per-click lease arrangements in which a DHS entity is the lessor and receives a per-click payment from a physician lessee for space or equipment used by the physician in the provision of services to patients who were referred by the entity lessor to the physician lessee. The final rule revises the lease exceptions at §§ 411.357(a)(5) and 411.357(b)(4), as well as the fair market value exception at 411.357(l), and the exception for indirect compensation arrangements at § 411.357(p), and provides that per unit-of-service rental charges are not allowed to the extent that such charges reflect services

provided to patients referred by the lessor to the lessee. The prohibition on per-click payments for space or equipment used in the treatment of a patient referred to the lessee by a physician applies regardless of whether the physician himself or herself is the lessor or whether the lessor is an entity in which the referring physician has an ownership or investment interest. The prohibition also applies where the lessor is a DHS entity that refers patients to a physician lessee or a physician organization lessee.

We are delaying the effective date of the amendments to §§ 411.357(a)(5) and 411.357(b)(4) until October 1, 2009, in order to afford parties adequate time to restructure arrangements.

We are also taking this opportunity to remind parties to per-use leasing arrangements that the existing exceptions include the requirements that the leasing agreement be at fair market value (§ 411.357(a)(4) and § 411.357(b)(4)) and that it be commercially reasonable even if no referrals were made between the parties (§ 411.357(a)(6) and § 411.357(b)(5)). For example, we do not consider an agreement to be at fair market value if the lessee is paying a physician substantially more for a lithotripter or other equipment and a technologist than it would have to pay a non-physician-owned company for the same or similar equipment and service. As a further example, we would also have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease. In some cases, depending on the circumstances, such arrangements may also implicate the anti-kickback statute.

1. Support for Proposal

Comment: Many commenters, including a national provider of diagnostic imaging services, an association of practitioners, an association of radiologists, an association of radiology group practice managers, a radiation oncologists and several radiology group practices, stated that they supported the proposal to revise the space and equipment rental exceptions to prohibit per-click payments in those situations in which a physician leases space to a DHS entity, such as a hospital or IDTF, and the DHS entity utilizes the leased space or equipment to furnish services to patients referred by the physician lessor. These commenters believed that our proposed revision is consistent with the goal of eliminating, or at least reducing, the ability of a referring physician to profit directly from his or her own referrals for DHS, thereby reducing the risk of overutilization and abuse. Another commenter, a provider of diagnostic imaging services, stated that we can prevent a significant area of abuse by restricting the availability of unit-of-service based payments to a physician lessor for services rendered by a lessee to patients referred by the lessor to the lessee. Another commenter, an association of radiologists, stated that it strongly supports banning unit-of-service based leases. The commenter maintains that such leases fuel an incentive to order unnecessary examinations and that this practice is as potent as if the ordering physician is a partner in a joint venture.

One commenter, a radiation oncologist, said that some leasing arrangements are abusive and provide incentives to physicians to narrow their choice of treatment options to those for which they will realize a profit. Similar concerns were expressed by two companies that lease lasers, and individuals who apparently are employed by one of the companies. One of the commenters stated that: Financial motivation is driving treatment choices (that is, whereas options exist for the treatment of diseases, physician ownership of equipment plays a key role in influencing what the patient ultimately will be prescribed); physicians sometimes steer patients to facilities that are willing to lease equipment from the physicians; overutilization is created by practices that, due to physician ownership, use treatments that yield lower efficacy outcomes and causes the need for re-treatment; and, physicians pressure hospitals to use their leasing company despite not being the low cost provider. Another of the commenters also expressed concern that the utilization of antiquated or lesser technology in order to contain cost and keep profitability as high as possible, may result in the patient not receiving the best possible procedure, and leasing arrangements involving physician lessors may lead to increased insurance claims. An individual employed by one of the laser companies said that he has seen gross abuses of the current physician self-referral law, following the proliferation of urologist-owned LLCs, which include investments in treatments beyond lithotripsy, such as laser treatments, brachytherapy, and cryotherapy. The abuses claimed by the commenter include: Physicians threatening hospitals into using the physician's company; hospitals violating contracts because they believe that the consequences of a broken contract will be less severe than not letting the physician have his or her way; and physicians steering patients to equipment they own, rather than use a third party for which the hospital has contracted, even if it means having the patient travel to a non-convenient hospital. The commenter alleges that hospital administrators are aware of steerage, but fear that reporting the physicians will result only in more lost business.

A supplier of medical equipment said that it provides its equipment on a per-click basis, and also provides a clinical support technician to operate the equipment. It said that it has seen an increase in the number of equipment providers that are owned by physicians, and that physician-owned leasing groups are anti-competitive and undermine a hospital's independence. The commenter alleged that if a hospital demands that its business will be awarded to the lowest bidder of equivalent services, physician-owned leasing groups will threaten to move the cases that its physician owners control to another hospital. The commenter stated that in one instance a hospital that had been dealing with a physician-owned leasing company switched its business to the commenter with the result that many of the referrals went to other hospitals that dealt with the physician-owned company. The commenter also alleged that a physician group that has no equipment, but which controls the referral of cases, can say to a hospital's current equipment provider that it must be the physician group's subcontractor under a new contract between the physician group and the hospital. The commenter asserted that it had been approached by a physician that was assembling a group of urologists to join a physician-owned entity that would provide equipment and technicians for urological procedures. According to the commenter, its company would have acted as the subcontractor for the physician-owned entity; that is, it

would have been the actual supplier of the equipment.

An individual who owns a business that leases lasers for urological procedures stated that his company has obtained new technology lasers that offer improved clinical results and other benefits to patients, but that his company sometimes has difficulties in persuading physicians to allow the newer technology lasers to be brought into a hospital because the physicians have no ownership in the equipment. A medical sales representative stated that he has witnessed unethical business conduct due to physician ownership in surgical laser devices. According to the commenter, surgical lasers make up a large portion of per-click leasing arrangements.

An association that represents employers urged us to prohibit per-click payments to physician lessors for services rendered to patients referred by the physician lessors. The commenter considered such payments to be based on the volume of referrals or other business generated by the parties, and said that such payments provide incentives to overutilize services, increase costs and reduce competition. A few commenters, including an organization that represents rehabilitation therapists, stated that clinical efficacy, not financial gain, should be the motivating factor in patient care, and that the proposed rule would reinstate balanced competition, promote competitive pricing, factoring in of quality of care, and would help to reduce healthcare costs.

MedPAC stated that it believes that the financial incentives of leasing arrangements involving physician lessors could lead to overutilization of imaging services. MedPAC recommended that we prohibit these arrangements by expanding the definition of physician ownership to include interest in an entity that derives a substantial proportion of its revenue from DHS providers. (See page 167 of MedPAC's March 2005 Report to the Congress, available at *http://www.medpac/publications/congressional_Reports/Mar05_TOC.pdf*).

Response: We are finalizing our proposal due, in part, to many of the concerns expressed by commenters regarding lease arrangements that provide for per-click payments to a physician lessor for services provided to patients referred to the entity lessee by the physician lessor. We believe that such lease arrangements create the incentive for overutilization, because the more referrals the physician lessor makes, the more revenue he or she earns through the lease arrangement. We are also concerned that such agreements provide the incentive for the physician lessor to refer patients to the lessee of the physician's space or equipment, rather than to entities that may employ a different, and possibly more efficacious or appropriate, treatment modality (and in some cases, the appropriate course of action may be no treatment at all). We are also concerned that such lease agreements may foster anti-competitive behavior because entities may enter into such agreements due to fears of losing the physician lessor's referrals.

We decline to adopt the approach recommended by MedPAC, by which we would expand the definition of physician ownership to include an interest in an entity that derives a substantial proportion of its revenue from DHS providers. We believe that attempting to define what would constitute a ''substantial'' proportion of an entity's revenue, for purposes of whether to consider it a DHS entity, may be difficult, both in terms of implementation and enforcement. Moreover, MedPAC's recommended approach may be both underinclusive and overinclusive in some instances. That is, under the MedPAC approach, a physician-owned entity would be considered to be a DHS entity only if a substantial proportion of its revenue is derived from DHS entities. Such an approach could be underinclusive in situations in which, as a minor part of its business, a physician-owned entity leases equipment to a hospital but also, as the much greater portion of its business, owns and manages real estate. Also, MedPAC's approach could, in effect, allow overutilization and restrictions on competition provided that such effects were but a relatively small part of an entity's enterprise. On the other hand, we believe MedPAC's approach would be overinclusive with respect to a physician-owned entity that only leases equipment to a DHS entity (thereby meeting the ''derives a substantial proportion of its revenue'' test) but which does not lease the equipment on a per-click basis. (Additional discussion of MedPAC's approach is contained below, in section VII.G. of this preamble.)

2. Authority for Proposal

Comment: Several commenters said that Congress specifically intended to permit per-click leases and, therefore, we should not prohibit them. One commenter said that if Congress has spoken on an issue in legislative history, an agency's contrary interpretation must be set aside. One commenter said that it recognizes the potential for abuse but believes that per-click leases may be clearly permissible under the statute and current regulations. Another commenter said that although we possess authority under section 1877(e)(1) of the Act to impose requirements for space and equipment leases to protect against program or patient abuse, it is questionable whether that authority allows us to override a clear Congressional mandate. Some commenters noted that in the Phase I final rule with comment period (66 FR 876), we cited the Conference Report to the 1993 amendments to the physician self-referral law as support for the proposition that Congress intended that per-click payment was an accepted compensation method under the statutory space and equipment lease exceptions. A few commenters stated that we said in the CY 2008 PFS proposed rule that the statute does not expressly forbid per-click payments to a lessor for patients referred to the lessee. Another commenter said that it recognizes our concerns, but that per-click payments of the type addressed in the proposed rule may be clearly permissible under the statute, and, therefore, we should conduct further analysis prior to moving forward with any specific changes.

Response: Although we agree that Congress specifically intended to permit certain per-click leases, we disagree that Congress intended an unqualified exception for per-click leases under the physician self-referral statute. We recognize that in the Phase I final rule, we stated that the legislative history of the space and equipment lease exceptions led us to the conclusion that Congress clearly intended to permit leases that included per-click payments even for services provided to patients referred by the physician lessor. However, upon further analysis of the legislative history, we no longer believe that the interpretation we adopted in the Phase I final rule is the only reasonable interpretation of the statute and legislative history.

In order for a space or equipment lease to satisfy the exceptions under §§ 1877(e)(1)(A)(iv) or (e)(1)(B)(iv), the rental charges over the term of the lease must not be ''determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.'' The Conference Report to the 1993 amendments to the physician self-referral statute explains the intent underlying these provisions as follows: ''[t]he conferees intend that charges for space and equipment leases may be based on daily, monthly, or other time-

based rates, or rates based on units-of-service furnished, so long as the amount of the time-based or units-of-service rates does not fluctuate during the contract period based on the volume or value of referrals between the parties to the lease or arrangement.'' H. Conf. Rep. No. 103–213 at 814 (1993). Where the total amount of rent (that is, the rental charges) over the term of the lease is directly affected by the number of patients referred by one party to the other, those rental charges can arguably be said to ''take into account'' or ''fluctuate during the contract period based on'' the volume or value of referrals between the parties. Thus, both the statutory language and the Conference Report can reasonably be interpreted to exclude from the space and lease exceptions leases that include per-click payments for services provided to patients referred from one party to the other.

We rely on our authority under §§ 1877(e)(1)(A)(vi) and (e)(1)(B)(vi) to impose upon space and equipment leases additional requirements for per click leases needed to protect against program or patient abuse. In reaching our decision to prohibit certain per click payments for space and equipment leases under §§ 1877(e)(1)(A)(vi) and (e)(1)(B)(vi), we begin with the clear, overarching purpose of the statute. As we noted in the 1998 proposed rule (63 FR 1661), a number of studies prior to enactment of section 1877 consistently found that physicians who had financial relationships with entities to which they referred ordered more services than physicians without such financial relationships. Congress recognized that a physician's financial incentive to refer can affect utilization, patient choice, and competition. 135 Cong. Rec. H240 (Feb. 9, 1989) (statement of Rep. Stark). Congress chose a preventive approach to the self-referral problem: it essentially prohibited many abusive financial relationships between physicians and DHS entities and imposed strict liability on the DHS entity for claims submitted in violation of the statute (knowing violations of the statute by DHS entities and referring physicians are subject to additional sanctions).

The statute—with its significant financial sanctions—is far-reaching in its effect on the health care industry, touching virtually all major industry sectors. As stated in the Phase I preamble (66 FR 860), while the statute must be implemented to achieve its intent, we should be cautious in interpreting its reach so broadly as to prohibit potentially beneficial financial arrangements, and thus we would focus our regulations on financial relationships that may result in overutilization. We also indicated that we would ''continue to monitor financial arrangements in the health care industry and will revisit particular regulatory decisions if we determine that there is abuse or overutilization (66 FR 860).

The statute responds to the context of the times in which it was enacted (by addressing known risks of overutilization and, in particular, by creating exceptions for common business arrangements), and also incorporates sufficient flexibility to adapt to changing circumstances and developments in the health care industry. For example, in section 1877(b)(4), Congress authorized the Secretary to protect additional beneficial arrangements by promulgating new regulatory exceptions. In addition, Congress included the means to address evolving fraud risks by inserting into many of the exceptions—and notably, for our purposes, in the lease exceptions—specific authority for the Secretary to add conditions as needed to protect against abuse. See §§ 1877(b)(2), (e)(1)(A)(vi), (e)(1)(B)(vi), (e)(2)(D), (e)(3)(A)(vii), (e)(5)(C), (e)(6)(B), and (e)(7)(A)(vii). This design reflects a recognition that a fraud and abuse law with sweeping coverage over most of the health care industry could not achieve its purpose over the long term if it were frozen in time. In short, the statute evidences Congress' foresight in anticipating that the nature of fraud and abuse—and of beneficial industry arrangements—might change over time.

The evidence on the issue of overutilization and anti-competitive behavior persuades us that the lease exceptions need to be modified at this time to address a burgeoning risk of abuse and increased costs to the Medicare program. In our earlier rulemaking, we had been hopeful that risk of overutilization would be adequately controlled by the other conditions in the lease exceptions and by our interpretation permitting only those per-service (and similar) payments that are immutable and fair market value. With the passage of time, we are persuaded otherwise. Addressing this growing risk now is fully consistent with the statutory design and purpose.

3. Hospitals as Risk-Averse and Access to Care

Comment: Commenters stated that physician joint ventures have brought new, innovative therapeutic technology to communities because physicians were willing to bear the risk of failure. According to the commenters, hospitals are risk-averse and per-click arrangements with physicians are necessary to alleviate hospitals' concerns over low volume. Some commenters explained that to accommodate hospitals' fear of failure, urology groups have created joint ventures to purchase state-of-the-art equipment and lease it on a per-click basis to hospitals. The commenters asserted that by doing so, the urology joint ventures take the entrepreneurial risks and the hospitals are able to avoid the risk that the volume will be lower than projected. One urologist gave the example of how his physician group practice raised its own capital to purchase a DaVinci robot and lithotripsy machine when hospitals refused to purchase them. Many other urologists contended that sometimes the patient will need a procedure that is less often performed and it is difficult to factor this into the compensation arrangement.

One commenter said that per-click arrangements create efficiencies because they permit expensive equipment to be utilized by multiple parties. Without these types of arrangements, certain services may be unavailable to patients, particularly in rural areas where practices are too small to independently purchase such equipment. Another commenter said that he co-owns a lithotripter that travels around the state, including to rural hospitals where procedure volume may be too low to allow for a fixed monthly rental. Another commenter said that per-click fees work well with both low and high volume facilities and allow for smaller, rural hospitals to offer services locally to patients with little or no risk and with adequate compensation. The commenter contended that a weekly, monthly or yearly rental fee would not work given the great disparity of case loads and effectiveness of treatment.

One commenter said that our proposal would force hospitals to bear the risk of leasing equipment, and would effectively eliminate the provision of certain part-time or mobile health care services, including mobile lithotripsy services, thereby eliminating access to health care in smaller communities where there is not sufficient volume to support the full-time provision of such modalities. One commenter stated that the proposal will have a negative impact on the healthcare system. The commenter's group practice asserted that it was able to purchase a lithotripter at a cost in excess of $400,000 and there is not enough need at the various hospitals for a full time machine. Further, per-click arrangements are vital to the provision of lithotripsy services

as they are infrequent and often require additional treatments.

One commenter said that the prohibition on per-click payments would limit the efficacy of care. Another commenter said that because lithotripsy equipment is portable, it makes very little sense to have an expensive piece of equipment sitting in a hospital seven days a week when it is used only two or three days a week. Another commenter stated that although some per-click arrangements may be susceptible to abuse, many agreements provide enormous community benefit and have safeguards built in to prevent abuse.

Another commenter stated that it expects that physician-owned ventures and lobbies will seek to delay the implementation of the proposal by claiming disruption to clinical services, but that, based on its experience, there are numerous independent businesses ready to service and purchase the equipment and take over contracts without creating an interruption of services. A radiation oncologist stated that the argument in support of joint ventures with regard to ancillary services such as diagnostic testing, radiation therapy and pathology services generally centers on improved access to care. However, the commenter contended, there are no access issues with respect to radiation therapy services, as very few patients are not within a reasonable distance of a radiation oncology center. The commenter further explained that the decision with regard to the most appropriate therapy for patients with localized prostate cancer must remain independent of financial incentives.

Response: We are not convinced that per-click arrangements of the type that we are disallowing through this final rule are necessary to bring innovative technology to communities. We believe that, to the extent that hospitals or other DHS entities do not wish to purchase new technology, there will be a sufficient number of non-physician entities willing to lease the technology to them on a per-use or other basis. (Also, where it is not economically feasible for all hospitals in a given area to purchase the equipment, one hospital could purchase it and contract with the other hospitals to enable them to provide the service under arrangements.) Likewise, we believe that current leasing arrangements with physician lessors can be restructured on a block time or other basis. We further observe that the adoption of the proposal does not mean that physicians are prohibited from leasing to entities equipment or space on a per-use basis with respect to services rendered to patients that were referred by others; rather, consistent with the statutory directive that rental fees not take into account the volume or value of referrals or other business generated between the parties, a physician lessor may not receive per-use rental fees for services that were rendered to patients that he or she referred for DHS. Thus, if a physician wishes to lease equipment or space to an entity and refer patients for DHS to that entity, it may be possible for the parties to structure the arrangement so that the physician would receive per-use fees for services rendered to patients referred by others, but would receive compensation calculated on some other basis for services that were rendered to patients who were referred by the physician. We caution that leases that are structured to provide for a per-click payment methodology only with respect to those services that were furnished to patients who were not referred to the lessee by the lessor can implicate the anti-kickback statute. Regardless of the lease structure, in order to comply with the exception for space leases or the exception for equipment leases, payments under the agreement must be at fair market value (see § 411.357(a)(4) and § 411.357(b)(4)) and the agreement must be commercially reasonable even if no referrals were made between the parties (see § 411.357(a)(6) and § 411.357(b)(5)).

With respect to the commenters' assertion that physicians are willing to take risks in bringing new technology to communities and hospitals are risk-averse, to the extent that this is true, it begs the question of whether physicians are less concerned about risk because they can control the referral stream and whether hospitals are more concerned about risk because they fear that referrals will go to their competitors if they either purchase the equipment or refuse to enter into per-click leasing arrangements with physician lessors. We believe that the proposal as finalized will create a more level playing field between hospitals and physicians and also among hospital competitors. We note that although many of the physician commenters touted the benefits of per-click arrangements for hospitals, only one hospital commented and echoed this view. To the contrary, a large hospital association supported our proposal, as did two hospitals.

4. Evidence of Overutilization: Therapeutic Versus Diagnostic Procedures

Comment: Several commenters, including a radiologist, an association representing cardiologists, a pulmonologist, and a law firm objected to our proposals. They stated that our concerns are theoretical and no data has been presented that per-click arrangements involving radiology have resulted in overutilization of services, abusive practices, or otherwise threaten program integrity. One commenter said that there is insufficient support for the contention that per-click payments in space and equipment leases result in abusive practices. The commenter believes that the current requirements in the regulations provide sufficient safeguards; that is, the lease payments must be at fair market value and the equipment or space being leased must be reasonable and necessary for the legitimate purposes of the lease.

We also received many comments from urologists and others who stated that therapeutic procedures do not lend themselves to overutilization. Several of these commenters distinguished lithotripsy and other urological procedures from radiological procedures on the basis that the former are therapeutic procedures and thus do not pose the risk of overutilization that diagnostic radiological procedures do. For example, one commenter said that lithotripsy services present virtually no risk of overutilization. According to the commenter, this is so for two reasons. First, lithotripsy is a therapeutic, not a diagnostic, procedure. The commenter quoted us as having stated ''the procedure itself apparently documents the medical necessity to prescribe it. As we understand ESWL, the kidney stone is located, identified, and the progress of the therapy is recorded as part of the visualization process'' (63 FR 1682). Second, the commenter asserted that lithotripsy cannot be overutilized because of the strict standards of care for the use of a lithotripter. The commenter stated that, after a stone has been diagnosed, there are clearly defined guidelines for physicians to follow in the treatment of ureteral and kidney stones, based on the size and location of a stone and the clinical status of the patient. In addition, the commenter stated that there are formal protocols for the appropriate management of stone disease, all accredited lithotripsy facilities have thorough utilization review and quality assurance programs in place to ensure physician treatments are appropriate, and many facilities incorporate physician and staff review of each case prior to treatment to confirm its appropriateness and likely clinical efficacy. An association of urologists said that procedures such as green light laser procedures and cryotherapy also

would be affected by the proposed change to the space and lease equipment exception, and that, as with lithotripsy, these are therapeutic services, and there is little or no risk that these types of services will be overutilized. In contrast, one hospital stated that per-click arrangements for lithotripsy services are among the most abusive, and another hospital stated that per-click arrangements between hospitals and physicians are grounds for potential abuse.

Response: As noted above, per-click leases create the incentive for overutilization because the more referrals the physician lessor makes, the more revenue he or she earns through the lease arrangement. Even in the case of leases for therapeutic, rather than diagnostic equipment, there remains the potential for a physician lessor, in order to protect his or her investment or gain additional profits, to refer to the lessee of that equipment instead of referring to another entity that utilizes the same or different (and perhaps more efficacious) technology to treat the patient's condition, or to refer to the lessee instead of making no referral where the best course of action is no treatment. In this regard we note that we received comments from a radiation oncologist who stated that one must assume that the recent interest in radiation oncology facility ownership by urologists is largely, if not solely, due to the potential financial benefit in referring patients for Intensity Modulated Radiation Therapy (IMRT) because of the favorable reimbursement IMRT receives as a new technology. Similarly, we have also received informal public comments from a professional advocacy organization concerned about the potential for overuse of IMRT that is provided in urology practices using the in-office ancillary services exception. This commenter notes that the incentives may be greater for these physicians to prescribe IMRT to the vast majority, if not all, of their patients and that patients should not be steered to a specific treatment based on physicians' financial incentives. We are also concerned about the potential for anti-competitive behavior that exists for entities to enter into leasing arrangements with physician-owned companies instead of entering into leasing arrangements with non-physician-owned companies, or instead of purchasing their own space or equipment, because of a real or perceived fear of losing referrals from the physician lessor.

We also do not believe that it is necessary for us to have actual evidence of abuse involving lithotripsy or other therapeutic procedures in order to regulate per-click leasing arrangements; rather, we believe that the potential for abuse inherent in such arrangements, regardless of the nature of the service, allows us to issue a prophylactic rule. Several studies have established a link between physician self-referral and increased utilization. As an example of overutilized therapeutic treatments, we note that a large hospital system settled a case against several of their physicians who were accused of performing unnecessary cardiac surgeries. Federal officials alleged that the physicians entered a scheme to cause patients to undergo unneeded, invasive, cardiac procedures such as artery bypass and heart valve replacement surgeries. The hospital system agreed to pay $54 million to settle the Federal case.

5. Per-Click Payments as Best Measure of Fair Market Value

Comment: One commenter claimed that, under per-click leasing arrangements, the amount of payment per service is the same irrespective of how many patients are referred and, in practice, compensation to the physician owner does not take into consideration the actual number of patients referred, but is based on a *per capita* distribution of RVUs performed by each physician. The commenter further stated that per-click leases are often the best measure of fair market value as they ensure that payment is made only for actual services provided, and also allow fixed costs to be appropriately spread out over all clicks, thus providing a more accurate reflection of fair market value. Furthermore, per-click arrangements are common in the industry, not only for physician-owned entities, but for non-physician-owned entities as well. The commenter also asserted that per-click arrangements also may reduce overutilization, as a lessee who must pay a fixed amount lease may be more likely to use the equipment to ensure that the lease costs are covered. A second commenter stated that per-click arrangements result in more accurate and fairer allocations of risk and compensation than flat rate lease arrangements. The commenter contended that referrals for therapeutic procedures ebb and flow by the week, by the month and by the year. In addition, the commenter stated, hospitals are unwilling to commit to an amount that may be too high for the services received and physician ventures are unwilling to commit to an amount that would be too low for the services rendered. Another commenter stated that the per-click methodology is the fairest manner for hospitals to contract for devices and services for which their capital budget prevents them from acquiring. The commenter believed that if a hospital were to contract for 200 procedures, it would be paying twice the fair market value if only 100 procedures were in fact performed. The commenter argued that in such a situation, the hospital's overpayment for the services could be considered an inducement for urologists to refer their patients to the hospital, and that per-click arrangements prevent this sort of abuse.

Response: The points raised by the first commenter fail to address our concerns. Even though the amount of payment per service may not vary, the incentive for overutilization remains because the greater number of referrals, the greater amount of revenue realized by the lessor. Whether a physician receives a per-click payment directly or whether the entity in which the referring physician has an ownership or investment interest receives the payment, and revenues, profits and bonuses are then distributed to the various physician owners/investors, it remains true that the lessor has an incentive for overutilization. The potential for anti-competitive behavior is even more of a concern with respect to physician entity lessors, as such entities typically have more leverage over referral streams than do individual physicians. With respect to the statements that per-click leases are often the best measure of fair market value, we believe other types of arrangements can satisfy the fair market value requirement of the lease exceptions without presenting the same risk of overutilization or other abuse. (Again, we note that whereas the commenters emphasize the benefits of per-click leasing arrangements to hospitals, those entities and their associations generally have not echoed this view.) Moreover, in practice, per-click leases may be, in some cases, antithetical to fair market value compensation. That is because an entity leasing space or equipment on a per-use basis may pay willingly a significantly higher amount in per-click rental fees to a physician-owned entity, rather than leasing comparable space or equipment from a non-physician entity, because the lessee may still be realizing a profit, or breaking even, on services that are the subject of the lease and may not wish to risk losing referrals for those services and referrals for other services if it contracts with a non-physician lessor. Likewise, the physician entity lessor may be unwilling to enter into an arrangement under which the rental charges are reasonably based on the cost

of the equipment and its maintenance and its useful life, because it may earn much more through per-click fees where it has the ability to steer referrals to the hospital. The fact that per-click arrangements are common for physician-owned entities does not alleviate our concern of overutilization, but rather intensifies it. Nor does the fact that such agreements are commonly used mean that they are at fair market value. Finally, we are not persuaded by the statement that per-click arrangements may reduce overutilization, which is based on the theory that a lessee who must pay a fixed amount lease may be more likely to use the equipment to ensure that the lease costs are covered, because in many, if not most, cases the lessee is not in a position to refer patients for the service.

We are similarly unpersuaded by the second commenter. We disagree with the contention that fair market value necessarily is best reflected in the number of procedures performed where a lessee has exclusive possession of equipment or space that may be used very sparingly, the per-click payments by the lessee may be less than fair market value taking into consideration the cost of the equipment or space involved and the amount of rent that would be charged under a block time or other arrangement. Conversely, where a lessee has exclusive use of equipment or space that is used very frequently, the per-click payments made by the lessee may be above fair market value, taking into consideration the cost of the equipment or space involved and the amount of rent that would be charged under a block time or other arrangement.

We note that we are not prohibiting per-click arrangements involving non-physician-owned lessors to the extent that such lessors are not referring patients for DHS, nor are we prohibiting per-click payments to physician lessors for services rendered to patients who were not referred to the lessee by the physician lessors, because such arrangements do not carry with them risk under the physician self-referral statute. Of course, such arrangements must still satisfy all the requirements of the lease exceptions, including the requirements that they be at fair market value and be commercially reasonable.

6. Lithotripsy as not DHS

Comment: Some commenters wanted to know whether we consider lithotripsy to be a DHS, and cited the district court decision of *Am. Lithotripsy Soc.* v. *Thompson,* 215 F. Supp. 2d 23 (D.D.C. 2002), in which the court held that lithotripsy is not a DHS. A commenter noted that we did not address the above-referenced court decision in prior rulemakings. It stated that it assumes that the decision is binding only for lithotripsy services provided to Medicare beneficiaries in the District of Columbia, and that outside of that jurisdiction, lithotripsy services remain a DHS, because they are billed as inpatient or outpatient hospital services. Another commenter said that the rule should specify that lithotripsy is not a DHS. Other commenters wanted to know how the proposal would apply to per-use arrangements for lithotripsy services, given that lithotripsy services have been held not to be DHS. One commenter said that although we are concerned with per-click arrangements for DHS, the proposal would apply the ban more broadly to all physician-owned services. The commenter provided the example of a patient undergoing lithotripsy who may need a stent placed or removed or a ureteroscopy to push a stone into a more favorable position.

Response: We presently do not consider lithotripsy to be a DHS. An arrangement under which a physician would refer patients to an entity for lithotripsy services (or other services not classified as DHS) and receive a per-use rental fee for such patients would not, by itself, constitute a violation of the physician self-referral law and regulations. However, a lessor/lessee relationship between a physician and an entity creates a compensation arrangement regardless of whether the lease involves the provision of DHS or other services (or no services at all). Therefore, a lease arrangement for the lease of a lithotripter in exchange for per-click fees that are prohibited by this final rule that is entered into on or after October 1, 2009, will constitute a non-excepted compensation arrangement, and, as a result, the physician would not be able to refer patients to the entity for DHS unless those referrals meet some other exception under the physician self-referral law or regulations.

7. Time-Based Rental Arrangements

Comment: A hospital association stated that we should consider prohibiting time-based rental arrangements only when they permit payment for the use of leased space or equipment ''on demand.'' The commenter stated that if the aggregate amount of time for which space or equipment is available is not set in advance, but instead, the space or equipment is available on demand, the physician can pay to lease the space or equipment only when the physician needs it to provide specific patient care services. On the other hand, the commenter contended that, if the total amount of time leased by the physician is set in advance, the arrangement should be permitted because it would not fluctuate based on referrals and the physician would have financial responsibility for the rental payments without regard to the volume of services the physician provides using that space or equipment. An association of radiologists said that we should ban all time-based leasing arrangements. One commenter recommended that we not distinguish between per-click and time-based leasing arrangements. The commenter stated that although payments to a physician lessor would not increase directly through the referral of additional patients, as it would under a per-click agreement, the physician nevertheless has a financial incentive to refer patients to the provider in exchange for the fixed payment. Another commenter asked us to clarify that time-based rental payments, such as ''block time'' leases (for example, $1,000 per month) would be acceptable. Another commenter, which objected to our proposal, stated that if we were to require a ''flat fee'' lease, it would be almost impossible to comply with the requirement that the rental charges not take into account the volume or value of referrals.

Response: We agree that ''on demand'' rental agreements are problematic. We believe that they are essentially a per-use or per-click type of arrangement, and consider them to be covered by our revisions in this final rule. We decline to accept, at this time, the commenter's suggestion that we prohibit all time-based leasing arrangements. We also disagree with the comment that parties to a ''flat fee'' leasing arrangement, which we interpret as an agreement in which the rental charges over a period of time are fixed and are thus unaffected by the usage of the equipment (or, in other words, a time-based lease), will find it very difficult to avoid having the rental charges reflect the volume or value of any referrals or other business generated between the parties. We believe that time-based rental payments, such as block time leases, depending on how they are structured, may meet the requirements of the space and equipment lease exceptions, including the requirements that the agreement be at fair market value and be commercially reasonable, even if no referrals were made between the lessee and the lessor, and that they not take into account the volume or value of any referrals or other business generated

between the parties. We believe that the same concerns we identified above with respect to certain per-click lease arrangements can exist with certain time-based leasing arrangements, particularly those in which the lessee is leasing the space or equipment in small blocks of time (for example, once a week for 4 hours), or for a very extended time (which may indicate the lessee is leasing space or equipment that it does not need or cannot use in order to compensate the lessor for referrals). We will continue to study the ramifications of ''block time'' leasing arrangements and may propose rulemaking in the future. Parties entering into block leases should structure them carefully, taking into account the anti-kickback statute.

8. Physician Entities as Lessors

Comment: One commenter stated that because leasing arrangements are usually between a DHS entity and a physician group practice or investment entity owned by a group of physicians rather than individual physicians, in order for the proposed revision to have any real effect on overutilization through physician self-referrals, we would need to eliminate or modify the indirect compensation exception or carry through on our proposal to develop some type of ''stand in the shoes'' provision for physician investors. Two commenters stated that, although they were in support of the proposal, we need to go further and prohibit unit-of-service based payments that reflect services furnished to patients referred to the lessee by a physician lessor or any physician owner or investor in the lessor. Another commenter suggested that we clarify that the proposed prohibition on physician lessors would apply to a referring physician and any entity with which the physician has a financial relationship.

Response: We agree that the prohibition on per-click payments for space or equipment, to the extent that such payments reflect services provided to patients referred by the lessor to the lessee, should apply regardless of whether the physician himself or herself is the lessor or whether the lessor is an entity in which the referring physician has an ownership or investment interest. We agree with the commenter that our concerns with per-click payments for office space or equipment are not fully addressed if parties could structure an equipment or office space lease arrangement as an indirect compensation arrangement that would qualify for the exception in § 411.357(p). Likewise, we do not believe that parties should be able to circumvent the prohibition by using the fair market value exception at § 411.357(l) (which is applicable to equipment leases). Accordingly, we are making corresponding changes to the exception in § 411.357(p) to prohibit the use of per-click payments in the determination of rental charges for office space and equipment arrangements, and to the exception in § 411.357(l) to prohibit the use of per-click payments in the determination of rental charges for equipment. We decline, at this time, to adopt the commenter's suggestion that we clarify that the prohibition on per-click payments to physician lessors would apply to a referring physician and any entity with which the physician has a financial relationship. We understand the commenter's suggestion as encompassing the situation in which a physician, employed by Entity A, refers a patient to Hospital B for a procedure that uses equipment owned and leased by Entity A to Hospital B (with the physician having no ownership interest in Entity A). We understand that the potential for abuse exists in this situation for the physician's employer to direct or influence the physician to refer patients to a lessee that pays per-click rental charges to the employer, but are concerned that adopting the commenter's suggestion would not be a logical outgrowth of the proposed rule. Instead, we may propose rulemaking on this issue in the future, and we caution that if we make and finalize such a proposal we may not provide a lengthy delayed effective date.

9. Physicians and Physician Entities as Lessees

Comment: A hospital association stated that per unit-of-service payments should be prohibited when the physician is the lessee and the DHS entity is the lessor. A large association of radiologists also supported prohibiting per-click payments made by physician lessees to entity lessors. It said that most leasing arrangements are economically driven, do not contribute to patient convenience or any other attributes that promote better patient care and generally drive up utilization. It was particularly concerned with the ''scheme'' by which a referring physician leases space on a unit-of-service or *per diem* basis from an MRI facility and then submits a claim to Medicare for the global fee. A radiology group practice said that we should prohibit a physician from leasing equipment from a hospital for use on a patient that the physician has referred, because one should anticipate that some physicians and attorneys might scheme with a hospital to set up ''cross referral'' arrangements. The commenter stated that the only sure mechanism to prevent abuse is to prohibit entirely unit-of-service lease arrangements for physicians who are either lessors or lessees directly, or indirectly as owners of a lessee or lessor entity.

One commenter, a radiology practice, said that, in its experience, the situation in which a DHS entity leases space and/or equipment to a referring physician to perform and bill for the technical component services the physician orders for his or her patients, is also prevalent and can lead to overutilization if the rental is based on a per-click payment to the DHS entity, because the physician pockets the difference between the lease fee and the reimbursement from Medicare. Therefore, the commenter urged us to prohibit per-click lease payments by physician lessees. A radiology benefits management company said we should develop a prohibition on per-click or time-based payments by physicians. An association that represents employers said unit-of-service lease arrangements should be prohibited when the referring physician is either the lessor or the lessee.

Response: In the proposed rule, we stressed the situation in which a physician is the lessor and the DHS entity is the lessee; however, we solicited comments on the issue of whether we should prohibit time-based or unit-of-service based payments to an entity lessor by a physician lessee, to the extent that such payments reflect services rendered to patients sent to the physician lessee by the entity lessor (72 FR 38183). After considering the comments and after studying the matter further, we have decided to adopt a symmetrical approach. That is, because physicians themselves may submit claims for DHS, there is the potential for overutilization and for anti-competitive behavior where patients are referred to physician (or physician organization) lessees by an entity lessor that receives a per-click payment each time the physician uses space or equipment in treating the referred patient. We note that the language of the proposed rule (''Per unit-of-service rental charges are not allowed to the extent that such charges reflect services provided to patients referred by the lessor to the lessee'') was neutral insofar as it did not specify ''physician'' lessors, and, thus, we believe it is not necessary to substantively revise this language to accommodate the policy that the prohibition on certain per-click payments applies to both physician lessors and other entity lessors. We are

not, at this time, extending the prohibition to time-based leasing arrangements (other than ''on-demand'' time-based arrangements, as discussed above in this section of the preamble).

10. Effective Date

Comment: One commenter that supported the proposal stated that if we finalize the proposal, we should provide an appropriate grace period before the change would take effect, in order to allow parties time to restructure or unwind existing lease arrangements. The commenter was concerned that if an appropriate transition period is not provided, patient access to important services would be jeopardized and hospitals could be subjected unnecessarily to potential liability for services. A second commenter that supported the proposal said that there should be a one-year period in which parties can unwind current arrangements. A third commenter urged us not to adopt the proposal because frequent changes in regulatory standards are extremely disruptive to the continued provision of services. A fourth commenter stated that, in the event we impose a ''blanket prohibition'' on per-click payment agreements, existing arrangements should be grandfathered.

Response: Our revisions to § 411.357(a) and § 411.357(b), concerning per-click fees, are effective for lease payments made on or after October 1, 2009. We believe this delayed effective date will provide parties sufficient time to restructure existing compensation arrangements or to unwind lease arrangements. We are not providing for grandfathering of existing per-click arrangements that are otherwise prohibited by this final rule given the concerns we have expressed above. We reiterate that the final rule does not impose a blanket prohibition on per-click payments, but rather prohibits per-click payments to the extent that such payments reflect services provided by the lessee to patients referred to the lessee by the lessor.

G. Services Provided ''Under Arrangements'' (Services Performed by an Entity Other Than the Entity That Submits the Claim)

In the CY 2008 PFS proposed rule, we proposed to revise the definition of ''entity'' at § 411.351 so that a person or entity is considered to be furnishing DHS if it is the person or entity that has performed the DHS or presented a claim or caused a claim to be presented for Medicare benefits for the DHS (72 FR 38186–38187). In this final rule, we are finalizing that proposal with modification. We also proposed in the CY 2008 PFS proposed rule that an ''entity'' would not include a physician organization that bills for the professional component (PC) of a diagnostic test where the anti-markup provisions of § 414.50 are applicable to the PC and the physician organization bills in accordance with the anti-markup provisions. We finalized that proposal in the CY 2008 PFS final rule with comment period (72 FR 66400).

The physician self-referral rules prohibit a physician from making referrals for DHS to an entity with which the physician (or an immediate family member) has a financial relationship, and prohibits the entity from billing Medicare for the DHS, unless an exception applies. Under the Phase I revision to the definition of ''entity'' at § 411.351, an ''entity'' includes only the person or entity that bills Medicare for the DHS, and not the person or entity that performs the DHS where the person or entity performing the DHS is not the person or entity billing for it.

In the CY 2008 PFS proposed rule, we noted our continuing concern about the risk of overutilization with respect to services provided ''under arrangements'' to hospitals and other providers because the risk of overutilization that we identified in the 1998 proposed rule has continued, particularly with respect to hospital outpatient services for which Medicare pays on a per-service basis (72 FR 38186). We proposed to revise our definition of entity at § 411.351 to include both the person or entity that performs the DHS, as well as the person or entity that submits claims or causes claims to be submitted to Medicare for the DHS.

We received many comments both in favor of, and in opposition to, the proposal. We read carefully and considered each comment. Space limitations prevent us from summarizing each comment; however we discuss below all of the significant points raised by commenters in favor of, or in opposition to, our proposal. Commenters in favor of the proposal stated that they believed that existing contractual arrangements between physician-owned service providers and hospitals are inconsistent with the purpose of the physician self-referral law and are susceptible to abuse. Notably, two large national hospital associations expressed support for the proposal, whereas only a few hospitals were opposed to it. Many of the commenters in support of the proposal pointed to the potential for overutilization and anti-competitive behavior with respect to all types of procedures, including therapeutic services such as radiation oncology services used in the treatment of prostate cancer. The commenters opposed to the proposal largely were physician organizations and physicians, many of whom are urologists and cardiologists. These commenters argued that hospitals are unable or unwilling to invest in technology to provide services directly, and that their joint ventures provide care in an efficient manner, meet a community need, and offer good quality. They asserted that patient access would be negatively impacted if we adopted our proposal. Urologists engaged in joint ventures with hospitals for the treatment of prostate conditions, including prostate cancer, stressed their view that, unlike the case with imaging, there is no risk of overutilization with therapeutic services.

Many of the commenters in favor of or in opposition to the proposal also commented on the proposal to disallow ''per-click'' lease payments in certain circumstances (see section VIII.F. of this final rule for a discussion of that proposal) and, in many cases, the comments made specifically with respect to one proposal were applicable to the other. In some cases, it was not clear on which proposal the commenters were commenting. Because we believe that the issues are intertwined, in finalizing the ''under arrangements'' proposal, we considered the comments to both the ''under arrangements'' and ''per-click'' proposals.

In this final rule, we are adopting our proposal with modification and amending the definition of ''entity'' at § 411.351 to clarify that a person or entity is considered to be ''furnishing'' DHS if it is the person or entity that has performed the DHS, (notwithstanding that another person or entity actually billed the services as DHS) or presented a claim for Medicare benefits for the DHS. Note that where one entity performs a service that is billed by another entity, both entities are DHS entities with respect to that service. We are delaying the effective date of the amendment to the definition of ''entity'' at § 411.351 until October 1, 2009 in order to afford parties an adequate time to restructure arrangements. A discussion of specific comments is presented below.

1. Support for Proposal

Comment: Many commenters supported the proposal. An association of radiologists stated that it shares our concerns that referring physicians have profited from joint venturing with

hospitals for imaging services provided ''under arrangements'' with hospitals. According to these commenters, these arrangements are essentially thinly-veiled substitutes for the imaging centers that were the original target of the physician self-referral law. Moreover, many of these arrangements do not appear to improve clinical quality or value, yet they may increase costs to the Medicare program and its beneficiaries. An organization that represents imaging providers and professionals and imaging equipment and supply vendors stated its belief that the proposed change to the definition of ''entity'' would preclude referrals that are based upon financial incentives and result in overutilization. An association that represents radiology practice managers and other radiology business professionals supported the proposal, asserting that the change is necessary because the existing definition of ''entity'' runs counter to the plain intent of the physician self-referral law. A radiology group practice contended that physician-hospital arrangements are an attempt to extort more money out of an already underfunded system. According to that commenter, it is particularly egregious where the hospital has the ability to provide the service. A different radiology group practice described its firsthand experience with what it believed to be the type of abusive arrangement described in the proposed rule. The commenter asserted that if a hospital or a freestanding imaging center has a solid business model and provides good services, only in rare circumstances would it need the capital of referring physicians to finance its operations. According to the commenter, we should consider such arrangements to be thinly-disguised forms of kickbacks and ban them entirely. One commenter asserted that the proposal, if finalized, will contribute importantly to closing the perceived ''under arrangements'' loophole that has been used inappropriately to circumvent the physician self-referral prohibition.

A nonprofit organization that represents large employers stated that it strongly supports the proposal, asserting that services performed in a non-hospital setting on registered hospital outpatients, under a contract between the hospital and the separate provider, present conflicts of interest and provide incentives for overutilization when the referring physicians have an ownership interest in the separate provider.

One commenter, a urologist, stated that although some joint ventures certainly improve access to care and new technology, joint ventures have been abused and that intensity modulated radiation therapy (IMRT) for prostate cancer treatment is an example of how ''under arrangements'' contracts are being abused. According to the commenter, because the profit margin is $15,000 per patient, numerous joint ventures have been established purely to capture this passive income. Another commenter, a radiation oncologist, wrote that he was compelled to comment on our proposal because of his recent experiences in dealing with referring physicians and because of the ''call for action'' that has been forwarded by a urological association to its members, urging them to comment on how proposed changes will impact negatively their practices. The commenter stated that the proposed changes will not have a negative or serious effect on the way urology is practiced. The commenter's view of the argument in support of joint ventures with regard to ancillary services such as diagnostic testing, radiation therapy and pathology services is that it generally centers on improved access to care. The commenter attempted to discredit this argument by asserting, with respect to radiation therapy services, there are no access issues, as very few patients are not within a reasonable distance of a radiation oncology center. The commenter noted further that urology practices' interest in external beam services is a relatively new phenomenon, although the use of external beam radiation therapy in the treatment of patients with prostate cancer is not. The commenter also stated that IMRT, a sophisticated form of external beam radiation, has become the new standard of care with respect to external beam therapy for patients with localized prostate cancer. According to the commenter, as a new technology, IMRT has a favorable reimbursement profile. In addition, the commenter stated that because the reimbursement is the only variable that has changed, the recent interest in radiation oncology facility ownership by urologists is largely, if not solely, due to the potential financial benefit in referring patients for IMRT at the urologist's own facility. The commenter emphasized that the decision regarding the most appropriate therapy for patients with localized prostate cancer must remain independent of financial incentives.

One commenter, an association of radiation oncologists, endorsed the position of the Agency for Health Care Research and Quality (AHRQ), that no single therapy can be considered the preferred treatment for localized prostate cancer due to limitations in the evidence, as well as the likely tradeoffs an individual patient must make between estimated treatment effectiveness, necessity and adverse effects. The commenter asserted that prostatectomy, IMRT, and brachytherapy are equivalent treatments for local prostate cancer; that the right treatment for any particular prostate cancer patient depends on the patient's interests, age, concerns, disease status, and physiology; and that sometimes the best treatment might be no treatment at all. The commenter expressed its concern that, whereas some may argue that therapeutic services cannot be overused, because of inappropriate financial incentives, prostate cancer patient choice is being eroded and overutilization may be occurring. The commenter recounted reports from its members of instances where patients who might otherwise appropriately be monitored for disease progression (that is, watchful waiting) are being treated in urology practices with IMRT (which is permissible under the in-office ancillary services exception). Thus, the commenter believed, patients who might choose to monitor disease progression are undergoing significant procedures and treatment because the diagnosing physician is influenced by financial incentives.

One commenter, a radiation oncologist, stated that since a large group practice in his county, consisting of about 38 urologists and 2 radiation oncologists purchased a freestanding radiation oncology practice, with two linear accelerators, IMRT has been used in lieu of other types of treatment (or in lieu of no treatment, which is sometimes appropriate). In particular, the commenter contended that brachytherapy, an equally efficacious but significantly less expensive alternative to IMRT, is performed at a fraction of its past volume in his county. He also reported that community-based surgery is occurring significantly less than in the past. According to the commenter, because every cancer surgeon in his county and many in another county have been approached to join the group practice, hospitals have been forced to propose various ''under arrangements'' contracts or joint ventures to stem the tide of business lost to the group practice. The commenter concluded that, in his county, patients with prostate cancer who are treated by physicians in the group practice are being steered primarily in one direction to a single treatment, IMRT, at a single facility. In his opinion, the quality of prostate cancer treatment in his county

has been impacted negatively by inappropriate financial incentives.

A commenter representing a medical equipment company asserted that hospitals use physician-owned vendors instead of other vendors simply because of the physicians' ownership even though other companies competing for the business had better service, equipment and pricing. The commenter contended that competition is stifled where a physician's investment is taken into account when deciding a service issue. The commenter also claimed knowledge of a situation in which patients are not able to get the best technology and service available because a physician will use only equipment from the company in which he or she is invested.

One commenter offered its strong support for our proposal, as it would correct abuses that occur due to the increasingly prevalent use of providing services ''under arrangements.'' The commenter asserted that, historically, services were furnished ''under arrangements'' as a means to provide access to patients for necessary services without having multiple parties acquire and operate the same specialized services and technology. In addition, the commenter stated that the increasing frequency of ''under arrangements'' contracts, coupled with greater Medicare payment for hospital services (as opposed to payment for the same service under the Medicare physician fee schedule), provides what may be an irresistible financial incentive for physicians to refer patients to the entity contracted to provide the services ''under arrangements'' to the hospital or other provider. The commenter, a large health benefits company, also stated that, because hospitals use the same billing system for both Medicare and private commercial payers, hospitals are frequently reimbursed where services were performed by entities under contract with the hospital to provide services, such as ASCs. Because the commenter's contractual reimbursement rate is higher for hospitals than for ASCs, in an ''under arrangements'' situation, the commenter sometimes inadvertently provides excessive reimbursement for the actual cost of care rendered, thereby inflating the cost of medical care.

A commenter asserted that the number of physician-owned entities providing services ''under arrangements,'' including cardiac catheterization laboratories, have proliferated in recent years, presumably because of the physician self-referral rules. The commenter supported our proposal and opined that there appears to be no legitimate reason for these arranged services other than to allow referring physicians an opportunity to share revenue from referrals they make for separately payable services.

One commenter, a national hospital association, offered support for our proposal, recognizing the legitimate concerns that may exist when a physician-owned joint venture provides the same services to a hospital ''under arrangements'' that the hospital previously provided directly, without expanding the type of services provided, upgrading the facility or the equipment, or otherwise contributing to the improvement of healthcare quality or accessibility in the community. According to the commenter, the ''under arrangements'' concept, which originally was solely a payment concept, has been used in recent years as a way to work around the physician self-referral rules, as growing numbers of physicians and hospitals have exploited what amounts to a loophole in the regulations. The commenter asserted that we are ''clamping down'' appropriately on these abusive arrangements, which, when unraveled, are quite often merely a sophisticated way of circumventing the basic purpose of the physician self-referral law. Another national hospital association and two state hospital associations noted their support of our effort to ensure that services provided ''under arrangements'' meet a community need, that individual patients receive care in the setting most medically appropriate to their needs, and that only those arrangements that foster needed improvements in the delivery system, sustain community access to essential services, promote clinical integration or enhance efficiencies should be permitted. However, these commenters were concerned that our proposal unintentionally may eliminate hospital-physician joint ventures designed to achieve those goals.

MedPAC commented on the CY 2008 PFS proposal, asserting that the ''under arrangements'' model was used originally by hospitals to provide certain services to their patients that were not available at the hospital because they were required infrequently. It shared our concern regarding the growth of services provided ''under arrangements'' to hospitals by physician-owned entities, and stated that our proposal, if adopted, would be an effective way to address this issue.

Response: We are adopting our proposal with modification. Our conclusion that the Congress intended an entity that performs services that are billed as DHS to be a DHS entity, notwithstanding that the entity contracts with another to bill Medicare, is supported by both the language of the physician self-referral statute and its underlying purpose. Section 1877(a) of the Act contains two basic prohibitions with respect to physician self-referral. First, under section 1877(a)(1)(A) of the Act, if a physician (or an immediate family member) has a financial relationship with an ''entity,'' it may not make a referral to the entity for the ''furnishing'' of DHS, unless the financial relationship meets an exception. Second, under section 1877(a)(1)(B) of the Act, an entity that receives a prohibited referral may not present or cause to be presented a claim to Medicare, and also may not bill any individual, third party payor, or other entity.

Section 1877(a)(1)(A) of the Act does not define ''entity'' as any particular type of organization but rather defines it in a functional sense, that is, an organization that furnishes DHS. Our current definition of ''entity'' at § 411.351 similarly provides that an ''entity'' is any type of organization, regardless of form of ownership (for example, partnership, LLC or corporation) that ''furnishes'' DHS. We believe that furnishing DHS includes performing services that are billed as DHS to the Medicare program, irrespective of whether the entity performing the services submits the claim or whether some other entity (such as a hospital providing the services ''under arrangements'') submits the claim. In this regard, we note that section 1877(a)(1)(B) of the Act provides that an entity that furnishes DHS may not present, or cause to be presented, a Medicare claim. This language demonstrates that the Congress intended that furnishing DHS encompasses not only the entity that bills for the DHS, but also the entity that performs it, if those are not the same entities; otherwise there would be no need to include the language ''cause to be presented.''

Our conclusion is also consistent with the purpose of the statute. A basic premise of the physician self-referral statute is that, subject to some specific exceptions in section 1877(d) of the Act, a physician may not refer a patient to an entity in which he or she (or an immediate family member) has an ownership or investment interest. The general prohibition on self-referral to an entity in which the physician has an ownership or investment interest is not predicated upon a showing by us of actual or potential abuse; rather, the Congress has made a policy decision to

disallow self-referrals involving an ownership or investment interest, except in a few specified instances. We fail to see why the Congress would have intended to prohibit a physician from referring patients to a freestanding laboratory or imaging facility that he or she owns, but would have wanted to permit the physician to make such a referral simply because the laboratory or imaging service is sold to another entity that does the billing for it. (Likewise, we fail to see why the Congress would have intended that the general prohibition on physician referrals to entities in which they have an ownership or investment interest could be circumvented merely by arranging for the service provider to reassign to another, for a fee, the right to receive Medicare payment.)

We also note that, in enacting the exception in section 1877(d)(3) of the Act for ownership or investment in a hospital, the Congress admonished that the exception is unavailable where the ownership or investment interest is in ''merely a subdivision of the hospital.'' If a physician may not purchase an interest in the radiology department of a hospital, refer patients to the hospital for radiology procedures, and claim the benefit of the hospital exception in section 1877(d)(3) of the Act, he or she should not be allowed to enter into a joint venture with the hospital through which the hospital effectively moves its radiology department (or part of its radiology department) outside of the hospital and into a facility in which the physician has an ownership interest and to which the physician refers patients for DHS that are billed ''under arrangements.'' Finally, we believe that the fact that Congress enacted an ownership exception for in-office ancillary services (which does not include inpatient or outpatient hospital services, and which has specific requirements as to where the services can be performed) is further indication that Congress did not intend to protect generally a physician's ownership in an entity that performs services that are then billed to Medicare as DHS by a hospital ''under arrangements.'' See 66 FR at 894.

2. MedPAC Approach

In the CY 2008 PFS proposed rule, we noted that MedPAC recommended in its March 2005 Report to Congress that a physician should be prohibited from referring patients for DHS to an entity if that entity derives a ''substantial portion'' of its revenue from a provider of DHS (hereinafter referred to as the ''MedPAC approach''). There, we stated that we believed that our proposed approach—that an entity is considered to be a DHS entity if it performs the DHS or bills for it—was more straightforward than MedPAC's approach (which we believe is more difficult to apply and to enforce), but we solicited comment as to whether we should adopt MedPAC's approach, either in lieu of, or in addition to, our proposed approach (72 FR 38187).

Comment: Two commenters believed that the MedPAC approach was preferable to our proposal. The first commenter asserted that the MedPAC approach would permit legitimate businesses to provide services to a referral source, and referrals would be prohibited only if that entity derives a substantial portion of its revenue from the DHS provider, whereas our proposal would prohibit any level of business activity with a DHS provider, without any investigation into the circumstances that cause some ''under arrangements'' joint ventures to be abusive. The second commenter argued that our proposal should be limited only to diagnostic services and should incorporate MedPAC's proposed approach.

Most commenters disagreed with the MedPAC approach. For example, one commenter was concerned that the MedPAC approach virtually would eliminate ''under arrangements'' service contracts between hospitals and physicians or physician groups, potentially disrupting access and prompting duplication of investment in facilities and equipment. One commenter, although opposed to our proposal, contended that we would have difficulty defining ''substantial proportion of its revenue'' under the MedPAC approach. Another commenter that disagreed with our proposal said that MedPAC's ''substantial proportion of revenue'' test is overbroad and would have unintended and far-reaching consequences. According to the commenter, the MedPAC approach is not limited to entities performing, furnishing or billing for DHS, but instead effectively prohibits physician ownership of entities providing any service to a provider of DHS, if the service results in revenue significant enough to trigger the test's application.

A commenter suggested that the most significant difference between our proposal and the MedPAC approach appears to be that our proposal would affect only companies that perform DHS in their own right, whereas the MedPAC approach would also affect companies that provide only ''inputs'' into the DHS, or indeed, services that have no relationship whatsoever to DHS. One commenter asserted that our proposal was ambiguous and could contribute to confusion in the industry and stated that the MedPAC approach was clear, but that its adoption would impact many other types of arrangements between physicians and hospitals, such as lease arrangements that comply with the physician self-referral rules and that do not present an incentive for overutilization. Finally, a commenter disagreed with both our proposal and the MedPAC approach, contending that the MedPAC approach is contrary to the basic tenets of a hospital's right to furnish services ''under arrangements.''

Response: At this time, we decline to adopt the ''substantial proportion of revenue'' test suggested by MedPAC. In addition to our concerns that such a test would be difficult to administer and enforce, we are concerned that entities that do not directly perform a service or otherwise cause a claim to be presented, but rather have only tangential connection to the service by providing another entity with supplies or equipment could be included within the test. We question whether such a result is appropriate policy, as well as whether we would have the authority to adopt such a test. We note that in its comments on our proposal, MedPAC offered its support and merely noted that it had recommended that we expand the definition of ''physician ownership'' to include interests in an entity that derives a substantial proportion of its revenue from a provider of DHS.

3. Authority for Proposal

Comment: A large association representing internists and medical students claimed that we lacked authority to expand the scope of the statute to apply to entities that do not bill the Medicare or Medicaid programs for DHS.

Response: We disagree. For the reasons stated above, we believe our decision to clarify that an entity that performs services that are billed as DHS is a DHS entity, is consistent with both the language and the purpose of the physician self-referral statute. As stated above, section 1877(a)(1)(A) of the Act does not define ''entity'' as any particular type of organization; rather, the prohibition applies to any entity that ''furnishes'' DHS. Again, we note that section 1877(a)(1)(B) of the Act provides that an entity that furnishes DHS may not present, or cause to be presented, a Medicare claim. Accordingly, an entity that ''furnishes'' DHS can include more than just the entity that bills for the DHS. We believe that ''furnishing'' DHS should include performing services that are billed as DHS to the Medicare program, irrespective of whether the entity performing the services submits

the claim or whether some other entity (such as a hospital providing the services ''under arrangements'') submits the claim.

Comment: Several commenters alleged that the proposal was contrary to the Congress's decision, and/or our decision, to treat an ''under arrangements'' relationship as a compensation arrangement, rather than an ownership interest, between the parties. A few commenters believed that the statutory compensation exception for ''under arrangements'' services at section 1877(e)(7) of the Act indicated that we have questionable authority to promulgate regulations that would contradict this expression of Congressional intent. The commenters also believed that in enacting amendments to the physician self-referral law in 1993, the Congress determined that such service arrangements with group practices should be protected as compensation arrangements if certain standards are satisfied. According to one commenter, the Congress unequivocally decided that the physicians' ownership interest in the ''under arrangements'' service provider is not an ownership interest in an entity furnishing DHS services, and that the only financial arrangement that triggers the physician self-referral law is the service agreement between the hospital and the under arrangements service provider. The commenter argued that this interpretation is supported by the exception's plain meaning and other sources. According to the commenter, if the Congress thought there was any ownership interest created under the physician self-referral law with these types of arrangements, it would have placed such an exception in section 1877(b) of the statute, which contains all the exceptions that protect both ownership and compensation. Also, the commenter asserted that to meet the exception at section 1877(e)(7) of the Act, physicians participating in the arrangement must refer substantially all of their similar cases through the arrangement, and, therefore, our stated concern about the abusive incentives we see with arranged-for services cannot be reconciled with the Congress's comfort in requiring a high level of self-referral.

Response: We disagree that, in enacting section 1877(e)(7) of the Act, the Congress determined that ownership in the entity performing DHS under arrangements is not ownership in a DHS entity. The commenters confuse which financial relationships our proposal addressed. Contrary to their arguments, there is no indication in either the text of the statute or its legislative history that the Congress intended to except ownership interests in the entity performing the service on behalf of the hospital. Instead the language of section 1877(e)(7) of the Act clearly says that a group practice will not have a prohibited compensation arrangement with a hospital, if certain conditions are met; it does not address whether a referring physician has a prohibited ownership interest in the entity performing the service. Moreover, the plain language of section 1877(e)(7) of the Act demonstrates that the Congress intended to protect compensation from a hospital to physicians performing services ''under arrangements'' only in very narrow circumstances. The exception at section 1877(e)(7) of the Act (and at § 411.357(h) of our regulations) protects compensation from hospitals to group practices only (that is, not to individual physicians or to physician organizations not meeting the definition of a ''group practice'' as defined at section 1877(h)(4) of the Act and § 411.352 of our regulations), and with respect to only inpatient services billed by the hospital (that is, not with respect to outpatient hospital services or other types of DHS). Also, in order to be protected, the arrangement with the hospital had to have begun prior to December 19, 1989 (the date of enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239) and must have continued without interruption since that time. We also do not agree with the commenter that Congress was comfortable in requiring a high level of self-referral, because, according to the commenter, in order to meet the exception at section 1877(e)(7) of the Act, physicians participating in the arrangement must refer substantially all of their similar cases through the arrangement. The exception requires only that substantially all of the under arrangement services furnished to patients of the hospital must be furnished by the group under the arrangement; the exception does not require the group physicians to refer their patients to the hospital. In sum, we believe that, to the extent that section 1877(e)(7) of the Act evinces any intent of the Congress toward physician ownership in entities that provide services for a hospital to bill under arrangement, the fact that the Congress enacted such a narrow compensation exception would indicate that the Congress was not favorably disposed to protecting physician ownership in such entities.

Comment: Two commenters asserted that, in the 2001 Phase I final rule with comment period, we stated that we would not consider an ''under arrangement'' relationship to constitute an ownership interest for several reasons: (i) To do so would disrupt patient care; (ii) such relationships easily could be structured to comply with the personal services arrangements or fair market value exceptions; and (iii) there was precedent in the statute for treating such financial relationships as creating a compensation arrangement. The commenter stated that it was unaware of anything that had occurred over the years to mitigate the reasons stated in Phase I for treating ''under arrangements'' relationships as compensation arrangements, rather than ownership interests.

Response: We do not believe that the proposal is inconsistent with the position we took in Phase I. The preamble discussion in the Phase I rule referred to by the commenters focused on the relationship between physicians and a hospital. There, we stated that we were concerned that the provision of services ''under arrangements'' could be used to circumvent the prohibition in section 1877(c)(3) of the Act of physician ownership of parts of hospitals. We said that we understood that some hospitals were leasing hospital space to physician groups, which the groups then used to provide services ''under arrangements'' that the hospital had previously provided directly, and that these arrangements raised significant issues under section 1877 of the Act, as well as the anti-kickback statute. We said that, although the physician self-referral statute could reasonably be interpreted to prohibit ''under arrangements'' relationships as constituting prohibited ownership interests in a part of a hospital, we declined to do so at that time. However, we cautioned that we would monitor ''under arrangements'' relationships and that we might reconsider our decision if it appears that the arrangements are abused (66 FR 942). In contrast to the preamble discussion in the Phase I rule, our proposal did not focus on the financial relationship between a physician and a hospital (or other entity) that bills Medicare for services furnished ''under arrangements''. Rather, it focused on the ownership interest that a physician has with an entity that performs DHS that are furnished ''under arrangements'' with a hospital or other entity that bills Medicare for the DHS. We believe that where a physician has an ownership or investment in an entity that performs DHS, the application of the physician self-referral statute should not be avoided simply by having another entity bill Medicare for the DHS.

We also believe that the preamble discussion in the 1995 final rule demonstrates that we recognized a distinction between the question of whether a physician or group practice has an ownership (as opposed to a compensation) relationship with a hospital and the question of whether a physician has an ownership interest in a service provider that contracts with a hospital for the billing of services ''under arrangements.'' There, we noted that a commenter believed that, if there is an under arrangement agreement between a hospital and a group practice for the group practice to provide laboratory services to hospital patients under section 1861(w)(1) of the Act, it is the hospital and not the group practice physicians that is making a referral for the purposes of the self-referral proscription found in section 1877 of the Act. We responded that we did not believe that the Congress intended to allow physicians to circumvent the referral prohibition by imputing their referrals to an operating entity such as a clinic, hospital, or other institution. We acknowledged that ''the exception in section 1877(e)(7) of the Act could apply to allow referrals based on part of this scenario'' but

> [t]here is, however, a complicating factor in the commenter's scenario. That is, the group practice physicians are referring to their own group practice laboratory. It is likely that these physicians are receiving compensation from the group practice that owns the laboratory or that they own some portion of the group practice and the laboratory. The compensation or ownership interests involved here would require a separate exception in order to allow the group practice physicians to refer. The services could, for example, be excepted under the in-office ancillary services exception in section 1877(b)(2) of the Act, which allows a group practice to refer to its own laboratory if certain criteria are met (66 FR 41941).

4. Suggested Changes and Clarifications to Definition of ''Performs the Service''

Comment: One commenter, although supporting generally the proposal, was concerned that the proposal that an entity that ''performs'' the DHS is a DHS entity within the meaning of § 411.351, may not have its desired effect because of the potential ambiguity of the meaning of ''performs.'' The commenter suggested that the final rule give a specific definition of ''performs.'' One commenter stated that the proposed language in the definition ''has performed the DHS'' was ambiguous, and questioned whether it included individuals, management companies, lessors or vendors. Two commenters asked us to provide a clear definition of performing DHS. A commenter said that it is very common, with respect to a variety of healthcare participants, for equipment to be leased from one party, space to be leased from another, and personnel employed, leased or contracted from or by multiple organizations. Two commenters said that the meaning of the phrase ''person or entity that has performed the DHS'' is unclear because the phrase could apply to the physician who performs the service, the location where the services are performed, the person or entity that owns the equipment with which a DHS is performed, or possibly some other person.

Another commenter cautioned that further guidance may be necessary to better define who ''performs'' DHS in fact patterns in which billing entities acquire inputs from multiple sources to deliver DHS. A commenter that supported the proposal suggested that a better way to define ''entity'' would be to specify ''entity'' as any business arrangement, and provide one exception for physician investment in a large publicly traded corporation. Another commenter that supported the proposal said that the definition could be improved if, in addition to including the person or entity that furnished the service or billed for it, we also included ''the person or entity that owns or leases the space or equipment to either of the above.'' One commenter questioned whether the definition of entity would extend to entities that provide billing staff or equipment used in furnishing DHS, because neither of these activities constitutes providing DHS. A commenter stated that it is unclear whether an entity that performs a component of DHS ''performs'' the DHS. The commenter stated it does not believe that an entity that provides management services performs DHS within the meaning of the proposed definition. Another commenter stated that although it believes that providing only some of the components of DHS should not be considered performing DHS or causing a claim to be submitted, the proposed rule created a level of uncertainty. The commenter stated that, taken to its extreme, the proposed definition of ''entity'' could be viewed as making any equipment lessor or entity that performs services for a DHS entity, even a provider of linens or food services, into a DHS entity itself. The commenter further stated that the provision of equipment and customized devices for a medical procedure and/or the services of a technician to monitor the equipment should not be defined as ''performing the DHS.'' A large association representing group practices said that if we were to adopt the proposal, we should make clear that the new provision does not apply to companies that merely lease equipment.

Response: We decline to provide a specific definition of ''perform,'' but rather intend that it should have its common meaning. We note that the language ''performing'' a service, or ''perform'' a service, or ''performed'' a service, or ''services performed'' appears numerous times in title XVIII of the Act and in our regulations, without a definition of what ''perform'' or any of its derivations means. For example, section 1861(q) of the Act defines ''physicians' services'' as ''professional services performed by physicians'' without elaboration as to what ''performed'' means. Physicians and other suppliers and providers generally know when they have performed a service and when they are entitled to bill for it. By way of example only, we consider a service to have been ''performed'' by a physician or physician organization service if the physician or physician organization does the medical work for the service and could bill for the service, but the physician or physician organization has contracted with a hospital and the hospital bills for the service instead. We do not mean to imply that a physician service provider can escape the reach of the physician self-referral statute by doing substantially all of the necessary medical work for a service, and arranging for the billing entity or some other entity to complete the service. We do not consider an entity that leases or sells space or equipment used for the performance of the service, or furnishes supplies that are not separately billable but used in the performance of the medical service, or that provides management, billing services, or personnel to the entity performing the service, to perform DHS.

Comment: Commenters addressed the issue of whether physician-owned implant or other medical device companies should or should not be considered to be an entity within the meaning of § 411.351. One commenter noted that orthopedic surgeons may have an ownership interest in a manufacturer of spinal implants that sells its implants to the hospital where the surgeon performs his or her surgeries. The commenter also stated that, because the proposed definition of ''entity'' would extend to an entity that ''performs the DHS,'' arguably the manufacturer could be considered to be an ''entity'' under § 411.351. This commenter urged us to exclude such manufacturers from the definition of ''entity.'' It stated that the indirect types

of arrangements involving spinal implants would still trigger the self-referral prohibition if they are not at fair market value. Comments submitted on behalf of a manufacturer of spinal implants asserted that, despite superficial similarities, joint ventures involving medical devices differ in many material ways from the types of arrangements over which we expressed concern. This commenter also said that the meaning of ''has performed the DHS'' is unclear and that we should clarify that the proposal applied only to ''true'' under arrangement relationships with hospitals, but that, in any event, implantable devices are not DHS. The commenter further stated that, even if implantable devices were deemed to be DHS, the rigorous physician self-referral exceptions (for example, the indirect compensation exception) are still available to protect the arrangement, and that if we were to interpret the proposal as applying beyond formal ''under arrangement'' relationships, we would be sliding down an impermissibly slippery slope if we in fact intend our approach to be different than the one that was proposed by MedPAC.

After the comment period closed for the CY 2008 PFS proposed rule, we received a comment from a large medical device manufacturer that requested that we examine the current prevalence of physician-owned implant companies and the impact that these ventures have on program or patient abuse, as well as what it considered to be the negative impact on competition among physician investor ventures and non-physician ventures. The commenter suggested that we deem physician-owned implant companies to be DHS entities under certain circumstances. The commenter also suggested that a physician-owned implant company should not be considered to have caused a claim to be presented where the referring physician is named as an inventor on an issued patent for the implantable item and the physician does not receive any remuneration from the company based on the value or volume of referrals, or where the physician's investment interest meets the requirements of § 411.356(a) for large, publicly traded entities.

Response: In this final rule, we are not adopting the position that physician-owned implant or other medical device companies necessarily ''perform the DHS'' and are therefore an ''entity'' on that basis. In the FY 2009 IPPS proposed rule, we solicited comments as to whether such companies should be considered to be an ''entity'' within the meaning of § 411.351. We may decide to issue proposed rulemaking on this issue in the future.

5. Cause Claim To Be Submitted

Comment: Some commenters were concerned with the aspect of the proposal that would include ''a person or entity that causes claims to be submitted'' within the definition of ''entity.'' Another commenter stated that the term ''causes a claim to be submitted'' is unclear and is susceptible to varying interpretations. One commenter asserted that our interpretation would make all vendors DHS entities. A commenter maintained that we did not indicate which entities would be subject to the physician self-referral prohibition as an individual or entity ''that causes claims to be submitted.'' An association that represents oncologists was concerned that the proposed definition could be read to include management and billing companies. Because billing and management companies submit claims for DHS on behalf of their physician or provider clients, arguably they ''cause a claim to be presented'' for DHS. The commenter stated that it believed that we did not foresee or intend this result.

Response: The proposed rule would have amended the definition of ''entity'' in § 411.351 to provide that ''[a] person or entity is considered to be furnishing DHS if it—(i) Is the person or entity that has performed the DHS, or (ii) Presented a claim or caused a claim to be presented for Medicare benefits for the DHS.'' We are not revising the definition of ''entity'' in § 411.351 to include the ''or cause a claim to be presented'' language in proposed paragraph (ii). As noted above, section 1877(a)(1)(A) of the Act and our regulations define ''entity'' as any organization that is ''furnishing'' DHS, and section 1877(a)(1)(B) of the Act and § 411.353(b) of our regulations prohibits an entity that receives a prohibited referral from presenting a claim to Medicare or causing such a claim to be presented. In this final rule we are revising the definition of ''entity'' to clarify that a person or entity that is performing DHS is furnishing DHS (as is a person or entity that presents a claim for Medicare benefits for DHS). We believe that an entity that performs services that are billed as DHS is furnishing DHS and, therefore, is a DHS entity. Under section 1877(a)(1) of the Act, and in accordance with our current regulations at § 411.353, once a person or entity has furnished DHS, and therefore is considered to be a DHS entity with respect to that service, the person or entity is prohibited from either presenting a claim or causing a claim to be submitted if the referral for the DHS was prohibited. We do not believe it is practical to attempt to define, through general rulemaking, what does or does not constitute causing a claim to be submitted. Rather, such a determination must be made, through adjudication, on a case-by-case basis.

6. Proposal Based on Anecdotal Evidence

Comment: A large association representing internists and medical students stated that, whereas it fully understands and shares concerns about inappropriate utilization of certain services, completely restricting the ability of physicians to invest in their own industry is far from the answer. The commenter noted that throughout the proposal, we continued to cite anecdotal evidence of arrangements that are at risk for fraud and abuse, yet provided no actual evidence of program abuse. Other commenters stated that we have not substantiated our concerns with comprehensive analyses or objective data. One commenter, an association of cardiologists, stated that its members can demonstrate that collaborations between physicians and hospitals reduce duplication of services and competition for technical staff within local service areas, thus reducing practice expense and equipment costs for Medicare providers and the Medicare program.

Response: We are finalizing the proposal because we believe that it would be inconsistent with Congress's intent to not consider an entity that performs DHS as a DHS entity. In addition, we have concerns that contractual arrangements between physician-owned service providers and hospitals may lead to overutilization and anti-competitive behavior. These concerns are based on studies that show an increase in utilization where physician ownership of services is involved, as well as anecdotal evidence.

7. Community Benefit and Access to Care

Comment: One commenter stated that, in contrast to past policy statements, the proposed rule did not in any way recognize the positive role of arranged-for services in today's health care system, but instead seems to condemn them all with one-size-fits-all sweeping claims. According to the commenter, in the Phase I rule, we recognized that under arrangement relationships ''are pervasive in the hospital industry'' and that many help ''avoid unnecessary duplication of costs and underutilization of expensive equipment.'' (66 FR 942). One commenter stated that, although the

proposed rule discusses anecdotal reports related to ''under arrangements'' ventures that are presumably abusive, there is no suggestion that these concerns are equally applicable to all types of services, and yet, the proposed changes would eliminate completely this significant option utilized by hospitals, particularly those without significant financial resources, to bring certain services, such as new technology, to their community. The commenter believed that before we implement any changes to the physician self-referral regulations that will restrict or eliminate ''under arrangements'' ventures with entities that are owned in whole or in part by physician referral sources, it is imperative that we assess the potentially significant impact such a change will have on the quality and scope of care offered by many institutions.

One commenter stated that many organized independent medical groups have fostered good working relationships with hospitals that benefit the community. A regional state-of-the-art cancer center that is a joint venture between physicians and a hospital allows Medicare beneficiaries to receive high quality, cost effective care in one setting. This type of arrangement is in contrast to one where each physician group in the community buys duplicative cancer technology, competes directly with the hospital, and little collaboration among providers exists.

A health system stated that in circumstances where particular services are needed, but not frequently performed, having one provider develop consistent practices and expertise may afford a higher quality of care for patients seeking the service and ''under arrangements'' contracts prevent multiple health care providers from purchasing the same types of equipment in any given community, and as a result, the cost of care is actually reduced because of efficient resource management. One commenter stated that many of the ''under arrangements'' contracts result in significant community benefit and patient benefit, and avoid duplication of services, thus producing cost savings to the program. Another commenter, representing a public hospital district, stated that there are compelling and legitimate reasons for public hospitals and local physicians to create collaborative arrangements to deliver care in the community. It asserted that participation in collaborative ventures with local physicians reduces the operating burden on public hospitals.

Another commenter said that hospitals that enter into ''under arrangements'' relationships are relieved of the burden of maintaining or expanding a particular service line, while still being able to provide much needed services to members of its community. This frees hospital capital to be spent on other needed services and space and other resources within the hospital to be used on other services. The commenter said that it has been its experience that hospitals have found themselves unable to keep up with the demand for outpatient surgery capacity and have found investing in ASCs to be a better use of their resources as compared to building and staffing larger outpatient surgery areas within the hospitals.

Two commenters stated that we should encourage ''under arrangements'' contracts between physicians and hospitals. They stated that, in many instances, it can make financial and clinical sense to enter into a venture with a partner that can provide capital, shared risk, and operational expertise to a hospital striving to improve its specialty services and programs. The commenters further stated that the fact that physicians can sometimes bring these resources to a hospital should not exclude them automatically as participants in these efforts, and in many ways physicians are ideal hospital partners and offer benefits to hospitals beyond mere referral of patients, such as careful cost control and quality improvement expertise. Another commenter stated that it appeared incongruous that we appear to support gainsharing but also appear ready to prohibit economic models that seeks to align physician incentives with those of hospitals.

Many commenters also expressed concern that if we finalize the proposal access to care will be disrupted, particularly in underserved or rural areas. A large association representing group practices commented that if we finalize our proposal, we should clarify that the ''new restriction'' will not impact the exception available for rural markets. The commenter further asserted that it would be an ironic result and an unfortunate policy if a physician's referral to a rural hospital were prohibited because of an ''under arrangements'' contract between the hospital and an entity in which the physician had an interest, when the same physician's referral to the same entity would be clearly protected. A rural hospital commented that, in its market, provider-based entities protect against unnecessary duplication of services, equipment, staff and facilities and offer several other advantages. Some urologists complained that the proposal would prohibit providing lithotripsy and other services to rural patients. For example, one urologist said that adoption of the proposal would prohibit the provision of many services, including, but not limited to, laser services, cryotherapy services and IMRT, as well as the newer services transurethral microwave therapy (TUMT) and transurethral needle ablation of the prostate, which, more often than not, are performed in the office. Other physicians, primarily urologists, and an organization whose members form joint ventures with urologists, commented that physician joint ventures have provided Medicare beneficiaries with access to effective treatments that they otherwise would not have had and/or have saved Medicare millions of dollars.

Comments submitted on behalf of a large multi-specialty physician group asserted that many ''under arrangements'' relationships have existed for many years and benefit both the hospital and the patient. The comments maintained that the hospital is able to secure services that it otherwise could not provide efficiently, through contracting with an outside supplier that often is an expert in these services. In addition, the comments stated that not all ''under arrangements'' relationships result in higher Medicare reimbursement levels, but where this is true, we should address any incentives due to differences in reimbursement between the PFS and OPPS by eliminating those differences in reimbursement rather than by revising the definition of entity. Finally, comments stated that independent physician groups cannot be further disadvantaged to the benefit of hospital system providers that enjoy special privileges of significantly higher reimbursement for similar services, wide latitude to create built-in referral relationships by employing physicians and, in many instances, the financial benefit of tax-exempt status.

Response: We recognize that in some circumstances, providing services ''under arrangements'' may be beneficial to patients, providers and the program. We are not prohibiting services to be furnished ''under arrangements.''

We are finalizing the proposal because we believe that it would be inconsistent with the Congress's intent to not consider an entity that performs DHS as a DHS entity. We note that in enacting ownership exceptions, the Congress did not provide for an exception based on lack of access per se, but rather enacted an exception only for

rural providers. With respect to service providers that furnish services to rural patients, our proposal as adopted in this final rule does not alter the availability of the exception for an ownership interest in a rural provider. However, as clarified in this final rule, as a DHS entity, a physician owner/investor in such a service provider would need an ownership exception (such as the rural provider exception) in order to protect his or her referrals to the service provider.

With respect to ownership/investment interests that will not qualify for the rural provider exception because of the patient population they serve, we do not believe that patient access will be significantly disrupted, for several reasons. First, we are not prohibiting physician group practices or other physician organizations from contracting with hospitals for the provision of services ''under arrangements.'' Any physician that has a compensation arrangement with, but not an ownership/investment interest in, the physician group practice or other physician organization (such as an employee or contractor physician with the group practice or other physician organization) may refer patients for services that are provided by a hospital ''under arrangements'' provided that one of the compensation exceptions is met. Also, the definition of ''referral'' at § 411.351 excepts services that are personally performed by the referring physician. Thus, to the extent that an owner/investor in the physician service provider has referred the patient for a service but then personally performs the service, there is no ''referral'' within the meaning of § 411.351 and the physician self-referral law is not implicated. (Note that if there is a technical component to a service or a facility fee, that is billed by a provider ''under arrangements,'' the fact that the referring physician performs the professional component, and thus there is no ''referral'' for the professional component, does not alter the fact that there is a ''referral'' for the TC or the facility fee. Note also that the definition of ''referral'' states that DHS is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members. See, *e.g.*, 66 FR 941.) Also, we expect that hospitals that have not been furnishing services directly, but rather have been furnishing them ''under arrangements,'' will begin doing so. We believe that, in some instances, hospitals would prefer to furnish services directly but have been concerned about losing referral streams if they compete with physician service providers. (In this regard we note that we received very few comments from hospitals objecting to our proposal, and instead two major hospital associations were generally supportive of it.) We also believe that, conversely, in many cases physician groups could provide the services and bill for them directly, that is, without the need to contract with a hospital to provide them ''under arrangements'', and that, to the extent the services would be DHS when performed and billed by the physician group, referrals to the physician entity could be protected by the in-office ancillary services exception or another exception. We also note that to the extent that the physician service providers are furnishing lithotripsy (and based on the comments we received it appears that lithotripsy makes up a significant portion of the services furnished ''under arrangements''), we presently do not consider lithotripsy to be a DHS. Finally, the delayed effective date of the revision to § 411.351, that is October 1, 2009, will provide sufficient time for arrangements to be restructured.

8. Hospitals as Risk-Averse

Comment: Several urologists objected to what they perceive as our view that physicians who invest in joint ventures to provide services ''under arrangements'' do so at the expense of good patient care. These commenters and others stated that hospitals balk at investing in new technology because of the risk of obsolescence (that is, what is new technology today may be soon outmoded) and because doing so will result in lesser use of other services that they currently provide. Also, a single hospital often does not have the volume to justify the expense of a large capital investment. Joint ventures involve physicians so that usage can be spread among several hospitals.

One urologist stated that urologic joint ventures have been able to offer state-of-the-art services to the community while lowering costs and improving care. An association that represents urologists stated that state-of-the-art equipment made available by physician-owned companies fills the critical gap between what advances the latest technology can offer and what hospitals can afford.

Response: With respect to the commenters' assertions that physicians are willing to take risks in bringing services to communities and that hospitals are risk averse, to the extent that this is true, it begs the question of whether physicians are less concerned about risk because they can control the referral stream and whether hospitals are more concerned about risk because they fear that referrals will go to their competitors if they do not enter into contractual arrangements with physician groups. We believe that the proposal as finalized will create a more level playing field between hospitals and physicians and also among hospital competitors. We note that, although many of the physician commenters emphasized the benefits to hospitals of contracting with physician groups to provide services ''under arrangements,'' the hospital associations and hospitals that commented on the proposal generally did not support this view.

9. Cardiac Catheterization and Personally Performed Services

Comment: Several commenters stressed the efficiency and quality of services offered by their joint ventures with hospitals for the provision of cardiac catheterization services. Some commenters stated that the vast bulk of the services provided to the hospital are based on flat fees for specific categories of services, which include the full costs for these services, and thus, the joint venture assumes the risk of all costs of providing the services. They further stated that the agreed-upon fees are reviewed periodically by a third-party valuation company to ensure that the fees are at fair market value. Other commenters stated that the physicians can provide the service at a lower cost than the hospital, that the physicians desire a greater level of clinical excellence by becoming more involved in the management of the service, and the service is not a priority for the hospital but is a priority for the physicians.

Several commenters stated that the proposed rule made no attempt to distinguish under arrangement services involving personally performed services as opposed to other services. Another commenter stated that if services such as cardiac catheterizations or outpatient surgery were performed in an ASC or physician's practice, they would not qualify as DHS and therefore would not be subject to the physician self-referral law. Commenters recommended that we should clarify that these services constitute personally performed services excepted from the definition of ''referral'' or exclude these types of service providers from the definition of ''entity.''

Response: This final rule does not prohibit physician group practices and other physician organizations from furnishing cardiac catheterization

services. Where a group practice or other physician organization provides the service and bills for it, the service is not DHS and the physician self-referral statute will not apply. Where a group practice or other physician organization provides the service and, pursuant to a contractual arrangement, a hospital bills for it as an outpatient or inpatient service, the service is DHS and therefore the group practice or other physician organization would be a DHS entity with respect to that service. If the referral to the group practice or other physician organization is made by a physician owner/investor, an ownership exception would be needed to protect the referral. If the referral is made by a non-owner/investor physician who has a compensation relationship with the group practice or other physician organization (that is a physician employee or contractor), a compensation exception would be needed to protect the referral. The definition of ''referral'' at § 411.351 excepts services that are personally performed by the referring physician. Note that the definition of ''referral'' states that DHS is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members. (Note also that if there is a technical component to a service or a facility fee, that is billed by a provider ''under arrangements,'' the fact that the referring physician performs the professional component, and thus there is no ''referral'' for the professional component, does not alter the fact that there is a ''referral'' for the TC or the facility fee.)

10. Lithotripsy and Therapeutic Versus Diagnostic Procedures

Comment: Several commenters stated that, because we do not consider lithotripsy to be a DHS because of the district court decision of *Am. Lithotripsy Soc.* v. *Thompson,* 215 F. Supp. 2d 23 (D.D.C. 2002), they cannot be deemed to be performing DHS or causing a claim to be submitted when performing lithotripsy procedures. Some commenters stated that because the *American Lithotripsy Society* case held that lithotripsy is not DHS, common sense would dictate that other therapeutic procedures performed by urologists would also not be DHS. Other commenters requested that we clarify that lithotripsy would not be subject to the proposal. Another commenter stated that, generally, the physician who refers a patient for lithotripsy is the same physician who performs the service.

Response: We presently do not consider lithotripsy to be a DHS, regardless of whether it is performed by a physician-owned service provider and billed by that provider, or whether it is sold by such a provider to a hospital that bills for it. Because the *American Lithotripsy Society* case was limited to lithotripsy, we see no reason to except other therapeutic services from being DHS if they are billed by a hospital as outpatient or inpatient hospital services. As noted in the response to the previous comment, the definition of ''referral'' excepts services that are personally performed by the referring physician.

Comment: Many urologists asserted that, unlike diagnostic testing, lithotripsy and other urological procedures, such as BPH, do not present a risk of overutilization because they are therapeutic procedures. For example, the presence of kidney stones can be objectively determined, therefore lithotripsy is only used when needed by the patient. One commenter said that it is quite clear that if a patient does not have a stone, lithotripsy would not be appropriate. Another commenter said that urology joint ventures are not amenable to abuse unless fraud is being perpetrated. One commenter stated that, in 1992, Florida studied therapeutic versus diagnostic services and concluded that there was no overutilization where physicians have ownership in and render therapeutic services. Other commenters said that there has been no objective proof of overutilization of lithotripsy and other therapeutic urologic procedures. One commenter stated that because the procedure is done in a hospital, there is additional scrutiny, including peer review, which guards against overutilization. An organization whose members form joint ventures with urologists stated that our perspective is overly cynical. This organization asserted that in the late 1990s many of the urologists who formed joint ventures to purchase first generation TUMT units came to realize that the older surgical approach for BPH was better for most of their patients and therefore did not use the TUMT partnership equipment despite their financial investment, and as a result, the joint ventures failed. The commenter also stated that, despite the fact that laser ventures are only minimally profitable, urologists are willing to invest in newer equipment to more effectively treat their patients. Finally, the commenter stated that, although a significant number of its members purchased one type of laser, they purchased newer and more expensive higher-powered lasers, despite having a significant investment in the older model, despite still owing money on loans for the older model, and despite being advised that there was no resale market for the older model.

Response: As stated above, we believe that the Congress intended that an entity that performs services that are billed as DHS is a DHS entity, irrespective of whether it or some other entity does the billing for the services. The Congress did not provide for a general ownership exception for therapeutic procedures. Inpatient and outpatient hospital services are DHS, and thus subject to the general prohibition on ownership/investment interests in a DHS facility, regardless of whether the service is surgical or medical, or therapeutic or diagnostic. Although we do not doubt that the great majority of physicians are honest and honorable, the profit potential inherent in self-referral can corrupt medical decision-making both through deliberate and less-conscious behavior. In a self-disclosure case, a hospital agreed to pay $270,000 to maintain its existing compliance program and to undertake certain integrity obligations for a three-year period to resolve its liability under the CMP provisions applicable to kickbacks. The OIG alleged that the hospital entered into a series of contracts with an entity owned by urologists under which the hospital paid the entity in excess of fair market value for the lease of a lithotripter and contracted lithotripsy services. The OIG alleged that the hospital's payments were made to induce Federal healthcare program referrals from the urologists who owned the lithotripsy entity.

In an example of overutilized therapeutic treatments, we note that a large hospital system settled a case against several of their physicians who were accused of performing unnecessary cardiac surgeries. Federal officials alleged that the physicians entered a scheme to cause patients to undergo unneeded, invasive, cardiac procedures such as artery bypass and heart valve replacement surgeries. The hospital system agreed to pay $54 million to settle the Federal case.

We are also mindful of the comments we received on this proposal, our proposal on ''per-click'' lease payments, and our solicitation of comments on the in-office ancillary services exception, that self-referral of therapeutic procedures is abusive at times, because patients are being steered to one type of procedure when another procedure may be more appropriate or less costly, and because in some cases it is appropriate that patients have no procedure at all.

Comment: Several commenters stated that the proposal would ban legitimate physician joint ventures from contracting with hospitals to provide therapeutic services that are DHS only because they are performed in a hospital setting. According to the commenters, such therapeutic procedures include a variety of laser procedures for benign prostate disease and cryotherapy for cancer of the prostate. Some commenters asserted that we want to ban services furnished ''under arrangements'' because it has heard of questionable diagnostic imaging arrangements. Commenters further argued that the Congress made diagnostic imaging DHS regardless of the setting in which the imaging is performed, due to overutilization and improper referrals as identified in studies, and that we do not identify any overuse of, or improper referrals for, other services, such as laser services or other urological procedures. According to some commenters, simple fairness dictates that the proposal should not apply to services that are not DHS if they are not furnished in a hospital. Other commenters stated that it would be helpful if we excepted other procedures that are not DHS when not performed ''under arrangements'' from the proposed changes. One commenter stated that the applicable physician referral triggering the physician self-referral law is the referral for inpatient and outpatient hospital services. According to the commenter, inherent in this logic is that the hospital is the entity furnishing DHS, which contrasts with the proposed rule that attempts to invoke physician self-referral law jurisdiction on the ''under arrangements'' service provider by declaring it is an entity furnishing DHS.

Response: As discussed above, we believe that a more reasonable, (and perhaps the better), reading of the statute is that an entity that performs DHS is a DHS entity, as is the entity that submits the claim for the DHS (which continues under our regulations to be treated as an entity that has furnished the DHS). Also as discussed above, we have program integrity concerns relating to services provided ''under arrangements'', and these concerns are not limited to diagnostic imaging. We disagree that it is unfair that an entity that performs services should be considered to have performed DHS if those services are billed as outpatient or inpatient hospital services. Where an entity performs services that are billed as DHS, we believe that it is appropriate and consistent with Congressional intent to consider the entity to have furnished DHS and to be a DHS entity with respect to such services.

11. Professional Fee Greater Than Incremental Return for Technical Component

Comment: Several urologists and a law firm representing urologists stated that when urologists refer patients for therapeutic procedures that the urologists perform, the fee the urologist receives for performing the professional component of the procedure is greater than the incremental increase in the profit distribution to the urologist as a result of his or her participation in the joint venture. Therefore, the commenters maintained, the referring physician is not likely to be induced to refer based on the portion of the technical fee he or she will earn in distributions from the investment, and, accordingly, we should not prohibit services to be furnished ''under arrangements'' where the investor physician performs the professional portion of the procedure. An association whose members form joint ventures with urologists offered similar comments and stated further that underlying the proposal is our sense that surgeons in general, and urologists in particular, recommend a particular surgical procedure based on the professional fee they will receive rather than because the patient needs the procedure.

Response: The arguments raised by the commenters would seem to be applicable to physician ownership in any DHS entity, including those that bill Medicare, yet Congress did not except professional fees for ownership/investment interests in DHS entities. In the Phase I rule, we stated that creating an exception for implants furnished in an ASC would not increase the risk of overutilization beyond what is already presented by the surgeon's professional fee and was consistent with Congress's decision not to include ASC services as a specific DHS. However, we noted there that in creating the exception we were motivated by our desire not to cause a site of service shift for implants to the more expensive setting of hospital outpatient services, and we specifically declined to allow the exception for implants in a setting other than an ASC (66 FR 934). In contrast, services provided ''under arrangements'' by a hospital are, by definition, billed at the outpatient or inpatient rate.

12. Existing Exceptions Are Sufficient Protection

Comment: Several commenters said that it is not necessary to adopt the proposal and revise the definition of ''entity'' because the existing protections in our physician self-referral rules and the anti-kickback safe harbors are adequate. Some of these commenters pointed specifically to the indirect compensation exception at § 411.357(p). One commenter stated that the indirect compensation exception strikes an appropriate balance between permitting physician investment in entities that do business with hospitals and ensuring that physician-owned businesses are not overpaid by hospitals and other DHS entities to which they refer. Another commenter said that any profit a referring physician could make through his ownership of the entity that provides DHS to an entity that bills for the DHS would be limited to fair market value under the current physician self-referral exceptions, as well as under the anti-kickback statute.

Response: For the reasons explained above, we believe that under the statute, an entity that performs a service and contracts with a hospital or other provider in order for the hospital or other provider to furnish the services as DHS ''under arrangements,'' is properly considered a DHS entity. The statute requires referrals from a physician who has (or whose immediate family member has) an ownership/investment interest in a DHS entity to be protected by an ownership exception. In addition, we note that some of the protections contained in the compensation exceptions, such as the requirement that the compensation be at fair market value and not determined on the basis of the volume or value of referrals, would not provide protection against overutilization or anti-competitive behavior caused by inappropriate referrals from physician owners. The potential for overutilization or anti-competitive behavior that exists where a physician refers patients for DHS to an entity in which he or she has an ownership/investment interest and which perform DHS under contract for a hospital or other provider occurs because of the returns on investment such physician stands to earn, regardless of whether the physician also has a compensation arrangement with the hospital that is at fair market value.

Commenter: A commenter agreed that the proposed rule identified a number of potentially abusive arrangements, but said such troubling arrangements clearly violate the existing physician self-referral rules, the anti-kickback statute or our ''under arrangement'' payment rules. The commenter further stated that, because the proposed rule fails to identify any loopholes that need to be closed, we should enforce the physician self-referral rules and not create more

regulations. With respect to the physician self-referral rules, the commenter stated that the most applicable exception is the fair market value exception. The commenter noted that, to be in compliance with that exception, the arrangement must, among other things, be commercially reasonable but for referrals, with the compensation consistent with fair market value, and the arrangements described in the proposed rule fail these tests. With respect to the anti-kickback statute, the commenter acknowledged that determining whether there is a violation of that statute is difficult and fact-intensive, but asserted that the arrangements described in the proposed rule would likely be investigated by the OIG and the Department of Justice as they appear to be driven by referrals without any *bona fide* clinical reasons.

Response: With respect to the comment that the arrangements described in the proposed rule necessarily violate the existing physician self-referral rules, the anti-kickback statute or our ''under arrangement'' payment rules, we do not agree. We did not suggest in the proposed rule that the compensation relationship between physician-owned service providers and hospitals are not at fair market value, or that they violate the anti-kickback statute. To the contrary, we assume that in the great majority of cases the compensation relationships between physicians and hospitals or other providers are at fair market value, and again, the fact that a compensation interest is at fair market value does not address the Congress's general prohibition on physician ownership in DHS entities and the potential for abuse that exists through the returns on equity. Likewise, we assume that the great majority of arrangements between physicians and hospitals or other providers do not involve illegal kickback schemes. Also, irrespective of whether the arrangements described in the proposed rule could violate the anti-kickback statute (and we express no opinion on the matter), we would be abrogating our statutory authority under the physician self-referral statute if we were to refrain from attempting to regulate what we see are potentially abusive arrangements simply because we might believe that the government might be able to prove that certain conduct violates the anti-kickback statute.

13. Differences in Payment For Services Rendered in Hospital Setting Versus Payment for Same Services in ASC Setting

Comment: Two commenters stated that the proposal was inconsistent with the legislative intent to allow physicians to refer patients to ASCs in which they have ownership or investment interests, which is allowed based on the evidence that surgical cases are by nature not subject to unnecessary referrals. A third commenter said that several urologic procedures such as lithotripsy, green light photo vaporization of the prostate, and cryotherapeutic ablation of the prostate can be easily, safely and more cost effectively performed on an outpatient basis in an ASC, yet inequities in the present reimbursement rules make it cost prohibitive to perform these procedures in an ASC, and thus they must be performed in a hospital setting. In addition, the commenter stated, hospitals encourage a one-day stay for cryotherapeutic ablation of the prostate patients, because outpatient PPS reimbursement is not sufficient to cover the cost of the procedure. A fourth commenter, an association that represents urologists, stated that therapeutic services provided ''under arrangements'' can be provided only in the hospital or a provider-based department of a hospital, and therefore, our concern that patients are receiving services in a less medically-intensive setting than a hospital is misplaced with respect to therapeutic services.

Response: In the Phase I rule we agreed that prosthetic devices implanted in a Medicare-certified ASC by the referring physician or a member of the referring physician's group practice should be protected. We stated that we were taking this position because implanted prosthetic devices, implanted prosthetics and implanted DME are not included in the bundled ASC payment rate (and thus would not fall under the exception to the definition of DHS for items paid under a composite rate such as the ASC payment rate), and that, as a practical matter, the absence of an exception for these items implanted in an ASC was likely to result in these procedures moving to more costly outpatient settings (66 FR 934). As we noted in the proposed rule, we are concerned that services that are relatively less resource intensive are being furnished ''under arrangements'' in order to secure higher reimbursement. The third commenter, although opposed to the proposal, reinforced this concern through its statements. We believe that the reimbursement under the ASC payment system is fair and adequate, and that it is inappropriate for us to provide an incentive to game the system by allowing self-referral for services furnished through an ''under arrangements'' contract with a hospital that otherwise would be safely and effectively performed in an ASC or similar setting. Likewise, we do not believe it is appropriate for hospitals to admit a patient, in order to gain the higher inpatient reimbursement, for a procedure than can be safely and effectively performed on an outpatient basis. The fourth commenter is correct that, under § 410.27 of our regulations, therapeutic procedures (urologic or otherwise) that are furnished ''under arrangements'' by a hospital must be performed in the hospital or in space that we designate as a department of a hospital.

14. Exceptions to Definition of DHS Entity

Comment: Several commenters stated that if we were to adopt the proposal it should create one or more exceptions, so that not all physician-owned service entities are considered DHS entities. Two commenters stated that we should craft an exception for DHS that are furnished by a physician-owned entity, where the DHS involve a technology that requires a considerable capital investment and where the risk of overutilization is minimal because the number of patients to be treated with the technology is relatively small. One of these commenters stated that the exception could be narrowed further by requiring the technology or service to be used in the treatment of a serious or life-threatening illness or injury. Another commenter urged us to institute a degree of materiality into the existing ''under arrangements'' payment rules, rather than revise the definition of ''entity.'' The commenter stated that, for example, we could require that if some material portion of the service (perhaps 50 percent) is outsourced to a provider in a less intensive setting, the hospital will be reimbursed at a reduced rate for the service rather than the higher provider-based rate. Another commenter suggested that if we adopt the proposal we should either prohibit physicians from owning or operating certain ancillary service providers, thereby ensuring sufficient demand for the hospital service, or devise an exception that will allow hospitals and physicians to provide services to their respective patients on a cost-sharing basis.

Another commenter recommended an exception for high cost, low volume procedures such as lithotripsy, dialysis, radiation therapy, and cardiac

catheterization labs. This commenter pointed out that in 2001–2003, 60.6 percent of stable angina patients who received cardiac catheterization immediately underwent a percutaneous coronary intervention. Another commenter stated that we should consider applying the proposal only to entities that provide services ''under arrangements'' for a fixed fee that does not vary based on the volume of services provided.

One commenter stated that although it would be desirable to carve out an exception to the proposed definition in the case of arms-length transactions in areas that are underserved, in practice, if a physician owns any part of an entity (other than a publicly traded entity) that provides products or services to a facility, he or she will benefit from referrals.

Response: As noted above, we are finalizing the proposal in part because we believe the better reading of the statute is that an entity that performs services that are billed as DHS is a DHS entity, as is the entity that submits the claim for the DHS (which continues under our regulations to be treated as an entity that has furnished the DHS. Also as noted above, we are delaying the date of applicability for revised § 411.351 until October 1, 2009 because we wish to give parties time to restructure arrangements if necessary. We have authority under section 1877(b)(4) of the Act to create exceptions in addition to those specified in the statute only where we conclude there is no risk of program or patient abuse. We are not establishing an ownership exception for ownership/investment interests in one or more types of physician-owned service providers because we do not have sufficient information to persuade us that such an exception is necessary or to allow us to craft appropriate conditions for such an exception. In any event, if we were to create such an exception at this time we might be proceeding outside the scope of the proposed rulemaking. We welcome comments on whether we should create such an exception, and if so, what conditions for the exception should be included. We may issue a proposed rulemaking for such an exception in the future.

15. Outpatient Services Treated Differently Than Inpatient Services

Comment: Commenters stated that, in several places, the proposal expressed a higher level of concern about the incentives inherent with arranged-for outpatient hospital services than with respect to inpatient hospital services. The commenters inferred that we might decide to regulate such outpatient hospital services differently from inpatient services, and that any differentiation would be misguided.

Response: The final rule makes no distinction between outpatient and inpatient hospital services. If an entity performs services that, pursuant to a contractual arrangement with a hospital or other provider, are ultimately billed as DHS, the entity will be considered to have furnished DHS, regardless of whether the services are billed as outpatient hospital services, inpatient hospital services, or some other category of DHS.

16. Miscellaneous Services

Comment: One commenter stated that the proposal would require a large number of sleep centers to restructure or unwind their ''under arrangements'' joint ventures, which would create a patient access problem.

Response: Services performed at freestanding sleep centers generally are not DHS. Therefore, to the extent that sleep centers wish to perform sleep study services as well as bill for them, the physician self-referral statute will not be implicated. However, if the services are sold to a hospital for the hospital to bill for them as hospital services, the services will be DHS, because Congress included all inpatient and outpatient hospital services as DHS, and referrals from physician owners/investors in a sleep center will need to be protected by an ownership exception. As noted above, referrals from non-owner/investor physicians to a physician-owned service provider should be able to fit within a compensation exception. Also as discussed above, we believe that most services currently performed by a physician-owned service provider but sold to a hospital could continue to be performed by the physician-owned service provider and billed by that provider. In this regard, we note that the commenter provided no explanation as to why it believes that the final rule will create an access problem for patients in need of sleep studies.

Comment: One commenter stated that, in many rural areas, hospitals do not have either the technical or financial ability to provide dialysis services, especially if the need is only intermittent or involves a small number of patients, and that such hospitals need to be able to provide dialysis services to inpatients. The commenter further stated that because hospitals lose money on inpatient care furnished to ESRD patients, a hospital would not maintain a dialysis service simply to encourage admissions of ESRD patients, and that it is difficult to overutilize dialysis because the need for dialysis is very well defined.

Response: The physician self-referral statute applies only to referrals for DHS. One category of DHS is inpatient hospital services. However, the definition of inpatient hospital services at § 411.351 excludes dialysis furnished by a hospital that is not certified to provide ESRD services under subpart U of 42 CFR part 405. We believe the exclusion addresses the commenter's concerns.

17. Effective Date

Comment: One commenter stated that the proposal, if adopted, would result in a significant restructuring of a number of arrangements currently in effect and would have a significant impact on both DHS providers and physicians. Another commenter stated that it would be unfair for us to reverse our position after years of reliance on it by the industry and that it would require the unwinding and dissolution of numerous arrangements that have heretofore constituted lawful co-ownership of non-DHS entities. A national hospital association, while supporting our proposal, urged us to consider a phase-in of any changes, which would permit the termination or restructuring of existing relationships and arrangements before absolute compliance is triggered. Three commenters asked that we grandfather all arrangements existing at the time the proposed rule was published, because it would be unfair to apply the changes ''retroactively.''

Response: We are providing a delayed effective date until October 1, 2009. We are interested in receiving comments on whether we should create any exception for physician ownership/investment interests in physician service providers, and if so, what conditions the exception should contain, for consideration in any future rulemaking. We are not grandfathering existing arrangements because we believe it is inconsistent with the statute to treat an entity that performs DHS as something other than a DHS entity.

H. Exceptions for Obstetrical Malpractice Insurance Subsidies

In Phase II, we rejected the wholesale importation of the anti-kickback statute safe harbors into the physician self-referral law exceptions, but, using our authority under section 1877(b)(4) of the Act, we determined that exceptions for referral services and obstetrical malpractice insurance subsidies could be established by incorporating the corresponding safe harbors in § 1001.952(f) and (o), respectively (69

FR 16115, 16141). Accordingly, we created a new exception in § 411.357(r) for arrangements involving the provision of obstetrical malpractice insurance subsidies that complied with the anti-kickback statute safe harbor for such arrangements. In response to Phase II, we received a comment asserting that the exception in § 411.357(r) is too narrow. The commenter noted that even an agreement that received a favorable advisory opinion from OIG, despite not fitting within the safe harbor, would fail to satisfy the requirements of § 411.357(r) and, thus, would be prohibited under the physician self-referral law.

Our conclusion in Phase II that the wholesale importation of safe harbors would be problematic was based, in part, on our recognition that the anti-kickback statute safe harbors and the physician self-referral law exceptions appropriately diverge in some instances for reasons attributable to the difference in the scope of the statutes, core prohibited conduct, or liability standards (69 FR 16115). We continue to believe that differences in the anti-kickback and physician self-referral regulatory schemes are appropriate and sometimes necessary. We further believe that, upon revisiting the exception in § 411.357(r) and reviewing the comments received in response to our proposal in the CY 2008 PFS proposed rule, the physician self-referral law exception need not incorporate by reference without modification the safe harbor in § 1001.952(o) in order to provide adequate protection against program and patient abuse.

In the CY 2008 PFS proposed rule, we expressed concern that the current exception for obstetrical malpractice insurance subsidies may be too narrow, and proposed revising the exception in § 411.357(r) to list specifically the conditions that we believe are appropriate to safeguard against program or patient abuse when remuneration is provided by a hospital to a physician in the form of an obstetrical malpractice insurance subsidy (72 FR 38182). As with the Phase III revisions to the exceptions for retention payments and physician recruitment noted above, concern regarding beneficiary access to services was a significant basis for our proposal. We requested comments regarding barriers to patient access to obstetrical care in communities in which obstetrical malpractice insurance premiums are relatively high. We also requested recommendations for revising the exception without creating a risk of program or patient abuse.

We received 14 comment letters in response to our proposal to revise the exception in § 411.357(r) for obstetrical malpractice insurance subsidies. All commenters agreed with the concerns that we expressed in the CY 2008 PFS proposed rule that the current exception for obstetrical malpractice insurance subsidies is unnecessarily restrictive. Many commenters stated that the existing exception is unlikely to have the effect of increasing access to obstetrical care. Commenters generally supported revisions to the exception, and offered various suggestions for requirements we might include in a revised exception.

After consideration of the public comments received, in this final rule we are revising § 411.357(r) to (1) retain the provisions of the current exception (renumbered as § 411.357(r)(1)); and (2) provide an alternative set of requirements under which hospitals, federally qualified health centers, and rural health clinics (but not other entities) may provide obstetrical malpractice insurance subsidies (new § 411.357(r)(2)). We believe that the provisions in new § 411.357(r)(2) will reduce perceived obstacles to maintaining or improving patient access to needed obstetrical services by providing flexibility for the provision to qualifying physicians of obstetrical malpractice insurance subsidies. New § 411.357(r)(2) allows hospitals, federally qualified health centers, and rural health clinics to provide an obstetrical malpractice insurance subsidy to a physician who regularly engages in obstetrical practice as a routine part of a medical practice that is: (1) Located in a primary care HPSA, rural area, or area with a demonstrated need, as determined by the Secretary in an advisory opinion; or (2) is comprised of patients at least 75 percent of whom reside in a medically underserved area (MUA) or are part of a medically underserved population (MUP). The expansion to additional practice locations and patient populations is found also in the requirements regarding the composition of the patient population treated by the physician under the coverage of the malpractice insurance and the determination of ''costs of malpractice insurance premiums.'' Where possible, we maintain parallel structure and conditions in the exceptions to the physician self-referral law. In Phase III, we similarly revised the exception for retention payments in underserved areas in § 411.357(t) to incorporate criteria that are based on the patient population served by the physician receiving the retention payment, rather than focusing the requirements of the exception solely on the location of the hospital making the retention payment (72 FR 51065 through 51068). Our concerns regarding beneficiary access to services was a significant basis for this revision, as well as for the revisions to the exception for physician recruitment in § 411.357(e) with respect to the allocation of certain costs where a physician is recruited into a practice in a rural area or HPSA to replace a retired, relocated, or deceased physician (72 FR 51047 through 51054).

We are not revising the exception to adopt only the provisions in new § 411.357(r)(2) and to discard the provisions of the current exception, because the current exception, through its incorporation of § 1001.952(o), applies to subsidies provided by a ''hospital or other entity,'' and we did not propose in the CY 2008 PFS proposed rule to limit the types of entities that may provide subsidies under the exception. On the other hand, we are unwilling to extend the provisions in new § 411.357(r)(2) to entities beyond hospitals, federally qualified health centers, and rural health clinics, because we are not persuaded that, if we did so, there would be no risk of program or patient abuse (as required under section 1877(b)(4) of the Act for new exceptions or modifications to existing exceptions). (We note that, although the provisions of new § 411.357(r)(2) apply to hospitals, federally qualified health centers, and rural health clinics, for ease of reference and readability, we refer throughout the discussion below to all three types of entities as ''hospitals.'')

Finally, our revisions to the exception in § 411.357(r) for obstetrical malpractice insurance subsidies should not be construed as having any effect on the safe harbor under the anti-kickback statute for obstetrical malpractice insurance subsidies in § 1001.952(o), nor as a commentary on what we believe is or is not permitted under the anti-kickback statute. We discuss below the specific comments that we received in response to our proposal in the CY 2008 PFS proposed rule.

Comment: Several commenters asserted that conditioning the availability of an obstetrical malpractice insurance subsidy on the location of the physician's medical practice in a primary care HPSA disadvantages patients. Numerous commenters questioned the link between a hospital's ability to provide an obstetrical malpractice insurance subsidy and the lack of primary care physicians in a particular area. (The exception in

§ 411.357(r), by incorporating § 1001.952(o), requires that the physician's medical practice be located in a primary care HPSA.) These commenters noted that a community may be underserved with respect to obstetrical services, even if it is not underserved with respect to primary care services; in fact, an increase in primary care physicians in an area could cause the area to lose its HPSA designation, despite no corresponding increase in obstetrical services. Many of the commenters suggested that the exception should condition a hospital's ability to provide an obstetrical malpractice insurance subsidy on the location of the physician's practice in an area that has a shortage of obstetrical services. One commenter provided possible criteria for determining whether an area is an ''obstetrician shortage area.''

Response: We agree generally with the commenters that asserted that, rather than be restricted to providing obstetrical malpractice insurance subsidies only in situations where the physician's practice is located in a primary care HPSA, a hospital should be able to provide a subsidy to physicians who serve underserved areas or patient populations. We share the commenters' concern that an increase in primary care physicians in an area could cause the area to lose its HPSA designation, thus making all physicians in the area ineligible to receive a needed obstetrical malpractice insurance subsidy. However, we continue to believe that designation as a primary care HPSA is one appropriate way to establish need for additional obstetrical patient care services, because obstetrics is one of the specialties included by HRSA in its determination regarding whether an area should be designated as a primary care HPSA (together with general family practice, general internal medicine, pediatrics, and gynecology).

In this final rule, we provide greater flexibility for hospitals (and federally qualified health centers and rural health clinics, as discussed above) to facilitate continued patient access to obstetrical patient care services through the provision of needed obstetrical malpractice insurance subsidies. Under new § 411.357(r)(2), a physician who engages in obstetrical practice as a routine part of his or her medical practice will be eligible for receipt of an obstetrical malpractice insurance subsidy if his or her medical practice is: (1) Located in a primary care HPSA, a rural area, or an area with demonstrated need for the physician's obstetrical services, as determined by the Secretary in an advisory opinion; or (2) is comprised of patients, at least 75 percent of whom reside in a MUA or are members of a MUP. We are not adopting the commenter's suggestion that we adopt a definition for ''obstetrician shortage area'' and permit the provision of obstetrical malpractice insurance subsidies in such an area. We believe that it would be difficult to define ''obstetrician shortage area'' (and maintain updates to the definition), and that our policy as finalized here affords sufficient flexibility for physicians and for hospitals, federally qualified health centers, and rural health clinics.

Comment: Two commenters suggested that we remove all requirements in the exception relating to the location of the physician practice receiving the subsidy. Three commenters suggested that we impose no limitations at all on the location of the hospital providing the obstetrical malpractice insurance subsidy. Another commenter suggested that the exception permit obstetrical malpractice insurance subsidies where there is no other facility to which the physician receiving the subsidy could refer his or her obstetrical patients.

Response: We agree with the commenters with respect to not including requirements for the location of the hospital making the obstetrical malpractice insurance subsidy payment, but disagree with the commenters that a practice location restriction on the eligibility for receipt of an obstetrical malpractice insurance subsidy is unnecessary or inappropriate. The provision of obstetrical malpractice insurance (or a contribution towards its cost) is a valuable benefit to a physician, and we believe that the requirement that the physician provide obstetrical services in an underserved area (that is, a primary care HPSA, rural area, or area of designated need) or to an underserved population is necessary to help ensure that this valuable benefit is provided only to maintain or improve patient access to needed obstetrical services, rather than as an inducement for referrals to the hospital providing the subsidy. This requirement, in combination with the other requirements in new § 411.357(r)(2), is necessary to satisfy the mandate of section 1877(b)(4) of the Act that any exception issued using such authority pose no risk of program or patient abuse. As we described in the previous response, although we continue to include requirements with respect to the location of a physician's medical practice as a determining factor for eligibility for receipt of an obstetrical malpractice insurance subsidy, we are permitting subsidies to physicians who provide obstetrical services in medical practices located in areas other than a primary care HPSA and to patient populations that reside in areas other than a primary care HPSA.

We disagree with the commenter that advocated permitting obstetrical malpractice insurance subsidies to physicians where there is no other facility to which the physician could refer his or her obstetrical patients. We believe that the commenter is arguing that there is no risk of program or patient abuse if a hospital provides an obstetrical malpractice insurance subsidy payment to a physician who would have referred all of his or her obstetrical patients to the hospital regardless of the existence of the subsidy. We do not believe that the risk of program or patient abuse is reduced merely because the physician would have referred his or her obstetrical patients to the hospital regardless of the subsidy. The subsidy could serve as an inducement for referrals to the hospital of other DHS.

Comment: One commenter urged that the exception in § 411.357(r) be revised to permit a hospital located in a rural area to provide an obstetrical malpractice insurance subsidy, regardless of the location of the physician's medical practice. The commenter argued that there would be no risk of program or patient abuse if we adopt this suggestion given the nature of obstetrical services; that is, according to the commenter, obstetricians have no ability to increase the number of deliveries that they perform because the volume of deliveries is determined by the number of pregnancies in the area, and not based on the therapy choice of a physician. The commenter contrasted this with the risk of program and patient abuse in other specialties where a physician who wishes to increase his or her revenue could do so by increasing the number of procedures that he or she performs.

Response: We do not agree necessarily with the commenter's assertion regarding the relative risk of program or patient abuse between obstetrical services and other medical specialties, and we decline to adopt the commenter's suggestion. We believe that a restriction on the location of the hospital providing the obstetrical malpractice insurance subsidy, by itself, does not guarantee an improvement to or the maintenance of access to obstetrical services to patients most in need of the services. Rather, we believe that the location or composition of the physician's medical practice is a better indicator of which physicians are providing obstetrical services to the patient populations we believe would

be harmed if the physician discontinued his or her obstetrical medical practice. We continue to require that the location or composition of the physician's obstetrical medical practice determine the availability of the exception in § 411.357(r), although we have expanded the exception to cover obstetrical medical practices located in rural areas. With respect to the commenter's point that obstetricians have no ability to increase the number of deliveries that they perform because the volume of deliveries is determined by the number of pregnancies in the area, we reiterate that obstetrical malpractice insurance subsidies can serve as an inducement for referrals of other DHS.

Comment: Some commenters suggested that we revise or eliminate the requirement that 75 percent of the patients treated under the subsidy reside in a HPSA or MUA, or be part of a MUP. Two commenters asserted that this requirement imposes a substantial administrative burden on physicians, as the determination of whether a patient resides in a HPSA or MUA must be completed manually; that is, there is no automated, simple way to determine the information needed to make the certification required in § 1001.952(o)(2), as incorporated by reference in § 411.357(r). Moreover, according to one of the commenters, determining the exact location or boundaries of a HPSA is difficult because HPSAs are registered by census tract with boundaries that are not easily defined. According to the other commenter, physician practice management systems are not configured so that the physician can abstract HPSA or MUA status from patient records. Rather, systems are equipped to capture zip code information, not the census data that delineate HPSAs and MUAs. One commenter suggested that the exception require only that a physician who receives an obstetrical malpractice insurance subsidy from a hospital certify initially that his or her medical practice is in or near a HPSA, and that more than one half of his or her patients are expected to reside in a MUA or be part of a MUP. This commenter and another suggested that certification be required less frequently than annually.

Response: We continue to believe that this requirement is necessary to ensure that arrangements that satisfy the requirements of the exception in § 411.357(r) (whether under renumbered § 411.357(r)(1) or new § 411.357(r)(2)) pose no risk of program or patient abuse. We understand the commenters' assertions regarding administrative burden. However, particularly in light of the expansion of the exception to permit the inclusion of patients who live in rural areas in the calculation of patients treated under the subsidized malpractice insurance coverage, we do not believe that this requirement is an undue burden for a physician where the physician is receiving a valuable benefit in the form of an obstetrical malpractice insurance subsidy. For purposes of satisfying the exception under the new alternative requirements in § 411.357(r)(2), we are permitting the inclusion of patients who reside in a rural area when calculating whether at least 75 percent of the patients treated under the coverage of the subsidized malpractice insurance reside in an underserved area (that is, a HPSA or MUA) or are part of a MUP. We believe that doing so adds needed flexibility without posing a risk of program or patient abuse. We have made no other changes to this requirement, however. (We note that ''rural area'' is defined at § 411.351 as an area that is not an urban area. ''Urban area'' is defined at § 412.62(f)(1)(ii) as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget (or certain New England counties specified in the regulation.) Determining whether a patient lives in a rural area should be simple and not pose an undue administrative burden.) Given our concerns regarding the maintenance or improvement of patient access to needed obstetrical services described above, we believe that it is important to require the continued provision of services to the neediest patients in exchange for a physician's receipt of an obstetrical malpractice insurance subsidy.

Comment: Several commenters argued that the requirement that 75 percent of the physician's obstetrical patients be treated under the coverage of the malpractice insurance for which the subsidy is provided may be too high, given the low reimbursement rates for obstetrical services and the high cost of malpractice insurance. One commenter suggested that the obstetrical patient treatment requirement be lowered to 25 percent of the physician's obstetrical patients treated under the coverage of the malpractice insurance.

Response: We disagree with the commenters. We believe that requiring less than 75 percent of the physician's obstetrical patients to be treated under the coverage of the malpractice insurance for which the subsidy is provided may be insufficient to ensure continued access to obstetrical services for the neediest patients. We also believe that the 75 percent threshold, in combination with the other requirements of the exception, ensures that arrangements protected by the exception pose no risk of program or patient abuse.

Comment: Numerous commenters urged us to expand the scope of the exception in § 411.357(r) to permit malpractice insurance subsidies to specialties other than obstetrics. The commenters' arguments in support of such an expansion include the increase in malpractice insurance premiums generally; an expansion would be in keeping with guidance provided by OIG regarding malpractice insurance assistance (specifically, OIG's Letter on Hospital Corporation's Malpractice Insurance Assistance Program, its Compliance Guidance for Hospitals, and OIG Advisory Opinion 04–19); and the lack of statutory authority to limit any exception to certain medical specialties, rural areas, or HPSAs.

One commenter asserted that, because malpractice insurance is unaffordable in some geographic locations, some physicians practice medicine without any professional malpractice insurance coverage. According to the commenter, this disadvantages patients and other providers, because insurers' costs in defending malpractice claims against physicians with no insurance coverage are passed on disproportionately to hospitals (because hospitals are named as co-defendants). The commenter suggested that we expand the exception to include other physician specialties, and recommended that the subsidy be available only to a physician practicing in a particular specialty that is identified by an independent third party as having a demonstrated shortage of physicians practicing in that particular specialty in the geographic area served by the hospital providing the malpractice insurance subsidy. In addition, according to the commenter, the amount of the subsidy could be capped at the amount that the average premium for that specialty in the hospital's community exceeds the national average for that specialty. The commenter suggested further protection against program and patient abuse, for example, a requirement that hospitals not provide malpractice insurance subsidies in a targeted, preferential or discriminating manner, or in a manner that takes into account the volume or value of referrals or other business generated by the referring physician.

One commenter suggested that we permit a hospital to provide a malpractice insurance subsidy to any member of the hospital's medical staff, regardless of the physician's specialty.

Another commenter suggested that we permit hospitals to provide malpractice insurance subsidies to physicians who practice in any specialty in a State in which malpractice premiums are ''relatively high,'' and suggested that we could compare the percentage increase of malpractice insurance premiums to the salary of the average physician in that specialty to determine this relativity. A different commenter suggested that, if we expand the exception to cover all medical specialties, we could impose a cost sharing requirement similar to that included in our exception for the donation of electronic health records items and services in § 411.357(w).

Response: In Phase III, we addressed the issue of our statutory authority to limit the exception in § 411.357(r) to physician practices in HPSAs (72 FR 51064). There, we stated:

> Section 1877(b)(4) of the Act allows us to create additional exceptions to the general prohibition on physician self-referral where doing so would not result in a risk of program or patient abuse. It does not require us, where we exercise such authority, to make the additional exceptions available to all types of entities and physicians, or make them applicable in all areas. The Congress and CMS have long recognized the special needs and character of rural, urban, and underserved areas. Malpractice insurance availability in HPSAs poses specific concerns not present in other areas and supports a targeted exception.

Our position with respect to limiting the exception to physician practices in certain identified locations has not changed, nor are we persuaded by the commenters' similar argument regarding our statutory authority to limit the applicability of the exception to obstetrical malpractice insurance only (rather than to permit subsidies of malpractice insurance for all specialties or for certain specified medical specialties).

We decline to expand the exception to cover the provision of malpractice insurance subsidies to physicians practicing in other medical specialties, as suggested by many of the commenters. The commenters did not provide us with information indicating that, without an expansion of the exception, beneficiary access to necessary medical services is hindered, nor are we independently aware of such data. Such information would be helpful to ensuring that an expansion of the exception to other (or all) medical specialties would not pose a risk of program or patient abuse. We note also that we addressed this issue in Phase III in response to a comment urging us to expand the exception to all specialties and hospitals (72 FR 51063). There, we stated:

> The exception in § 411.357(r) is one of several exceptions that allow DHS entities to provide assistance with malpractice insurance. Other exceptions that permit DHS entities to provide such assistance are the fair market value compensation exception (as discussed above in response to the previous comment) in § 411.357(l), the exception for *bona fide* employment relationships in § 411.357(c), and the exception for personal service arrangements in § 411.357(d) (provided that the value of the assistance is commensurate with the value of actual services furnished to the hospital by the physician). These exceptions allow any DHS entity to provide assistance with malpractice insurance, without regard to the specialty of the physician or the area in which the physician practices.

We believe that the exceptions to the physician self-referral prohibition discussed in our Phase III response provide sufficient flexibility for hospitals that desire to provide assistance with the costs of malpractice insurance coverage.

Comment: According to one commenter, it would be more cost-effective for hospitals to subsidize malpractice premiums to retain physicians than to lose those physicians and have to pay expensive recruitment packages to recruit new physicians to the area.

Response: We assume that the commenter is arguing that the exception should be expanded in light of the commenter's assertion regarding the cost-effectiveness of providing malpractice insurance subsidies versus recruitment packages to replace physicians who leave the geographic area due to high malpractice insurance costs. Regardless of whether the commenter's assertion regarding cost-effectiveness is accurate, cost effectiveness is not an indicator that an arrangement is without risk of program or patient abuse, and we are obliged to follow the mandate in section 1877(b)(4) of the Act that new exceptions that we create under that authority, or modifications of existing exceptions created under that authority, must not pose a risk of program or patient abuse. We believe that the provisions of new § 411.357(r)(2) will enable hospitals to subsidize obstetrical malpractice premiums for some physicians who would not have qualified for them under our previous rules.

I. Ownership or Investment Interest in Retirement Plans

In the CY 2008 proposed rule we proposed to revise § 411.354(b)(3)(i) to clarify that the exclusion from the definition of ''ownership or investment interest'' of an interest in a retirement plan pertains only to an interest in an entity arising from a retirement plan offered by that entity to the physician (or the physician's immediate family member) through the physician's (or immediate family member's) employment with that entity (72 FR 38224). That is, where a physician has an interest in a retirement plan offered by Entity A, through the physician's (or immediate family member's) employment with Entity A, we intended to except from the definition of ''ownership or investment interest'' any interest the physician would have in Entity A by virtue of his or her interest in the retirement plan; we did not intend to exclude from the definition of ''ownership or investment interest'' any interest the physician may have in Entity B through the retirement plan's purchase of an interest in Entity B.

As we explained in the CY 2008 PFS proposed rule, we made our proposal because we were concerned that some physicians may be using retirement plans to purchase or invest in other entities (that is, entities other than the one that is sponsoring the retirement plan) to which they refer patients for DHS (72 FR 38183). After consideration of the public comments, we are adopting our proposal. We address below the specific comments we received in response to out proposal in the CY 2008 PFS proposed rule.

Comment: Three commenters agreed with the proposed revision. Another commenter stated that the proposal ''represented another example of our broad-brush approach to physician practices by punishing and restricting all physicians based on negligible and likely unsubstantiated, anecdotal evidence of questionable physician investment.''

Response: The commenter that did not agree with our proposal offered no reason why the exclusion from the definition of ''ownership and investment interest'' in § 411.354(b)(3)(i) should pertain to a physician's (or immediate family member's) interest in an entity that is purchased by the retirement plan in which the physician (or immediate family member) has an interest by virtue of the physician's (or immediate family member's) employment, regardless of how frequent or infrequent such purchases by retirement plans take place. The purpose of the original exclusion in § 411.354(b)(3)(i), and as clarified in this final rule, is to exclude automatically a physician's (or immediate family member's) interest in a retirement plan offered by an entity as a result of the physician's (or immediate family

member's) employment from being considered an ''ownership or investment interest'' in that entity. Without such a *per se* exclusion, a physician's ability to refer patients for DHS to an entity that extends a retirement plan to the physician (or his or her immediate family member) as a result of the physician's (or immediate family member's) employment without running afoul of the physician self-referral rules would be in doubt in some cases, because what would otherwise be a compensation arrangement (based on the physician's or immediate family member's employment) could be considered to be an ownership or investment interest. Where a retirement plan offered by the entity that employs the physician (or his or her immediate family member) purchases or invests in another DHS entity, however, we see no need to exclude *per se* the physician's (or immediate family member's) interest in the retirement plan from being considered an ownership or investment interest in the other entity. To do otherwise would create the potential for abuse. For example, assume that a group practice offers a retirement plan to its members and, through the assets of the retirement plan, purchases or invests in an imaging facility to which the members of the group practice refer patients for DHS. Had the members of the group practice purchased or invested directly in the imaging facility, the requirements of an exception (such as the rural provider exception) would need to be satisfied in order for the physicians to refer patients to the imaging facility for DHS. If, however, the members of the group practice used the assets of the retirement plan to purchase the imaging facility, in the absence of the regulatory provision finalized here, the members of the group practice would have effectively skirted the general prohibition on ownership in entities to which they refer patients for DHS.

J. Burden of Proof

In the CY 2008 PFS proposed rule, we proposed to add a new regulatory provision to clarify that, consistent with our existing procedures with respect to claims denials, in any appeal of a denial of payment for a designated health service that was made on the basis that the service was furnished pursuant to a prohibited referral, the burden is on the entity submitting the claim for payment to establish that the service was not furnished pursuant to a prohibited referral (72 FR 38224). That is, the burden of proof is not on us or our contractors to establish that the service was furnished pursuant to a prohibited referral.

We received several public comments objecting to our proposal as unfair or inconsistent with the current rules. After consideration of the public comments, we are adopting our proposal as final and clarifying that the burden of proof (otherwise known as the burden of persuasion) is on the claimant throughout the course of the appellate proceeding (and at each level of appeal), whereas the burden of production initially is on the claimant but may shift to us or our contractor during the course of the proceeding. The new provision is codified in revised § 411.353(c)(2) in this final rule. We address below the specific comments that we received in response to our proposals in the CY 2008 PFS proposed rule.

Comment: Many commenters expressed concern regarding the statement in the CY 2008 PFS proposed rule that, in an appeal brought by a provider, the burden of proof is on the entity submitting the claim for payment to establish that a service was not furnished pursuant to a prohibited referral. Some commenters asserted that the burden of proof should be on us because, according to these commenters, the law historically places the burden on the party that makes the rules. The commenters concluded that we are in a better position to determine whether actions were illegal, as we draft the regulations that provide interpretations of whether these actions are legal. Other commenters asserted that placing the burden on providers makes us ''the judge and jury,'' fails to adhere to the fundamental principle that people are ''innocent until proven guilty,'' or amounts to us taking an unconstitutional action. Some commenters concluded that the proposed language amounts to a ''hidden tax'' requiring physicians to prove that they conducted their actions legally. One commenter expressed concern that providers already render healthcare services for the prices we set, and placing the burden of proof on providers is an additional onus that impacts them unfairly.

Response: Our proposal was intended only to clarify existing procedures with respect to the Medicare claims appeals process (which is the administrative remedy for providers and suppliers, regardless of whether the denial is for physician self-referral reasons, lack of medical necessity grounds, or some other reason). The claimant traditionally has borne the ultimate burden of proof in the Medicare claims appeals process, which is set forth in 42 CFR Part 405, Subpart I of our regulations (and which formerly appeared in 42 CFR Part 405, Subparts G and H), as well as in the Social Security beneficiary claims appeals process, which is set forth in 20 CFR Part 404, Subpart J (and which is the model upon which the Medicare claims appeals process is based). Because government funds are at issue, it is appropriate to place the burden on providers and suppliers to show that they are entitled to payments from the public fisc, and not on the government to show that the provider or supplier is not entitled to such payments. Our regulations expressly state that the provider, supplier or beneficiary must furnish sufficient information for our contractors to determine whether payment is due and the amount of such payment. (*See* 42 CFR 424.5(a)(6); *see also* section 1833(e) of the Act.) We note also that section 205(a) of the Act, as incorporated into title XVIII by section 1872 of the Act, gives the Secretary broad authority to allocate the burden of proof. The Supreme Court has noted that the general rule is that the burden of proof lies with the party seeking relief, and that the Congress expressed its approval of the general rule when it chose to apply it to administrative proceedings under the Administrative Procedure Act (5 U.S.C. 556(d)). (*See Shaffer* v. *West*, 546 U.S. 49, 57–58 (2005).) We do not agree that, because we draft the physician self-referral regulations, the burden of proof should be on us and the Medicare program.

Comment: One commenter stated that, because many exceptions to the physician self-referral prohibition require compliance with the anti-kickback statute, the proposal would require a provider to satisfy the burden of proving that it: (1) Meets an anti-kickback statute safe harbor; (2) has received a favorable advisory opinion from OIG; or (3) otherwise does not violate the anti-kickback statute. The commenter concluded that providers will have the unreasonable burden of having to ''prove a negative,'' even though the government has the burden to prove intent under the anti-kickback statute. Two other commenters expressed similar concerns, and stated that the language in the proposed regulation would shift the burden from the government to the provider with respect to the anti-kickback statute. Other commenters expressed concerns about having to ''prove a negative'' with respect to other requirements of exceptions for certain compensation arrangements, such as the requirements that: (1) Compensation does not take into account the volume or value of referrals or other business between the

parties; (2) equipment or space is not shared by others; (3) an arrangement would be commercially reasonable even in the absence of referrals; and (4) no payment is made directly or indirectly as an inducement to reduce or limit medically necessary services.

Response: Section 1877(b)(4) of the Act authorizes us to create additional exceptions to the physician self-referral statute, provided that such exceptions do not pose a risk of program or patient abuse. All of the exceptions for financial relationships promulgated using our authority in section 1877(b)(4) of the Act include the requirement that the financial relationship covered by the exception not violate the anti-kickback statute, which is an intent-based criminal statute, or any Federal or State law or regulation governing billing or claims submission. Similarly, most of the exceptions applicable to compensation arrangements, including those prescribed by statute and those created using our authority in section 1877(b)(4) of the Act, contain a requirement that the compensation not take into account the volume or value of referrals or other business generated between the parties. We recognize that requiring claimants to prove that they did not violate the anti-kickback statute may, in some cases, be difficult. However, our proposal and this final rule pertain to the ultimate burden of proof (or burden of persuasion) and not to the burden of production (or burden of going forward with evidence).

As explained by courts and legal commentators, the burden of proof remains on the same party throughout the appellate proceeding, whereas the burden of production on a particular issue or element may shift from one party to another (and even back to the first party) as evidence is put forth. We believe it is appropriate that the burden of production be on the claimant initially with respect to all requirements in our physician self-referral regulations. The claimant may produce evidence in such quantity or quality so as to shift the burden of production to the Medicare program requiring us to show that the requirement was not met. Thus, although a claimant would have the initial burden to show that it did not violate the anti-kickback statute, the claimant may produce evidence that is conclusive on the issue (such as showing that the arrangement satisfied a safe harbor to the anti-kickback statute) or is sufficient to shift the burden of production to the government to show that the financial relationship at issue did violate the anti-kickback statute. We decline to attempt to prescribe by regulation what type or quantity of evidence is sufficient to shift the burden of production to us on any given requirement of our physician self-referral regulations, as this would be impractical, if not impossible, to do given the infinite factual variations that may be present. We instead leave to the adjudicators that hear the appeals the question of whether the burden of production has shifted.

Comment: Several commenters asserted that it will be difficult for providers to prove that compensation arrangements were made at fair market value because valuation experts may disagree about what constitutes fair market value. A few commenters stated that hospitals may contract with physicians at a rate that was low in an effort not to have the arrangement questioned, and complained that requiring a hospital to prove fair market value will further disadvantage parties negotiating rates under hospital-physician contractual arrangements.

Response: In Phase III, we addressed requests for us to comment on fair market valuation methodologies. There, we stated ''[n]othing precludes parties from calculating fair market value using any commercially reasonable methodology that is appropriate under the circumstances and otherwise fits the definition at section 1877(h) of the Act and § 411.351. Ultimately, fair market value is determined based on facts and circumstances. The appropriate method will depend on the nature of the transaction, its location, and other factors'' (72 FR 51015 through 51016).

We believe that, in most instances, what constitutes fair market value for an item or service will be expressed as a range and, accordingly, claimants should not face significant difficulty in establishing fair market value, provided that they use a methodology that is reasonable under the facts and circumstances, determine a payment amount that is within the range that the methodology yields, and maintain documentation regarding the determination of fair market value that was created at the time of the financial relationship. We disagree that codifying burden of proof obligations should have the negative impact on business arrangements claimed by the commenters, these are the procedures that claimants must currently follow.

Comment: One commenter expressed concern that large fines may be imposed upon any party whom we believe violates the physician self-referral law. Another commenter asserted that the proposed provision should not affect the burden of proof that is applicable to other governmental sanction and enforcement provisions (including civil monetary penalties and exclusions).

Response: Our proposal (now finalized in § 411.353(c)(2) in this final rule) related only to administrative appeals of claims denials under the appeals process in 42 CFR Part 405, Subpart I of our regulations. Appeals of civil monetary penalties, exclusions or other remedies imposed because of a determination that a DHS entity or a physician knowingly violated the self-referral statute or regulations involve other appeals processes.

Comment: One commenter asked if the proposed regulation would trump evidentiary rules that may exist elsewhere, including under the False Claims Act.

Response: No, it would not. Our proposal was not intended to have any impact on the evidentiary rules in False Claims Act cases or in other types of cases, but instead was intended only to clarify existing procedures with respect to the Medicare claims appeals process. New § 411.353(c)(2) does not establish any standards of knowledge or other evidentiary rules, but merely clarifies that, in any case in which a claim is denied for failure to comply with the physician self-referral rules, the ultimate burden of proof (that is, the burden of persuasion) is on the claimant to demonstrate compliance and not on the Medicare program to demonstrate noncompliance. Thus, for example, if a claim is denied and a DHS entity appeals on the basis that it did not know the identity of the referring physician, the current standard of knowledge in § 411.353(e) (that is, the entity did not have actual knowledge of, and did not act in reckless disregard or deliberate ignorance of, the identity of the referring physician) continues to be applicable. The claimant would have the burden of persuasion that it did not know the identity of the referring physician, using the standard contained in § 411.353(e).

Comment: One commenter asked if the burden of proof remains on the provider at every level of appeal.

Response: At every level of appeal, the burden of proof (that is, the burden of persuasion) remains on the entity that submitted the claim.

Comment: One commenter suggested that, although providers have the burden to prove that services they provided are covered by Medicare, the same standard should not apply to compliance with the physician self-referral law and regulations. The commenter argued that an appeal of a claim that was denied due to lack of medical necessity differs from an appeal of a claim denied due to noncompliance with the physician self-referral law,

because the congressional intent underlying the two types of appeals is different and the potential consequences of failure to comply with the physician self-referral statute are significant.

Response: We do not agree that the allocation of the burden of proof should vary depending on the underlying reason for the claim denial. We note that the Congress has not indicated any intent to make such a differentiation. With respect to the commenter's statement that the potential consequences of failure to comply with the physician self-referral statute are significant, the same can be said for medical necessity denials and other types of coverage denials. Where a financial relationship between an entity and one or more referring physicians is found to fail to meet an exception, a few or many claims may be at issue, depending on the circumstances. Likewise, a contractor's denial, on medical necessity or other grounds, may affect a few claims of a supplier or provider or may affect an entire class of claims.

Comment: Several commenters reasoned that, because the physician self-referral law is a strict liability statute, it is even more important for the burden of proof to be on the government. One of these commenters asserted that we have the ''weight of the Federal bureaucracy behind [us]'' and that we should prove our case if a benefit is denied.

Response: We reiterate that the language finalized in § 411.353(c)(2) of this final rule is entirely consistent with the allocation of the burden of proof in appeals of Medicare claims denied for reasons other than due to a prohibited referral. Virtually all coverage rules carry with them ''strict liability,'' and, where a claim is denied, the burden of proof is on the claimant to establish coverage and not on the government to prove noncoverage. (We note an exception to the strict liability rule in section 1879 of the Act, under which Medicare may pay the provider or supplier if the provider or supplier can establish that neither it nor the beneficiary knew or reasonably should have known that the item or service was not covered. The Congress has not authorized such limitation of liability protection for physician self-referral denials.)

Comment: Two commenters disagreed that the proposal is consistent with our general policy and procedures regarding the appeals of claims denials. The commenters asserted that, when a claim is denied (in circumstances other than when a prohibited referral occurred), all that the provider must do to receive payment is produce a medical record that indicates that the service was provided and, in combination with accepted standards of care, was reasonable and necessary. In these circumstances, according to the commenters, each appeal is for only a single claim. The commenters contended that, when we do not pay a claim due to a violation of the physician self-referral law, thousands of claims are at stake, a huge fine is possible, and exclusion from Federal health care programs may occur.

Response: The Congress has enacted a general prohibition against physician self-referral that is subject to certain exceptions (most created under our regulatory authority in section 1877(b)(4) of the Act). We believe that it is appropriate to require a provider or supplier to be prepared to demonstrate that its financial relationship with a referring physician does, in fact, satisfy an exception and that the claims at issue should be paid. Also, in most instances, the question of whether a provider or supplier meets an exception will be a factual one. The documentation containing the particulars of the financial relationship at issue will be in the possession of the provider or supplier (and most often will not be in the possession of us or our contractors).

Although the commenters claim that appeals of claims denied for reasons other than alleged violations of the physician self-referral rules involve a single claim each and that the claimants need only produce the medical record to demonstrate medical necessity, many such appeals involve large numbers of aggregated claims and complex coverage issues. In addition, it is not true necessarily that any claims denial based on an alleged violation of the physician self-referral rules will involve thousands of claims or complex issues. In any event, it is not apparent to us why the number of claims, the amount of money involved, or the complexity of the issues should cut in favor of the government having the burden of proof, rather than the claimant. Finally, with respect to the commenters' point that the burden of proof should be on the government because an alleged violation of the physician self-referral rules may lead to a large fine and exclusion from Federal health care programs, the proposal, which is finalized in § 411.353(c)(2) in this final rule, relates only to appeals of claims denials, not to appeals of the imposition of civil monetary penalties, exclusion or other remedies.

Comment: Two commenters stated that the proposed rule will provide greater incentive for Medicare contractors to deny claims based on alleged violations of the physician self-referral law.

Response: We disagree with the commenters' assertion that the proposal, which is finalized in § 411.353(c)(2) in this final rule, will induce our contractors to deny claims based on physician self-referral violations. The burden has always been on the party seeking Medicare payment to prove entitlement to payment if the claim is denied, and we assume that our contractors have been aware of this longstanding policy. Contractors should make determinations to deny claims based on the merits of the case and not based on concerns as to who bears the burden of proof. However, to the extent that any contractor, prior to this final rule, may have been less inclined to deny a claim due to its mistaken belief that it would bear the burden of proof, it is appropriate that it be apprised of the proper allocation of the burden of proof.

IX. Financial Relationships Between Hospitals and Physicians

Most, if not all, hospitals have financial relationships with referring physicians. These financial relationships may involve ownership or investment interests, compensation arrangements, or both. The financial relationships may be direct or they may be indirect (such as through a physician group practice or limited liability company). The physician self-referral statute was first enacted in 1989, and the reporting requirements in the regulations in § 411.361 were first implemented in our December 3, 1991 interim final rule with comment period, published in the **Federal Register** at 56 FR 61374. Since that time, we have not engaged in a comprehensive reporting initiative to examine financial relationships between hospitals and physicians. Consistent with Congressional intent in enacting the physician self-referral statute, we believe it is important to query hospitals concerning their financial relationships with physicians.

To assist in enforcement of the physician self-referral statute and implementing regulations, we created an information collection instrument, referred to as the Disclosure of Financial Relationships Report (''DFRR''). The DFRR is designed to collect information concerning the ownership and investment interests and compensation arrangements between hospitals and physicians. In the FY 2009 IPPS proposed rule, using our authority under section 1877(f) of the Act and § 411.361, we proposed to send the DFRR to 500 hospitals, (both general

acute care hospitals and specialty hospitals), a number that we believe is necessary to provide us with sufficient information: (1) To identify arrangements that potentially may not be in compliance with the physician self-referral statute and implementing regulations; and (2) to identify practices that may assist us in any future rulemaking concerning the reporting requirements and other physician self-referral provisions (73 FR 23697). We note that to the extent we do not find a physician self-referral violation based on the results of the DFRR, this should not be taken as an affirmative statement that the financial relationships are in compliance, and the government will not be estopped from determining that there is a violation based on further review of information collected as part of the DFRR or additional different information. At this time we are proceeding with our proposal to send the DFRR to 500 hospitals (both general acute care hospitals and specialty hospitals). However, based on further review and comments we may receive in response to the revised Paperwork Reduction Act (PRA) package that will be published separately in the **Federal Register**, we may decide to decrease (but not increase) the number of hospitals to which we would send the DFRR.

In the FY 2009 IPPS proposed rule, we provided a discussion of the potential burden associated with completing the DFRR, including an analysis that provided estimates of the burden for small, medium, and large hospitals. In the proposed rule, based on a review of the DFRR by 33 hospitals, we estimated that the average number of hours to complete the DFRR was 31 hours. In addition, we sought comment on the accuracy of the time and burden estimates associated with this information collection instrument. Because the DFRR requires information that hospitals already should be keeping in the normal course of their business activities (even apart from the need to document compliance with the physician self-referral law), we anticipated that the majority of the time spent completing the DFRR would be spent by administrative staff. We believed that the tasks involved would include retrieving the information and printing it from electronic files or copying it from hard files, which largely should involve administrative personnel. In addition, the review and organization of the materials would also impose burden on the respondent. Nevertheless, in order to err on the side of more potential burden rather than less, we calculated costs using an hourly rate for accountants (73 FR 23697).

As discussed more thoroughly below, we have revised our estimate of the time it will take each hospital to complete the DFRR from 31 hours to 100 hours and concluded that many hospitals may choose to involve accounting staff and attorneys for legal review. Therefore, the costs per hospital, associated with completing the DFFR has increased from $1,550 to $4,080. We have calculated a revised total burden for 500 hospitals to be $2,040,000. A more detailed discussion of the aggregate burden may be found in the PRA section, section XI., of the preamble of this final rule. A revised PRA notice will be published separately in the **Federal Register**. The revised PRA notice will set forth a public comment period of 30 days from the date of display.

In the FY 2009 IPPS proposed rule, we proposed that the DFRR be completed, certified by the appropriate officer of the hospital, and received by us within 60 days of the date that appears on the cover letter or e-mail transmission of the DFRR. We solicited comments on the proposed 60-day timeframe for completing the DFRR (73 FR 23697). Although we received a few comments objecting to the proposed 60-day timeframe, we are adopting the proposed 60-day limit for completing the DFRR. In the FY 2009 IPPS proposed rule, we noted that § 411.361(f) provides that failure to submit timely the requested information concerning an entity's ownership, investment, and compensation arrangements may result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure. Although we have the authority to impose civil monetary penalties, we indicated in the proposed rule that we seek not to invoke this authority and will work with entities to comply with the reporting requirements. Prior to imposing a civil monetary penalty in any amount, we would issue a letter to any hospital that does not return the completed DFRR, inquiring as to why the hospital did not return timely the completed DFRR. In addition, a hospital may, upon a demonstration of good cause, receive an extension of time to submit the requested information (73 FR 23697). Although we did not make a specific proposal concerning the imposition of civil money penalties, we are informing the public in this final rule that, before imposing any civil money penalties, we will follow the procedures described above.

In the FY 2009 IPPS proposed rule, we solicited comments on the DFRR information collection instrument as follows:

- Whether the DFRR should be recurring, and, if so, whether it should be implemented on an annual or some other periodic basis;
- Whether the DFRR collects too much or not enough information, and whether it collects the correct (or incorrect) type of information;
- The amount of time it will take hospitals to complete the DFRR, the costs associated with completing the DFRR, and the amount of time we should give hospitals to complete and return their responses to us;
- Whether we should direct the collection instrument to all hospitals, and, if so, whether we should stagger the collection so that only a certain number of hospitals are subject to it in any given year;
- Whether hospitals, once having completed the DFRR, should have to send us yearly updates and report only changed information.

After consideration of the public comments we received, we are not adopting a regular reporting or disclosure process at this time, and thus, the DFRR will be used, at this time, as a one-time collection effort. (Depending on the information we receive on the DFRR and other factors, we may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument.) We have concluded that we are collecting the correct type and appropriate amount of information, and thus, we are finalizing the DFRR, as proposed, with minor modifications. (We refer readers to the revised PRA notice that will be published separately in the **Federal Register** which will offer the public the opportunity to comment on the proposed collection of information.) As discussed more thoroughly below and in section XI. of the preamble of this final rule, we are increasing the amount of time it will take hospitals to complete the DFRR from 31 hours to 100 hours, and the costs associated with completing the DFRR are being increased from $1,550 to $4,080 per hospital. We are finalizing our timeframe of 60 days to complete, certify, and return the DFRR to us.

We respond to specific comments below.

Comment: Several commenters asserted that neither the Deficit Reduction Act (DRA) of 2005, nor section 1877(f) of the Act, nor § 411.361 grants us the authority to impose ''such a far-reaching request,'' especially without the articulation of a specific

compliance problem to be addressed related to community hospitals. The commenters encouraged us to limit the scope of the DFRR to physician-owned specialty hospitals, as directed by the DRA. The commenters stated that, alternatively, and at the very least, the burden of the demand should be significantly reduced and the request be narrowly tailored to result in information aimed at addressing a clearly defined compliance problem.

Response: Our authority for the DFRR is not based on the DRA. We believe section 1877(f) of the Act and § 411.361 of our regulations give us authority to collect this information. These provisions provide that entities must submit to us information concerning their financial relationships with referring physicians in the form, manner and at the times we specify. Nor do we agree that the DRA directed us to confine the scope of the DFRR (which did not exist at the time of the DRA), or any other collection instrument, to physician-owned specialty hospitals. As stated above, since the enactment of the physician self-referral statute, we have not engaged in a comprehensive reporting initiative to examine financial relationships between hospitals and physicians, and consistent with section 1877(f) of the Act, we believe it is important to query hospitals concerning their financial relationships with physicians. Section 5006 of the Deficit Reduction Act of 2005 required the Secretary to develop a strategic and implementing plan to address certain issues relating to physician-owned specialty hospitals. The strategic and implementing plan that was included in our ''Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005'' issued on August 8, 2006, is available on our Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp* (hereinafter referred to as the ''DRA Report to Congresss.''. We also refer to the DRA Report to Congress, at page 69, wherein we stated that we would require hospitals to provide us information on a periodic basis concerning their investment and compensation relationships with physicians.

Comment: One commenter stated that we incorrectly asserted that section 1877(f) of the Act gives us the authority to obtain information about compensation arrangements that comply with an exception. The commenter stated that instead, section 1877(f) of the Act allows us to seek information only about compensation arrangements that do not meet an exception in section 1877(e) of the Act. The commenter further stated that section 1877(f) of the Act states that we may require information concerning compensation arrangements that are ''described in subsection (a)(2)(B) of [section 1877 of the Act].'' The commenter contended that section 1877(a)(2)(B) of the Act describes compensation arrangements that do not meet any of the exceptions contained in section 1877(e) of the Act. The commenter concluded that by including certain information that entities must report, Congress effectively excluded other information from our authority.

Response: We believe that Congress did not intend to limit our ability to capture information about compensation arrangements that meet an exception. Section 1877(f) of the Act states that ''each entity * * * shall provide the Secretary with the information concerning entity's * * * compensation arrangements * * * *including* the names and [UPINs] of all physicians with a compensation arrangement (as described in subsection (a)(2)(B)) * * *'' (emphasis added). We believe Congress' use of the word ''including'' meant that it was providing only examples of the type of information that we may require. To read the statute otherwise would effectively negate our ability to make fully informed decisions about the extent to which entities are complying with the physician self-referral law and instead, allow entities to report information only about those compensation relationships that they self-determine are out of compliance.

Comment: Most commenters stated that our estimated burden of 31 hours still fell short of what will be required within a facility to complete the DFRR. They indicated that steps a hospital will likely engage in are: (1) Identification of the relevant contracts; (2) retrieval of the contracts; (3) review and analysis of the contracts to determine the appropriate response to the DFRR; (4) review by an attorney for accuracy; (5) copying for submission; and (6) CEO certification. The commenters noted, anecdotally, the burden estimates for hospitals include at least 200 hours just to identify and assemble all the relevant contracts, 4 weeks to fully prepare responses, 3 months to respond with 1 FTE's time. Another commenter, a 232 bed hospital, identified similar steps (including the creation of an ad hoc committee), and provided a total estimate of 120 hours. Another commenter suggested that the burden hours were underestimated and that we should either abandon the DFRR or redesign the tool to reduce the scope of the information requested.

Response: Some of the commenters have identified an additional, self-imposed step in the process that, if taken into account, would increase the time and burden estimate, namely, legal review of all supporting documentation (including contracts). The DFRR requires hospitals to supply certain information and documentation concerning existing ownership/investment and compensation relationships with physicians, which relationships, presumably, underwent legal review prior to their inception. The information and documentation required by the DFRR is that which hospitals should already be keeping in the normal course of their business activities (even apart from the need to document compliance with the physician self-referral law), and therefore, the only burden imposed by the DFRR is the time needed to locate and compile the information and documentation. Notwithstanding our view that the true burden of responding to the DFRR does not properly include time for legal or other professional review, we have increased our time and burden estimates from 31 to 100 hours to complete and submit the DFRR. With respect to the suggestion that we either abandon the DFRR or reduce the scope of the information requested, we are adopting the DFRR as final, with some modification. (We refer readers to the revised PRA notice that will be published separately in the **Federal Register**.) We believe that each piece of information requested in the various worksheets of the DFRR is necessary to assist us in identifying arrangements between hospitals and physicians that may not be compliant with the physician self-referral prohibition regulations, and to identify examples and areas of noncompliance that may assist us in future rulemaking concerning our existing, and potentially new, exceptions. We remind the reader that to the extent we do not find a physician self-referral violation based on results of the DFRR, this should not to be taken as an affirmative statement that the financial relationships are in compliance, and the government will not be estopped from determining that there is a violation based on further review of information collected as part of the DFRR, or additional, different information.

Comment: One commenter believed that we continue to underestimate the burdensomeness and costs associated with completing the DFRR. For example, the commenter believes that the estimated hours to respond will range between 50 hours for a smaller

facility to over 200 hours for a larger facility. Cost estimates for personnel needed to complete the work, which would include clerical, administrative, accounting and legal support, would range from $5,000 to $15,000. The estimate of $50 an hour, based on accounting personnel, underestimates the manpower costs of fully and accurately completing the survey document and that accountants and legal counsel will review all documentation related to the DFRR so their involvement should be considered when calculating the burden. Several commenters asserted that some questions require information on arrangements of which a simple review of the agreement will not be sufficient. Another commenter expressed a similar objection stating that administrative staff would not be able to complete Worksheet 7 with the instruction that reads '' For those compensation arrangements listed in Columns A through D, include not only those that you believe fit within an exception in 42 CFR 411.357, but those that are implicated by the referenced exception.'' Several comments argued that knowing which specific exception an arrangement relied on, when more than one may be applicable, will not necessarily be noted in the contract. The commenters further stated that only an attorney's review will allow a hospital to determine that information

Response: As noted above, we have taken into account the time and costs involved for hospitals to involve attorneys in the process of completing and submitting the DFRR to ensure that all supporting documentation satisfies the specific exception(s) upon which the arrangement relied on when the agreement was executed. Therefore, we have revised the costs associated with completing the DFRR. As discussed more thoroughly in section XI. of the preamble of this final rule, we have increased the time and burden estimate (per hospital) from 31 to 100 hours. In addition, we have calculated costs using an hourly rate for accountants and attorneys. Specifically, we are attributing 60 hours to administrative and accounting staff that will assemble relevant documentation, and we are allotting an additional 40 hours to account for the burden associated with hospitals that voluntarily seek input from legal counsel. We are revising our average cost per hospital to $4,080. A more detailed analysis of the total time and burden estimate associated with the DFRR may be found in section XI. of the preamble of this final rule and in the revised PRA notice that will be published separately in the **Federal Register**.

Comment: A commenter recommended that if the DFRR is implemented, it be initially tested as a targeted pilot program. The commenter stated that the pilot should be limited to a minimum number of hospitals needed to test the accuracy of the survey instrument and its effectiveness in securing the information sought.

Response: We do not believe that testing the DFRR with a pilot group of hospitals is necessary. As we stated in the FY 2009 IPPS proposed rule, we proposed to send the DFRR to 500 hospitals, a number that we believe is necessary to provide us with sufficient information: (1) To identify arrangements that potentially may not be in compliance with the physician self-referral statute and implementing regulations; and (2) to identify practices that may assist us in future rulemaking. As stated earlier, we note to the extent we do not find a physician self-referral violation based on the results of the DFRR, this should not be taken as an affirmative statement that the financial relationships are in compliance, and the government will not be estopped from determining that there is a violation based on further review of information collected as part of the DFRR or additional, different information. At this time, we are proceeding with our proposal to send the DFRR to 500 hospitals. However, based on further review and comments we may receive in response to the revised PRA package that will be published separately in the **Federal Register**, we may decide to decrease (but not increase) the number of hospitals that we would send the DFRR. With respect to the commenter's concern about the accuracy of the instrument, the DFRR builds upon information that was previously requested in the voluntary DRA survey, and thus, should help increase the accuracy of the instrument. In addition, as a result of public comments received in response to our PRA packages published in the **Federal Register** on May 18, 2007 (72 FR 28056), and September 14, 2007 (72 FR 52568), respectively, we have revised the DFRR instructions and worksheets to address ambiguities.

Comment: Many commenters noted that the DFRR requires information on nine different categories of compensation arrangements. These commenters stated that, depending on the size of the hospital, documents will be required for hundreds or thousands of contracts. Another commenter, a 300 bed hospital, estimated that it would spend approximately 80 hours to gather data from 224 agreements with physicians to complete Worksheets 7 and 8. The commenter stated that the hours would be much less if the proposed DFRR were to address only compensation arrangements that involve a physician owner.

Response: We acknowledge that the DFRR would take less time to complete if we required hospitals to report only compensation arrangements involving a physician owner. However, confining the DFRR to such relationships would significantly reduce the scope of the collection instrument and, therefore, potentially fail to capture much needed information. Moreover, so restricting the DFRR would be inconsistent with the commitment we made at page 69 of the DRA Report to Congress to require hospitals to provide us information on a periodic basis concerning their investment and compensation relationships with physicians. As stated above, the DFRR is designed to identify arrangements between hospital and physicians that may not be in compliance with the physician self-referral statute and regulations and to assist with our statutory obligation to ensure that no payment is made for a prohibited referral. In addition, in the DRA Report to Congress at page 69, we noted that a physician may be just as likely to refer patients to a hospital with which he or she has a compensation relationship, given that the physician may see a direct and immediate financial benefit from the compensation arrangement. To adopt the commenter's suggestion would have the effect of disproportionately impacting physician-owned hospitals.

Comment: Several commenters argued that under the current rule at § 411.361, routine mandatory reporting is not required. They stated that it was included in the 1998 proposed rule on reporting, and after receiving comments that routine mandatory reporting would be unduly burdensome, we decided not to use that approach. They further stated that the proposed rule on reporting also made clear that we were not developing any forms or recordkeeping requirements specific to reporting. They concluded that the DFRR, therefore, would circumvent our own rulemaking decision. Another commenter urged us to return to the position taken in the Phase II regulations in 2004 and not require each and every provider to supply the information required by the DFRR but merely to request information on a case-by-case basis.

Response: In the correction notice of the interim final rule with comment period entitled, Physicians' Referrals to Health Care Entities With Which They

Have Financial Relationships (Phase II); published in the **Federal Register** on April 6, 2004 (72 FR 17934), we stated that we did not intend at that time to develop any forms for the submission of information. The language referenced by the commenter referred to the creation of forms for a regular reporting process. At this time, we are not creating forms for a regular reporting process. Rather, we are pursuing a one-time collection effort which involves the use of the DFRR. Thus, we believe it would be best to proceed with sending the DFRR to the hospitals, and upon completion of the reviews, decide whether to issue a notice of proposed rulemaking concerning both the frequency of a reporting or disclosure process and any revisions to the DFRR to focus upon certain types of financial relationships or certain hospitals. We believe the use of a uniform information collection instrument is more efficient than a case-by-case approach because we are capturing the same type of information and analyzing it in the same manner. We disagree that proceeding with the DFRR is, in any way, inconsistent with, or circumvents, a prior ''rulemaking decision.''

Comment: One commenter recommended that the DFRR should not require paper submission of any kind, but rather all data should be scanned and submitted electronically to save hospitals significant unfunded administrative burden, as well as to spare us the storage capacity required for millions of paper pages. However, most commenters stated that recordkeeping is predominantly manual, not electronic, documents are decentralized, not centralized; there is no ''self-referral law'' filing system required, and of course the number of physicians on staff will affect the number of potential contracts. Thus, the commenters asserted that the burden estimate and our description of what a response will require are at odds with current recordkeeping processes in hospitals.

Response: We considered requiring hospitals to scan documents and submit them electronically, but we concluded that there was great variation in the recordkeeping systems of most hospitals. Therefore, we chose to encourage, but not require, that an electronic copy of the DFRR worksheets be submitted. We recognize that many hospitals will submit paper copies of all supporting documentation, and we have made arrangements for storage of the information collected. In response to an earlier comment, we have increased the time and burden estimate, which should assist in affording hospitals time in which to locate all required documentation.

Comment: Several commenters stated that under any new reporting initiative there will be a necessary ''learning curve'' for hospitals to determine the type of data necessary to accurately complete the report. The commenters asserted that this is especially true for the DFRR, as it will only be sent to a small subset of hospitals, and the hospitals will not know it is coming until it arrives. The commenters requested that we adopt a 5-month due date for the report, consistent with the time frame for completion of the Medicare cost report.

Response: We are not adopting the commenter's suggestions. The DFRR is not as complex as the Medicare cost report; and we believe that the 60-day timeframe specified in the proposed rule provides hospitals with sufficient time to complete and submit the DFRR to us. In addition, we will grant extensions of time beyond the 60 days to complete the DFRR in appropriate cases.

Comment: Many commenters also recommended that the DFRR be a one-time data collection effort, until we have fully evaluated responses from the initial reports filed. One of the commenters opposed an annual DFRR filing requirement, and supported a periodic or staggered filing requirement. The commenter also stated that where a pattern or history of problems was known to exist, more frequent reporting might be warranted.

Response: At this time we believe it is best to proceed with sending the DFRR to the hospitals, and upon completion of the reviews, decide whether to issue a notice of proposed rulemaking concerning both the frequency of a reporting or disclosure process and any revisions to the DFRR to focus upon certain types of financial relationships or certain hospitals.

Comment: One commenter recommended that hospitals should not have to submit a signed copy of each agreement related to Worksheet 7, unless we deem it necessary. If copies of agreement must be submitted, the commenter suggested that we permit hospitals to submit copies of uniform rental or recruitment agreements in those instances where a uniform rental or recruitment agreement has been prepared by the hospital and all of the elements present are materially the same.

Response: We are revising Worksheet 7 of the DFRR and the corresponding instructions to permit hospitals to submit one copy of a uniform rental or recruitment agreement. (Worksheet 7 also allows parties to submit one copy of a uniform personal services agreement.) We caution, however, that we consider an agreement to be ''uniform'' only if all material terms are the same. The following examples may prove helpful.

Example 1: Hospital has entered into lease agreements with different physicians or physician practices for space in the same medical office building (MOB A), and the value of the space is not materially different from one office to the next, the price per square foot charged to the physician or physician practice by the hospital is the same in all agreements (notwithstanding that amount of square footage, and thus, the monthly rental charges, may differ from office to office), and the rights and obligations are the same under each lease agreement. Under these facts, we would consider the agreements to be uniform for purposes of the DFRR and the hospital would need to transmit only one copy of the agreement (although it would be required to identify the other physicians who have entered into the similar agreements).

Example 2: Same facts as Example 1, with the additional facts that Hospital also owns medical office buildings B, C, and D (MOBs B, C, and D), which it also leases to physicians or physician practices. Within each building, the lease terms are materially the same, as described in Example 1, from office tenant to office tenant, although the lease terms vary significantly from MOB to MOB (for example, the price per square foot is much less for MOB C than it is for MOB D). Under these facts, we would consider the lease agreements to be uniform with respect to each MOB, but not uniform across all MOBs. Therefore, in responding to the DFRR, the hospital would need to send one copy of the lease agreement for MOB A, one copy of the lease agreement for MOB B, one copy of the lease agreement for MOB C, and one copy of the lease agreement for MOB D.

Example 3: Same facts as Example 1, except that the price per square foot varies slightly from office to office, with no two offices having the same price per square foot. In this case, we do not consider there to be a uniform agreement; therefore, in responding to the DFRR, the hospital would need to send a copy of the lease agreement for each physician or physician practice.

Comment: One commenter stated that the data requested would contain confidential information, and despite the reference to the Federal Trade Secrets Act (18 U.S.C. 1905) and the Freedom of Information Act (5 U.S.C. 552(b)(6)), which prevent information

provided to us from being released, expressed concern as to the specific safeguards in place to prevent such a release from occurring.

Response: We have established numerous safeguards to physically house the data provided to us. In addition, we will release such information, where appropriate, to federal law enforcement agencies such as the HHS's Office of Inspector General (OIG) and the Department of Justice (DOJ). We will not release information contained in the DFRR as matter of course to law enforcement agencies, but rather will do so only where we believe a specific referral to the OIG, DOJ, or other agency is warranted. Our policy is not to release any confidential business information or FOIA-protected personally identifiable information to the public. More detailed information concerning our disclosure policy is set forth in the general instructions accompanying the DFRR. We note that whereas the Trade Secrets Act prohibits federal agencies from releasing certain information under certain circumstances, the FOIA does not prohibit federal agencies from releasing information—rather, the FOIA allows us to withhold certain information under certain circumstances.

Comment: One commenter questioned the placement of the DFRR within the FY 2009 IPPS proposed rule and stated that the DFRR should be evaluated and approved by OMB and be consistent with the PRA. In addition, the commenter stated that we should contact physicians directly, rather than requesting that hospitals gather this information from each of their physicians.

Response: Our aim in including the DFRR in the FY 2009 IPPS proposed rule was to increase the likelihood that the general public would be aware of our proposed information collection request and submit comments concerning it. Therefore, we outlined the proposed requirements of the DFRR in the preamble, included a discussion of the costs associated with the DFRR in the Collection of Information section (section XI.B.) of the preamble of the proposed rule, and sent forth to OMB a PRA package concerning the DFRR. Pursuant to procedures required by the PRA, a revised PRA package, reflecting the changes to the DFRR that we have made based on comments received thus far, has been sent to OMB for its review and approval. The revised PRA notice will be published separately in the **Federal Register**. The revised PRA notice will set forth a public comment period of 30 days from the date of display.

X. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's recommendations regarding hospital inpatient payments in our annual proposed and final IPPS rules. Having reviewed both MedPAC's March 2008 ''Report to the Congress: Medicare Payment Policy'' and its June 2007 ''Report to Congress: Promoting Greater Efficiency in Medicare,'' we have given those reports careful consideration in conjunction with the policies set forth in this document.

Recommendation 2A–1: MedPAC's March 2008 Report to Congress states that ''The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2009 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.'' This recommendation is discussed in Appendix B to this final rule.

Recommendation 2A–2: MedPAC also recommended that ''The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive payment program.''

Response to Recommendation 2A–2: Redirecting funds obtained by reducing the IME adjustment to fund a quality incentive payment program is consistent with the VBP initiatives to improve the quality of care and, therefore, merits consideration. However, section 502(a) of Public Law 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FYs 2005 and thereafter. Consequently, CMS does not have the authority to implement MedPAC's recommendation to reduce the IME adjustment in 2009. We note that included in the President's FY 2009 budget proposal was a proposal to reduce the IME adjustment from 5.5 percent to 2.2 percent over 3 years, starting in FY 2009, in order to better align IME payments with the estimated costs per case that teaching hospitals may face.

In its June 2007 Report to Congress, MedPAC made recommendations concerning the Medicare hospital wage index. Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare hospital wage index classification system applied under the Medicare IPPS, including any alternatives that MedPAC recommended to the method to compute the wage index under section 1886(d)(3)(E) of the Act. In addition, section 106(b)(2) of the MIEA–TRHCA required the Secretary taking into account MedPAC's recommendations on the Medicare hospital wage index classification system, to include in this FY 2009 IPPS proposed rule one or more policies to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The MedPAC recommendations and our policies concerning the Medicare hospital wage index are discussed in section III.B. of the preamble of the FY 2009 IPPS proposed rule and this final rule.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, visit MedPAC's Web site at: *http://www.medpac.gov.*

XI. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format. However, some files are available on diskette as well as on the Internet at: *http://www.cms.hhs.gov/providers/hipps.* We listed the data files and the cost for each file, if applicable, in the FY 2009 IPS proposed rule (73 FR 23698 through 23700).

Commenters interested in discussing any data used in constructing the proposed rule or this final rule should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

2. Requirements in Regulatory Text

In the FY 2009 IPPS proposed rule (73 FR 23700 through 23702), we solicited public comment on each of the issues listed under section XI.B.1. of this preamble for the following sections of this document that contain information collection requirements (ICRs). We discuss and respond to any public comments we received in each individual sections.

a. ICRs Regarding Reporting Requirements (§ 411.361)

Section 411.361(a) of the regulations states that, except for entities that furnish 20 or fewer Part A and Part B services during a calendar year, or for Medicare covered services furnished outside the United States, all entities furnishing services for which payment may be made under Medicare must submit information to CMS or to the Office of the Inspector General (OIG) concerning their reportable financial relationships (any ownership or investment interest, or compensation arrangement) in the form, manner, and within the timeframe that CMS or OIG specifies. As described in section IX.C. of the preamble of this final rule and in accordance with its authority under § 411.361(e), we are requiring that hospitals provide information concerning their ownership, investment, and compensation arrangements with physicians by completing the DFRR instrument.

An information collection request concerning the DFRR was previously submitted to OMB for approval. We announced and sought public comment on the information collection request in both 60-day and 30-day **Federal Register** notices that were published on May 18, 2007 (72 FR 28056), and September 14, 2007 (72 FR 52568), respectively. In the FY 2009 IPPS proposed rule (73 FR 23695 and 23700), we discussed the requirement for submission of information using the DFRR instrument and the time and cost burden associated with completing and submitting the instrument.

As further discussed in section IX.C. of the preamble of this final rule, we have decided to obtain additional input from the public concerning the time and cost burden associated with completing and submitting the DFRR instrument. In addition to the discussion of the revised burden estimates for the DFRR information collection request included in the preamble of this final rule and below in this collection of information section, we will publish, under a separate notice and comment period, a 30-day **Federal Register** notice for the associated information collection request prior to submitting the information collection request to OMB for review and approval.

We believe that hospital accounting personnel will be responsible for: (1) Ensuring that the appropriate data or supporting documentation is retrieved; (2) completing the DFRR instrument; and (3) submitting the DFRR to the Chief Executive Officer, Chief Financial Officer, or comparable officer of the hospital for his or her signature on the certification statement.

Initially, CMS would require (no greater than) 500 hospitals to complete and submit the DFRR instrument. Based on public comments we received, we have revised our estimated completion time for the DFRR that we presented in the proposed rule. The estimated amount of time needed to comply with this information collection request is 100 hours for each of the hospitals. Thus, the total number of burden hours required for 500 hospitals to complete the DFRR instrument is 50,000 hours.

b. ICRs Regarding Risk Adjustment Data (§ 422.310)

As discussed in section IV.H. of the preamble of the proposed rule and this final rule, § 422.310(b) states that each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. In addition, § 422.310(b) states that CMS may collect data necessary to characterize the functional limitations of enrollees of each MA organization. Section 422.310(c) lists the nature of the data elements to be submitted to CMS.

For the proposed rule, we estimated the burden associated with these requirements to be the time and effort necessary for the MA organization to submit the necessary data to CMS. These requirements are subject to the PRA and the associated burden is currently approved under OMB control number 0938–0878. However, we noted that under notice and comment periods separate from the proposed rule, we intended to revise the currently approved information collection request to include burden estimates as they pertain to § 422.310. The preliminary burden estimate for the proposed rule was as follows: Currently, there are 676 MA organizations. Assuming that 99 percent of encounter data claims are submitted electronically and 1 percent are submitted manually, we estimated that it would take 1,089 hours annually for submission of electronic claims and 73,335 hours annually for submission of manual claims. The estimated annual burden associated with these requirements was an annual average of 110 hours per MA organization.

Comment: A few commenters stated that the burden estimates in the proposed rule were inadequate to capture the time associated with collecting and submitting risk adjustment data. Another commenter stated that CMS' estimate did not account for the impact on a plan's already-existing verification processes and procedures, including internal audit processes, which are undertaken to ensure the ''completeness, truthfulness and accuracy'' of the data. One commenter requested that CMS discuss in more detail the current impact analysis before finalizing the rule. One commenter noted that, while the estimates in the proposed rule gauged that an MA plan would spend less than 110 hours annually to comply with this request, its plan's RAPS transmission takes about 2 hours each month to run. Another commenter stated that CMS' preliminary estimate that 99 percent of claims are assumed to be electronic is inaccurate for the majority of PACE organizations. One commenter estimated that the cost of submitting encounter data would be no less than 2,000 hours a year in addition to having to retool internal systems as well as change or amend provider contracts.

Response: We appreciate the input of the commenters on their plans regarding the time and effort involved in their data collection efforts. While we will take these commenters' concerns into account, we also plan to obtain feedback from a wide variety of MA organizations regarding the work that would be involved in implementing and reporting encounter data. Because we want to wait until we have designed our reporting process and have obtained specific information about what work will be needed on the part of MA organizations to report such data, in this final rule, we are not changing our preliminary burden estimates presented in the FY 2009 IPPS proposed rule. Instead, we will address the issue in the PRA information collection request that will be released for public comment

prior to the implementation of encounter data collection.

c. ICRs Regarding Basic Commitments of Providers (§ 489.20)

As discussed in section IV.I. of the preamble of this final rule, § 489.20(r)(2) states that a hospital, as defined in § 489.24(b), must maintain an on-call list of physicians on its medical staff who are available to provide treatment necessary to stabilize patients who are receiving services required under § 489.24 in accordance with the resources available to the hospital. The burden associated with this requirement is the time and effort necessary to draft, maintain, and periodically update the list of on-call physicians. We estimate that it will take 3 hours for each Medicare-participating hospitals (including CAHs) to comply with this recordkeeping requirement. The estimated annual burden associated with this requirement is 300 hours.

However, after further review, we have determined that maintenance of a list of on-call physicians is a usual and customary business practice as hospitals routinely maintain the required information. Hospitals are required to maintain an on-call list of physicians to comply with the section 1866(a)(1)(I)(iii) of the Act. In accordance with 5 CFR 1320.3(b)(2), we are removing the aforementioned 300-hour annual burden associated with this requirement. As stated in 5 CFR 1320.3(b)(2), the burden associated with the time, effort, and financial resources necessary to comply with an ICR that would be incurred by persons in the normal course of their activities (that is, in compiling and maintaining business records) is exempt from the PRA.

As discussed in section VII. of the preamble of this final rule, § 489.20(u)(1) states that, in the case of a physician-owned hospital as defined in § 489.3, the hospital must furnish written notice to all patients at the beginning of their hospital stay or outpatient visit that the hospital is a physician-owned facility. In addition, patients must be advised that a list of the hospital's owners or investors who are physicians (or immediate family members of physicians) is available upon request. Upon receiving the request of the patient or an individual on behalf of the patient, a hospital must immediately disseminate the list to the requesting patient.

The burden associated with the requirements in this section is the time and effort necessary for a hospital to furnish written notice to all patients that the hospital is a physician-owned hospital. Because this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–1034, with an expiration date of February 28, 2011.

In addition, there is burden associated with furnishing a patient with the list of the hospital's owners or investors who are physicians (or immediate family members of physicians) at the time of the patient's request. However, CMS has no way to accurately quantify the burden because we cannot estimate the number of this type of requests that a hospital may receive. We solicited public comments on the annual number of requests a hospital may receive for lists of physician owners and investors in the FY 2009 IPPS proposed rule (73 FR 23528). However, we did not receive any public comments to assist us in our burden analysis. While we acknowledge that there is a burden associated with this ICR, we also acknowledge that we have no way to quantify this requirement's burden. For that reason, we are assigning 1 token burden hour to this requirement until such a time that we can conduct an accurate burden analysis for this information collection requirement.

Section 489.20(u)(2) requires disclosure of physician ownership as a condition of continued medical staff membership or admitting privileges. The burden associated with this requirement is the time and effort required for a hospital to develop, draft, and implement changes to its medical staff bylaws and other policies governing admitting privileges. Approximately 175 physician-owned hospitals will be required to comply with this requirement. We estimate that it will require a hospital's general counsel 4 hours to revise a hospital's medical staff bylaws and policies governing admitting privileges. Therefore, the total annual hospital burden is 700 hours.

In addition, § 489.20(u)(2) imposes a burden on physicians. As stated earlier, all physicians who are also members of the hospital's medical staff must agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients they refer to the hospital any ownership or investment interest in the hospital held by themselves or by an immediate family member. The disclosure must be made at the time the referral is made. The burden associated with this requirement is the time and effort necessary for a physician to draft a disclosure notice and to provide it to the patient at the time the referral is made to the physician-owned hospital. We estimate that it will take each physician, or designated office staff member, 1 hour to develop a disclosure notice and make copies that will be distributed to patients. In addition, we estimate that it will take 30 seconds to provide the disclosure notice to each patient and an additional 30 seconds to record proof of disclosure in each patient's medical record.

Although we can estimate the number of physician-owned hospitals, we are unable to quantify the numbers of physicians (or their immediate family members) that possess an ownership or investment interest in hospitals. There is limited data available concerning physician ownership in hospitals. The studies to date, including those by CMS and the GAO, pertain to physician ownership in specialty hospitals (cardiac, orthopedic, and surgical hospitals). These specialty hospital studies published data concerning the average percentage of shares of direct ownership by physicians (less than 2 percent), indirect ownership through group practices, and the aggregate percentage of physician ownership, but did not publish the number of physician owners in these types of hospitals. More importantly, § 489.20(u)(2) applies to physician ownership in any type of hospital. Our other research involved a review of enrollment data. However, the CMS Medicare enrollment application (CMS 855) requires that physicians report ownership interests that exceed 5 percent or greater, and, thus, most physician ownership is not captured. While we acknowledge there is a burden associated with this ICR, we also acknowledge that we have no way to quantify this requirement's burden. For that reason, we are assigning 1 token burden hour to this requirement until such a time that we can conduct an accurate burden analysis for this information collection requirement.

Section 489.20(v) states that the aforementioned requirements in § 489.20(u)(1) and (u)(2) do not apply to a physician-owned hospital that does not have at least one referring physician who has an ownership or investment interest in the hospital, or who has an immediate family member who has an ownership or investment interest in the hospital. To comply with this exception, an eligible hospital must sign an attestation to that effect and maintain the document in its records. Therefore, the number of hospitals that are subject to the disclosure requirement would be slightly reduced. However, there may be a minimal burden attributable to the requirement that the hospital maintain an attestation statement in its records.

The burden associated with this requirement is limited to those physician-owned hospitals that do not

have at least one referring physician who has an ownership or investment interest in the hospital, or who has an immediate family member who has an ownership or investment interest in the hospital. The burden includes the time and effort for these hospitals to develop, sign, and maintain the attestations in their records. We estimate that 10 percent, or approximately 18, of the estimated 175 physician-owned hospitals will be subject to this requirement. We estimate that it will take each of these physician-owned hospitals an average of 1 hour to develop, sign, and maintain the attestation in its records. The estimated annual burden associated with this requirement is 18 hours. However, we have no way of knowing for certain the number of physician-owned hospitals that do not have at least one referring physician who has an ownership or investment interest in the hospital, or who has an immediate family member who has an ownership or investment interest in the hospital.

In the FY 2009 IPPS proposed rule (73 FR 23528), we solicited public comments on the number of physician-owned hospitals that do not have at least one referring physician who has an ownership or investment interest in the hospital, or who has an immediate family member who has an ownership or investment interest in the hospital. However, we did not receive any public comments to assist us in our burden analysis. Therefore, we are submitting the burden estimate for this requirement as it appeared in the proposed rule.

Section 489.20(w) requires all hospitals, as defined in § 489.24(b), to furnish all patients notice, in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine, or a doctor of osteopathy, is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there are no physicians present in the hospital. The burden associated with this requirement is the time and effort necessary for each hospital to develop a standard notice to furnish to its patients. Because this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–1034, with a current expiration date of February 28, 2011.

ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 411.361	0938–New	500	500	100	*50,000
§ 422.310(b)	0938–0878	676	676	110	**74,424
§ 489.20(u)(1) and (w)	0938–1034	2,679	49,735,635	***	839,599
§ 489.20(u)(2)	0938–New	175	175	4	700
§ 489.20(v)	0938–New	18	18	1	18
Total					964,741

*For a comprehensive summary of our rationale for modifying these burden estimates, we refer readers to section IX.C. of the preamble of this final rule.

**Burden estimate is based on revisions to the currently approved OMB control number.

*** There are multiple requirements associated with the regulation section approved under this OMB control number. There is no uniform estimate of the burden per response.

3. Associated Information Collections Not Specified in Regulatory Text

As we indicated in the FY 2009 IPPS proposed rule, this final rule imposes ICRs as outlined in the regulation text and specified above. However, this rule also makes reference to several associated information collections that are not discussed in the regulation text. The following is a discussion of these collections, which have received OMB approval.

a. Present on Admission (POA) Indicator Reporting

Section II.F.8 of the preamble of this final rule discusses the POA indicator reporting requirements. As stated earlier, POA indicator information is necessary to identify which conditions are acquired during hospitalization for the hospital-acquired condition (HAC) payment provision, and for broader public health uses of Medicare data. Through Change Request No. 5499 (released May 11, 2007), CMS issued instructions that require IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims.

The burden associated with this requirement is the time and effort necessary to place the appropriate POA indicator codes on Medicare claims. Because the requirement is subject to the PRA; the associated burden is approved under OMB control number 0938–0997, with an expiration date of August 31, 2009.

b. Add-On Payments for New Services and Technologies

Section II.J. of the preamble of the FY 2009 IPPS proposed rule and this final rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2010 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold.

We detailed the burden associated with this requirement in the September 7, 2001 IPPS final rule (66 FR 46902). As stated in that final rule, we believe the associated burden is exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Collection of the information for this requirement is conducted on individual case-by-case basis.

c. Reporting of Hospital Quality Data for Annual Hospital Payment Update

As noted in section IV.B. of the preamble of the proposed rule and this final rule, the RHQDAPU program was originally established to implement section 501(b) of Public Law 108–173, thereby expanding our voluntary HQI. The RHQDAPU program originally consisted of a ''starter set'' of 10 quality measures. OMB approved the collection of data associated with the original

starter set of quality measures under OMB control number 0938–0918, with a current expiration date of January 31, 2010.

We added additional quality measures to the RHQDAPU program and submitted the information collection request to OMB for approval. This expansion of the RHQDAPU measures was part of our implementation of section 5001(a) of the DRA. Section 1886(b)(3)(B)(viii)(III) of the Act, added by section 5001(a) of the DRA, requires that the Secretary expand the ''starter set'' of 10 quality measures that were established by the Secretary as of November 1, 2003, to include measures ''that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings.'' The burden associated with these reporting requirements is currently approved under OMB control number 0938–1022 with a current expiration date of June 30, 2011.

However, for FY 2009, we submitted to OMB for approval a revised information collection request using the same OMB control number (0938–1022). In the revised request, we added three new RHQDAPU quality measures that we adopted for the FY 2009 RHQDAPU program to the PRA process. These three measures are as follows:

- Pneumonia 30-day Mortality (Medicare patients);
- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose; and
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

The revised information collection request was announced in the **Federal Register** via an emergency notice on January 28, 2008 (73 FR 4868). The burden associated with these reporting requirements has been approved under OMB control number 0938–1022, with a current expiration date of June 30, 2011. However, as stated in section IV.V.2. of this final rule, we are submitting another revised information collection request to obtain approval for the 13 new RHQDAPU program measures listed below;

- SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
- Heart Failure (HF) 30–Day Risk Standardized Readmission Measure
- Death among surgical patients with treatable serious complications (Medicare patients)
- Iatrogenic pneumothorax, adult (Medicare patients)
- Postoperative wound dehiscence (Medicare patients)
- Accidental puncture or laceration (Medicare patients)
- Abdominal aortic aneurysm (AAA) mortality rate (with or without volume) (Medicare patients)
- Hip fracture mortality rate (Medicare patients)
- Mortality for selected surgical procedures (composite) (Medicare patients)
- Complication/patient safety for selected indicators (composite) (Medicare patients)
- Mortality for selected medical conditions (composite) (Medicare patients)
- Failure to Rescue (Medicare claims only)
- Participation in a Systematic Database for Cardiac Surgery

Section IV.B.5. of the preamble of the proposed rule and this final rule also discusses the requirements for the continuous collection of HCAHPS quality data. The HCAHPS survey is designed to produce comparable data regarding the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. We also added the HCAHPS survey to the PRA process in the information collection request currently approved under OMB control number 0938–1022, with a current expiration date of June 30, 2011.

Section IV.B.9. of the preamble of the FY 2009 IPPS proposed rule and this final rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to CMS requesting that we reconsider our decision. The hospital's letter must explain the reasons why it believes it did meet the RHQDAPU program requirements. While this is a reporting requirement, the burden associated with it is not subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information collection requirements imposed subsequent to an administrative action is not subject to the PRA.

d. Occupational Mix Adjustment to the FY 2009 Index (Hospital Wage Index Occupational Mix Survey)

Section III. of the preamble of this final rule details the changes to the hospital wage index. Specifically, section III.D. addresses the occupational mix adjustment to the FY 2009 wage index. While the preamble does not contain any new ICRs, it is important to note that there is an OMB approved information collection request associated with the hospital wage index.

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data at least once every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index. We collect the data via the occupational mix survey.

The burden associated with this information collection requirement is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. Because this burden is subject to the PRA, it is approved under OMB control number 0938–0907, with an expiration date of February 28, 2011.

C. Waiver of Proposed Rulemaking, Waiver of Delay in Effective Date, and Retroactive Effective Date

1. Requirements for Waivers and Retroactive Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA). However, we can waive notice and comment procedures 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 rule. Section 553(d) of the APA also ordinarily requires a 30-day delay in effective date of final rules after the date of their publication. However, this 30-day delay in effective date can be waived if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. Moreover, section 1871(e)(1)(A) of the Act generally prohibits the Secretary from making retroactive substantive changes in policy unless retroactive application of the change is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to the public interest.

2. FY 2008 Puerto Rico-Specific Rates

We are waiving notice-and-comment procedures and the 30-day delay in effective date with respect to the application of the documentation and coding adjustment to the Puerto Rico-specific operating standardized amounts

and the Puerto Rico specific capital payment rate for FY 2008. As discussed in section II.D.3. of this final rule, the documentation and coding adjustment established in the FY 2008 final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the authority to adjust ''the standardized amounts computed under this paragraph'' to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix. We believe that the application of the documentation and coding adjustment to the Puerto-Rico specific rates in the FY 2008 IPPS final rule was not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act. Therefore, we are revising the Puerto-Rico specific rates for FY 2008 to remove the application of the documentation and coding adjustment. We are waiving notice and comment procedures with respect to this policy change because we believe it would be unnecessary and contrary to the public interest to undertake notice-and-comment procedures prior to changing our policy to make the policy consistent with the plain meaning of the section of the statute upon which the policy was based. For the same reasons, we are waiving the 30-day delay in effective date because we believe it would be unnecessary and contrary to the public interest to delay the policy change beyond the October 1, 2007 effective date of the FY 2008 IPPS final rule. We are also applying this policy change retroactive to October 1, 2007, under section 1871(e)(1)(A)(i) of the Act because it would be contrary to the public interest for our policy not to be consistent with the plain meaning of the section of the statute upon which the policy was based.

3. Rebasing of Payments to SCHs

We are waiving notice-and-comment procedures with respect to the provisions relating to the rebasing of payments to SCHs discussed in section IV.D.2. of the preamble of this final rule. As discussed in that section, section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) provides that, for cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on an FY 2006 hospital-specific rate (that is, based on their updated costs per discharge based on their 12-month cost reporting period beginning during Federal fiscal year 2006), if this results in the greatest payment to the SCH. Therefore, effective with cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on the rate that results in the greatest aggregate payment using either the Federal rate or their hospital-specific rate based on their 1982, 1987, 1996, or 2006 costs per discharge. This statutory provision is self-implementing. Therefore, we are waiving notice-and-comment procedures with respect to incorporating this change in our regulations. We believe it is unnecessary and contrary to the public interest to undertake notice-and-comment procedures prior to incorporating the policy in the regulations, consistent with the provisions of the statute.

4. Technical Change to Regulations Governing Payments to Hospitals With High Percentage of ESRD Discharges

As discussed in section II.G.12.g. of the preamble of this final rule, the existing regulation at § 412.104 specifies the rules for an additional payment to hospitals where 10 percent or more of their patients who are discharged receive dialysis treatment during an inpatient stay. However, there are specific DRGs cited in the regulation that are excluded from this additional payment. Because, beginning in FY 2008, we adopted MS–DRGs to replace the DRGs cited in the regulation, we are making a technical change to cite the appropriate replacement MS–DRGs. We believe that it is unnecessary and contrary to the public interest to undertake notice and comment procedures for this technical conforming change.

5. Changes to Regulations at 42 CFR 412.230, 412.232, and 412.234 Relating to Procedures for Terminating and Withdrawing Certain Reclassifications

Our changes to 42 CFR 412.230, 412.232, and 412.234 will be effective on September 2, 2008, the deadline for hospitals to submit applications for reclassifications for the FY 2010 wage index. In addition, the procedures we have described in section III.I.7. of the preamble of this final rule will be effective upon publication. It is in the public interest of hospitals for the changes to the reclassification thresholds to be in place at the time their applications are due to the MGCRB for FY 2010. This provides confidence to hospitals that the applications they are filing are using correct thresholds. It also is unnecessary for the changes to §§ 412.230, 412.232, and 412.234 to have a delayed effective date, as the changes to these regulatory provisions will have no effect on FY 2009 reclassifications but rather will affect only FY 2010 reclassifications. Thus, in the most practical sense, hospitals have more than a year's worth of notice regarding the standards that will be applied for FY 2010. Finally, even if the thresholds were effective at a later date, the MGCRB would use the thresholds that are in effect at the time it makes its reclassification decisions.

The rules discussed in section III.I.7. of the preamble of this final rule are simply procedural and thus are not subject to any delay in effective date. Even if they were, however, it is in the public interest to make them effective upon publication, as they provide a necessary and expeditious timetable for both CMS and hospitals to respond to intervening MIPPA legislation. In addition, we view these rules as ''relieving a restriction'' under 5 U.S.C. 553(d)(1), as they allow affected hospitals another opportunity to withdraw or terminate reclassifications in response to the intervening MIPPA legislation. Finally, we note that section 1871(b)(2)(B) of the Act allows for waiver of notice and comment rulemaking when a statute creates a deadline for implementation that is less than 150 days after the date of enactment of the statute. The time between MIPPA enactment (July 15, 2008) and the date by which the extended reclassifications and special exceptions must take effect (October 1, 2008) is less than 150 days.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 422

Administrative practice and procedure, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

■ 2. Section 411.351 is amended by—
■ a. Revising paragraph (1) of the definition of ''entity''.
■ b. Revising the definition of ''physician''.
■ c. Revising the definition of ''physician organization''.

The revisions read as follows:

§ 411.351 Definitions.

* * * * *

Entity means—

(1) A physician's sole practice or a practice of multiple physicians or any other person, sole proprietorship, public or private agency or trust, corporation, partnership, limited liability company, foundation, nonprofit corporation, or unincorporated association that furnishes DHS. An entity does not include the referring physician himself or herself, but does include his or her medical practice. A person or entity is considered to be furnishing DHS if it—

(i) Is the person or entity that has performed services that are billed as DHS; or

(ii) Is the person or entity that has presented a claim to Medicare for the DHS, including the person or entity to which the right to payment for the DHS has been reassigned in accordance with § 424.80(b)(1) (employer) or (b)(2) (payment under a contractual arrangement) of this chapter (other than a health care delivery system that is a health plan (as defined at § 1001.952(l) of this title), and other than any managed care organization (MCO), provider-sponsored organization (PSO), or independent practice association (IPA) with which a health plan contracts for services provided to plan enrollees).

* * * * *

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Act. A physician and the professional corporation of which he or she is a sole owner are the same for purposes of this subpart.

* * * * *

Physician organization means a physician, a physician practice, or a group practice that complies with the requirements of § 411.352.

* * * * *

■ 3. Section 411.353 is amended by—
■ a. Revising paragraph (c).
■ b. Adding a new paragraph (g).

The revision and addition read as follows:

§ 411.353 Prohibition on certain referrals by physicians and limitations on billing.

* * * * *

(c) *Denial of payment for services furnished under a prohibited referral.*

(1) Except as provided in paragraph (e) of this section, no Medicare payment may be made for a designated health service that is furnished pursuant to a prohibited referral. The period during which referrals are prohibited is the period of disallowance. For purposes of this section, with respect to the following types of noncompliance, the period of disallowance begins at the time the financial relationship fails to satisfy the requirements of an applicable exception and ends no later than—

(i) Where the noncompliance is unrelated to compensation, the date that the financial relationship satisfies all of the requirements of an applicable exception;

(ii) Where the noncompliance is due to the payment of excess compensation, the date on which all excess compensation is returned, by the party that received it, to the party that paid it and the financial relationship satisfies all of the requirements of an applicable exception; or

(iii) Where the noncompliance is due to the payment of compensation that is of an amount insufficient to satisfy the requirements of an applicable exception, the date on which all additional required compensation is paid, by the party that owes it, to the party to which it is owed and the financial relationship satisfies all of the requirements of an applicable exception.

(2) When payment for a designated health service is denied on the basis that the service was furnished pursuant to a prohibited referral, and such payment denial is appealed—

(i) The ultimate burden of proof (burden of persuasion) at each level of appeal is on the entity submitting the claim for payment to establish that the service was not furnished pursuant to a prohibited referral (and not on CMS or its contractors to establish that the service was furnished pursuant to a prohibited referral); and

(ii) The burden of production on each issue at each level of appeal is initially on the claimant, but may shift to CMS or its contractors during the course of the appellate proceeding, depending on the evidence presented by the claimant.

* * * * *

(g) *Special rule for certain arrangements involving temporary noncompliance with signature requirements.* (1) An entity may submit a claim or bill and payment may be made to an entity that submits a claim or bill for a designated health service if—

(i) The compensation arrangement between the entity and the referring physician fully complied with an applicable exception in § 411.355, § 411.356 or § 411.357, except with respect to the signature requirement in § 411.357(a)(1), § 411.357(b)(1), § 411.357(d)(1)(i), § 411.357(e)(1)(i), § 411.357(e)(4)(i), § 411.357(l)(1), § 411.357(p)(2), § 411.357(q) (incorporating the requirement contained in § 1001.952(f)(4)), § 411.357(r)(2)(ii), § 411.357(t)(1)(ii) or (t)(2)(iii) (both incorporating the requirement contained in § 411.357(e)(1)(i)), § 411.357(v)(7)(i), or § 411.357(w)(7)(i); and

(ii) The failure to comply with the signature requirement was—

(A) Inadvertent, and the parties obtain the required signature(s) within 90 consecutive calendar days immediately following the date on which the compensation arrangement becomes noncompliant (without regard to whether any referrals occur or compensation is paid during such 90-day period) and the compensation arrangement otherwise complies with all criteria of the applicable exception; or

(B) Not inadvertent, and the parties obtain the required signature(s) within 30 consecutive calendar days immediately following the date on which the compensation arrangement becomes noncompliant (without regard to whether any referrals occur or compensation is paid during such 30-day period) and the compensation arrangement otherwise complies with all criteria of the applicable exception.

(2) Paragraph (g)(1) of this section may be used by an entity only once every 3 years with respect to the same referring physician.

* * * * *

■ 4. Section 411.354 is amended by—
■ a. Revising paragraph (b)(3)(i).
■ b. Revising paragraph (c)(1)(ii).
■ c. Revising paragraph (c)(2)(iv).
■ d. Revising paragraph (c)(3)(ii).
■ e. Adding paragraphs (c)(3)(iii).

The revisions and additions read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

(b) * * *

(3) * * *

(i) An interest in an entity that arises from a retirement plan offered by that entity to the physician (or a member of his or her immediate family) through the physician's (or immediate family member's) employment with that entity;

* * * * *

(c) * * *

(1) * * *

(ii) Except as provided in paragraph (c)(3)(ii)(C) of this section, a physician is deemed to stand in the shoes of his or her physician organization and have a direct compensation arrangement with an entity furnishing DHS if—

(A) The only intervening entity between the physician and the entity furnishing DHS is his or her physician organization; and

(B) The physician has an ownership or investment interest in the physician organization.

(iii) A physician (other than a physician described in paragraph (c)(1)(ii)(B) of this section) is permitted to ''stand in the shoes'' of his or her physician organization and have a direct compensation arrangement with an entity furnishing DHS if the only intervening entity between the physician and the entity furnishing DHS is his or her physician organization.

(2) * * *

(iv)(A) For purposes of paragraph (c)(2)(i) of this section, except as provided in paragraph (c)(3)(ii)(C) of this section, a physician is deemed to ''stand in the shoes'' of his or her physician organization if the physician has an ownership or investment interest in the physician organization.

(B) For purposes of paragraph (c)(2)(i) of this section, a physician (other than a physician described in paragraph (c)(2)(iv)(A) of this section) is permitted to ''stand in the shoes'' of his or her physician organization.

(3) * * *

(ii) The provisions of paragraphs (c)(1)(ii) and (c)(2)(iv)(A) of this section—

(A) Need not apply during the original term or current renewal term of an arrangement that satisfied the requirements of § 411.357(p) as of September 5, 2007 (see 42 CFR Parts 400–413, revised as of October 1, 2007);

(B) Do not apply to an arrangement that satisfies the requirements of § 411.355(e); and

(C) Do not apply to a physician whose ownership or investment interest is titular only. A titular ownership or investment interest is an ownership or investment interest that excludes the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment.

(iii) An arrangement structured to comply with an exception in § 411.357 (other than § 411.357(p)), but which would otherwise qualify as an indirect compensation arrangement under this paragraph as of August 19, 2008, need not be restructured to satisfy the requirements of § 411.357(p) until the expiration of the original term or current renewal term of the arrangement.

* * * * *

■ 5. Section 411.357 is amended by—

■ a. Republishing the introductory text of the section.

■ b. Revising paragraph (a).

■ c. Revising paragraph (b).

■ d. Revising paragraph (l).

■ e. Revising paragraph (p)(1).

■ f. Revising paragraph (r).

The revisions read as follows:

§ 411.357 Exceptions to the referral prohibition related to compensation arrangements.

For purposes of § 411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined—

(i) In a manner that takes into account the volume or value of any referrals or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred between the parties.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following the expiration of an agreement of at least 1 year that met the conditions of paragraphs (a)(1) through (a)(6) of this section satisfies the requirements of paragraph (a) of this section, provided that the holdover rental is on the same terms and conditions as the immediately preceding agreement.

(b) *Rental of equipment.* Payments made by a lessee to a lessor for the use of equipment under the following conditions:

(1) A rental or lease agreement is set out in writing, is signed by the parties, and specifies the equipment it covers.

(2) The equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee and is not shared with or used by the lessor or any person or entity related to the lessor.

(3) The agreement provides for a term of rental or lease of at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(4) The rental charges over the term of the agreement are set in advance, are consistent with fair market value, and are not determined—

(i) In a manner that takes into account the volume or value of any referrals or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed on or business generated by the use of the equipment; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred between the parties.

(5) The agreement would be commercially reasonable even if no referrals were made between the parties.

(6) A holdover month-to-month rental for up to 6 months immediately following the expiration of an agreement of at least 1 year that met the conditions of paragraphs (b)(1) through (b)(5) of this section satisfies the requirements of paragraph (b) of this section, provided that the holdover rental is on the same terms and conditions as the immediately preceding agreement.

* * * * *

(l) *Fair market value compensation.* Compensation resulting from an arrangement between an entity and a physician (or an immediate family member) or any group of physicians (regardless of whether the group meets the definition of a group practice set forth in § 411.352) for the provision of items or services (other than the rental of office space) by the physician (or an immediate family member) or group of physicians to the entity, or by the entity to the physician (or an immediate family member) or a group of physicians, if the arrangement is set forth in an agreement that meets the following conditions:

(1) The arrangement is in writing, signed by the parties, and covers only identifiable items or services, all of which are specified in the agreement.

(2) The writing specifies the timeframe for the arrangement, which can be for any period of time and contain a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than 1 year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change.

(3) The writing specifies the compensation that will be provided under the arrangement. The compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician. Compensation for the rental of equipment may not be determined using a formula based on—

(i) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated through the use of the equipment; or

(ii) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred between the parties.

(4) The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.

(5) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(6) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a Federal or State law.

* * * * *

(p) *Indirect compensation arrangements.* Indirect compensation arrangements, as defined at § 411.354(c)(2), if all of the following conditions are satisfied:

(1)(i) The compensation received by the referring physician (or immediate family member) described in § 411.354(c)(2)(ii) is fair market value for services and items actually provided and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS. Compensation for the rental of office space or equipment may not be determined using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space or to the services performed or business generated through the use of the equipment; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred between the parties.

(ii) The compensation arrangement described in § 411.354(c)(2)(ii) is set out in writing, signed by the parties, and specifies the services covered by the arrangement, except in the case of a *bona fide* employment relationship between an employer and an employee, in which case the arrangement need not be set out in a written contract, but must be for identifiable services and be commercially reasonable even if no referrals are made to the employee; and

(iii) The compensation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

* * * * *

(r) *Obstetrical malpractice insurance subsidies.* Remuneration that meets all of the conditions of paragraph (r)(1) or (2) of this section.

(1) Remuneration that meets all of the conditions set forth in § 1001.952(o) of this title.

(2) A payment from a hospital, federally qualified health center, or rural health clinic that is used to pay for some or all of the costs of malpractice insurance premiums for a physician who engages in obstetrical practice as a routine part of his or her medical practice, if all of the following conditions are met:

(i)(A) The physician's medical practice is located in a rural area, a primary care HPSA, or an area with demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(B) At least 75 percent of the physician's obstetrical patients reside in a medically underserved area or are members of a medically underserved population.

(ii) The arrangement is set out in writing, is signed by the physician and the hospital, federally qualified health center, or rural health clinic providing the payment, and specifies the payments to be made by the hospital, federally qualified health center, or rural health clinic and the terms under which the payments are to be provided.

(iii) The arrangement is not conditioned on the physician's referral of patients to the hospital, federally qualified health center, or rural health clinic providing the payment.

(iv) The hospital, federally qualified health center, or rural health clinic does not determine (directly or indirectly) the amount of the payment based on the volume or value of any actual or anticipated referrals by the physician or any other business generated between the parties.

(v) The physician is allowed to establish staff privileges at any hospital(s), federally qualified health center(s), or rural health clinic(s) and to refer business to any other entities (except as referrals may be restricted under an employment arrangement or services contract that complies with § 411.354(d)(4)).

(vi) The payment is made to a person or organization (other than the physician) that is providing malpractice insurance (including a self-funded organization).

(vii) The physician treats obstetrical patients who receive medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(viii) The insurance is a *bona fide* malpractice insurance policy or program, and the premium, if any, is calculated based on a *bona fide* assessment of the liability risk covered under the insurance.

(ix)(A) For each coverage period (not to exceed 1 year), at least 75 percent of the physician's obstetrical patients treated under the coverage of the obstetrical malpractice insurance during the prior period (not to exceed 1 year)—

(*1*) Resided in a rural area, HPSA, medically underserved area, or an area with a demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(*2*) Were part of a medically underserved population.

(B) For the initial coverage period (not to exceed 1 year), the requirements of paragraph (r)(2)(ix)(A) of this section will be satisfied if the physician certifies that he or she has a reasonable expectation that at least 75 percent of the physician's obstetrical patients treated under the coverage of the malpractice insurance will—

(*1*) Reside in a rural area, HPSA, medically underserved area, or an area with a demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(*2*) Be part of a medically underserved population.

(x) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(3) For purposes of paragraph (r)(2) of this section, *costs of malpractice insurance premiums* means:

(i) For physicians who engage in obstetrical practice on a full-time basis, any costs attributable to malpractice insurance; or

(ii) For physicians who engage in obstetrical practice on a part-time or sporadic basis, the costs attributable exclusively to the obstetrical portion of the physician's malpractice insurance, and related exclusively to obstetrical services provided—

(A) In a rural area, primary care HPSA, or an area with demonstrated need for the physician's obstetrical services, as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(B) In any area, provided that at least 75 percent of the physician's obstetrical patients treated in the coverage period (not to exceed 1 year) resided in a rural area or medically underserved area or were part of a medically underserved population.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Public Law 106–113 (113 Stat. 1501A–332).

■ 7. Section 412.22 is amended by—

■ a. In the introductory text of paragraph (e), removing the phrase ''paragraph (f) of this section'' and adding in its place ''paragraphs (e)(1)(vi) and (f) of this section''.

■ b. Adding a new paragraph (e)(1)(vi).

The addition reads as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

(1) * * *

(vi) Effective October 1, 2008, if a State hospital that is occupying space in the same building or on the same campus as another State hospital cannot meet the criterion under paragraph (e)(1)(i) of this section solely because its governing body is under the control of the State hospital with which it shares a building or a campus, or is under the control of a third entity that also controls the State hospital with which it shares a building or a campus, the State hospital can nevertheless qualify for an exclusion if it meets the other applicable criteria in this section and—

(A) Both State hospitals occupy space in the same building or on the same campus and have been continuously owned and operated by the State since October 1, 1995;

(B) Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and

(C) Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the inpatient prospective payment system through September 30, 2008.

* * * * *

■ 8. Section 412.64 is amended by—

■ a. Republishing the introductory text of paragraph (b)(1)(ii) and revising paragraph (b)(1)(ii)(A).

■ b. Revising paragraph (e)(1)(ii).

■ c. Adding a new paragraph (e)(4).

■ d. In the introductory text of paragraph (h)(4), removing the date ''September 30, 2008'' and adding in its place ''September 30, 2011''.

The revisions and additions read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(b) * * *

(1) * * *

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget; or

* * * * *

(e) * * *

(1) * * *

(ii) Except as provided in paragraph (e)(4) of this section, the annual updates and adjustments to the wage index under paragraph (h) of this section are made in a manner that ensures that aggregate payments are not affected; and

* * * * *

(4) CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) and the imputed floor under paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions. Beginning October 1, 2008, such adjustment will transition from a nationwide to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010.

* * * * *

§ 412.78 [Redesignated]

■ 9. Section 412.78 is redesignated as § 412.76.

■ 10. A new § 412.78 is added to read as follows:

§ 412.78 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 2006 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 2006 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 or the hospital-specific rates for either FY 1982 under § 412.73, FY 1987 under § 412.75 or FY 1996 under § 412.77, this 2006 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after January 1, 2009.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this

section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 2006 rebasing*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 2006, and before September 30, 2007, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 2007 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 2006 and before September 30, 2007, and does have a cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 2006, the hospital will not have a hospital-specific rate based on fiscal year 2006.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2006, the update factor is determined using the methodology set forth in § 412.73(c)(15).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2006 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination under this section of the hospital-specific rate for a hospital is subject to administrative and judicial review in accordance with § 412.77(h).

(i) *Modification of hospital-specific rate.* The intermediary recalculates the hospital-specific rate determined under this section in the manner set forth in § 412.77(i).

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate determined under this section in the manner set forth in § 412.77(j).

■ 11. Section 412.87 is amended by—

■ a. Revising paragraph (b)(1).

■ b. Adding a new paragraph (c).

The revision and addition read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

* * * * *

(b) * * *

(1) A new medical service or technology represents an advance that substantially improves, relating to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

* * * * *

(c) *Announcement of determinations and deadline for consideration of new medical service or technology applications.* CMS will consider whether a new medical service or technology meets the eligibility criteria specified in paragraph (b) of this section and announce the results in the **Federal Register** as part of its annual updates and changes to the IPPS. CMS will only consider, for add-on payments for a particular fiscal year, an application for which the new medical service or technology has received FDA approval or clearance by July 1 prior to the particular fiscal year.

■ 12. Section 412.92 is amended—

■ a. Republishing the introductory text of paragraph (d)(1).

■ b. Adding a new paragraph (d)(1)(v).

The addition reads as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals*—(1) *General rule.* For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period.

* * * * *

(v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.

* * * * *

■ 13. Section 412.104 is amended by revising paragraph (a) to read as follows:

§ 412.104 Special treatment: Hospitals with high percentages of ESRD discharges.

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into MS–DRG 652 (Renal Failure), MS–DRG 682 (Renal Failure with MCC), MS–DRG 683 (Renal Failure with CC), MS–DRG 684 (Renal Failure without CC/MCC) and MS–DRG 685 (Admit for Renal Dialysis), where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges.

* * * * *

■ 14. Section 412.105 is amended by revising paragraph (f)(1)(vi) to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(vi) Hospitals that are part of the same Medicare GME affiliated group or emergency Medicare GME affiliated group (as defined in § 413.75(b) of this subchapter) may elect to apply the limit specified in paragraph (f)(1)(iv) of this section on an aggregate basis, as specified in § 413.79(f) of this subchapter. Effective beginning on or after October 1, 2008, home and host hospitals with valid emergency Medicare GME affiliation agreements are exempt from the application of the ratio cap specified in paragraph (a)(1)(i) of this section.

* * * * *

■ 15. Section 412.230 is amended by—

■ a. Revising paragraph (d)(1)(iv)(C).
■ b. Adding new paragraphs (d)(1)(iv)(D) and (d)(1)(iv)(E).

The additions and revision read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(d) * * *

(1) * * *

(iv) * * *

(C) With respect to redesignations for fiscal years 2002 through 2009, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(D) With respect to redesignations for fiscal year 2010, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 84 percent, and in the case of a hospital located in an urban area, at least 86 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(E) With respect to redesignations for fiscal year 2011 and later fiscal years, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 86 percent, and in the case of a hospital located in an urban area, at least 88 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

* * * * *

■ 16. Section 412.232 is amended by—
■ a. Revising paragraph (c)(1).
■ b. Revising paragraph (c)(2).
■ c. Adding a new paragraph (c)(3).

The revisions and addition read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

* * * * *

(c) * * *

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010.*

(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the rural county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010.* With respect to redesignations effective for fiscal year 2010, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 86 percent of the average hourly wage in the adjacent urban area.

(3) *Aggregate hourly wage for fiscal year 2011 and later fiscal years.* With respect to redesignations effective for fiscal year 2011 and later fiscal years, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 88 percent of the average hourly wage in the adjacent urban area.

* * * * *

■ 17. Section 412.234 is amended by—
■ a. Revising paragraph (b)(1).
■ b. Revising paragraph (b)(2).
■ c. Adding a new paragraph (b)(3).

The revisions and addition read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

* * * * *

(b) * * *

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010.*

(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the urban county must be at least 85 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010.* With respect to redesignations effective for fiscal year 2010, the aggregate average hourly wage for all hospitals in the urban county must be at least 86 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(3) *Aggregate hourly wage for fiscal year 2011 and later fiscal years.* With respect to redesignations effective for fiscal year 2011 and later fiscal years, the aggregate average hourly wage for all hospitals in the urban county must be at least 88 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

* * * * *

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

■ 18. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

■ 19. Section 413.79 is amended by—
■ a. Adding a heading to paragraph (f)(6)(i).
■ b. Revising paragraph (f)(6)(ii).
■ c. In paragraph (f)(6)(iv), removing the cross-reference ''§ 413.75(d)'' and adding the cross-reference ''paragraph (d) of this section'' in its place.

The revisions read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(f) * * *

(6) * * *

(i) *Requirements for submission of emergency Medicare GME affiliation agreements.* * * *

(ii) *Deadline for submission of the emergency Medicare GME affiliation agreement.* Each participating home and host hospital must submit an emergency Medicare GME affiliation agreement to CMS and submit a copy to the CMS fiscal intermediary/MAC by the applicable due date.

(A) For emergency Medicare GME affiliation agreements that would otherwise be required to be submitted by June 30, 2006, or July 1, 2006, each participating host and home hospital must submit an emergency Medicare GME affiliation agreement to CMS and submit a copy to its CMS intermediary/MAC on or before October 9, 2006.

(B) Except for emergency Medicare GME affiliation agreements specified in paragraph (f)(6)(ii)(A) of this section, for emergency Medicare GME affiliation agreements that would otherwise be required to be submitted prior to October 1, 2008, the following due dates are applicable:

(*1*) *First year.* The later of 180 days after the section 1135 emergency period begins or by June 30 of the academic year in which the section 1135 emergency was declared; or

(*2*) *Subsequent academic years.* The later of 180 days after the section 1135

emergency period begins, or by July 1 of each academic year.

(C) For emergency Medicare GME affiliation agreements that would otherwise be required to be submitted after October 1, 2008, the following due dates are applicable:

(*1*) *First year.* By 180 days after the end of the academic year in which the section 1135 emergency was declared;

(*2*) *Second academic year.* By 180 days after the end of the next academic year following the academic year in which the section 1135 emergency was declared; or

(3) *Subsequent academic years.* By July 1 of each academic year.

* * * * *

PART 422—MEDICARE ADVANTAGE PROGRAM

■ 20. The authority citation for part 422 continues to read as follows:

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

■ 21. Section 422.310 is revised to read as follows:

§ 422.310 Risk adjustment data.

(a) *Definition of risk adjustment data.* Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.

(b) *Data collection: Basic rule.* Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) *Sources and extent of data.*

(1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Items and services covered under the original Medicare program.

(ii) Medicare covered items and services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) *Other data requirements.*

(1) MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.

(f) *Use of data.* CMS uses the data obtained under this section to determine the risk adjustment factors used to adjust payments, as required under §§ 422.304(a) and (c). CMS also may use the data for updating risk adjustment models, calculating Medicare DSH percentages, conducting quality review and improvement activities, and for Medicare coverage purposes.

(g) *Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate. CMS may adjust these deadlines, as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting items and services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) CMS allows a reconciliation process to account for late data submissions. CMS continues to accept risk adjustment data submitted after the March deadline until January 31 of the year following the payment year. After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary. Risk adjustment data that are received after the annual January 31 late data submission deadline will not be accepted for the purposes of reconciliation.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 22. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

■ 23. Section 489.3 is amended by revising the definition of ''physician-owned hospital'' to read as follows:

§ 489.3 Definitions.

* * * * *

Physician-owned hospital means any participating hospital (as defined in § 489.24) in which a physician, or an immediate family member of a physician (as defined in § 411.351 of this chapter), has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at § 411.356(a) or (b) of this chapter.

* * * * *

■ 24. Section 489.20 is amended by—

■ a. Revising paragraph (r)(2).

■ b. Revising paragraph (u).

■ c. Redesignating paragraphs (v) and (w) as paragraphs (w) and (x), respectively.

■ d. Adding a new paragraph (v).

The revisions and addition read as follows:

§ 489.20 Basic commitments.

* * * * *

(r) * * *

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan, in accordance with § 489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital; and

* * * * *

(u) Except as provided in paragraph (v) of this section, in the case of a

physician-owned hospital as defined at § 489.3—

(1) To furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care, in accordance with § 482.13(b)(2) of this subchapter. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a physician-owned hospital specified in § 489.3 and that the list of the hospital's owners or investors who are physicians or immediate family members (as defined at § 411.351 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(2) To require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital that is held by the physician or by an immediate family member (as defined at § 411.351 of this chapter) of the physician. Disclosure must be required at the time the referral is made.

(v) The requirements of paragraph (u) of this section do not apply to any physician-owned hospital that does not have at least one referring physician (as defined at § 411.351 of this chapter) who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital, provided that such hospital signs an attestation statement to that effect and maintains such attestation in its records.

* * * * *

■ 25. Section 489.24 is amended by—
■ a. Revising paragraph (a)(2).
■ b. Revising paragraph (f).
■ c. Revising paragraph (j).

The revisions read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) * * *

(2) *Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a pubic health emergency, as provided for by section 1135(e)(1)(B) of the Act.

* * * * *

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive case units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at § 412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

* * * * *

(j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under § 489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under § 489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

■ 26. Section 489.53 is amended by revising paragraph (c) to read as follows:

§ 489.53 Termination by CMS.

* * * * *

(c) *Termination of agreements with hospitals that fail to make required disclosures.* In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u) or (w). In the case of other participating hospitals, as defined at § 489.24, CMS may terminate the provider agreement if the participating hospital failed to comply with the requirements of § 489.20(w).

* * * * *

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

Dated: July 24, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 31, 2008.

Michael O. Leavitt,

Secretary.

Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.

Addendum—Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2008

I. Summary and Background

In 2007, Congress passed the MMSEA, Public Law 108–173, and section 117 of that Act extended section 508 wage index reclassifications and certain special exceptions through FY 2008, with the special reclassifications and exceptions scheduled to expire September 30, 2008. However, before these reclassifications and exceptions could expire, on July 15, 2008, Congress enacted Public Law 110–275 (MIPPA). Section 124 of that Act further extended the 508 reclassifications and special exceptions through the end of FY 2009—or September 30, 2009. As a result of this intervening legislation, section 508 or special exception hospitals that would have otherwise been reclassified under section 1886 of the Act will no longer be considered as such, thus affecting the wage index calculations. We did not have sufficient time between the passage of the legislation and the deadline for publication of this final rule to recalculate wage indices based on the new reclassification data. Therefore, we are not able to provide all of the final FY 2009 wage index tables, payment rates, or impacts in this final rule. Because the wage data affect the calculation of the outlier threshold as well as the outlier offset and budget neutrality factors that are applied to the standardized amounts, we are only able to provide tentative figures at this time. These tentative amounts will be revised once section 124 of Public Law 110–275 is implemented and as a result the wage index will be finalized. Subsequent to this final rule, we will publish a **Federal Register** document listing the final standardized amounts, outlier offsets, and budget neutrality factors that are effective October 1, 2008, for FY 2009. The final data also will be published on the CMS Web site.

In this Addendum, we are setting forth a final description of the methods and data we used to determine the prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the rate-of-increase percentages for updating the target amounts for certain hospitals and hospital units excluded from the IPPS. We note that, because certain hospitals excluded from the IPPS are paid on a reasonable cost basis subject to a rate-of-increase ceiling (and not by the IPPS), these hospitals are not affected by the tentative figures for standardized amounts, offsets, and budget neutrality factors. Therefore, in this final rule, we are finalizing the rate-of-increase percentages for updating the target amounts for certain hospitals and hospital units excluded from the IPPS that are effective for cost reporting periods beginning on or after October 1, 2008.

In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, also known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge. For cost reporting periods beginning on or after January 1, 2009, section 122 of Public Law 110–275 amended section 1886(b)(3) of the Act and added the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment. We refer readers to section IV.D.2. of this final rule for a discussion of this provision.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever was higher. (MDHs did not have the option to use their FY 1996 hospital-specific rate.) However, section 5003(a)(1) of Public Law 109–171 extended and modified the MDH special payment provision that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Public Law 109–171, if the change results in an increase to an MDH's target amount, we must rebase an MDH's hospital-specific rates based on its FY 2002 cost report. Section 5003(c) of Public Law 109–171 further required that MDHs be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based on the provisions of section 5003(d) of Public Law 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals located in Puerto Rico, the payment per discharge is based on the sum of 25 percent of an updated Puerto Rico-specific rate based on average costs per case of Puerto Rico hospitals for the base year and 75 percent of the Federal national rate. (We refer readers to section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2009. In section III. of this Addendum, we discuss our policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2009. Section IV. of this Addendum sets forth our changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2009. The tables to which we refer in the preamble of this final rule are presented in section V. of this Addendum of this final rule. Some of these tables are based upon tentative data, and the final tables will be presented in a separate document that will be published on the CMS Web site, as well as in the **Federal Register** after publication of this final rule but prior to October 1, 2008.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2009

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

In summary, the tentative standardized amounts set forth in Tables 1A, 1B, and 1C, of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the tentative standardized amounts and tentative Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E), and 1886(d)(9)(C)(iv) of the Act.
- Final updates of 3.6 percent for all areas (that is, the estimated full market basket percentage increase of 3.6 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- A final update of 3.6 percent to the tentative Puerto Rico-specific standardized amount (that is, the full estimated rate-of-increase in the hospital market basket for IPPS hospitals), as provided for under § 412.211(c), which states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas.
- An adjustment to the standardized amount to ensure budget neutrality for DRG

recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.

• An adjustment to ensure the wage index update and changes are budget neutral, as provided for under section 1886(d)(3)(E) of the Act.

• An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2008 budget neutrality factor and applying a revised factor.

• An adjustment to remove the FY 2008 outlier offset and apply an offset for FY 2009 as provided for in section 1886(d)(3)(B) of the Act.

• An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Public Law 108–173 are budget neutral, as required under section 410A(c)(2) of Public Law 108–173.

• An adjustment to eliminate the effect of coding or classification changes that do not reflect real changes in case-mix, as provided for in section 1886(d)(3)(A)(vi) of the Act and as discussed below and in section II.D. of the preamble to this final rule.

We note that, beginning in FY 2008, we applied the budget neutrality adjustment for the rural floor to the hospital wage indices rather than the standardized amount. For FY 2009, we are continuing to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amounts, beginning with FY 2009, we are applying the imputed floor budget neutrality adjustment to the wage indices. Beginning in FY 2009, we are also applying the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality changes concerning the rural floor and the imputed floor, including the within-State budget neutrality adjustment, we refer readers to section III.B.2.b. of the preamble to this final rule.

A. Calculation of the Tentative Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. For Puerto Rico hospitals, the Puerto Rico-specific standardized amount is based on per discharge averages of adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d)(9) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established for urban and rural hospitals in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered to be the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2009, we are not changing the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2008. Therefore, the labor-related share continues to be 69.7 percent for the national standardized amounts and 58.7 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 69.7 percent of the national standardized amount. For hospitals located in Puerto Rico, we are applying a labor-related share of 58.7 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For hospitals located in Puerto Rico whose Puerto Rico-specific wage index values are greater than 1.0000, we are applying a labor share of 62 percent.

The tentative standardized amounts for operating costs appear in Table 1A, 1B, and 1C of the Addendum to this final rule.

2. Computing the Tentative Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are calculating FY 2009 national and Puerto Rico standardized amounts irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Tentative Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are updating the equalized standardized amount for FY 2008 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171. The percentage change in the market basket reflects the average change in the price of goods and services comprising routine, ancillary, and special care unit inpatient hospital services. The most recent forecast of the hospital market basket increase for FY 2009 is 3.6 percent. Thus, for FY 2009, the update to the average standardized amount is 3.6 percent for hospitals in all areas. The market basket increase of 3.6 percent is based on the 2008 second quarter forecast of the hospital market basket increase (as discussed in Appendix B of this final rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, provides for a reduction of 2.0 percentage points from the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any ''subsection (d) hospital'' that does not submit quality data, as discussed in section IV.A. of the preamble of this final rule. The tentative standardized amounts in Tables 1A through 1C of section V. of the Addendum to this final rule reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1) or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 3.6 percent.

Although the update factors for FY 2009 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2009 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth in Appendix B of this final rule.

We note that the implementation of section 124 of Public Law 110–275 will have no affect on the market basket increase factor of 3.6 percent. Therefore, the update factors of 3.6 and 1.6 percent are final and not tentative. These update factors (3.6 and 1.6 percent) are one element that will be used to determine the FY 2009 standardized amounts. Other factors, such as the outlier offset and the rural floor budget neutrality factors, are yet to be determined pending the implementation of section 124 of Public Law 110–275. (We note that the rural floor budget

neutrality adjustment is applied to the wage index and not the standardized amount as explained below). The market basket increase of 3.6 percent is based on the second quarter forecast of the hospital market basket increase by Global Insight, Inc. (as discussed in Appendix B of this final rule).

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2009 standardized amount to remove the effects of the FY 2008 geographic reclassifications and outlier payments before applying the FY 2009 updates. We then applied budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2009 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after updates in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year's adjustment, we would not have satisfied these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We included outlier payments in the simulations because they may be affected by changes in these parameters.

We are also adjusting the standardized amount this year by an estimated amount to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration program, as required under section 410A of Public Law 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Public Law 108–173. For FY 2009, we are no longer applying budget neutrality for the imputed floor to the standardized amount, and to apply it instead to the wage index, as discussed in section of II.B.2. of the preamble to this final rule. For FY 2009, we are also applying an adjustment to eliminate the effect of coding or classification changes that do not reflect real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act, by the percentage specified in section 7 of Public Law 110–90.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this final rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we made a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. Consistent with current policy, for FY 2009, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.D. of the preamble to this final rule.

To comply with the requirement that DRG reclassification and recalibration of the relative weights and the updated wage index be budget neutral, we used FY 2007 discharge data to simulate payments and compared aggregate payments using the FY 2008 relative weights and wage indices to aggregate payments using the proposed FY 2009 relative weights and wage indices. The same methodology was used for the FY 2008 budget neutrality adjustment. Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.999580 to be applied to the national standardized amount. As we have done in the past, we also adjusted the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor of 0.998795 to be applied to the Puerto Rico-specific standardized amount. These budget neutrality adjustment factors are applied to the standardized amounts for FY 2008 without removing the prior year's budget neutrality adjustments. In addition, as discussed in section IV. of this Addendum, we applied the same DRG reclassification and recalibration budget neutrality factor of 0.998795 to the hospital-specific rates that will be effective for cost reporting periods beginning on or after October 1, 2008. We note that the preceding budget neutrality adjustment factors use pre-reclassified wage indices and are not affected by the implementation of section 124 of Public Law 110–275, therefore, these budget neutrality factors are final and not tentative.

b. Reclassified Hospitals—Tentative Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account ''in applying any budget neutrality adjustment with respect to such index'' under section 1886(d)(8)(D) of the Act. To calculate the tentative budget neutrality factor for FY 2009, we used FY 2007 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we calculated a tentative adjustment factor of 0.991339 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The tentative adjustment factor is applied to the standardized amount after removing the effects of the FY 2008 budget neutrality adjustment factor. We note that the FY 2009 tentative adjustment reflects FY 2009 wage index reclassifications approved by the MGCRB or the Administrator. (Section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years. As we note earlier in this final rule, we have yet to implement section 124 of Public Law 110–275. Therefore, we will calculate the final budget neutrality adjustments for geographic reclassification subsequent to this final rule, but prior to October 1, 2008, and will make this information available with the wage indices and final IPPS rates.

c. Rural and Imputed Floor Budget Neutrality

As discussed in the preamble in section III.B.2.b. of the preamble of this final rule, we are adopting as final our proposal for State level budget neutrality for the rural and imputed floors in this rule, to be effective beginning with the FY 2009 wage index. However, in response to the public's concerns and taking into account the potentially significant payment cuts that could occur to hospitals in some States if we implement this change with no transition, we have decided to phase in, over a 3-year period, the transition from the national rural floor budget neutrality adjustment on the wage index to the State level rural floor budget neutrality adjustment on the wage index. In FY 2009, hospitals will receive a blended wage index that is comprised of 20 percent of the wage index adjusted by applying the State level rural and imputed floor budget neutrality adjustment and 80 percent of the wage index adjusted by applying the national budget neutrality adjustment. In FY 2010, the blended wage index will be determined by adding 50 percent of the wage index adjusted by applying the State level budget neutrality adjustment and 50 percent of the wage index adjusted by applying the national budget neutrality adjustment. In FY 2011, the adjustment will be completely transitioned to the State level methodology, such that the wage index will be determined by applying 100 percent of the State level budget

neutrality adjustment. We note that the rural floor budget neutrality adjustment is applied to the wage index and not the standardized amount. However, because these blended wage indices reflecting the 20 percent State rural and imputed floor budget neutrality adjustment and the 80 percent national rural and imputed floor budget neutrality adjustment are used in calculating the FY 2009 outlier threshold (as discussed below), we are explaining our calculation of the rural floor budget neutrality adjustments (in this section) below.

In order to compute a budget neutral wage index that is a blend of 20 percent of the wage index adjusted by the State level rural and imputed floor budget neutrality adjustment and 80 percent of the index adjusted by the national rural and imputed floor budget neutrality adjustment, similar to our calculation of the FY 2008 wage index (72 FR 47329), we used FY 2007 discharge data and FY 2009 wage indices to simulate IPPS payments. First, we compared the national simulated payments without the rural and imputed floors applied to national simulated payments with the rural and imputed floors applied to determine the national rural and imputed floor budget neutrality adjustment factor of 0.996355. This national adjustment was then applied to the wage indices to produce a national rural and imputed floor budget neutral wage index, which was used in determining the FY 2009 blended wage indices for the first year of the transition (as described below). We then used the same methodology to determine each State's rural or imputed floor budget neutrality adjustment by comparing each State's total simulated payments with and without the rural or imputed floor applied. These State level rural and imputed floor budget neutrality factors were then applied to the wage indices to produce a State level rural and imputed floor budget neutral wage index, which was used in determining the FY 2009 blended wage indices for the first year of the transition (as described below). (As noted above, the final adjustment factors used for each state will be published in a forthcoming notice in the **Federal Register** implementing section 124 of Pub. L. 110–275).

To determine the FY 2009 wage indices for the first year of the transition, we then blended the national and State level wage index values (computed above) by taking 80 percent of the national rural and imputed floor budget neutral wage index and 20 percent of the State level rural and imputed floor budget neutral wage index. Because of interactive effects between the payment factors applied under the IPPS and/or rounding issues, the blended wage index calculated above does not necessarily result in overall budget neutrality. That is, aggregate IPPS payments simulated using the blended budget neutral wage index may not be equal to aggregate IPPS payments simulated using the wage index prior to the application of the rural and imputed floors. Therefore, in order to ensure that national payments overall remain budget neutral after application of the rural and imputed floor, an additional adjustment factor of 0.999923 must be applied to the blended wage indexes calculated as described above. We note that, because we have yet to determine the final geographic wage index reclassifications as a result of Public Law 110–275, we will publish the final rural floor budget neutrality adjustment factors in a subsequent notice in the **Federal Register**.

d. Case-Mix Budget Neutrality Adjustment

As stated earlier, beginning in FY 2008, we adopted the new MS–DRG patient classification system for the IPPS to better recognize severity of illness in Medicare payment rates. In the FY 2008 IPPS final rule with comment period, we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. In that final rule, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010. On September 29, 2007, Public Law 110–90 was enacted. Section 7 of Public Law 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with the provision of section 7 of Public Law 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 national standardized amounts (as well as other payment factors and thresholds) accordingly, with these revisions effective October 1, 2007. For FY 2009, section 7 of Public Law 110–90 requires a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment specified in the FY 2008 IPPS final rule with comment period. As required by statute, we are applying a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 is in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent.

As discussed in more detail in section II.D. of the preamble of this final rule, in calculating the FY 2008 Puerto Rico standardized amount, we made an inadvertent error and applied the documentation and coding adjustment established using our authority in section 1886(d)(3)(A)(vi) of the Act (which only applies to the national standardized amounts) to the Puerto Rico-specific standardized amount. Therefore, we are correcting this inadvertent error by removing the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific rates. The revised FY 2008 Puerto Rico-specific operating standardized amounts are: $1,471.10 labor share and $901.64 nonlabor share for a hospital with a wage index greater than 1; and $1,392.80 labor share and $979.94 nonlabor share for a hospital with a wage index less than or equal to 1. The revised FY 2008 Puerto Rico capital payment rate is $202.89. These revised rates are effective October 1, 2007, for FY 2008. As discussed in section II.D. of the preamble of this final rule, we are not applying the documentation and coding adjustment to the Puerto Rico-specific standardized amount for FY 2009, but we may consider doing so for the FY 2010 Puerto Rico-specific standardized amount in the FY 2010 rulemaking. In calculating the FY 2009 Puerto Rico-specific standardized amount for this final rule, we have removed the −0.6 percent documentation and coding adjustment that was inadvertently applied to the FY 2008 Puerto Rico-specific standardized amount.

We note that the implementation of Section 124 of Public Law 110–275 will have no affect on the document and coding adjustment factor. Therefore, the document and coding adjustment factor is final and not tentative.

e. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2009 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS

Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*.

(1) FY 2009 Tentative Outlier Fixed-Loss Cost Threshold

As stated above, some of the wage index tables, rates, and impacts will not be final in this final rule because we have not implemented section 124 of Public Law 110–275. Therefore, we are only able to provide tentative standardized amounts, relative weights, offsets, and budget neutrality factors in this final rule. The same circumstances apply to the outlier threshold. Without final wage index data, final standardized amounts, final offsets and final budget neutrality factors, we are only able to provide a tentative fixed loss outlier threshold in this final rule. Subsequent to this final rule, we will publish a final fixed-loss outlier threshold that will be effective for discharges on and after October 1, 2008, for FY 2009. However, in this final rule, we are adopting as final the methodology we will use to calculate the final outlier fixed-loss cost threshold.

For FY 2009, we proposed to continue to use the same methodology used for FY 2008 (72 FR 47417) to calculate the outlier threshold. Similar to the methodology used in the FY 2008 final rule with comment period, for FY 2009, we proposed to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2009 outlier threshold, we simulated payments by applying FY 2009 rates and policies using cases from the FY 2007 MedPAR files. Therefore, in order to determine the proposed FY 2009 outlier threshold, we inflate the charges on the MedPAR claims by 2 years, from FY 2007 to FY 2009.

We proposed to continue to use a refined methodology that takes into account the lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2006 in combination with the first quarter of FY 2007 (July 1, 2006 through December 31, 2006) to the last quarter of FY 2007 in combination with the first quarter of FY 2008 (July 1, 2007 through December 31, 2007). This rate of change was 5.84 percent (1.0585) or 12.03 percent (1.1204) over 2 years.

As we have done in the past, we established the proposed FY 2009 outlier threshold using hospital CCRs from the December 2007 update to the Provider-Specific File (PSF)—the most recent available data at the time of the proposed rule. This file includes CCRs that reflected implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2009, we proposed to continue to use the same methodology to calculate the CCR adjustment by using the FY 2007 operating cost per discharge increase in combination with the actual FY 2007 operating market basket increase determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. (We note that the FY 2007 actual (otherwise referred to as ''final'') operating market basket increase reflects historical data whereas the published FY 2007 operating market basket update factor was based on Global Insight, Inc.'s 2006 second quarter forecast with historical data through the first quarter of 2007.) By using the operating market basket rate-of-increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2009, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2005 to FY 2006 (1.0538) from the cost report and dividing it by the final operating market basket increase from FY 2006 (1.0420). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the nonprice factors in the cost increase (for example, quantity and changes in the mix of goods and services). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the operating market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of operating costs per discharge of 1.0629 divided by FY 2004 final operating market basket increase of 1.0400, FY 2004 to FY 2005 percentage increase of operating costs per discharge of 1.0565 divided by FY 2005 final operating market basket increase of 1.0430). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006, which resulted in a mean ratio of 1.0154. We multiplied the 3-year average of 1.0154 by the FY 2007 final operating market basket percentage increase of 1.0340, which resulted in an operating cost inflation factor of 5.0 percent or 1.05. We then divided the operating cost inflation factor by the 1-year average change in charges (1.058474) and applied an adjustment factor of 0.9920 to the operating CCRs from the PSF.

As stated in the FY 2008 final rule with comment period, we continue to believe it is appropriate to apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9 months for fiscal intermediaries (or, if applicable, the MAC) to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average ''age'' of hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2008 is approximately 1 year. Therefore, as stated above, we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2005 to FY 2006 (1.0462) from the cost report and dividing it by the final capital market basket increase from FY 2006 (1.0090). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of capital costs per discharge of 1.0315 divided by FY 2004 final capital market basket increase of 1.0050, FY 2004 to FY 2005 percentage increase of capital costs per discharge of 1.0311 divided by FY 2005 final capital market basket increase of 1.0060). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006, which resulted in a mean ratio of 1.0294. We multiplied the 3-year average of 1.0294 by the FY 2007 final capital market basket percentage increase of 1.0120, which resulted in a capital cost inflation factor of 4.17 percent or 1.0417. We then divided the capital cost inflation factor by the 1-year average change in charges (1.058474) and applied an adjustment factor of 0.9842 to the capital CCRs from the PSF. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

For purposes of estimating the proposed outlier threshold for FY 2009, we assume 3.0 percent case-mix growth in FY 2009 compared with our FY 2007 claims data (that is, a 1.2 percent increase in FY 2008 and an additional 1.8 percent increase in FY 2009). The 3 percent case-mix growth was projected by the Office of the Actuary as the amount case-mix is expected to increase in response to adoption of the MS–DRGs as a result of improvements in documentation and coding that do not reflect real changes in patient severity of illness. It is necessary to take the 3 percent expected case-mix growth into account when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2009. If we did not take this 3 percent projected case-mix growth into account, our estimate of total payments would be too low, and as a result, our estimate of the outlier threshold would be too high. While we assume 3 percent case-mix growth for all hospitals in our outlier threshold calculations, the FY 2009 national standardized amounts used to calculate the outlier threshold reflect the statutorily mandated documentation and coding adjustment of −0.9 percent for FY 2009, on top of the −0.6 percent adjustment for FY 2008.

Using this methodology, we calculated a proposed outlier fixed-loss cost threshold for FY 2009 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $21,025.

Comment: Many commenters, including major hospital associations, commented that CMS currently projects that outlier payments in FY 2008 are estimated at 4.8 percent of

total payments. The commenters commended CMS for making refinements such as applying an adjustment factor to CCRs when computing the outlier threshold but noted that, because CMS is still not reaching the 5.1 percent target, there is still room for improvement. Specifically, the commenters suggested that the methodology to develop the adjustment factor to the CCRs is unnecessarily complicated and does not lead to a more accurate result. The commenters urged CMS to adopt a methodology that uses recent historical industry wide average rate of change, similar to the methodology used to develop the charge inflation factor. Further, in addition to applying an adjustment to the CCRs based on historical data, the commenters suggested that the CCRs should be projected over different periods of time, some less or more than one year, based on variations in hospital fiscal year ends. The commenters believed this methodology would more accurately project the decline in CCRs. In addition, the commenters noted that CMS used the December 2007 CCR update for the proposed rule and has historically used the March update for the final rule. The commenters urged CMS to use the June 2008 update instead of the March 2008 update for the final rule.

Response: Similar to our response in the FY 2008 final rule (72 FR 47418), in response to the comment that CCRs should be projected over different periods of time, as we have mentioned in the past, it is possible that some of the CCRs in the March PSF will be used in FY 2009 for actual outlier payments, while other CCRs may be one year old. Therefore, we apply a 1-year adjustment to the CCRs. However, once we have a complete FY 2008 MedPAR claims database to determine the actual FY 2008 outlier percentage (as opposed to the current estimate of the FY 2008 outlier percentage in this final rule which is based on FY 2007 MedPAR claims), we will closely study and consider the commenters' proposal for the future.

With respect to the comment on our methodology used to adjust the CCRs, as we stated in the FY 2008 IPPS final rule with comment period (72 FR 47418), we continue to believe this calculation of an adjustment to the CCRs is more accurate and stable than the commenter's methodology because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor. There are times where the market basket and the cost per discharge will be constant, while other times these values will differ from each other, depending on the fiscal year. Therefore, as mentioned above, using the market basket in conjunction with the cost per discharge takes into account two sources that measure potential cost inflation and ensures a more accurate and stable cost adjustment factor. Additionally, we are continuing to use the March update of the PSF for the final rule because the June PSF update will not be ready for use until the end of July, which is beyond the timetable necessary for us to compute the outlier threshold and publish this final rule with comment period by August 1.

Because we are not making any changes to our methodology for this final rule, for FY 2009, we are using the same methodology we proposed to calculate the outlier threshold. We used the blended wage indices (as discussed above) when we simulated payments in our outlier modeling to determine the tentative outlier threshold for FY 2009. Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges per case from the first quarter of FY 2007 in combination with the second quarter of FY 2007 (October 1, 2006 through March 31, 2007) to the first quarter of FY 2008 in combination with the second quarter of FY 2008 (October 1, 2007 through March 31, 2008). This rate of change was 5.7549 percent (1.057549) or 11.841 percent (1.11841) over 2 years.

As we have done in the past, we established the tentative FY 2009 outlier threshold using hospital CCRs from the March 2008 update to the PSF—the most recent available data at the time of this final rule with comment period. This file includes CCRs that reflected implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

For FY 2009, we calculated the CCR adjustment by using the operating cost per discharge increase in combination with the market basket increase determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. We determined the operating CCR adjustment by taking the percentage increase in the operating costs per discharge from FY 2005 to FY 2006 (1.0550) from the cost report and dividing it by the final market basket increase from FY 2006 (1.042). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the non-price factors in the cost increase (that is, quantity and changes in the mix of goods and services) to increase the projected market basket for estimating the future cost increase. We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of operating costs per discharge of 1.0622 divided by FY 2004 final market basket increase of 1.040, FY 2004 to FY 2005 percentage increase of operating costs per discharge of 1.0571 divided by FY 2005 final market basket increase of 1.043). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006 which resulted in a mean ratio of 1.0158. We multiplied the 3-year average of 1.0158 by the FY 2007 final market basket percentage increase of 1.034, which resulted in an operating cost inflation factor of 5.03 percent or 1.0503. We then divided the operating cost inflation factor by the 1-year average change in charges (1.057549) and applied an adjustment factor of 0.9932 to the operating CCRs from the PSF.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2005 to FY 2006 (1.0446) from the cost report and dividing it by the final capital market basket increase from FY 2006 (1.0090). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of capital costs per discharge of 1.0307 divided by FY 2004 final capital market basket increase of 1.0050, FY 2004 to FY 2005 percentage increase of capital costs per discharge of 1.0324 divided by FY 2005 final capital market basket increase of 1.0060). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006, which resulted in a mean ratio of 1.0290. We multiplied the 3-year average of 1.0290 by the FY 2007 final capital market basket percentage increase of 1.0120, which resulted in a capital cost inflation factor of 4.14 percent or 1.0414. We then divided the capital cost inflation factor by the 1-year average change in charges (1.057549) and applied an adjustment factor of 0.9847 to the capital CCRs from the PSF. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

Similar to the proposed rule, for purposes of estimating the tentative outlier threshold for FY 2009, we assume 3.0 percent case-mix growth in FY 2009 compared with our FY 2007 claims data (that is, a 1.2 percent increase in FY 2008 and an additional 1.8 percent increase in FY 2009). The 3 percent case-mix growth was projected by the Office of the Actuary as the amount case-mix is expected to increase in response to adoption of the MS–DRGs as a result of improvements in documentation and coding that do not reflect real changes in patient severity of illness. It is necessary to take the 3 percent expected case-mix growth into account when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2009. If we did not take this 3 percent projected case-mix growth into account, our estimate of total payments would be too low, and as a result, our estimate of the outlier threshold would be too high. While we assume 3 percent case-mix growth for all hospitals in our tentative outlier threshold calculations, the FY 2009 national standardized amounts used to calculate the outlier threshold reflect the statutorily mandated documentation and coding adjustment of −0.9 percent for FY 2009, on top of the −0.6 percent adjustment for FY 2008.

Using this methodology, we calculated a tentative outlier fixed-loss cost threshold for FY 2009 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $20,185. With this threshold, we project that outlier payments will equal 5.1 percent of total IPPS payments. We note that, in this final rule, we are adopting this methodology to compute the final outlier fixed-loss cost threshold for FY

2009, although the final dollar amount of the outlier threshold will be published in a subsequent **Federal Register** document.

As we did in establishing the FY 2008 outlier threshold (72 FR 47419), in our projection of FY 2009 outlier payments, we are not making any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the outlier final rule (68 FR 34494, June 9, 2003), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are not making any assumptions about the effects of reconciliation on the outlier threshold calculation.

We also note that there are some factors that contributed to a lower tentative fixed loss outlier threshold for FY 2009 compared to FY 2008. First, the case-weighted national average operating CCR declined by approximately an additional 1.3 percentage points from the March 2007 update (used to calculate the FY 2008 outlier threshold) to the March 2008 update of the PSF (used to calculate the FY 2009 outlier threshold). In addition, as discussed in sections II.C. and II.H. of the preamble of this final rule, we began a 2-year phase-in of the MS–DRGs in FY 2008, with the DRG relative weights based on a 50 percent blend of the CMS DRGs and MS–DRGs in FY 2008 and based on 100 percent of the MS–DRGs beginning in FY 2009. Better recognition of severity of illnesses with the MS–DRGs means that regular operating IPPS payments will compensate hospitals for the higher costs of some cases that previously received outlier payments. As cases are paid more accurately, in order to meet the 5.1 percent target, we need to decrease the fixed-loss outlier threshold so that more cases qualify for outlier payments. In addition, as noted previously, in our modeling of the tentative outlier threshold, we included a 3-percent adjustment for expected case-mix growth between FY 2007 and FY 2009. Finally, the market basket estimate increased from 3.0 percent in the proposed rule to 3.6 percent for this final rule. Adding an extra 0.6 percent to the standardized amount increases funds to typical cases and requires that we lower the outlier threshold to increase the amount of atypical cases in order to reach the 5.1 percent target. Together, we believe that the above factors cumulatively contributed to a lower tentative fixed-loss outlier threshold in FY 2009 compared to FY 2008.

Comment: One commenter recommended that CMS make a midyear change to the outlier threshold if it appears that the 5.1 percent target will not be met. The commenter suggested that CMS use more recent CCR data for a midyear correction to the outlier threshold and use thresholds such as if outlier payments less than 95 percent or greater than 105 percent of the 5.1 percent target to trigger a midyear adjustment. Other commenters recommended that CMS further lower the threshold because CMS did not spend the total allocated pool of cost outlier funds allocated for outlier payments in FYs 2005, 2006, and 2007.

Response: With respect to these comments, we have responded to similar comments in the FY 2006 IPPS final rule (70 FR 47495). We refer readers to that final rule.

Comment: One commenter stated that it may be time for CMS to reconsider the appropriateness of continuing with a yearly target of 5.1 percent outlier payments. The commenter explained that the introduction of MS–DRGs has increased the accuracy of DRG payments representing fair estimates of the costs of treating particular diagnosis and has resulted in the significant decline in the outlier threshold since implementation of the MS–DRGs. The commenter noted that CMS is bound by language in the Act that requires payments be between 5 and 6 percent of total DRG payments. As a result, the commenter urged CMS to consider this issue and seek from Congress a change in the statutory requirement that would allow for a lower outlier target percentage.

Response: We thank the commenter for the comment. However, as noted above and by the commenter, section 1886(d)(5)(A)(iv) of the Act requires outlier payments to be not less than 5 percent nor more than 6 percent of total estimated or projected payments.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2009 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.35 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 2009 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The tentative outlier adjustment factors that are applied to the standardized amount for the FY 2009 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948975	0.946457
Puerto Rico	0.954561	0.93139

We are applying the tentative outlier adjustment factors to the tentative FY 2009 rates after removing the effects of the FY 2008 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide average CCRs for hospitals with CCRs that fell below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.196 or capital CCRs greater than 0.145, or hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as described at (412.84(i)(3) of our regulations), we still use statewide average CCRs to determine whether a hospital qualifies for outlier payments.[25] Table 8A in this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2008, these statewide average ratios will replace the ratios published in the IPPS final rule for FY 2008 (72 FR 48126–48127). Table 8B in this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B will be used during FY 2009 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, we refer readers to section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating

[25] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

and/or capital CCRs to work with their fiscal intermediaries (or MAC, if applicable) on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement, thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and cost-to-charge ratios, visit the Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf.*

Comment: One commenter stated that it was unable to replicate the estimated FY 2009 capital outlier percentage of 5.73 percent cited in the proposed rule (73 FR 23711 and 23718). Instead, its analysis resulted in a somewhat lower capital outlier percentage. Consequently, the commenter recommended that CMS reevaluate its calculations to ensure that the estimated capital outlier percentage for FY 2009 is correct.

Response: Section 412.312(c) of our regulations establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both operating IPPS and capital IPPS payments. The outlier threshold is set so that operating IPPS outlier payments are projected to be 5.1 percent of total operating IPPS payments.

In the proposed rule (73 FR 23711), we discussed that for purposes of estimating the proposed outlier threshold for FY 2009, we assumed 3.0 percent case-mix growth in FY 2009 compared with our FY 2007 claims data (that is, a 1.2 percent increase in FY 2008 and an additional 1.8 percent increase in FY 2009), based on the Office of the Actuary's estimate of the amount that hospitals' case-mix is expected to increase in response to the adoption of the MS–DRGs due to improvements in documentation and coding that do not reflect real changes in patient severity of illness. As discussed above, it is necessary to take the 3 percent expected case-mix growth into account when establishing an outlier threshold for FY 2009 that would result in operating IPPS outlier payments being between 5 and 6 percent of total operating IPPS payments in accordance with section 1886(d)(5)(A)(iv) of the Act. If we did not take this 3 percent projected case-mix growth into account, our estimate of total operating IPPS payments would be too low, and, as a result, our estimate of the outlier threshold for FY 2009 would be too high.

Upon review of our calculations of the proposed FY 2009 outlier fixed-loss amount, we realized that, while we had discussed applying the 3.0 percent expected case-mix increase adjustment, in actuality, we unintentionally neglected to apply the assumed 3.0 percent case-mix growth for FY 2009. We appreciate the commenter bringing this inadvertent error in our outlier calculations to our attention, and we have revised our outlier calculations for this final rule accordingly. As discussed above, in this final rule, based on more recent data and the rates and policies finalized in this final rule, we are establishing a tentative fixed-loss amount for FY 2009 of $20,185. We are projecting that this outlier threshold for FY 2009 will result in outlier payments that will equal 5.1 percent of operating IPPS DRG payments and 5.35 percent of capital IPPS payments based on the Federal rate.

(3) FY 2007 and FY 2008 Outlier Payments

In the FY 2008 IPPS final rule (72 FR 47420), we stated that, based on available data, we estimated that actual FY 2007 outlier payments would be approximately 4.6 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2006 MedPAR file (discharge data for FY 2006 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2007 bills, but instead reflected the application of FY 2007 rates and policies to available FY 2006 bills.

Our current estimate, using available FY 2007 bills, is that actual outlier payments for FY 2007 were approximately 4.64 percent of actual total DRG payments. Thus, the data indicate that, for FY 2007, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2007. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2007 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2008 will be approximately 4.7 percent of actual total DRG payments, 0.4 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2008. This estimate is based on simulations using the FY 2007 MedPAR file (discharge data for FY 2007 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2008 by applying FY 2008 rates and policies, including an outlier threshold of $22,185 to available FY 2007 bills. We note that the FY 2007 MedPAR file does not contain claims that account for upcoding. As a result, in our simulation of the estimate of the FY 2008 outlier percentage, it was necessary to increase the charges on the claims by 1.2 percent to account for one year of upcoding.

Comment: Some commenters simulated the FY 2008 estimate and calculated an estimate of 4.3 percent of outlier payments for that year. The commenters noted this percentage was very different from the 4.8 percent estimate CMS calculated in the proposed rule. The commenters requested that CMS revisit its calculation and publish an explanation of its estimate.

Response: We verified our calculation of the FY 2008 estimate and did not find any discrepancies that would result in an estimate similar to the commenters. We believe we have explained our process above with one minor adjustment from the proposed rule. The difference from the proposed rule to this final rule is that we inflated the claims by 1.2 percent to account for upcoding which slightly changed our FY 2008 estimate from 4.8 percent in the proposed rule to 4.7 percent in this final rule. As stated above, we will monitor the FY 2008 outlier payout once the FY 2008 MedPAR claims database is available and will then consider and evaluate the commenters comments on modifiying the outlier threshold methodology.

e. Tentative Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)

Section 410A of Public Law 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Public Law 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.H. of the preamble to this final rule with comment period, we have satisfied this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,753,106. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration program. For 13 participating hospitals, the total annual impact of the demonstration program for FY 2009 is $22,790,388. The required tentative adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999764.

In order to achieve budget neutrality, we adjust the tentative national IPPS rates by a tentative amount sufficient to account for the added costs of this demonstration. In other words, we apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, consistent with past practice. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

5. Tentative FY 2009 Standardized Amount

The tentative adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the tentative national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2009. The tentative Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The tentative amounts shown in Tables 1A and

1B differ only in that the labor-related share applied to the tentative standardized amounts in Table 1A is 69.7 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we apply a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we apply a labor-related share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include tentative standardized amounts reflecting the full 3.6 percent update for FY 2009, and tentative standardized amounts reflecting the 2.0 percentage point reduction to the update (a 1.6 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this amount is set forth in Table 1A). The tentative labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2009 are set forth in Table 1C of this Addendum. This table also includes the tentative Puerto Rico standardized amounts. The labor-related share applied to the tentative Puerto Rico specific standardized amount is 58.7 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

We note that, in this final rule, we are not supplying a table that illustrates the changes from the FY 2008 national average standardized amount. Because we are only setting the standardized amounts tentatively, we do not believe it is appropriate to include this table in this final rule. However, we will publish a table in the subsequent notice to this final rule that details the calculation of the final standardized amounts.

B. Tentative Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the tentative labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2009. This section addresses two types of adjustments to the tentative standardized amounts that were made in determining the prospective payment rates as described in this Addendum.

1. Tentative Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this final rule, we discuss the data and methodology for the FY 2009 wage index. We note that because we have not implemented section 124 of Public Law 110–275, we will not be publishing Tables 4A, 4B, 4C, 4D–1, 4D–2, 4E, and 4F in this final rule. However, we will publish these tables in a subsequent **Federal Register** notice and post them on the CMS Web site once all the data are finalized and prior to October 1, 2008.

2. Final Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2009, we adjusted the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this final rule, we have developed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the relative weights that we will apply to discharges occurring in FY 2009. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2009.

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2009 equals the Federal rate.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge. For cost reporting periods beginning on or after January 1, 2009, section 124 of Public Law 110–275 amended section 1886(b)(3) of the Act and added the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment. This provision is discussed in detail in section IV.D.2. of the preamble of this final rule.

The prospective payment rate for SCHs for FY 2009 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2009 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for hospitals located in Puerto Rico for FY 2009 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of this Addendum).

The Federal rate as determined in Step 5 is then further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 is increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that for cost reporting periods beginning prior to January 1, 2009, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge. As discussed above, for cost reporting periods beginning on or after January 1, 2009, section 124 of Public Law 110–275 amended section 1886(b)(3) of the Act and added the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment. We refer readers to section IV.D.2. of the preamble of this final rule for further discussion of this provision.

As discussed previously, we are required to rebase MDHs hospital-specific rates to their FY 2002 cost reports if doing so results in higher payments. In addition, effective for discharges occurring on or after October 1, 2006, MDHs are to be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent (changed from 50 percent) of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge. Further, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990, final rule with comment (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section III. of this Addendum. The resulting rate is used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2008.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2009

We are increasing the hospital-specific rates by 3.6 percent (the hospital market basket percentage increase) for FY 2009 for those SCHs and MDHs that submit qualifying quality data and by 1.6 percent for SCHs and MDHs that fail to submit qualifying quality data. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2008, is the market basket rate-of-increase for hospitals that submit qualifying quality data and the market basket rate-of-increase minus 2 percent for hospitals that fail to submit qualifying quality data. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided for under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2009, is the market basket rate-of-increase for hospitals that submit qualifying quality data and the market basket rate-of-increase minus 2 percent for hospitals that fail to submit qualifying quality data.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2008, and Before October 1, 2009

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (Table 1C of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate is then further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2009

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2009, which will be effective for discharges occurring on or after October 1, 2008. We note that, as discussed in detail in section III.I. of the preamble of this final rule, section 124 of newly enacted Public Law 110–275 extends, through FY 2009, wage index reclassifications under section 508 of Public Law 108–173 (the MMA) and the special exceptions contained in the final rule published in the **Federal Register** on August 11, 2004 (69 FR 49105, 49107) and extended under section 117 of the MMSEA of 2007 (Pub. L. 110–173). As a result, we cannot finalize the FY 2009 capital rates, including the GAF/DRG adjustment factor, the outlier payment adjustment factor, and the outlier threshold, until we recompute the wage indices for FY 2009 as a result of these extensions. Therefore, the capital Federal rate, the GAF/DRG adjustment factor, and the outlier payment adjustment factor for FY 2009 discussed below are tentative. The final capital rates and factors for FY 2009, reflecting the extension of the reclassification provisions noted above, will be published in a forthcoming notice in the **Federal Register**.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital

capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the respective fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital Federal rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital Federal rate made in FY 1996 as a result of the revised policy for paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which required that, for discharges occurring on or after October 1, 1997, the budget neutrality adjustment factor in effect as of September 30, 1995, be applied to the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate. That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was effective from October 1, 1997 through September 30, 2002, making the total reduction 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), the 2.1 percent reduction was restored to the unadjusted capital payment rates effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we discontinued use of the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for blended payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals located in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals located in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the national capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Public Law 108–173 increased the national portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provided that the national portion of operating IPPS payments for hospitals located in Puerto Rico is equal to 75 percent and the Puerto Rico-specific portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals located in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico-specific capital rate and 75 percent of the national capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the FY 2008 IPPS final rule with comment period (72 FR 66886 through 66888), we established a capital Federal rate of $426.14 for FY 2008. In the FY 2009 IPPS proposed rule (73 FR 23720), we proposed to establish a capital Federal rate of $421.29 for FY 2009. In the discussion that follows, we explain the factors that we used to determine the FY 2009 capital Federal rate in this final rule. In particular, we explain why the FY 2009 capital Federal rate will decrease approximately 0.51 percent, compared to the FY 2008 capital Federal rate. However, taking into account an estimated increase in Medicare fee-for-service discharges in FY 2009 as compared to FY 2008, as well as the estimated increase in payments due to documentation and coding (discussed in section VIII. of Appendix A to this final rule), we estimate that aggregate capital payments will increase during this same period (approximately $40 million). Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are projected to increase in FY 2009 compared to FY 2008.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The update factor for FY 2009 under that framework is 0.9 percent based on the best data available at this time. The update factor under that framework is based on a projected 1.4 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a −0.5 percent adjustment for the FY 2007 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of the Addendum to this final rule, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2009 CIPI projection in that same section of this Addendum. In addition, as also noted below, the capital rates will be further adjusted to account for documentation and coding improvements under the MS–DRGs discussed in section II.D. of the preamble of this final rule. Below we describe the policy adjustments that we are applying in the update framework for FY 2009 presented in this final rule.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher

weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent the projected increase in case-mix resulting from documentation and coding improvements under the adoption of the MS–DRGs, as we presented in the proposed rule, for FY 2009, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will also equal 1.0 percent for FY 2009. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, as we proposed, the net adjustment for case-mix change in FY 2009 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2007 DRG reclassification and recalibration as part of our update for FY 2009. As we presented in the proposed rule, we estimate that FY 2007 DRG reclassification and recalibration resulted in a 0.5 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, as we proposed, we are making a −0.5 percent adjustment for DRG reclassification in the update for FY 2009 to maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of 0.10 percentage point was calculated for the FY 2007 update. That is, current historical data indicate that the forecasted FY 2007 CIPI (1.1 percent) used in calculating the FY 2007 update factor slightly understated the actual realized price increases (1.2 percent) by 0.1 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed asset prices and moveable asset prices into the market basket. However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, as we proposed, we are making a 0.0 percent adjustment for forecast error in the update for FY 2009.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (*Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988* by G. M. Carter, J. P. Newhouse, and *D. A. Relles,* R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady increase of 1.0 to 1.5 percent per year. However, we used 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below), and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, as we explained in the proposed rule, the intensity adjustment for FY 2009 is based on data from the 5-year period beginning with FY 2003 and extending through FY 2007. There continues to be a substantial increase in hospital charges for 3 of those 5 years without a corresponding increase in the hospital case-mix index. Most dramatically, for FY 2003, the change in hospitals' charges is over 16 percent, which is reflective of the large increases in charges that we found in the 4 years prior to FY 2003 and before our revisions to the outlier policy in 2003 (discussed below). For FY 2004 and FY 2005, the change in hospitals' charges is somewhat lower in comparison to FY 2003, but is still significantly large. For FY 2006 and FY 2007, the change in hospitals' charges appears to be slightly moderating. However, the change in hospitals' charges for FYs 2003 and 2004 and to a somewhat lesser extent FY 2005 remains similar to the considerable increase in hospitals' charges that we found when examining hospitals' charge data in determining the intensity factor in the update recommendations for the past few years, as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285), the FY 2006 IPPS final rule (70 FR 47500), the FY 2007 IPPS final rule (72 FR 47500), and the FY 2008 IPPS final rule with comment period (72 FR 47426). If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally. As we discussed most recently in the FY 2008 IPPS final rule with comment period (72 FR 47426), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2008 just as we did for FYs 2004 through 2007.

On June 9, 2003, we published in the **Federal Register** revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is

beginning to occur, that is, the increase in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. Specifically, the increases in charges in FY 2004 and FY 2005 (approximately 12 percent and 8 percent, respectively), for example, which, while less than the increase in the previous 3 years, are still much higher than increases in years prior to FY 2001. In addition, these increases in charges for FYs 2003, FY 2004, and FY 2005 significantly exceed the respective case-mix increases for the same period. Based on the significant increases in charges for FYs 2003 through 2005 that remain in the 5-year average used for the intensity adjustment, as we discussed in the proposed rule, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data, because it may have taken hospitals some time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2003, FY 2004, FY 2005 charge data may still be skewed. Although it appears that the change in hospitals' charges is more reasonable because the intensity adjustment is based on a 5-year average, and although the new outlier policy was generally effective in FY 2004, we believe the effects of hospitals attempting to maximize outlier payments, while lessening costs, continue to skew the charge data.

Therefore, as we proposed, we are making a 0.0 percent adjustment for intensity for FY 2009. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2009 until any increase in charges during the 5-year period upon which the intensity adjustment is based can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the 0.9 percent capital update factor under the capital update framework for FY 2009 as shown in the table below.

CMS FY 2009 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.4
Intensity:	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.4
Effect of FY 2007 Reclassification and Recalibration	−0.5
Forecast Error Correction	0.0
Total Update	0.9

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2008 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2009. However, in that same report, in assessing the adequacy of current payments and costs, MedPAC recommended an update to the hospital inpatient and outpatient PPS rates equal to the increase in the hospital market basket in FY 2009, concurrent with a quality incentive program. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2008, Section 2A).

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

In the FY 2008 IPPS final rule with comment (72 FR 66887), we estimated that outlier payments for capital will equal 4.77 percent of inpatient capital-related payments based on the capital Federal rate in FY 2008. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 5.35 percent for inpatient capital-related payments based on the capital Federal rate in FY 2009. Therefore, we are applying an outlier adjustment factor of 0.9465 to the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2009 will be higher than the percentages for FY 2008. This increase is primarily due to the decrease to the fixed-loss amount, which is discussed in section II.A. of this Addendum.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2009 outlier adjustment of 0.9465 is a −0.61 percent change from the FY 2008 outlier adjustment of 0.9523. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2009 is 0.9939 (0.9465/0.9523). Thus, the outlier adjustment decreases the FY 2009 capital Federal rate by 0.61 percent compared with the FY 2008 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we will no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the factors for FY 2009, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2008 DRG relative weights and the FY 2008 GAF to estimated aggregate capital Federal rate payments based on the FY 2009 relative weights and the FY 2009 GAFs. We established the final FY 2008 budget neutrality factors of 0.9902 for the national capital rate and 0.9955 for the Puerto Rico capital rate. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are applying an incremental budget neutrality adjustment of 1.0016 for FY 2009 to the previous cumulative FY 2008 adjustments of 0.9902, yielding an adjustment of 0.9918, through FY 2009. For the Puerto Rico GAFs, we are applying an incremental budget neutrality adjustment of 1.0010 for FY 2009 to the previous cumulative FY 2008 adjustment of 0.9955, yielding a cumulative adjustment of 0.9965 through FY 2009.

We then compared estimated aggregate capital Federal rate payments based on the FY 2008 DRG relative weights and the FY 2009 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2009 DRG relative weights and the FY 2009 GAFs. The incremental adjustment for DRG classifications and changes in relative weights is 0.9995 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAFs through FY 2009 are 0.9995 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAFs through FY 2009 are 0.9912 (calculated with unrounded numbers) nationally and 0.9960 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	---
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
2009[15]	1.00155	0.99945	1.00100	0.99120	1.00097	0.99945	1.00041	0.99595

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11]Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13]Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14]Incremental factors are applied to average of the cumulative factors for 2005.
[15] Tentative factors for FY 2009, pending the implementation of section 124 of Pub. L. 110-275, which affects wage indices and GAFs for FY 2009, as discussed above.

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The methodology used to determine the recalibration and geographic adjustment factor (DRG/GAF) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital IPPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

In the FY 2008 IPPS correction notice (72 FR 57636), we calculated a GAF/DRG budget neutrality factor of 0.9996 for FY

2008. For FY 2009, we are establishing a GAF/DRG budget neutrality factor of 1.0010. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the adjustment from FY 2008 to FY 2009 is 1.0010. The cumulative change in the capital Federal rate due to this adjustment is 0.9912 (the product of the incremental factors for FYs 1994 though 2008 and the incremental factor of 1.0010 for FY 2009). (We note that averages of the incremental factors that were in effect during FYs 2004 and 2005, respectively, were used in the calculation of the cumulative adjustment of 0.9912 for FY 2009.)

The factor accounts for DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2009 geographic reclassification decisions made by the MGCRB compared to FY 2008 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) of our regulations requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2009 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments are made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the FY 2008 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets the following criteria: (1) A project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). One of these hospitals closed in May 2005. Because we have cost reports ending in FY 2006 for all five of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2006 from the March 2008 update of the HCRIS data, we divided the capital special exceptions payment amounts for the five hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2006, this ratio is rounded to 0.0001. We also computed the ratio for FY 2005, which rounds to 0.0002, and the ratio for FY 2004, which rounds to 0.0003. Because the ratios are trending downward, we are making an adjustment of 0.0001. Because special exceptions are budget neutral, we are offsetting the capital Federal rate by 0.01 percent for special exceptions payments for FY 2009. Therefore, the exceptions adjustment factor is equal to 0.9999 (1 − 0.0001) to account for special exceptions payments in FY 2009.

In the FY 2008 IPPS final rule with comment period (72 FR 47430), we estimated that total (special) exceptions payments for FY 2008 would equal 0.03 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9997 (1 − 0.0003) to determine the FY 2008 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2009 will equal 0.01 percent of aggregate payments based on the FY 2009 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9999 to the capital Federal rate for FY 2009. The exceptions adjustment factor for FY 2009 is somewhat lower than the factor used in determining the FY 2008 capital Federal rate in the FY 2008 IPPS final rule. The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the FY 2009 capital Federal rate is 1.0002 (0.9999/0.9997).

5. Capital Standard Federal Rate for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 66888), we established a capital Federal rate of $426.14 for all hospitals for FY 2008. In the FY 2009 IPPS proposed rule, we proposed an update of 0.7 percent in determining the proposed FY 2009 capital Federal rate. In this final rule, we are establishing an update of 0.09 percent in determining the FY 2009 capital Federal rate. In the proposed rule, under the statutory authority at section 1886(d)(3)(A)(vi) of the Act, and as specified in section 7 of Public Law 110–90, we proposed to make an additional 0.9 percent reduction to the standardized amounts for both capital and operating Federal payment rates in FY 2009.

Comment: A few commenters expressed opposition to the proposal to apply the 0.9 percent adjustment for FY 2009 for improvements in documentation and coding that do not reflect real changes in patient severity of illness in response to the adoption of the MS–DRGs. These commenters argued that they have already committed funds toward various capital projects with the expectation that Medicare funding would be available to reimburse a portion of the cost of those expenses, and that a reduction in this funding would impede their ability to maintain their facilities while providing necessary technological upgrades. Therefore, the commenters recommended that CMS do not apply the 0.9 percent adjustment and provide the full update in determining the capital Federal rate for FY 2009.

Response: In the FY 2008 IPPS final rule with comment period (72 FR 47186), we established a documentation and coding adjustment for FY 2008, FY 2009, and FY 2010. The establishment of these documentation and coding adjustments was subject to notice and comment rulemaking, and when we established these adjustments, we carefully considered the concerns expressed by commenters on the proposal presented in the FY 2008 IPPS proposed rule and provided detailed responses to those comments in the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186). Subsequently, Congress enacted Public Law 110–90, which mandated that the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period be changed to −0.6 percent for FY 2008 and −0.9 percent for FY 2009 (72 FR 66886 through 66887). As we discussed in the FY 2009 IPPS proposed rule (73 FR 23720), consistent with section 7 of Public Law 110–90, we proposed the additional 0.9 percent reduction to the proposed standardized amounts for both capital and operating Federal payment rates in FY 2009.

As we discussed in greater detail in the FY 2008 IPPS final rule with comment period (72 FR 23710), beginning in FY 2008, we adopted the new MS–DRG patient classification system for the IPPS to better recognize severity of illness in Medicare payment rates. In that same final rule, we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. Without a documentation and coding adjustment, the changes to MS–DRGs would not be budget neutral. As explained in the same final rule (72 FR 47179), substantial evidence supports our conclusion that the case-mix will increase as a result of adoption of MS–DRGs without corresponding growth in patient severity. We provided evidence

from studies going back over 20 years that show that hospitals respond to incentives when payment classifications are changed to improve documentation and coding to receive higher payments. In addition, in its public comments on the FY 2008 IPPS proposed rule, MedPAC indicated that the increases in payments that result from improvements in documentation and coding are not warranted because the increase in measured case-mix does not reflect any real change in illness severity or the cost of care for the patients being treated. (72 FR 47181) Therefore, offsetting adjustments to the IPPS payment rates are needed to maintain budget neutrality and if the assumed increase in hospitals' case-mix is realized, even with the 0.9 percent offset to the capital Federal rate, aggregate capital IPPS payments would remain at the same level they would have been had the MS–DRGs not been adopted.

Consequently, we continue to believe it is necessary and appropriate to apply an adjustment to the national capital Federal payment rate for FY 2009 to account for changes in documentation and coding due to the adoption of the MS–DRGs. Therefore, in this final rule, as proposed, the national capital Federal payment rate was determined by applying the 0.9 percent reduction for FY 2009. As discussed in greater detail above in section III.A.1.a. of Addendum to this final rule, in accordance with the analytical framework set forth at § 412.308(c)(1), the update to the capital Federal rate for FY 2009 is 0.9 percent. This analytical update framework takes into account changes in the CIPI and several other policy adjustment factors; however, it does not include the adjustment to account for changes in documentation and coding, which is applied separately in the determination of the FY 2009 capital Federal rate. As discussed in the proposed rule (73 FR 23720 through 23721), although the 0.9 percent reduction is outside the established process for developing the capital Federal payment rate, it nevertheless is a factor in the final prospective payment rate to hospitals for capital-related costs. For that reason, the national capital Federal payment rate in this final rule was determined by applying the 0.9 percent reduction. (As discussed below in section II.A.6.of this Addendum, we are not applying the 0.9 percent reduction in developing the FY 2009 Puerto Rico-specific capital rate.) As a result of the 0.90 percent update and other budget neutrality factors discussed above, we are establishing a capital Federal rate of $423.96 for FY 2009. The capital Federal rate for FY 2009 was calculated as follows:

- The FY 2009 update factor is 1.0090, that is, the update is 0.90 percent.
- The FY 2009 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAFs is 1.0010.
- The FY 2009 outlier adjustment factor is 0.9465.
- The FY 2009 (special) exceptions payment adjustment factor is 0.9999.
- The FY 2009 reduction for improvements in documentation and coding under the MS–DRGs is 0.9 percent.

Because the capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAFs. As noted above, section 124 of Public Law 110–275 extends, through FY 2009, wage index reclassifications under section 508 of Public Law 108–173 (the MMA) and special exceptions contained in the final rule published in the **Federal Register** on August 11, 2004 (69 FR 49105, 49107) and extended under section 117 of the MMSEA of 2007 (Pub. L. 110–173). As a result, we cannot finalize the FY 2009 capital rates, including the GAF/DRG adjustment factor, the outlier payment adjustment factor, and the outlier threshold, until we recompute the wage indices for FY 2009 as a result of these extensions. (A complete discussion on the extension of these provisions can be found in section III.I. of the preamble to this final rule). Therefore, the capital Federal rate, GAF/DRG adjustment factor and the outlier payment adjustment factor for FY 2009 discussed in this section are tentative. The final capital rates and factors for FY 2009, reflecting the extension of the reclassification provisions noted above, will be published in a forthcoming notice in the **Federal Register**.

We are providing the following chart that shows how each of the factors and adjustments for FY 2009 affected the computation of the tentative FY 2009 capital Federal rate in comparison to the FY 2008 capital Federal rate. The FY 2009 update factor has the effect of increasing the capital Federal rate by 0.90 percent compared to the FY 2008 capital Federal rate. The GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.09 percent. The FY 2009 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.61 percent compared to the FY 2008 capital Federal rate. The FY 2009 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.02 percent. The adjustment for improvements in documentation and coding under the MS–DRGs has the effect of decreasing the FY 2009 capital Federal rate by 0.9 percent as compared to the FY 2008 capital Federal rate. The combined effect of all the changes decreases the capital Federal rate by 0.51 percent compared to the FY 2008 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2008 CAPITAL FEDERAL RATE AND TENTATIVE FY 2009 CAPITAL FEDERAL RATE

	FY 2008	FY 2009 [4]	Change	Percent change [5]
Update Factor [1]	1.0090	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor [1]	0.9996	1.0010	1.0010	0.10
Outlier Adjustment Factor [2]	0.9523	0.9465	0.9939	−0.61
Exceptions Adjustment Factor [2]	0.9997	0.9999	1.0002	0.02
MS–DRG Coding and Documentation Improvements Adjustment Factor [3]	0.9940	0.9910	0.9910	−0.90
Capital Federal Rate	$426.14	$423.96	0.9949	−0.51

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2008 to FY 2009 resulting from the application of the 1.0010 GAF/DRG budget neutrality factor for FY 2009 is 1.0010.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2009 outlier adjustment factor is 0.9465/0.9523, or 0.9939.

[3] Adjustment to FY 2009 IPPS rates to account for documentation and coding improvements expected to result from the adoption of the MS–DRGs, as discussed above in section III.D. of the Addendum to this final rule.

[4] Factors for FY 2009, as discussed above in section III. of this Addendum. The GAF/DRG adjustment factor, outlier adjustment factor and capital Federal rate for FY 2009 are tentative pending the implementation of section 124 of Public Law 110–275, as discussed above.

[5] Percent change of individual factors may not sum due to rounding.

We are also providing the following chart that shows how the tentative final FY 2009 capital Federal rate differs from the proposed FY 2009 capital Federal rates s as presented in the FY 2009 IPPS proposed rule (72 FR 23721).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2009 CAPITAL FEDERAL RATE AND TENTATIVE FINAL FY 2009 CAPITAL FEDERAL RATE

	Proposed FY 2009	Final FY 2009*	Change**	Percent change**
Update Factor	1.0070	1.0090	0.02	0.20
GAF/DRG Adjustment Factor	1.0007	1.0010	1.0003	0.03
Outlier Adjustment Factor	0.9427	0.9465	1.0040	0.40
Exceptions Adjustment Factor	0.9998	0.9999	1.0001	0.01
MS–DRG Upcoding Adjustment Factor	0.9910	0.9910	1.0000	0.00
Capital Federal Rate	$421.29	$423.96	1.0063	0.63

* The GAF/DRG adjustment factor, outlier adjustment factor and capital Federal rate for FY 2009 are tentative pending the implementation of section 124 of Public Law 110–275, as discussed above.

** Percent change of individual factors may not sum due to rounding.

6. Special Capital Rate for Puerto Rico Hospitals

a. General

Section 412.374 provides for the use of a blended payment system for payments to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section V. of the preamble of this final rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate. Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

b. Revised Puerto Rico-Specific Rate for FY 2008

As noted above, Puerto Rico hospitals are paid based on 75 percent of the national capital Federal rate and 25 percent of the Puerto Rico-specific capital rate. As discussed in section II.D.3. of the preamble of this final rule, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the authority to adjust ''the standardized amounts computed under this paragraph'' to eliminate the effect of changes in coding or classification that do not reflect real changes in case-mix. Section 1886(d)(3)(A)(vi) of the Act applies to the national operating standardized amounts computed under section 1886(d)(3) of the Act, but does not apply to the Puerto Rico-specific standardized amount computed under section 1886(d)(9)(C) of the Act. In calculating the FY 2008 payment rates, we made an inadvertent error and applied the FY 2008 −0.6 percent documentation and coding adjustment to the Puerto Rico-specific operating standardized amount, relying on our authority under section 1886(d)(3)(A)(vi) of the Act which does not apply to the Puerto-Rico-specific standardized amount. In this final rule, consistent with the correction to the Puerto Rico-specific operating standardized amount for FY 2008 presented in section II.D.3. of the preamble of this final rule, we are correcting this inadvertent error by removing the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific rates. The revised FY 2008 Puerto Rico capital rate, effective October 1, 2007, is $202.89. The statute gives broad authority to the Secretary under section 1886(g) of the Act, with respect to the development of and adjustments to a capital PPS. As we discussed in the proposed rule (73 FR 23721), although we would not be outside the authority of section 1886(g) of the Act in applying the documentation and coding adjustment to the Puerto Rico-specific portion of the capital payment rate, we have historically made changes to the capital PPS consistent with those changes made to the IPPS. Thus, we are removing the documentation and coding adjustment from the FY 2008 Puerto Rico-specific capital rate, consistent with its removal from the Puerto Rico-specific operating standardized amount.

c. Puerto Rico-Specific Rate for FY 2009

As noted above, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. As also noted previously, because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, for FY 2009, the GAF budget neutrality factor is 1.0010, while the DRG adjustment is 0.9995, for a combined cumulative adjustment of 1.0004.

For FY 2008, before application of the GAF, the special capital rate for hospitals located in Puerto Rico was $201.67 for discharges occurring on or after October 1, 2007, through September 30, 2008 (72 FR 66888). However, as discussed above, in this final rule, we are revising this rate retroactive to October 1, 2007, to remove the application of the 0.6 percent documentation and coding adjustment for FY 2008, consistent with the correction to the Puerto Rico specific standardized amount for FY 2008. The revised FY 2008 Puerto Rico capital rate, effective October 1, 2007, is $202.89. Consistent with our development of the Puerto Rico-specific operating standardized amount, we are not applying the 0.9 percent documentation and coding adjustment to the FY 2009 Puerto Rico-specific capital rate. However, as also discussed in section II.D.3. of the preamble of this final rule, we may propose to apply such an adjustment to the Puerto Rico operating and capital rates in the future. With the changes we are making to the other factors used to determine the capital rate, the FY 2009 special capital rate for hospitals in Puerto Rico is $198.84.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2009

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2007. The applicable capital Federal rate was determined by making the following adjustments:

• For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and

• For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, DSH adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2009, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2009 are in section II.A. of this Addendum. For FY 2009, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $20,185.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) up through the 10th year beyond the end of the capital transition period if it meets the following criteria: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital IPPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b), we paid the hospitals under the appropriate transition methodology (if the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period).

Under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 2002 in the FY 2006 IPPS final rule (70 FR 47387).

2. Forecast of the CIPI for FY 2009

Based on the latest forecast by Global Insight, Inc. (second quarter of 2008), we are forecasting the CIPI to increase 1.4 percent in FY 2009. This reflects a projected 2.1 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 2.9 percent increase in other capital expense prices in FY 2009, partially offset by 2.6 percent decline in vintage-weighted interest expenses in FY 2009. The weighted average of these three factors produces the 1.4 percent increase for the CIPI as a whole in FY 2009.

IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payment for services furnished in children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

In the FY 2009 IPPS proposed rule, we proposed that the FY 2009 rate-of-increase percentage for cancer and children's hospitals and RNHCIs was the percentage increase in the FY 2009 IPPS operating market basket, estimated to be 3.0 percent. For this final rule, we are using the most recent data available for the IPPS hospital market basket. For cancer and children's hospitals and RNHCIs, the FY 2009 rate-of-increase percentage that is applied to FY 2008 target amounts in order to calculate the FY 2009 target amounts is based on Global Insight, Inc.'s second quarter 2008 forecast of the IPPS operating market basket increase, which is estimated to be 3.6 percent, in accordance with the applicable regulations at 42 CFR 413.40.

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying lengths of time during which a portion of the prospective payment is based on cost-based reimbursement rules under 42 CFR Part 413 (certain providers do not receive a transitioning period or may elect to bypass the transition as applicable under 42 CFR Part 412, Subparts N, O, and P.) We note that the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended. For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to 42 CFR Part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to 42 CFR Part 413. Likewise, for cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem amount under the IPF PPS. Therefore, for cost reporting periods beginning on or after January 1, 2008, no portion of an IPF PPS payment is subject to 42 CFR Part 413.

V. Tables

This section contains a majority of the tables referred to throughout the preamble to this final rule and in this Addendum.

The following tables, which contain data relating to the FY 2009 wage indices and the hospital reclassifications and payment amounts for operating and capital-related costs that are affected by Public Law 110–275, which extends through September 30, 2009 (FY 2009) section 508 wage index reclassifications as discussed in section III.I.7. of this final rule, will be posted on the CMS Web site and published in a subsequent **Federal Register** notice prior to October 1, 2008:

Table 2.—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2007; Hospital Wage Indexes for Federal Fiscal Year 2009; Hospital Average Hourly Wages for Federal Fiscal Years 2007 (2003 Wage Data), 2008 (2004 Wage Data), and 2009 (2005 Wage Data); and 3-Year Average of Hospital Average Hourly Wages.

Table 4A.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA and by State—FY 2009.

Table 4B.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA and by State—FY 2009.

Table 4C.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA and by State—FY 2009.

Table 4D–1.—Rural Floor Budget Neutrality Factors—FY 2009.

Table 4D–2.—Urban Areas with Hospitals Receiving the Statewide Rural Floor or Imputed Floor Wage Index—FY 2009.

Table 4E.—Urban CBSAs and Constituent Counties—FY 2009.

Table 4F.—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA—FY 2009.

The following tables are included in this final rule as tentative tables and do not reflect the final calculation of the wage indices based on the extension of section 508 wage index reclassifications through FY 2009. Additional information appears with each table. Revised tables reflecting the final calculation of the FY 2009 wage indices will be posted on the CMS Web site and published in a subsequent **Federal Register** notice prior to October 1, 2008:

Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Is Greater Than 1).

Table 1B.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1).

Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor.

Table 1D.—Capital Standard Federal Payment Rate.

Table 2.—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2007; Hospital Average Hourly Wages for Federal Fiscal Years 2007 (2003 Wage Data), 2008 (2004 Wage Data), and 2009 (2005 Wage Data); and 3–Year Average of Hospital Average Hourly Wages.

Table 4J.—Out-Migration Adjustment—FY 2009.

Table 9A.—Hospital Reclassifications and Redesignations—FY 2009.

Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2009.

Table 10.—Tentative Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Medicare Severity Diagnosis-Related Group (MS–DRG)—July 2008.

The following tables are final and not subject to revision based on the final calculation of the FY 2009 wage index because of the extension of section 508 wage index reclassifications through FY 2009:

Table 3A.—FY 2009 and 3-Year Average Hourly Wage for Urban Areas by CBSA.

Table 3B.—FY 2009 and 3-Year Average Hourly Wage for Rural Areas by CBSA.

Table 5.—List of Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay.

Table 6A.—New Diagnosis Codes.

Table 6B.—New Procedure Codes.

Table 6C.—Invalid Diagnosis Codes.

Table 6D.—Invalid Procedure Codes.

Table 6E.—Revised Diagnosis Code Titles.

Table 6F.—Revised Procedure Code Titles.

Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2007 MedPAR Update—March 2008 GROUPER V25.0 MS–DRGs.

Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2007 MedPAR Update—March 2008 GROUPER V26.0 MS–DRGs.

Table 8A.—Statewide Average Operating Cost-to-Charge Ratios—July 2008.

Table 8B.—Statewide Average Capital Cost-to-Charge Ratios—July 2008.

Table 8C.—Statewide Average Total Cost-to-Charge Ratios for LTCHs—July 2008.

Table 11.—FY 2009 MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold.

The following tables discussed in section II. of the preamble of this final rule are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/:*

Table 6G.—Additions to the CC Exclusions List.

Table 6H.—Deletions from the CC Exclusions List.

Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions Table 6J.—Major Complication and Comorbidity (MCC) List.

Table 6K.—Complication and Comorbidity (CC).

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TABLE 1A.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (69.7 PERCENT LABOR SHARE/30.3 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Full Update (3.6 Percent)		Reduced Update (1.6 Percent)	
Tentative Labor-related	Tentative Nonlabor-related	Tentative Labor-related	Tentative Nonlabor-related
$3,571.82*	$1,552.74*	$3,502.87*	$1,522.76*

* Note: Subsequent to this final rule, we will publish the final standardized amounts based on the implementation of section 124 of Pub. L. 110-275.

TABLE 1B.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Full Update (3.6 Percent)		Reduced Update (1.6 Percent)	
Tentative Labor-related	Tentative Nonlabor-related	Tentative Labor-related	Tentative Nonlabor-related
$3,177.23*	$1,947.33*	$3,115.89*	$1,909.74*

* Note: Subsequent to this final rule, we will publish the final standardized amounts based on the implementation of section 124 of Pub. L. 110-275.

TABLE 1C.--ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Tentative Labor	Tentative Nonlabor	Tentative Labor	Tentative Nonlabor
National	$3,571.82*	$1,552.74*	$3,177.23*	$1,947.33*
Puerto Rico	$1,507.09*	$923.69*	$1,426.87*	$1,003.91*

* Note: Subsequent to this final rule, we will publish the final standardized amounts based on the implementation of section 124 of Pub. L. 110-275.

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

	Tentative Rate
National	$423.96*
Puerto Rico	$198.84*

* Note: Subsequent to this final rule, we will publish the final standardized amounts based on the implementation of section 124 of Pub. L. 110-275

TABLE 2.-- HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA), AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
010001	1.5540	22.1989	23.2195	25.0592	23.4783
010005	1.1196	23.6022	23.0203	25.7771	24.1412
010006	1.4817	23.4975	23.7502	25.1401	24.1338
010007	1.0616	19.9329	21.3492	22.0185	21.1334
010008	1.0233	17.9533	22.0793	23.2572	20.8434
010009	0.9973	23.5626	25.9011	25.8420	25.1053
010010	1.0950	27.0385	22.8602	24.8390	24.7463
010011	1.6750	27.6658	27.4668	27.1997	27.4387
010012	1.1633	24.4059	25.5767	26.4989	25.4689
010015	1.0456	22.3383	27.0806	23.6821	24.1699
010016	1.5773	24.6488	26.8611	28.9724	26.8031
010018	1.4886	23.7048	24.8974	26.9514	25.1715
010019	1.2547	22.8766	23.3460	25.0170	23.7424
010021	1.2255	19.7367	21.0624	21.7601	20.8461
010022	0.9944	25.8404	27.4318	28.7529	27.3478
010023	1.7659	25.4272	26.1739	28.2135	26.6957
010024	1.5996	22.0819	25.0715	26.6636	24.5917
010025	1.2916	22.7635	23.6186	23.8617	23.4234
010027	0.7390	16.4682	17.0513	18.2508	17.2827
010029	1.5956	23.9007	25.0468	24.3622	24.4413
010032	0.8804	19.3311	18.5545	20.8458	19.6449
010033	2.1374	27.4181	29.1471	29.2036	28.6057
010034	1.0161	17.7457	19.1549	21.3728	19.3907
010035	1.2483	24.2425	24.2746	26.5299	25.0070
010036	1.1531	21.5796	24.2887	23.3876	23.0897
010038	1.3336	23.7039	27.0752	28.9646	26.4793
010039	1.6469	26.9919	28.6462	29.8034	28.4935
010040	1.6524	24.3207	24.7657	25.9856	25.0415
010043	1.0886	21.9774	23.9121	25.3633	23.7101
010044	1.0621	22.5009	24.4276	23.4020	23.4236
010045	1.1534	20.4927	23.1695	24.2450	22.5595
010046	1.5233	23.4219	25.9105	25.4465	24.8784
010047	0.8828	26.4851	19.7542	21.7349	22.0982
010049	1.1411	21.7888	22.4248	23.1194	22.4566
010050	1.0831	22.9620	24.4060	25.3678	24.2277

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
010051	0.8989	18.7701	18.0305	20.0765	18.9092
010052	0.8785	25.9233	36.3638	22.7571	28.5538
010054	1.1305	23.3624	24.4810	25.4209	24.4491
010055	1.5990	22.5396	22.4145	25.3306	23.4248
010056	1.5852	23.7398	24.5754	25.7290	24.7311
010058	1.0206	19.5092	17.0150	31.1865	21.2665
010059	1.0081	23.0012	24.8199	27.8613	25.3460
010061	0.9840	24.1185	25.2454	25.7048	25.0192
010062	1.0319	21.4805	21.7112	22.9491	22.0345
010064	1.7118	24.8155	27.6149	26.6333	26.3107
010065	1.5058	23.0477	24.3346	24.4454	23.9571
010066	0.8889	19.8692	25.4612	25.6052	23.6383
010068	***	22.7156	24.4145	*	23.5620
010069	0.9714	23.1243	23.6272	27.3438	24.6221
010072	***	24.4989	*	*	24.4989
010073	0.9449	18.3963	19.0046	20.7833	19.3950
010078	1.6137	23.5279	24.3828	25.2897	24.4154
010079	1.2408	22.7337	22.3034	23.1025	22.7297
010083	1.1816	22.4279	24.0036	25.0422	23.8761
010084	***	26.3238	26.5079	27.5069	26.7176
010085	1.3041	24.2609	23.6280	24.0475	23.9696
010086	1.0253	22.2096	21.5584	26.9753	23.3510
010087	2.2143	22.4318	24.8320	27.4929	24.7678
010089	1.2954	25.0811	26.2628	25.9719	25.7580
010090	1.7253	26.0494	26.3957	25.6110	26.0163
010091	0.9052	23.1310	22.5272	23.6555	23.1157
010092	1.4950	26.6796	26.9959	28.8433	27.5243
010095	0.8395	16.5250	17.0024	17.8248	17.1164
010097	0.7533	19.4511	19.2481	18.4218	18.9975
010099	0.9931	20.8383	20.6736	22.3686	21.2840
010100	1.7251	23.8919	25.1460	25.4357	24.8856
010101	1.1725	24.2575	25.0974	26.2744	25.2377
010102	0.9522	25.6158	26.9859	26.6943	26.4292
010103	1.8652	27.8272	28.9636	30.4032	29.0802
010104	1.8542	27.6471	28.3126	30.4963	28.7445
010108	1.0589	24.6740	25.4325	26.8900	25.7632
010109	0.9572	17.6733	21.0449	21.9300	20.0805
010110	0.7379	26.0038	19.8738	22.1175	22.5117
010112	0.9788	17.1833	20.4027	21.3904	19.7108
010113	1.6326	22.3282	24.7170	25.0704	24.0143
010114	1.4027	25.6152	25.7090	25.3666	25.5603
010118	1.2131	21.4630	22.7191	25.3689	23.1089
010120	1.0321	20.9019	22.1868	22.8177	21.9917

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
010125	1.0383	21.5123	22.8911	23.6549	22.7016
010126	1.1495	23.9327	24.4957	25.7254	24.7212
010128	0.9058	23.6647	24.9881	25.9421	24.9329
010129	1.0650	22.1574	21.8502	24.4816	22.8949
010130	1.0042	23.7528	24.5644	25.2790	24.5387
010131	1.3758	26.4297	27.2707	28.0487	27.2978
010137	1.2330	27.5782	28.5843	30.4361	28.8910
010138	0.6215	16.7602	14.5551	15.0815	15.4265
010139	1.5830	26.8726	28.1473	29.3560	28.1537
010143	1.2044	26.2762	24.0674	25.0871	25.0925
010144	1.7235	22.5133	22.3916	23.8601	22.9476
010145	1.4438	24.5092	25.8293	27.3296	25.8988
010146	1.1256	22.6586	22.6879	23.8076	23.0618
010148	0.8896	23.9246	23.5714	25.0960	24.1958
010149	1.2287	24.4805	25.4354	26.8920	25.7365
010150	0.9968	23.6080	24.4098	25.0070	24.3381
010152	1.2616	22.4075	23.7803	26.0793	24.1157
010157	1.1619	23.3828	24.2206	27.1793	24.7601
010158	1.2539	23.5533	25.5905	26.2363	25.0904
010162	***	33.8777	*	*	33.8777
010163	***	*	34.0325	*	34.0325
010164	1.2290	*	23.2447	25.6759	24.4802
010165	***	*	28.8040	*	28.8040
010166	***	*	29.7256	*	29.7256
010167	1.6926	*	*	*	*
010168	1.3071	*	*	*	*
020001	1.7367	35.4232	36.5298	38.1784	36.7202
020004	***	31.8004	*	*	31.8004
020006	1.2843	34.3752	37.0211	37.2853	36.2134
020008	1.2050	36.1250	39.3432	40.6783	38.7270
020012	1.3629	32.5975	33.9375	36.1911	34.2982
020014	1.0565	29.4472	30.9722	30.6343	30.3733
020017	2.0214	35.4119	35.8804	38.2157	36.5161
020018	0.8982	*	*	*	*
020019	0.9135	*	*	*	*
020024	1.1774	29.5195	38.6934	39.9943	35.5854
020026	1.5382	*	*	*	*
020027	0.9594	*	*	*	*
020028	0.9512	*	*	*	*
030001	1.4994	32.4791	33.4178	35.9083	33.8237
030002	2.1093	30.2200	31.0818	32.9094	31.4276
030006	1.7180	27.0599	27.7421	29.1248	28.0036
030007	1.4627	31.1928	33.7213	35.5226	33.5067

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
030009	***	26.5408	*	*	26.5408
030010	1.4422	28.5684	30.6261	31.8640	30.4147
030011	1.5331	28.1423	28.8203	30.2096	29.0993
030012	1.4346	27.3895	29.1042	31.3068	29.3711
030013	1.5330	27.0111	31.2815	31.9162	30.1315
030014	1.5797	29.6582	29.8296	30.6308	30.0790
030016	1.2775	29.1980	30.7896	31.1878	30.4662
030017	2.0561	30.6007	34.4852	34.8488	33.3773
030018	1.3633	29.4566	31.8056	31.7240	31.0144
030019	1.3013	29.5921	30.1934	33.6553	31.0573
030022	1.7899	30.5710	30.3746	35.0772	31.9484
030023	1.8151	34.2142	35.8287	37.5523	35.8812
030024	2.1418	31.9247	33.1797	35.3556	33.5460
030030	1.6947	32.0994	34.4166	36.4772	34.2678
030033	1.3097	28.7508	29.9383	32.0362	30.2709
030036	1.5439	30.9834	33.0523	35.7464	33.4386
030037	1.9926	31.2877	34.1079	35.1342	33.3946
030038	1.6470	29.9314	31.7238	31.2928	31.0113
030040	***	27.5322	*	*	27.5322
030043	1.2286	26.5834	27.3856	28.3158	27.4535
030055	1.4744	27.1473	27.1621	31.0806	28.5337
030060	1.1691	24.8373	*	*	24.8373
030061	1.6358	28.0696	28.1337	33.0847	29.7503
030062	1.2368	26.6880	28.9587	29.9359	28.5908
030064	2.0318	28.3853	29.8226	31.6632	30.0081
030065	1.6333	29.5883	31.0817	31.4602	30.7663
030067	1.0076	20.7591	27.4497	27.0784	25.0402
030068	1.1300	23.1394	23.8792	26.0296	24.3903
030069	1.4773	30.2224	29.7802	30.7723	30.2562
030071	0.9977	*	*	*	*
030073	1.1304	*	*	*	*
030074	0.9181	*	*	*	*
030077	0.7963	*	*	*	*
030078	1.1346	*	*	*	*
030080	***	27.1360	28.6568	30.7682	28.9584
030083	1.3024	27.4983	33.5302	35.8521	32.0956
030084	1.0208	*	*	*	*
030085	1.6308	26.8364	28.1388	29.0774	28.0477
030087	1.6982	29.5962	31.2331	31.1094	30.6904
030088	1.3726	27.8604	29.9758	30.5738	29.5062
030089	1.5949	28.9068	30.1591	31.3179	30.1507
030092	1.5060	31.7512	30.6343	30.4394	30.8528
030093	1.3167	26.4430	27.8821	33.0720	29.2824

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
030094	1.5482	31.5422	33.4050	34.2040	33.1206
030099	0.9137	27.1402	26.9227	24.9127	26.3289
030100	2.0925	31.5628	34.7532	35.0981	33.8070
030101	1.4922	27.8302	30.6764	33.2139	30.6812
030102	2.4495	31.6285	33.6247	36.9539	34.0956
030103	1.7730	31.7322	32.2833	34.2770	32.8164
030105	2.3507	31.2970	32.7449	33.9875	32.7844
030106	1.6207	32.9840	36.4667	40.1657	36.8316
030107	1.9108	35.6197	35.5386	35.4562	35.5311
030108	2.0613	*	29.9395	34.8507	32.9308
030109	***	16.5906	*	*	16.5906
030110	1.6123	31.4852	29.7949	36.2158	32.4784
030111	1.0449	*	33.3711	28.5146	30.2239
030112	2.0028	*	36.6601	33.4810	34.6271
030113	0.9100	*	*	*	*
030114	1.4833	*	*	28.8466	28.8466
030115	1.4703	*	*	32.5885	32.5885
030117	1.2496	*	*	*	*
030118	1.1429	*	*	*	*
030119	1.2769	*	*	*	*
030120	0.8667	*	*	*	*
030121	1.0847	*	*	*	*
030122	1.0530	*	*	*	*
040001	1.0747	22.9327	22.9948	24.4962	23.4596
040002	1.1717	21.2020	25.0000	24.0487	23.3253
040004	1.6829	27.1741	28.1117	29.2714	28.2063
040007	1.7414	40.1291	29.1941	28.3305	32.3317
040010	1.4743	24.2315	26.5287	28.2375	26.3914
040011	1.0295	21.0967	22.2431	22.6327	22.0006
040014	1.3504	26.4777	28.9855	34.8279	29.4950
040015	1.1198	20.4279	20.1061	22.3148	20.9795
040016	1.7091	25.8056	26.5911	26.4806	26.3036
040017	1.1225	21.9147	23.8768	24.3772	23.3607
040018	1.1100	24.0026	25.6751	26.2521	25.2934
040019	1.0401	23.8706	24.9113	26.4932	25.0685
040020	1.6262	22.6497	23.9470	26.1529	24.2425
040021	1.5502	25.4046	26.1853	27.6799	26.3617
040022	1.4629	29.5000	27.9902	30.0250	29.1594
040026	1.5441	27.7931	29.5299	31.8588	29.7129
040027	1.5245	21.4252	23.8220	25.7935	23.6377
040029	1.4303	24.8409	25.1479	27.8882	25.9693
040036	1.6280	27.6234	29.7150	30.4906	29.2738
040039	1.2304	21.2712	21.4819	22.9807	21.9031

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
040041	1.1571	23.7787	26.4964	26.4435	25.5535
040042	1.2898	21.1716	19.8709	23.1661	21.3825
040047	1.0408	22.4249	23.0358	23.3557	22.9634
040050	1.1977	17.6906	18.5119	19.6946	18.6285
040051	0.9459	21.3342	22.0394	22.1981	21.8574
040054	***	18.0509	19.5353	*	18.7591
040055	1.5581	23.0448	24.9164	26.0150	24.6248
040062	1.6240	23.8994	25.2303	25.6554	24.9291
040067	1.1142	19.0471	18.9872	20.9700	19.6154
040069	1.0666	24.8060	24.9996	23.3117	24.3664
040071	1.5794	25.4680	25.2840	26.6645	25.8036
040072	1.1296	22.4741	22.1058	22.9671	22.5263
040074	1.2584	25.2699	26.2661	27.3897	26.2961
040076	1.0056	23.5742	23.0954	24.7903	23.8277
040078	1.6693	23.5915	26.1937	25.6886	25.0535
040080	1.0500	24.1921	24.8760	26.5905	25.2949
040081	0.8888	16.8437	17.2536	18.4759	17.5297
040084	1.2391	27.7626	26.6449	28.1570	27.5101
040085	1.0083	22.9916	25.7215	26.6987	25.1596
040088	1.6627	22.4860	23.6276	24.7119	23.6216
040091	1.1948	24.2398	23.1913	22.3311	23.2270
040100	***	21.3051	22.6131	24.5458	22.8470
040114	1.8338	26.7581	27.7928	28.5702	27.7161
040118	1.5311	26.0388	26.8908	26.5783	26.5256
040119	1.3869	24.3680	24.2419	25.6779	24.7945
040126	***	15.6985	17.3715	*	16.4167
040132	***	*	22.0054	21.8140	21.8932
040134	2.3507	31.9325	32.2832	34.9673	33.0719
040137	1.3584	25.9979	27.7360	27.7638	27.1685
040138	1.5078	27.8584	28.3342	33.0073	29.8707
040141	0.7864	26.1041	30.3475	33.8791	29.9331
040142	1.5546	21.4222	23.8620	23.1302	22.9025
040143	***	37.1976	*	*	37.1976
040144	***	21.4008	*	*	21.4008
040145	1.7997	*	24.4367	20.3878	22.2708
040146	***	*	33.7876	.	33.7876
040147	1.7505	*	*	35.7669	35.7669
040148	1.3585	*	*	*	*
050002	1.4582	35.5184	41.7336	43.1760	40.2441
050006	1.5894	33.5751	37.1639	41.7714	37.1465
050007	1.4369	43.4440	45.8773	49.5271	46.3434
050008	1.4565	49.3167	46.8706	50.9569	49.0492
050009	1.6486	43.0584	46.2186	49.7177	46.4665

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050013	1.8251	35.7591	43.5623	43.4906	40.8369
050014	1.2654	36.0305	37.4135	42.2044	38.6396
050015	1.6268	32.2188	*	*	32.2188
050016	1.3205	24.5768	31.0653	34.3863	30.1394
050017	2.0216	39.6653	42.2200	44.4857	42.1785
050018	1.2690	23.3204	31.8310	34.0338	29.0305
050022	1.5896	31.6467	33.0592	36.6360	33.8302
050024	1.1168	29.4062	33.4334	33.5247	32.1639
050025	1.8003	33.5466	32.7476	36.9233	34.4465
050026	1.5605	31.5250	33.1277	35.0306	33.2688
050028	1.2959	27.3826	28.5736	28.1584	28.0606
050030	1.2275	27.2945	30.9014	33.5654	30.5987
050036	1.5998	33.8000	36.0905	37.4298	35.8311
050038	1.6176	44.2265	48.7483	55.2197	49.5133
050039	1.6821	35.2630	36.6943	34.9262	35.5984
050040	1.3886	35.8322	35.7054	38.1665	36.6261
050042	1.4797	37.3760	40.3326	40.5791	39.4488
050043	1.6172	45.4887	48.2283	51.9529	48.5563
050045	1.3277	25.0150	27.0676	28.5952	26.9312
050046	1.2009	26.1926	29.1125	34.2529	29.6259
050047	1.7553	55.9367	45.1675	48.5961	49.7774
050054	1.1787	21.3650	24.0338	27.1320	24.3254
050055	1.3411	42.9516	44.2926	48.2796	45.1984
050056	1.4236	30.6126	32.7693	34.7964	32.7256
050057	1.6870	30.0236	31.7467	33.7574	31.8602
050058	1.6319	33.1409	37.2538	38.9843	36.4799
050060	1.5120	29.9762	32.0196	34.1183	31.9988
050063	1.4493	34.0906	36.3085	36.6301	35.6926
050065	***	34.9110	38.2421	42.0085	38.4619
050067	1.2068	38.8070	40.1393	41.8988	40.2614
050069	1.7315	34.6353	35.3850	38.1339	36.1121
050070	1.2564	47.4099	46.4009	48.9362	47.6533
050071	1.4005	50.7602	49.6495	52.0696	50.8737
050072	1.3909	49.4344	50.0343	51.4538	50.3895
050073	1.2828	49.9730	49.0069	50.6523	49.8763
050075	1.3622	54.4089	49.8290	51.1187	51.5268
050076	1.8082	52.3788	50.2039	50.5761	51.0240
050077	1.5357	34.8660	36.5384	37.4989	36.4390
050078	1.2482	32.0133	30.4274	37.1940	33.1215
050079	1.5753	47.3449	48.8994	48.3017	48.1345
050082	1.6645	38.2878	37.8905	42.0181	39.3655
050084	1.5655	35.5196	39.5748	41.1276	38.7781
050089	1.3632	33.9593	36.4018	39.6297	36.6479

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050090	1.2560	33.8953	37.7421	41.6026	37.7213
050091	1.0322	32.1301	37.1223	40.1063	36.4136
050093	1.5575	36.9481	36.8486	37.7244	37.1773
050095	***	*	*	44.2400	44.2400
050096	1.2535	34.9237	33.1322	33.3803	33.8097
050099	1.5379	33.4174	32.0650	34.3507	33.2478
050100	1.7374	31.4404	33.3959	34.2839	33.0487
050101	1.3241	42.4589	47.9327	48.7495	46.4307
050102	1.3930	32.0617	32.8434	33.2837	32.8161
050103	1.5455	34.0935	35.6773	37.3608	35.7535
050104	1.4136	32.3043	33.6204	37.4417	34.5122
050107	1.5309	32.5846	33.5687	36.5843	34.2447
050108	1.8616	38.8672	42.0131	45.3460	42.0947
050110	1.2381	26.8408	28.0670	30.9054	28.6075
050111	1.1657	28.7875	31.8766	31.9394	30.8314
050112	1.5362	37.7281	38.9483	39.9951	38.9375
050113	1.1689	39.4882	42.8884	46.3471	42.8016
050114	***	34.0309	35.7274	37.5924	35.8070
050115	1.4695	28.8051	32.5257	33.3013	31.6072
050116	1.6424	36.8825	37.6018	45.7510	40.4041
050117	***	34.2020	35.0531	*	34.3889
050118	1.2468	39.9683	41.6701	41.8191	41.1964
050121	1.2661	30.6105	34.6244	35.1135	33.4903
050122	1.6222	33.9812	34.0259	36.8821	34.9566
050124	1.2999	30.2522	29.9944	31.7690	30.6984
050125	1.4809	44.9523	47.7578	53.6300	49.3207
050126	1.5250	31.7619	32.6686	35.1909	33.2843
050127	1.2874	32.0355	40.7610	42.5226	37.9334
050128	1.4846	31.1308	33.4233	34.2364	32.9850
050129	1.8867	34.7359	36.9887	40.3786	37.3224
050131	1.4650	45.3152	47.5257	52.8228	48.8797
050132	1.4131	35.9199	39.6807	43.6747	39.6141
050133	1.5865	31.9527	33.1814	35.2433	33.7197
050135	1.0163	25.1813	25.3209	25.4431	25.3292
050136	1.3860	43.3747	46.6619	51.8508	47.5150
050137	1.5121	39.1496	40.2457	43.5305	41.2003
050138	1.6388	45.3727	40.6343	45.1011	43.5015
050139	1.4255	37.8986	38.7385	43.0734	40.1793
050140	1.2992	40.9725	39.4954	42.7590	41.1015
050144	***	33.6662	38.2424	40.4760	37.3687
050145	1.5417	42.2921	48.0796	49.4479	46.7694
050146	1.8178	*	*	*	*
050148	1.0935	28.2305	*	*	28.2305

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050149	1.5496	35.8821	37.3616	43.1926	39.0000
050150	1.2328	33.6583	37.9946	43.5937	38.2559
050152	1.4460	46.1553	51.6567	54.7176	50.9499
050153	1.4503	42.8955	47.6374	50.4884	47.2439
050155	***	16.9516	16.7756	*	16.8520
050158	1.3623	35.7805	39.9160	42.7874	39.6140
050159	1.2984	32.5704	34.6915	35.0153	34.1448
050167	1.4989	31.4798	34.0418	38.0742	34.4900
050168	1.5718	37.9784	40.5973	40.8362	39.8630
050169	1.5141	29.4693	31.4115	33.1130	31.4634
050173	1.3439	29.0576	31.6717	32.3265	30.9929
050174	1.5485	44.4199	48.1740	53.7113	48.9676
050175	***	33.3061	35.0152	*	34.1608
050177	***	24.0717	*	*	24.0717
050179	1.1896	30.4973	31.6651	34.6558	32.3090
050180	1.5816	42.0358	45.7099	48.7425	45.6265
050188	1.5401	41.0943	43.7381	45.8501	43.4426
050189	1.0373	30.1155	28.7580	31.5805	30.2846
050191	1.5029	37.7805	37.8756	41.7185	39.1869
050192	0.9783	27.1400	27.8386	27.4611	27.4788
050193	1.2326	33.9520	29.0623	36.7240	32.9059
050194	1.3496	44.7107	49.0030	49.8539	47.9020
050195	1.5745	48.8595	53.5583	57.6563	53.3870
050196	1.0781	34.0956	32.8293	41.1300	35.9362
050197	1.9804	50.0728	52.9998	55.3173	52.8654
050204	1.4030	32.0121	35.3954	38.8689	35.4360
050205	1.3877	29.3334	30.6322	30.6117	30.1783
050207	***	30.0062	31.3431	.	30.6661
050211	1.3078	35.0515	35.0289	42.9254	37.8246
050214	***	25.4647	*	*	25.4647
050215	***	48.8112	50.7578	*	49.8014
050219	1.3312	26.4143	25.8378	26.7061	26.3098
050222	1.6180	32.3882	33.7510	35.4045	33.9151
050224	1.6646	32.5010	35.7280	37.3442	35.2849
050225	1.3992	34.0836	35.1227	37.5252	35.6612
050226	1.5109	32.4411	35.4597	36.5354	34.8258
050228	1.3090	43.7939	47.1430	49.9063	46.9949
050230	1.5465	34.0600	35.8490	38.8901	36.2987
050231	1.7143	32.1813	33.7139	37.0245	34.3586
050232	1.7071	26.3004	34.3242	35.4055	32.1887
050234	1.4522	32.3726	34.8308	37.7125	34.9925
050235	1.4880	30.5405	37.0858	39.1744	35.6934
050236	1.4577	33.0686	32.6462	34.4257	33.3579

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050238	1.5301	33.3346	34.0823	35.1268	34.2459
050239	1.6814	33.1148	35.9041	36.3257	35.1520
050240	***	36.1154	40.7427	.	38.4427
050242	1.3861	46.4844	50.9882	53.8385	50.5812
050243	1.5756	32.9385	36.1209	37.8538	35.6833
050245	1.3718	27.3866	33.2556	34.7153	31.8988
050248	1.1233	*	40.4941	46.0329	43.3520
050251	***	27.8452	*	*	27.8452
050253	***	23.5381	*	*	23.5381
050254	1.2793	31.2386	33.0865	33.5069	32.6697
050256	***	29.6793	32.7159	32.6841	31.5755
050257	0.9390	20.1829	24.0737	29.2651	24.4844
050261	1.2956	29.2150	30.8704	33.7196	31.3402
050262	2.2137	39.9946	41.4835	43.7709	41.7556
050264	1.3686	47.7024	43.4181	50.1691	47.1232
050270	***	33.6855	36.0111	*	34.8609
050272	1.4211	29.4671	30.9290	32.2584	30.9775
050276	1.1187	41.1406	43.7943	47.2432	44.0838
050277	1.1811	35.4443	35.0079	*	35.2189
050278	1.5508	31.8712	34.3798	38.5689	35.0180
050279	1.1958	29.7118	31.6738	32.1695	31.1950
050280	1.7353	38.8341	41.3912	43.6243	41.3293
050281	1.4032	29.4882	31.6639	31.0706	30.7708
050283	1.6161	44.3122	43.6855	45.1132	44.3833
050289	1.6175	44.2814	50.1762	52.0918	49.0232
050290	1.7586	37.3563	40.6192	42.0099	39.9567
050291	1.9787	38.4365	41.2100	44.6102	41.6384
050292	1.0606	26.9786	27.3365	35.0372	29.9744
050295	1.4390	34.7382	38.4256	39.7399	37.8500
050296	1.1381	39.9842	42.5405	44.8135	42.4578
050298	1.2075	30.2022	33.7864	33.6947	32.5826
050299	***	35.1249	32.3707	*	33.6024
050300	1.4005	30.2874	33.6821	37.1275	33.7469
050301	1.2503	35.9491	37.1103	36.3681	36.4675
050305	1.4124	44.9681	48.5339	56.9756	50.1498
050308	1.5318	43.7413	46.4180	49.0132	46.4319
050309	1.4539	38.2659	40.1499	42.9280	40.4906
050312	***	36.8498	*	*	36.8498
050313	1.2017	35.0478	37.5024	39.0663	37.2467
050315	1.3068	33.2038	32.5538	37.3560	34.4363
050320	1.2613	45.7686	46.2071	50.6708	47.5847
050324	1.7814	34.5503	36.3474	37.1883	36.0615
050325	1.1836	31.3730	37.0441	34.0343	34.2479

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050327	1.6645	33.9507	35.9349	36.9550	35.6205
050329	1.2707	23.2927	33.0390	36.7669	31.1934
050333	1.0439	19.6352	18.6534	*	19.1327
050334	1.5870	43.9656	47.2968	50.9834	47.4808
050335	1.3862	30.9928	34.7192	37.2347	34.3861
050336	1.2383	30.4664	31.5480	33.0325	31.7352
050342	1.2518	29.2244	30.4226	29.8389	29.8444
050348	1.7778	31.5156	32.7107	33.5276	32.6288
050349	0.9668	24.4863	25.4266	23.1095	24.2537
050350	1.4256	31.0136	31.7908	34.6747	32.4882
050351	1.5356	30.6599	33.3064	35.0042	33.0094
050352	1.3549	36.7673	37.0807	38.6265	37.4932
050353	1.5199	29.4215	30.4206	37.1716	32.2263
050357	1.5072	32.6763	36.2089	38.9244	35.9970
050359	1.1857	29.8345	31.3391	30.3988	30.5271
050360	1.5232	47.4497	52.3811	55.3738	51.8406
050366	1.1491	33.6714	37.1527	41.8324	37.3706
050367	1.4841	38.6330	40.1904	40.0453	39.6604
050369	1.4761	30.6439	32.2467	33.3357	32.1010
050373	1.4391	35.1380	34.3737	37.6695	35.7070
050376	1.7720	34.3539	35.2837	36.7270	35.5031
050378	1.0573	37.9904	40.1923	42.0480	40.0792
050380	1.6762	46.0276	49.4258	52.5804	49.4116
050382	1.4498	30.4014	32.6683	32.9248	31.9913
050385	1.3016	36.8107	36.4188	36.5644	36.5960
050390	1.1228	27.3183	27.9359	33.0463	29.3108
050391	***	17.2141	*	*	17.2141
050393	1.3848	34.1743	35.6356	35.1887	35.0089
050394	1.6164	27.4861	32.1894	32.9572	30.9413
050396	1.5626	32.4918	37.3972	38.9944	36.2055
050397	0.8787	28.3671	29.6825	31.1621	29.8108
050407	1.1900	42.2748	44.6839	47.5591	44.8613
050411	1.3651	38.8294	38.6328	42.9884	40.3381
050414	1.3187	38.7585	41.8688	45.1621	42.0897
050417	1.3079	32.9341	36.1222	37.9951	35.7521
050420	***	35.2869	39.9237	*	37.6935
050423	1.0116	28.3768	31.9751	32.4108	31.1453
050424	1.9539	34.5680	36.6091	37.5246	36.2772
050425	1.3777	49.2245	46.6628	45.3743	46.8636
050426	1.4602	33.2031	34.9855	37.6505	35.2298
050430	0.9393	23.9045	24.5327	25.9368	24.7205
050432	***	33.1876	35.2416	*	34.2247
050433	***	21.3573	21.1287	23.0949	21.6681

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050434	0.9988	32.6255	33.7794	35.4807	33.9526
050435	1.1989	30.6530	33.0372	35.7427	33.2052
050438	1.5504	36.3026	36.2044	38.2855	36.9434
050441	1.9586	44.5694	46.6160	49.2129	46.8432
050444	1.4087	34.6313	37.6821	39.3947	37.5304
050447	2.2656	26.7960	29.0780	27.1271	27.7357
050448	1.2943	30.6201	32.7748	32.6682	32.0001
050454	1.9406	38.5833	40.2811	43.5230	40.8869
050455	1.5603	30.4606	34.5445	35.0232	33.3441
050456	***	21.6261	27.7659	27.9702	25.0704
050457	1.5982	47.8947	50.0282	53.3175	50.4345
050464	1.7387	38.3058	41.6235	42.6699	40.8478
050468	1.7696	31.1111	35.7409	37.3416	34.8297
050469	***	30.6502	*	*	30.6502
050470	***	27.8678	31.0466	32.5041	30.5212
050471	1.7142	35.4768	36.8680	36.8185	36.4104
050476	1.4103	38.7856	41.1042	41.7566	40.5869
050477	***	37.7668	40.1566	*	39.0877
050478	1.0317	40.2558	41.1668	41.5635	41.0395
050481	1.5137	36.1394	38.8650	42.8536	39.2911
050485	1.6495	36.1488	34.6219	34.7078	35.1977
050488	1.4371	42.6854	45.0630	49.3604	45.8657
050491	***	34.3598	*	*	34.3598
050492	1.3245	28.0826	30.7718	32.6609	30.4679
050494	1.4327	38.1177	40.6384	*	39.3703
050496	1.6953	48.2468	51.6363	56.7446	52.3161
050498	1.3488	37.1667	41.0350	45.3508	41.1741
050502	1.6484	28.7046	31.8872	32.9791	31.1615
050503	1.5137	34.0994	37.3605	37.7210	36.4448
050506	1.5258	37.7420	39.8586	40.6534	39.4430
050510	1.3261	52.5376	49.4533	51.3143	51.0106
050512	1.4936	50.9264	48.8057	50.1470	49.9316
050515	1.3742	38.9542	40.2957	42.0106	40.5532
050516	1.5086	39.8161	43.0249	45.6228	42.8823
050517	1.2962	20.0213	22.4096	29.3694	23.6400
050523	1.2875	40.6535	43.4579	46.9870	43.8657
050526	1.1838	28.1997	33.3964	35.5457	32.2794
050528	1.1507	31.4941	36.2908	38.3051	35.4348
050531	1.0514	27.1974	28.3348	28.4890	28.0136
050534	1.4335	33.1666	36.6447	38.1892	36.0378
050535	***	34.6143	37.8174	*	36.2328
050537	1.4811	34.9931	38.2145	41.5275	38.3289
050541	1.4181	52.5908	48.0867	51.4545	50.6109

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050543	0.7528	29.4443	24.4913	32.8367	28.6013
050545	0.6921	31.3080	35.3209	*	33.2475
050546	0.6795	33.2245	36.5099	*	34.9356
050547	0.9720	34.8401	33.8036	*	34.2850
050548	0.7102	39.2234	41.1075	*	40.1570
050549	1.6510	35.2792	38.3927	40.6796	38.1013
050550	***	30.9612	34.9476	39.2163	34.7858
050551	1.3450	34.0467	37.2506	37.6223	36.3787
050552	0.9459	33.0711	33.9810	35.3468	34.1390
050557	1.5989	33.3654	35.7023	39.2224	36.0927
050561	1.4983	38.0196	38.2543	40.1567	38.9096
050567	1.5114	35.7063	37.6384	39.0114	37.5242
050568	1.2462	25.2337	26.0908	26.7733	26.0580
050569	1.3207	31.6785	*	*	31.6785
050570	1.5522	34.5161	38.4373	40.6761	37.8616
050571	***	34.7627	39.0649	*	36.9575
050573	1.5659	34.7279	35.2842	36.8561	35.6380
050575	1.3186	25.1457	23.7990	22.1018	23.5661
050577	***	32.3744	*	*	32.3744
050578	1.4339	35.2390	31.3639	43.4917	36.9427
050579	***	42.5081	*	*	42.5081
050580	1.1501	31.5806	34.1531	35.0966	33.6235
050581	1.4146	34.0136	37.7567	40.0909	37.3049
050583	1.6432	34.5747	37.4450	40.5845	37.4777
050584	1.4504	30.3434	30.7839	31.9910	31.0596
050585	***	22.2521	*	*	22.2521
050586	1.3092	26.4782	31.3513	31.1932	29.6940
050588	1.3729	32.7556	37.7387	39.4251	36.6374
050589	1.2415	34.5100	37.6886	37.2056	36.5102
050590	1.2811	38.4971	41.7519	44.3382	41.5523
050591	***	30.6106	34.7133	*	32.5892
050592	***	27.3606	31.8053	32.2376	30.0890
050594	***	36.5256	42.0788	*	39.2148
050597	1.2969	28.8294	31.5625	32.8987	31.1676
050599	1.8594	32.7835	34.7187	36.6146	34.7402
050601	1.5286	36.0572	39.7717	43.2404	39.7372
050603	1.4514	34.0275	35.0279	35.4809	34.9113
050604	1.3442	55.0821	49.4446	49.6068	50.8842
050608	1.2713	30.4169	31.2909	30.7280	30.8127
050609	1.3266	41.7208	39.7397	43.4555	41.6214
050613	***	42.8108	42.9930	*	42.8892
050615	***	35.9547	39.1299	*	37.5269
050616	1.4916	37.7284	37.1200	40.7388	38.5140

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050618	1.0232	31.3182	33.1472	34.9177	33.1407
050624	1.3469	33.9594	35.9346	39.2553	36.4378
050625	1.7643	38.6591	41.0439	44.8482	41.6103
050633	1.2411	36.8302	38.4916	40.7383	38.7407
050636	1.2728	32.5576	33.0718	35.4565	33.7352
050641	1.3419	39.6921	32.3586	32.0508	34.3181
050644	1.0503	28.8237	30.7981	33.2777	30.9591
050660	1.7530	*	*	*	*
050662	0.7934	33.2446	38.3017	*	35.5809
050663	1.4158	27.7334	17.7035	17.7252	19.8507
050667	0.9377	24.2771	25.9161	25.8460	25.2825
050668	1.2595	56.6555	51.6049	52.7011	53.2603
050674	1.2608	48.0893	47.0720	48.6880	47.9701
050677	1.3718	38.5770	39.2161	41.8130	40.0238
050678	1.3259	32.4473	33.7633	35.8411	34.1151
050680	1.2898	38.2871	37.9856	39.0389	38.4556
050682	0.8353	17.9077	22.2193	22.3903	20.9020
050684	1.1173	27.5256	28.8378	33.5915	30.1555
050686	1.5782	41.0188	39.7757	42.1444	41.0018
050688	1.2095	44.1510	49.4062	53.2741	49.0718
050689	1.5964	45.0951	48.8533	48.9935	47.6639
050690	1.2603	50.9094	49.0226	51.6179	50.5323
050693	1.3935	34.5797	39.6838	42.8266	38.9562
050694	1.0550	30.7858	32.1065	34.8486	32.6640
050695	***	39.6004	49.0340	*	44.6756
050696	2.2704	37.3837	39.8963	39.4353	38.9126
050697	1.1055	16.6605	22.1441	26.7600	21.2678
050699	***	28.9083	21.5725	*	25.4400
050701	1.3490	31.9529	34.9876	37.2839	34.8714
050704	1.0457	29.7740	31.6097	32.2017	31.2016
050707	***	35.7311	43.5555	44.0254	40.8930
050708	1.5222	30.5860	31.8442	28.3074	30.2207
050709	1.4494	26.8549	24.5621	29.5364	27.1496
050710	1.2461	45.8022	44.2482	46.2533	45.4333
050713	***	21.1273	21.4825	*	21.2886
050714	1.4007	31.9527	34.1542	42.9797	36.5753
050717	1.5515	39.3227	38.8773	37.0875	38.4093
050718	***	25.5140	31.9622	*	28.5587
050720	0.9629	29.4726	30.3595	32.1173	30.5950
050722	0.9056	31.4867	33.7991	35.6741	33.7782
050723	1.3959	38.5446	38.7140	42.1571	39.9881
050724	2.0014	31.6910	35.2344	35.1020	34.1987
050725	0.8711	24.3100	30.0580	28.8389	27.6838

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
050726	1.5386	30.6479	28.6361	30.6105	29.9373
050727	1.3488	33.9118	32.7783	33.0932	33.2505
050728	***	39.3581	41.8263	*	40.4993
050729	***	36.5432	38.1882	*	37.4033
050730	***	37.0629	39.2046	*	38.1210
050732	2.3249	*	33.6831	34.3475	34.0205
050733	1.5889	*	40.1517	40.6320	40.3893
050734	***	*	31.2883	*	31.2883
050735	1.3945	*	*	36.6081	36.6081
050736	1.2088	*	*	41.8938	41.8938
050737	1.5003	*	*	38.0424	38.0424
050738	1.5039	*	*	43.9259	43.9259
050739	1.6285	*	*	57.2480	57.2480
050740	1.4580	*	*	54.0370	54.0370
050741	1.4520	*	*	51.1526	51.1526
050742	1.4461	*	*	39.2532	39.2532
050744	1.7431	*	*	48.4951	48.4951
050745	1.3420	*	*	42.5523	42.5523
050746	1.8199	*	*	43.2015	43.2015
050747	1.5410	*	*	44.5887	44.5887
050748	1.1282	*	*	43.1008	43.1008
050749	1.3889	*	*	28.2000	28.2000
050750	***	*	*	33.9915	33.9915
050751	2.8440	*	*	29.5488	29.5488
050752	1.4062	*	*	39.8035	39.8035
050753	1.6858	*	*	*	*
050754	1.1892	*	*	*	*
050755	1.3602	*	*	*	*
050757	1.5949	*	*	*	*
050758	1.3400	*	*	*	*
050759	2.2078	*	*	*	*
060001	1.5191	29.6191	31.0018	32.4226	30.9997
060003	1.4093	29.4809	31.3616	31.8637	30.9378
060004	1.1120	32.4609	32.0095	34.8428	33.1192
060006	1.3136	25.2139	27.2057	27.6453	26.6966
060008	1.2588	23.0947	26.5175	27.2071	25.5279
060009	1.4731	31.5210	32.4208	34.0151	32.6691
060010	1.5403	27.1916	29.5304	30.6424	29.1100
060011	1.5181	35.1573	32.1001	34.4171	33.8462
060012	1.5547	27.3885	28.7724	29.4365	28.5096
060013	1.5942	26.8675	27.9145	28.0800	27.6095
060014	1.8792	31.0542	31.9389	33.0366	32.0064
060015	1.8683	32.5285	32.2927	36.3296	33.6079

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
060016	1.1864	26.5427	27.1430	28.3055	27.3084
060018	1.2892	24.1086	25.3897	26.5788	25.3469
060020	1.5528	24.5992	25.9147	26.7362	25.7389
060022	1.6005	28.2944	29.3379	31.9376	29.8735
060023	1.6260	29.5760	31.1556	32.7922	31.1712
060024	1.8695	30.0279	31.5411	32.8206	31.5107
060027	1.5947	29.6121	30.9212	31.6134	30.7139
060028	1.4304	31.6900	32.1656	33.4966	32.4486
060030	1.4283	27.8642	29.9513	31.2932	29.7054
060031	1.5352	27.8345	29.3907	30.7381	29.3064
060032	1.4893	31.0686	32.7383	34.6447	32.7837
060034	1.7122	30.9359	32.1252	33.3656	32.1080
060036	1.0963	20.3226	22.8256	20.9370	21.3447
060041	0.9254	24.6142	25.9710	31.4739	27.2231
060043	0.9724	18.2143	21.9955	23.3908	21.1623
060044	1.1929	26.5611	24.8352	28.9200	26.6865
060049	1.4365	29.3724	30.2192	32.1589	30.6365
060054	1.4816	24.3389	25.0980	24.6721	24.6996
060064	1.7027	32.3681	33.2428	37.2407	33.8167
060065	1.4027	32.4735	33.8538	34.9205	33.7658
060071	1.1340	27.6657	28.1762	31.5388	29.2654
060075	1.3866	32.2545	37.6023	35.8081	35.2183
060076	1.2625	26.5631	30.7808	31.6044	29.6214
060096	1.6137	32.1310	37.8243	38.2249	36.0402
060100	1.7214	32.6104	33.2145	33.5356	33.1202
060103	1.3718	31.6314	32.9690	33.7542	32.8052
060104	1.4290	32.4232	35.4409	37.1434	34.8963
060107	1.5071	26.8388	28.0660	30.3991	28.4352
060112	1.6324	34.9272	34.7116	35.1308	34.9386
060113	1.4266	*	32.6073	35.2097	33.9050
060114	1.3912	*	34.8536	35.3056	35.0949
060115	0.8489	*	*	*	*
060116	1.2784	*	*	33.1547	33.1547
060117	1.4377	*	*	28.3112	28.3112
060118	1.4247	*	*	*	*
060119	2.0274	*	*	*	*
070001	1.5931	35.8958	37.0403	37.9438	36.9874
070002	1.8120	33.4398	34.7636	36.4269	34.8872
070003	1.1291	34.1352	35.6320	36.0524	35.2932
070004	1.1776	29.4448	29.9557	31.2115	30.2315
070005	1.4766	33.7813	34.9404	36.5502	35.0812
070006	1.3529	37.9148	39.3935	41.2165	39.5150
070007	1.2873	35.9617	36.2914	37.0984	36.4564

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
070008	1.2537	28.5506	30.7305	35.4969	31.5225
070009	1.3430	32.9299	35.5670	36.6382	35.0006
070010	1.6830	35.3730	36.7227	38.6114	36.9449
070011	1.4127	31.8987	31.6843	32.6835	32.0964
070012	1.4105	29.4216	31.9345	33.2477	31.5140
070015	1.4371	35.3385	37.3454	39.9249	37.5872
070016	1.4989	31.4930	33.2391	34.1266	32.9413
070017	1.3636	34.0490	35.6456	37.5855	35.7990
070018	1.3798	39.7515	41.8460	42.4771	41.4030
070019	1.3848	34.5125	33.7246	35.8618	34.6878
070020	1.2998	33.6453	32.9714	35.6542	34.1192
070021	1.1850	36.9241	38.5623	39.7793	38.4037
070022	1.6657	39.0462	40.2283	41.4721	40.2894
070024	1.3650	35.2323	34.7419	36.8997	35.6423
070025	1.7411	32.4085	34.5887	36.1322	34.3751
070027	1.4461	29.8513	30.4433	33.5979	31.3091
070028	1.5687	35.1966	38.0855	40.9645	38.1035
070029	1.2876	30.9299	31.0662	32.8504	31.6084
070031	1.2886	30.1915	30.4054	30.5924	30.4015
070033	1.4507	40.1594	41.7955	44.6717	42.2685
070034	1.4229	38.3965	40.1685	42.4111	40.3341
070035	1.2487	30.7440	32.2766	33.4047	32.1122
070036	1.6106	38.3413	42.3391	43.6374	41.4913
070038	0.8866	25.7914	35.8053	29.9516	29.4515
070039	0.9489	36.1369	34.7219	32.7153	34.7200
070040	1.0777	*	*	*	*
080001	1.6422	32.0105	33.5310	34.9507	33.5158
080002	***	29.6800	31.3391	33.0404	31.3610
080003	1.6240	30.7697	34.3048	30.5132	31.8523
080004	1.5576	30.1094	32.2443	34.3854	32.3024
080006	1.3095	27.4749	28.8862	31.0327	29.2093
080007	1.4821	30.1100	31.1645	33.4782	31.6266
090001	1.7470	36.6577	38.3043	40.1658	38.3545
090003	1.2353	31.0419	32.1960	34.4430	32.4446
090004	1.9221	35.6964	37.3798	38.5681	37.2415
090005	1.4079	33.0178	33.7448	35.2884	34.0317
090006	1.3916	29.4912	31.3562	32.3654	31.0336
090008	1.3020	32.0745	33.7471	36.6633	34.0300
090011	2.0092	36.7579	38.0654	39.0111	37.9697
100001	1.4977	26.4631	27.2809	27.8526	27.2117
100002	1.4286	27.2350	28.7068	30.6668	28.8638
100006	1.6266	29.1505	28.3673	28.9769	28.8246
100007	1.5841	28.5702	29.0472	30.3379	29.3443

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
100008	1.6967	29.1705	30.3392	32.1679	30.5838
100009	1.3613	27.4424	27.8618	30.0492	28.3838
100012	1.6169	28.4600	29.8353	30.8626	29.7789
100014	1.4501	25.1524	27.4019	27.4064	26.6909
100015	1.2723	26.0916	27.2483	28.6825	27.3090
100017	1.6227	27.9654	28.2402	29.8705	28.7078
100018	1.6118	30.2423	30.6545	32.8642	31.2766
100019	1.6093	28.6630	30.3008	31.4549	30.1359
100020	***	27.1257	*	*	27.1257
100022	1.6472	32.8088	36.7912	36.3355	35.3154
100023	1.5395	25.2652	25.4270	27.1032	26.0121
100024	1.2903	29.1894	29.5423	29.8918	29.5374
100025	1.7152	23.3843	26.7013	27.1665	25.7517
100026	1.5790	23.4730	26.0147	27.3044	25.6442
100027	***	18.9432	*	*	18.9432
100028	1.3546	27.7497	27.5664	28.7801	28.0289
100029	1.2103	28.8842	30.5382	31.6006	30.3882
100030	1.3535	24.6314	25.3513	26.3113	25.4482
100032	1.6734	26.8162	26.9275	27.8942	27.2245
100034	1.7956	28.1280	27.2915	28.9387	28.1276
100035	1.6018	29.4803	30.2382	32.5593	30.7190
100038	1.7175	31.3403	31.6657	32.8392	31.9635
100039	1.5742	28.2531	29.3699	29.0236	28.8795
100040	1.7002	26.2429	27.2835	28.3366	27.2953
100043	1.4115	26.4221	27.0054	26.8417	26.7597
100044	1.5461	30.3659	33.1141	34.3920	32.6326
100045	1.3109	29.7375	26.5413	25.5621	27.1978
100046	1.4578	26.9469	26.7702	27.7878	27.1809
100047	1.6993	26.7674	29.9729	31.4072	29.3536
100048	0.9287	19.3226	20.2657	21.7693	20.4251
100049	1.2229	24.0385	24.5571	27.6316	25.3725
100050	1.1478	21.5101	25.3354	23.5222	23.4898
100051	1.3817	28.0946	28.6225	30.1492	29.0850
100052	1.4597	23.6796	23.4036	25.1110	24.0882
100053	1.3314	28.5118	31.7415	31.9268	30.6750
100054	1.4053	28.7646	30.5515	30.9840	30.1178
100055	1.4673	25.6243	27.3826	29.7027	27.4754
100057	1.4389	24.8010	26.3134	27.7045	26.3256
100061	1.5263	31.4413	30.4528	31.9174	31.2654
100062	1.6288	25.1280	25.9597	26.3067	25.8139
100063	1.2912	25.5097	26.4139	27.0769	26.3653
100067	1.4254	26.8628	27.4762	27.5501	27.3164
100068	1.6639	26.1341	27.6576	27.7707	27.1967

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
100069	1.5191	25.7450	27.2108	29.0486	27.3039
100070	1.6948	26.8461	29.2005	29.1117	28.3502
100071	1.3016	26.3768	25.3667	25.1883	25.6303
100072	1.3890	25.7962	27.1889	27.6947	26.8993
100073	1.7633	30.5845	29.4165	31.0395	30.3569
100075	1.5144	25.7612	27.6534	26.7571	26.7480
100076	1.2089	23.4551	24.0412	24.0280	23.8481
100077	1.3903	30.6925	30.7564	27.9783	29.8156
100079	1.4455	*	*	*	*
100080	1.6166	28.2188	29.5346	31.0516	29.6122
100081	0.9395	16.9756	19.5711	19.7406	18.7146
100084	1.7032	27.4947	32.7503	30.6301	30.2194
100086	1.3910	28.5971	29.9072	31.3187	29.9266
100087	1.8439	29.5823	30.5938	32.1314	30.7630
100088	1.5782	26.7574	28.2825	29.4952	28.3038
100090	1.4705	26.5703	27.6175	28.9581	27.7930
100092	1.5190	27.8341	26.6315	28.6782	27.7167
100093	1.7252	21.6438	22.5555	23.4847	22.5925
100099	1.0283	25.8454	26.2395	28.0688	26.7414
100102	1.1033	26.1015	27.8551	29.0396	27.7077
100105	1.5861	29.9745	30.9915	30.8936	30.6091
100106	1.0483	24.7650	24.8098	25.6288	25.0616
100107	1.1887	27.4760	30.5764	31.2954	29.8961
100108	0.8653	21.3540	22.6270	22.8153	22.2181
100109	1.2494	25.5669	26.2446	26.7380	26.2241
100110	1.5719	29.4788	29.5985	30.3758	29.8439
100113	1.9750	28.0440	29.2429	30.6037	29.3071
100114	1.7025	29.2862	30.2544	32.3956	30.6152
100117	1.2427	27.7198	28.4928	30.0281	28.8266
100118	1.3882	27.6438	27.0981	28.3201	27.7205
100121	1.1206	26.2990	27.9353	25.0320	26.4001
100122	1.2313	24.6285	26.7175	27.6178	26.3638
100124	1.1992	24.0333	24.8880	26.2329	25.0386
100125	1.2232	29.7750	31.7749	33.3499	31.6849
100126	1.3207	29.6247	28.3213	28.9164	28.9571
100127	1.5766	26.0923	27.4632	27.0686	26.8842
100128	2.1323	29.2566	30.0324	30.6202	30.0011
100130	1.1415	26.0268	28.3651	29.5763	28.0238
100131	1.4730	27.8164	29.7647	30.9614	29.6471
100132	1.2882	26.0526	27.8180	27.6632	27.2146
100134	0.8985	20.7367	21.6544	22.9635	21.8252
100135	1.6378	26.7030	29.1856	29.8452	28.5455
100137	1.3331	24.8519	26.8391	28.3000	26.7265

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
100139	0.8645	18.2197	21.1310	21.4418	20.1385
100140	1.1162	26.1352	27.8352	28.5485	27.5013
100142	1.1345	24.8853	25.6999	26.8995	25.8488
100150	1.2582	26.8492	27.7740	29.3711	27.9653
100151	1.7425	30.6447	29.7267	31.3846	30.5882
100154	1.6106	28.2506	29.7332	31.3640	29.8242
100156	1.1426	27.5706	28.3927	28.3060	28.1077
100157	1.5713	29.7455	30.3086	30.3359	30.1505
100160	1.2523	30.7454	30.6902	32.3136	31.2769
100161	1.5304	28.0545	29.5673	30.8984	29.5199
100166	1.5061	28.8685	30.1811	31.9072	30.2726
100167	1.2256	30.2166	31.7813	32.4740	31.5299
100168	1.5602	27.6739	27.0938	28.0543	27.6186
100172	***	20.7857	22.2183	20.5518	21.2385
100173	1.6082	26.5436	28.6402	30.2491	28.5130
100175	0.9477	23.9665	25.0913	26.1723	25.0711
100176	1.8219	30.7087	33.3181	35.5849	33.1523
100177	1.3284	28.0089	29.6284	31.0085	29.5578
100179	1.7392	29.1111	29.2795	30.5439	29.6572
100180	1.5105	29.9238	31.0099	31.5485	30.8521
100181	1.1559	24.3708	23.9656	26.0682	24.7892
100183	1.2819	29.0270	30.5042	32.9893	30.7996
100187	1.3636	27.8144	30.7705	31.6660	30.0567
100189	1.3343	28.8320	29.9376	30.5516	29.8041
100191	1.3359	28.3710	29.4533	30.9212	29.5996
100200	1.3683	28.7694	29.6400	29.0731	29.1622
100204	1.5810	27.4763	27.2819	29.9334	28.2777
100206	1.2766	27.0295	27.7551	28.8625	27.8942
100209	1.5223	26.8473	28.5336	29.0462	28.1490
100210	1.5650	29.8515	32.0830	32.4566	31.4643
100211	1.2503	24.7533	26.2859	28.8328	26.5627
100212	1.4629	26.1846	27.7960	29.2500	27.7626
100213	1.5366	27.9283	29.5218	30.2271	29.2006
100217	1.3068	27.3989	27.7683	30.3325	28.4915
100220	1.6195	28.3868	29.3601	30.8292	29.5183
100223	1.5322	25.0332	26.1115	27.6775	26.3167
100224	1.2618	26.6446	28.0455	29.2008	27.9620
100225	1.3079	28.5259	30.8782	32.6906	30.6977
100226	1.3024	28.8165	28.8791	30.2857	29.3588
100228	1.3937	28.1396	30.1635	31.0222	29.7498
100230	1.3375	29.8493	31.9448	34.6133	32.1790
100231	1.7082	25.7037	26.6773	28.3652	26.9114
100232	1.2637	28.5537	28.3892	29.3797	28.7739

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
100234	1.3297	27.4456	28.8835	29.7818	28.7295
100236	1.4325	28.9955	28.3017	30.5719	29.2823
100237	1.8533	31.7848	33.1536	33.9626	32.9302
100238	1.5461	30.1094	31.4198	31.6353	31.0870
100239	1.3808	28.6893	29.0650	30.3234	29.3640
100240	0.9605	27.3523	29.7000	31.0951	29.4321
100242	1.5073	25.6083	26.1988	27.8169	26.5493
100243	1.4693	27.4534	28.3894	29.8323	28.5424
100244	1.4349	26.6876	28.2881	29.8287	28.3038
100246	1.5436	29.3310	30.1061	30.0467	29.8369
100248	1.5466	28.8082	30.2133	32.4725	30.5169
100249	1.2891	24.9876	26.4676	28.5117	26.7080
100252	1.1625	27.8256	27.1639	29.1448	28.0425
100253	1.3885	27.4927	28.7770	28.5617	28.3025
100254	1.4928	26.1406	27.4900	28.5262	27.4003
100255	1.3022	26.5571	27.3866	29.5172	27.8456
100256	1.7379	30.3081	30.2093	33.3936	31.2439
100258	1.5584	31.2203	33.8630	35.2225	33.4807
100259	1.2680	27.4809	29.0612	29.9294	28.8451
100260	1.3817	26.7129	28.2301	29.4907	28.1394
100264	1.4150	26.8216	28.0370	30.1980	28.3184
100265	1.3281	25.7432	26.3326	26.6940	26.2983
100266	1.3901	23.0208	24.2517	25.6382	24.3561
100267	1.2820	28.7259	28.9674	30.6051	29.4529
100268	1.1766	29.0668	30.5750	33.6225	31.0686
100269	1.3704	26.6047	27.8407	28.3745	27.6327
100271	2.0539	*	*	*	*
100275	1.3298	26.8943	28.7797	31.0487	28.9936
100276	1.2885	29.7606	30.5720	31.7067	30.6756
100277	1.5734	20.4791	24.1122	25.5926	23.9913
100279	1.4035	28.6383	29.2257	31.1951	29.7260
100281	1.3902	29.6698	30.9131	32.8840	31.2138
100284	1.0583	22.3134	25.2637	21.4420	22.7448
100285	1.2082	.	41.9481	34.7999	39.4597
100286	1.5462	28.3645	25.8085	26.5809	26.8131
100287	1.3877	28.1051	29.7536	30.3085	29.3369
100288	1.7418	28.7902	31.0506	32.9587	30.8738
100289	1.6220	29.6376	31.9011	31.4727	31.0136
100290	1.2300	27.1011	28.7111	29.7588	28.5289
100291	1.3426	28.4722	28.1515	28.3780	28.3303
100292	1.3751	26.7063	27.7644	28.5807	27.7208
100293	***	32.7963	*	*	32.7963
100294	***	30.7557	*	*	30.7557

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
100295	***	26.1983	*	*	26.1983
100296	1.3263	*	29.3870	31.1475	30.2854
100297	***	*	32.1536	.	32.1536
100298	0.8531	*	19.0297	21.9247	20.3578
100299	1.2918	*	34.3697	31.6840	33.1830
100300	***	*	*	33.1693	33.1693
100302	1.1530	*	*	*	*
110001	1.3715	26.4338	26.5640	27.6480	26.8761
110002	1.3146	26.4715	26.2228	28.9013	27.2277
110003	1.3138	22.7066	24.2097	25.0089	23.9368
110004	1.3651	24.9978	25.1846	27.2528	25.7800
110005	1.2920	28.1209	27.2826	29.6009	28.4195
110006	1.5579	28.3839	*	30.8495	29.6168
110007	1.5916	26.6396	26.3133	28.0684	27.0197
110008	1.3577	29.2947	30.9757	31.8387	30.6987
110010	2.1752	31.7185	33.2396	33.9848	32.9916
110011	1.2817	28.0598	28.5892	30.3534	29.0306
110015	1.0869	28.1274	28.8796	30.5016	29.2483
110016	1.2538	22.7263	24.3563	25.9209	24.3232
110018	1.1976	26.8016	30.1849	30.9422	29.3019
110020	1.2967	28.3822	27.5559	29.4641	28.5815
110023	1.3268	29.8061	29.3282	29.2018	29.4303
110024	1.4707	27.0225	27.3357	28.5660	27.6420
110025	1.4805	31.0703	30.2845	31.8968	31.0858
110026	1.0932	21.8018	22.8820	24.3863	23.0083
110027	1.0495	22.6058	25.5291	25.6532	24.4935
110028	1.7419	30.4641	31.4568	32.8706	31.5942
110029	1.7557	27.3618	29.2134	30.1146	28.9199
110030	1.3848	29.6841	29.9531	32.0275	30.6329
110031	1.2765	27.1989	29.5533	30.7462	29.1995
110032	1.2552	23.2586	25.1896	24.4968	24.3033
110033	1.7263	30.3415	32.4178	32.7039	31.8564
110034	1.7754	27.2338	28.7915	29.6819	28.5547
110035	1.7866	28.9408	30.1852	31.5737	30.2760
110036	1.8232	26.6664	27.2280	28.4041	27.4645
110038	1.5490	22.2720	22.9685	23.3669	22.8673
110039	1.3715	26.3503	26.2485	28.4376	26.8953
110040	1.1072	20.9487	23.9526	21.5762	22.1591
110041	1.2065	24.8864	26.1948	27.6609	26.2850
110042	1.0783	34.9954	33.4391	34.5137	34.3032
110043	1.7595	27.8477	28.8551	30.3728	28.9998
110044	1.2146	23.3039	24.3772	27.0431	24.8932
110045	1.0312	24.4275	27.7619	28.2232	26.7955

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
110046	1.1453	26.7464	*	28.6286	27.6800
110050	1.0896	27.5985	27.0651	27.1533	27.2629
110051	1.1237	20.1756	21.4898	22.1491	21.3081
110054	1.4214	28.9254	29.4691	31.5798	30.0230
110059	1.1551	23.2137	24.7838	24.9271	24.3031
110064	1.5810	24.1219	26.9363	28.7296	26.5866
110069	1.3423	26.2085	29.9098	30.6465	28.9861
110071	1.1199	21.3963	21.2041	23.6499	22.1662
110073	1.0249	18.5753	23.3571	23.0072	21.5479
110074	1.4902	27.9190	31.0062	29.0310	29.2540
110075	1.3139	23.7585	24.8244	26.1089	24.8951
110076	1.4845	28.7871	29.4344	31.0661	29.7184
110078	1.9453	29.9625	30.5196	32.0516	30.8607
110079	1.5692	26.8412	27.3274	29.0905	27.7231
110080	***	18.4714	*	*	18.4714
110082	1.9663	30.8320	30.1072	31.1478	30.7001
110083	1.9542	30.4287	34.0610	34.5798	33.0345
110086	1.2627	21.6898	22.9959	23.4772	22.7091
110087	1.4277	28.1633	31.0403	32.8029	30.7274
110089	1.1355	23.9026	24.3327	26.0116	24.7684
110091	1.2908	29.5337	27.0994	28.0637	28.1675
110092	1.1130	20.8911	21.4168	22.8602	21.7050
110095	1.4589	26.3075	28.0526	28.0480	27.4977
110100	0.9793	16.2575	20.8201	20.0638	18.9184
110101	0.9836	19.4257	21.0983	23.8601	21.3923
110104	1.2036	20.3777	21.8966	22.2596	21.5752
110105	1.3710	23.1405	23.4010	23.7752	23.4425
110107	1.9542	28.9352	30.1027	31.5783	30.2379
110109	1.0208	23.0376	21.6023	21.6019	22.0505
110111	1.1520	25.1270	25.7084	27.6501	26.1364
110112	1.0402	22.7672	26.4089	24.2935	24.5383
110113	0.9563	21.3417	22.0793	22.0472	21.8310
110115	1.7770	31.5074	32.7927	33.3902	32.5802
110121	1.0003	26.2336	23.4571	24.5653	24.7830
110122	1.5417	25.1934	25.4439	26.3071	25.6433
110124	1.0868	22.9212	22.9571	24.8552	23.5887
110125	1.2583	23.7834	24.7347	26.5006	24.9910
110128	1.2851	25.7839	25.4190	24.5284	25.2133
110129	1.5763	25.9625	30.0444	29.7332	28.5412
110130	0.9157	19.1284	20.4349	21.7089	20.4156
110132	1.0336	20.2502	21.2642	21.6039	21.0529
110135	1.2731	22.5346	24.0945	25.1027	23.9472
110136	***	18.8212	*	*	18.8212

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
110142	0.9807	21.3935	21.6286	22.2164	21.7487
110143	1.4244	28.6583	29.9139	30.9621	29.8787
110146	1.0836	27.0987	29.0193	30.1181	28.7425
110149	***	28.4040	*	*	28.4040
110150	1.2943	25.3742	26.9884	27.7920	26.7265
110153	1.1212	25.7467	29.3305	30.5108	28.4956
110161	1.5369	30.4885	31.5001	32.0002	31.3396
110163	1.4478	28.2169	27.7679	29.5693	28.5134
110164	1.7058	28.8946	30.0145	31.2830	30.1120
110165	1.4341	27.0977	28.7902	28.7925	28.2218
110168	1.7664	28.5700	29.7774	30.8750	29.7609
110172	1.4736	31.1234	31.3999	33.0452	31.8718
110177	1.9242	28.8356	29.7079	30.5526	29.7267
110183	1.2878	28.6208	28.3505	29.6622	28.9009
110184	1.2634	28.3545	29.4071	30.2920	29.4140
110186	1.3154	27.4925	28.2880	29.6503	28.4865
110187	1.2017	25.2139	26.9638	31.0164	27.7900
110189	1.1025	26.1418	26.2799	27.4207	26.6307
110190	1.0869	23.3204	24.5224	29.4198	25.5710
110191	1.3287	27.7760	30.9481	28.7505	29.1028
110192	1.4136	28.8267	30.0843	31.6627	30.2570
110193	***	27.9161	*	*	27.9161
110194	0.8965	19.1920	21.0826	20.5267	20.2840
110198	1.3548	31.0557	32.8171	34.0050	32.6135
110200	2.0255	24.9236	27.2974	29.4633	27.3158
110201	1.4529	31.0841	32.0967	33.4292	32.2173
110203	0.9588	29.7888	32.3441	32.0594	31.3303
110205	1.1762	22.0207	23.9738	26.1973	24.0314
110209	0.6196	21.1534	21.2428	22.4549	21.6330
110212	1.2056	*	*	*	*
110214	***	37.1450	*	*	37.1450
110215	1.3584	27.5566	29.5238	30.1793	29.1796
110219	1.3979	28.8814	32.2603	33.4481	31.6162
110220	***	37.5741	*	*	37.5741
110221	***	28.0500	*	*	28.0500
110222	***	35.6189	*	*	35.6189
110223	***	*	25.3071	*	25.3071
110224	***	*	33.6464	*	33.6464
110225	1.2067	*	29.5373	28.9773	29.2220
110226	1.1943	*	*	32.1840	32.1840
110228	0.8800	*	*	*	*
110229	1.2937	*	*	*	*
110230	1.3799	*	*	*	*

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
120001	1.7928	34.1385	39.6348	39.0371	37.5748
120002	1.2441	32.3784	34.1709	37.7287	34.7940
120004	1.2505	30.0668	31.3555	32.5164	31.3610
120005	1.2956	31.1985	33.6942	35.1996	33.3936
120006	1.2619	31.6785	34.2231	35.7089	33.9096
120007	1.6337	30.2473	30.8773	35.0193	31.9568
120010	1.9865	29.5714	30.8526	34.3371	31.4361
120011	1.4896	37.1792	39.1941	43.7527	40.2864
120014	1.3525	30.3463	30.9839	34.2127	31.8849
120019	1.1704	30.4257	33.0114	36.1879	33.2288
120022	1.8708	29.9527	32.5326	34.9048	32.4619
120026	1.4182	32.4566	34.2244	35.8413	34.2228
120027	1.3239	28.7905	29.5825	31.8177	30.1249
120028	1.2578	32.4847	34.0451	34.6354	33.7347
120029	***	*	44.6382	*	44.6382
130002	1.4061	24.7871	24.7266	24.3501	24.6133
130003	1.4679	28.6158	28.6136	29.8793	29.0080
130006	1.7567	27.2158	28.0048	29.0504	28.1050
130007	1.7289	28.7246	30.4958	31.2268	30.1210
130013	1.3627	30.9609	36.1570	33.8928	33.6909
130014	1.2424	27.2543	27.5936	28.2831	27.7163
130018	1.7532	27.3439	28.4041	30.2047	28.6014
130024	1.2010	23.6212	24.8035	25.3197	24.5769
130025	1.2294	21.1998	22.7962	23.8592	22.6628
130028	1.4345	27.2195	28.4934	29.3374	28.3741
130049	1.5625	27.3597	29.0185	29.7211	28.7367
130062	***	25.6467	29.1925	28.3419	27.9025
130063	1.3989	26.0955	27.7607	27.7697	27.1836
130065	1.9423	21.9792	30.4547	25.8998	26.3105
130066	2.0536	*	28.9883	28.1502	28.5238
130067	2.5439	*	21.3867	26.8285	23.8833
140001	1.1228	22.3001	22.2003	23.2233	22.5899
140002	1.3470	27.0165	27.4779	29.1097	27.9308
140007	1.4041	30.7378	31.4024	32.4449	31.5559
140008	1.4398	29.1767	31.8008	32.7618	31.2217
140010[3]	1.4990	31.8806	40.1360	39.3727	36.3257
140B10[3]	***	*	40.1360	39.3727	39.7558
140011	1.2146	23.8575	25.8864	26.2135	25.4087
140012	1.3111	29.0336	31.8213	31.9613	30.8960
140013	1.4664	23.9269	25.0951	26.4199	25.1256
140015	1.3514	24.4687	24.6409	25.2504	24.8027
140018	1.3672	26.3533	30.7398	31.5624	29.4472
140019	0.9137	21.3438	22.3179	22.2907	21.9790

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
140026	1.1533	25.9669	26.0493	28.1718	26.7527
140029	1.5833	30.2688	36.7722	34.8938	33.9301
140030	1.5072	30.2776	31.6822	32.1135	31.3508
140032	1.2665	26.7310	27.5367	28.5242	27.6001
140033	***	27.9993	29.5256	31.4347	29.2000
140034	1.1691	24.0470	24.4653	26.7250	25.0930
140040	1.2231	23.2293	24.5589	28.5016	25.3382
140043	1.2633	27.3469	29.8633	31.3754	29.6000
140046	1.4718	24.7334	25.6230	25.7925	25.3941
140048	1.2747	29.3877	30.6686	31.6290	30.5714
140049	1.5341	29.0976	30.8617	32.0239	30.6563
140051	1.5614	30.9696	32.1730	32.6517	31.9427
140052	1.3427	25.9617	26.9907	26.7916	26.5765
140053	1.7864	27.4518	28.4513	29.9487	28.5962
140054	1.4853	33.1406	34.2378	34.5369	33.9743
140058	1.2393	24.6058	25.2568	26.5671	25.4979
140059	1.0671	22.6743	21.6230	22.8597	22.3767
140062	1.3723	34.1230	36.8271	36.6718	35.8665
140063	1.4112	28.6559	30.5465	31.1266	30.0987
140064	1.2182	23.8639	25.7551	26.6249	25.4626
140065	1.4145	30.1856	31.5510	32.4661	31.3620
140066	1.1146	22.1524	22.0225	23.6304	22.6006
140067	1.8116	28.3506	29.8982	30.6911	29.6696
140068	1.2320	28.3938	26.7166	31.3463	28.7638
140075	1.2699	26.2626	35.9507	33.6872	31.5479
140077	0.9384	20.3999	21.6468	22.5074	21.5542
140080	1.4274	28.8791	29.9067	30.3788	29.7144
140082	1.6345	28.3429	31.0516	32.0562	30.4278
140083	0.9703	26.8919	27.2189	26.1639	26.6859
140084	1.2688	30.5036	30.7251	31.3307	30.8606
140088	1.8616	30.5450	32.6866	34.4137	32.6399
140089	1.2293	24.1066	24.9120	26.6955	25.2545
140091	1.7544	27.8536	28.2095	29.7381	28.6287
140093	1.2249	28.3298	28.6709	31.2973	29.5317
140094	1.0568	27.3841	28.7647	28.8621	28.3332
140095	1.2062	28.7617	29.7385	29.9626	29.4672
140100	1.4164	41.3374	37.2961	37.3044	38.5947
140101	1.2745	29.4081	28.9723	31.0070	29.8045
140103	1.1915	23.6406	24.0926	25.3630	24.3950
140105	***	29.5274	29.6590	30.7154	29.8408
140110	1.1357	28.6364	30.3432	31.3486	30.1332
140113	1.5834	29.5452	30.2542	31.6191	30.5044
140114	1.5009	28.2151	29.8316	31.1412	29.7624

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
140115	1.2617	26.0383	25.4576	26.2606	25.9070
140116	1.3663	34.5537	34.3876	34.2519	34.3948
140117	1.5087	27.7201	30.9679	28.5809	29.0537
140118	1.4569	32.5518	33.1987	33.8168	33.1845
140119	1.8092	34.2118	32.2185	34.6543	33.6436
140120	1.3092	23.9724	25.9275	26.2418	25.4013
140122	1.5060	30.5653	30.2888	32.4750	31.1102
140124	1.2519	35.7563	38.2191	38.8976	37.6297
140125	1.1586	22.7571	26.5801	27.6352	25.6700
140127	1.6268	25.6668	27.8363	29.3352	27.6421
140130	1.2281	32.6209	32.5425	34.9907	33.3763
140133	1.4043	31.0269	30.3259	32.8941	31.4197
140135	1.4195	23.3196	24.6645	25.9057	24.6643
140137	1.0555	23.4174	31.4349	*	26.5232
140143	1.1810	27.4499	26.1126	27.0312	26.8360
140145	1.0936	26.0875	25.2040	26.9344	26.0855
140147	1.0807	21.0686	21.1817	22.1035	21.4537
140148	1.6367	25.5677	27.0038	28.9471	27.2142
140150	1.6415	52.0970	35.5951	39.0316	41.9868
140151	0.8009	27.0312	26.0825	27.3552	26.8317
140152	***	30.2209	29.8647	32.2803	30.7794
140155	1.3171	29.5734	32.7960	35.0825	32.3966
140158	1.3557	27.3721	30.4445	32.0137	30.0264
140160	1.1752	25.8684	27.6905	28.9043	27.4939
140161	1.1449	25.2898	28.8266	28.8150	27.6828
140162	1.5508	29.4121	32.1810	33.0995	31.5175
140164	1.7457	24.6009	25.9726	27.3133	26.0027
140166	1.1833	26.4800	26.2875	27.6725	26.8375
140167	1.1520	22.8703	24.9904	24.2749	24.0641
140172	1.3869	32.1220	33.0926	33.4616	32.9116
140174	1.5866	30.5905	31.2231	33.9382	31.9696
140176	1.2304	32.9794	32.6145	33.2235	32.9416
140177	0.9826	26.4340	25.5725	26.0727	26.0355
140179	1.3093	29.3657	30.2944	31.3624	30.3158
140180	1.1865	27.8887	29.1352	29.8009	28.9370
140181	1.1553	25.0226	27.6835	27.5414	26.7417
140182	1.4699	30.1755	32.8972	26.4103	29.5353
140184	1.3083	25.2327	26.6104	27.5858	26.4850
140185	1.4353	25.2423	26.5398	27.9433	26.5578
140186	1.4996	29.8022	30.7212	32.8063	31.1269
140187	1.5066	24.8332	25.5873	26.9265	25.7708
140189	1.1613	22.5965	24.7013	29.1371	25.4817
140191	1.3260	28.5836	31.9943	29.7684	30.0533

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
140197	1.0750	24.0463	24.9103	24.8715	24.5948
140200	1.5127	28.8435	30.6641	31.3712	30.2730
140202	1.4540	32.7915	32.9433	34.3789	33.4146
140206	1.2003	29.7953	29.6275	31.1406	30.1681
140207	1.1263	26.0535	28.2262	31.6818	28.4333
140208	1.6431	29.5380	31.4035	26.1749	28.8267
140209	1.5745	26.3230	29.7965	28.8774	28.2742
140210	1.0666	20.6954	19.2053	22.2512	20.7152
140211	1.3335	30.3286	31.4539	34.5917	32.1855
140213	1.2461	31.6926	32.1031	33.3932	32.4256
140217	1.4730	32.1277	32.9404	33.2172	32.8062
140223	1.4984	31.7267	33.5083	34.6997	33.3198
140224	1.3772	29.6181	31.2237	30.2241	30.3481
140228	1.4746	27.9456	28.2855	28.7462	28.3358
140231	1.4725	30.0236	34.8291	35.6724	33.5077
140233	1.6727	29.7093	31.5168	32.3376	31.1992
140234	1.0941	24.5476	25.7353	25.7660	25.3484
140239	1.5138	31.1879	31.0918	33.7264	31.9847
140240	1.4530	31.5637	32.7986	28.0986	30.7327
140242	1.5130	34.6120	35.2351	36.8032	35.5022
140250	1.2465	29.6305	31.2533	32.9414	31.3015
140251	1.3766	28.0622	28.3598	29.5941	28.6558
140252	1.4508	34.4268	35.8762	36.1531	35.4963
140258	1.5542	34.2333	33.0093	34.5696	33.9319
140275	1.3642	27.8186	28.5064	26.7394	27.6734
140276	1.9215	31.6359	32.1048	32.7073	32.1545
140280	1.4886	24.9401	26.6536	26.9835	26.2020
140281	1.7880	33.3903	35.6589	37.5700	35.5878
140286	1.2075	30.3237	32.0048	32.2246	31.5113
140288	1.4837	31.5197	31.5944	32.5472	31.8990
140289	1.2847	23.8452	25.6847	26.0872	25.2082
140290	1.3714	31.8135	32.5247	35.9679	33.4777
140291	1.5220	31.9052	33.8706	32.7884	32.8714
140292	1.1459	28.5094	30.6917	32.4496	30.3858
140294	1.1034	24.0750	26.1595	26.9789	25.8215
140300	1.1732	35.1494	42.5240	37.4508	38.3125
140301	1.0845	49.9507	39.4295	35.9742	39.8412
140303	2.1297	29.6470	*	33.0359	31.1914
150001	1.1884	28.9075	31.8089	32.9804	31.2750
150002	1.4759	26.6222	27.6481	28.1076	27.6114
150003	1.5882	26.7585	26.9771	29.3660	27.7063
150004	1.4564	28.7336	30.9626	31.7867	30.4279
150005	1.2653	29.5371	30.5367	31.6090	30.6065

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
150006	1.3689	25.6265	27.1364	28.3403	27.0723
150007	1.4560	29.4971	30.0500	31.0384	30.2276
150008	1.4469	27.5703	27.0525	29.1492	27.9340
150009	1.4391	25.4496	25.7616	26.1517	25.7897
150010	1.5190	27.2272	28.4118	28.2616	27.9492
150011	1.3297	25.3178	26.7686	27.7870	26.5789
150012	1.5520	30.0348	31.2282	31.6762	30.9816
150015	1.3611	28.0931	27.3811	30.2516	28.5409
150017	1.8252	26.3973	26.3379	27.1262	26.6393
150018	1.5942	27.3689	29.1137	30.0928	28.9177
150021	1.8110	28.9196	30.0030	31.1158	30.0148
150022	1.0596	23.1041	23.8971	26.9525	24.4677
150023	1.5867	26.9095	27.7520	30.3667	28.3774
150024	1.4755	28.1655	28.4170	30.6154	29.0371
150026	1.3503	28.6517	30.4967	31.9397	30.4519
150029	1.3425	28.7187	29.9307	31.0692	29.8988
150030	1.1959	29.1493	29.3588	31.1986	29.9394
150033	1.4212	28.6838	29.7744	32.9469	30.4553
150034	1.4618	28.6429	28.0434	30.0048	28.9364
150035	1.5502	26.9700	27.8904	29.2039	28.0382
150037	1.2514	31.0935	29.0161	30.4640	30.1396
150038	1.1399	29.3156	33.0112	31.9552	31.4561
150042	1.3652	22.8786	25.1403	25.2456	24.4079
150044	1.4482	25.2137	25.2685	25.9284	25.4839
150045	1.0425	26.9818	27.5340	29.4323	27.9976
150046	1.5573	24.5593	26.5876	27.6228	26.2773
150047	1.7072	25.5194	25.8497	27.1847	26.1908
150048	1.4413	27.1233	28.1525	29.5588	28.3259
150051	1.6097	26.5655	28.9157	30.3764	28.6844
150056	1.9806	28.8727	29.3500	30.5777	29.6158
150057	2.0626	28.9529	30.3287	29.2358	29.4882
150058	1.6337	29.1444	29.1255	31.7558	30.0008
150059	1.4852	31.4987	31.3362	36.2570	33.0492
150061	1.1293	21.3711	22.6746	23.2427	22.4418
150064	1.2387	25.4987	28.7978	28.9430	27.8443
150065	1.2483	27.9283	30.2053	30.7970	29.6518
150069	1.1836	26.2028	26.0909	27.0740	26.4657
150072	1.1293	21.2120	21.7644	23.0619	21.9965
150074	1.4310	25.9321	28.5655	29.4135	28.0124
150075	1.1395	25.1568	25.7245	26.5987	25.8600
150076	1.2977	29.3249	30.1120	30.2972	29.9143
150082	1.5904	28.3494	26.4544	28.1302	27.6232
150084	1.8338	31.1720	33.1784	35.0288	33.1062

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
150086	1.2212	25.1992	26.6745	27.2580	26.4093
150088	1.2977	27.2103	29.1509	30.2396	28.8861
150089	1.5575	24.7233	24.8045	26.7290	25.4207
150090	1.5593	30.4835	30.6412	30.9274	30.6937
150091	1.1567	30.4234	32.1627	33.0421	31.9037
150097	1.1850	27.7468	29.1359	29.4797	28.7954
150100	1.6034	25.7997	26.9724	27.6339	26.7729
150101	1.0829	29.0301	30.5475	31.6031	30.3784
150102	1.0260	25.7424	25.8742	25.4717	25.6897
150104	1.1438	28.2552	28.7788	30.8984	29.3105
150109	1.5468	25.3367	26.8464	29.0076	27.0816
150112	1.4962	28.0068	29.8540	31.7966	29.8988
150113	1.2114	24.7960	25.9814	26.9098	25.9100
150115	1.3473	22.0747	22.5793	22.3571	22.3411
150125	1.5492	27.6535	29.3596	30.7113	29.2613
150126	1.3476	28.9454	29.4300	32.6488	30.2651
150128	1.4328	28.7810	29.5008	31.1071	29.8299
150129	1.1901	29.7398	31.4317	32.9629	31.3712
150132	***	27.6560	*	*	27.6560
150133	1.2140	25.1322	24.2538	23.0662	24.1079
150134	***	26.3249	21.6740	27.3983	24.7459
150146	1.1276	29.5256	30.3343	31.8757	30.6320
150147	1.4431	27.2339	26.1646	28.9269	27.6254
150149	0.9329	23.7026	24.9629	25.3350	24.7408
150150	1.3579	27.0542	26.7700	26.5984	26.7816
150153	2.3058	32.1022	35.0617	37.3948	35.1897
150154	2.4806	29.8514	29.8894	30.5775	30.1316
150155	***	45.0121	*	*	45.0121
150156	***	25.9681	*	*	25.9681
150157	1.7731	*	32.3106	32.9167	32.6162
150158	1.2486	*	*	30.4355	30.4355
150159	***	*	*	27.5595	27.5595
150160	2.0990	*	*	27.6375	27.6375
150161	1.6042	*	*	*	*
150162	1.8247	*	*	*	*
150163	1.0092	*	*	*	*
150164	1.1307	*	*	*	*
150165	1.3493	*	*	*	*
150166	1.0888	*	*	*	*
160001	1.2025	24.5108	25.7255	25.8686	25.3907
160005	1.2223	23.1034	24.7755	24.8597	24.2782
160008	1.0519	22.1402	22.4758	24.1282	22.9097
160013	1.1825	24.0956	24.4099	25.5162	24.6771

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
160016	1.5611	24.5338	27.1460	26.6537	26.0791
160024	1.5067	27.4158	29.3756	32.4253	29.7125
160028	1.3531	27.8535	30.0576	29.8343	29.2984
160029	1.5288	28.7324	30.6687	32.2035	30.5414
160030	1.4488	28.7786	30.9415	30.4779	30.0908
160032	1.0814	25.4662	26.2935	28.5645	26.7839
160033	1.6106	26.5315	27.2060	27.4810	27.0643
160040	1.3587	25.9032	26.8110	28.2982	27.0159
160045	1.6649	26.6463	27.5289	28.1681	27.4627
160047	1.3431	26.0227	28.1280	29.4286	27.7507
160057	1.3695	25.1272	25.6274	27.7969	26.2001
160058	1.9938	28.4167	28.9924	29.8975	29.1110
160064	1.5604	28.7668	28.4209	33.6082	30.2009
160067	1.3963	24.8137	26.0243	26.7679	25.8724
160069	1.5112	27.4473	27.6157	28.4081	27.8037
160079	1.4501	24.7372	26.1618	28.5034	26.4598
160080	1.2263	25.8252	27.2370	27.8745	26.9723
160082	1.7394	27.4718	28.7831	31.7508	29.3436
160083	1.6295	27.3004	28.3921	29.9489	28.5565
160089	1.2119	23.2149	23.2888	23.9194	23.4750
160101	1.1057	25.0503	25.4740	26.8515	25.8123
160104	1.6333	28.1891	29.8126	27.0538	28.2569
160110	1.4990	26.6633	28.8134	29.9094	28.6051
160112	1.2359	24.7957	25.2886	26.1721	25.4493
160117	1.3734	25.4659	27.3927	24.3326	25.6603
160122	1.1373	23.9177	24.4996	25.3192	24.5894
160124	1.1221	22.5482	24.3063	25.5048	24.1105
160146	1.4316	22.6949	24.8485	25.1834	24.2141
160147	1.2241	28.6303	29.8992	33.6394	30.7350
160153	1.6978	29.9378	30.6173	30.4356	30.3305
160155	2.0066	*	*	*	*
170001	1.1236	23.1260	23.8863	24.5942	23.8769
170006	1.3205	24.2068	27.1033	28.3527	26.6141
170009	1.0808	30.9025	29.6386	32.2847	30.9542
170010	1.2332	23.9707	25.5573	28.1802	25.9461
170012	1.6277	26.1367	27.1195	28.7878	27.3264
170013	1.7183	25.2476	26.7124	28.3051	26.7047
170014	1.0378	23.8135	24.2322	25.8165	24.6251
170016	1.5885	25.8061	26.7536	28.6817	27.0798
170017	1.1351	26.9657	27.2925	29.1463	27.8536
170020	1.5638	23.2757	24.1149	25.0561	24.1610
170023	1.4630	24.0561	23.9812	24.8827	24.3280
170027	1.4374	23.1766	23.4037	24.1133	23.5726

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
170033	1.3305	21.9709	24.1882	25.0404	23.6613
170039	0.9400	26.9852	26.0952	23.5975	25.4107
170040	1.9354	28.4458	30.2468	30.0828	29.6668
170049	1.5128	25.2070	26.4086	31.8595	27.9192
170058	1.1008	22.9210	26.5949	28.1330	25.7974
170068	1.2120	23.0635	23.8812	23.8509	23.5917
170074	1.1966	23.7829	23.0567	24.8871	23.9150
170075	0.8435	19.7760	19.9351	21.1965	20.2947
170086	1.5729	26.1362	26.3615	28.5260	27.0446
170094	0.9218	21.5295	16.5136	17.1719	18.5441
170103	1.2783	23.8042	24.2003	25.5671	24.5534
170104	1.4061	26.2990	27.6211	29.7793	27.8984
170105	1.1104	21.9606	22.7412	23.4332	22.7179
170109	1.0346	23.1088	23.8515	29.0197	25.4507
170110	0.8940	23.3260	23.9572	24.7927	24.0236
170114	0.5755	*	*	*	*
170120	1.3717	22.0253	22.2805	23.5287	22.6065
170122	1.6977	26.6605	28.7175	29.6337	28.2850
170123	1.6705	27.6653	27.0843	28.7627	27.8485
170133	1.0199	23.1226	25.2301	25.7129	24.7253
170137	1.3251	24.7096	25.3395	26.8029	25.6449
170142	1.3705	23.9527	24.6019	25.5567	24.7033
170145	1.0864	23.2162	23.3967	25.3745	23.9858
170146	1.5000	29.8858	29.0720	31.7023	30.2206
170147	***	22.4973	24.3268	21.4581	23.0048
170150	1.1416	20.9448	19.6160	22.0265	20.8658
170166	1.0164	21.0762	22.6968	24.1079	22.6644
170175	1.4821	25.6281	26.7229	31.7600	28.0197
170176	1.5683	27.2332	29.0735	30.1135	28.8502
170180	***	32.5010	*	*	32.5010
170182	1.4513	27.3503	28.9710	30.3805	28.8979
170183	1.9858	25.8340	26.1890	27.7207	26.5693
170185	1.2551	27.8139	28.1780	29.3226	28.5084
170186	2.5215	32.8392	30.2613	30.7673	31.2802
170187	1.6421	22.8493	24.1461	24.6419	23.8943
170188	1.9849	30.6844	32.2573	33.7247	32.2687
170190	1.0158	22.9540	26.2625	27.3041	25.5432
170191	1.8259	22.1197	24.3813	26.0305	24.3257
170192	1.7633	26.2724	27.7421	30.9230	28.4752
170193	1.3485	20.6821	24.8531	24.4131	22.9316
170194	1.2298	29.9014	27.6989	28.2004	28.5260
170195	2.4249	30.1001	29.5947	29.1787	29.5501
170196	2.4626	*	32.1832	29.9671	30.9618

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
170197	2.3264	*	*	*	*
170198	1.9320	*	*	*	*
180001	1.3075	27.6917	29.7423	29.9674	29.1418
180002	1.0681	25.7862	26.5488	27.3344	26.5498
180004	1.0771	22.0797	20.8805	22.0626	21.6725
180005	1.1489	24.9779	25.6159	27.4317	26.0710
180007	1.5447	25.7042	27.1924	26.9440	26.6131
180009	1.7523	26.4101	27.3228	28.7048	27.5590
180010	1.8284	25.6153	27.7600	28.2168	27.1711
180011	1.6299	25.5463	24.9909	25.0372	25.1739
180012	1.4747	25.6000	26.7279	27.2851	26.5359
180013	1.5054	23.7075	24.8125	26.8108	25.0989
180016	1.2929	24.8408	24.7091	26.9539	25.4649
180017	1.3108	21.8885	21.9715	25.4174	23.1030
180018	1.3550	20.9857	23.3035	24.9874	23.1020
180019	1.1159	24.0283	24.6279	27.6801	25.4956
180020	1.0619	24.6953	25.9975	26.8865	25.8900
180021	0.9617	20.7950	22.0740	22.3768	21.7650
180024	1.1593	31.1159	26.3532	26.9553	28.0403
180025	1.2349	22.6897	28.5935	28.4172	26.7274
180027	1.2008	20.8303	21.7639	23.3881	21.9097
180029	1.4658	25.6479	26.1528	26.3907	26.0665
180035	1.4800	31.0794	32.8461	34.0370	32.7274
180036	1.3333	25.2972	25.6959	30.2643	27.0565
180037	***	26.3132	27.8506	33.1897	29.1439
180038	1.5430	26.0440	26.9752	28.2430	27.1334
180040	1.8321	27.9979	28.5162	30.2471	28.9057
180043	1.1739	20.9326	20.6439	24.0582	21.9178
180044	1.6003	24.4569	25.8060	25.7990	25.3780
180045	1.3322	27.4732	29.4127	29.9366	28.9847
180046	1.0037	27.1034	27.0962	28.5568	27.5852
180048	1.3530	23.9230	24.3696	24.6800	24.3400
180049	1.4061	22.4769	24.3699	23.5756	23.4737
180050	1.1304	26.3604	25.9557	26.7726	26.3679
180051	1.2265	23.5299	24.3916	25.2369	24.4161
180053	0.9913	21.3044	22.1921	23.0302	22.2295
180056	1.1344	24.3074	24.5326	26.3973	25.0684
180064	1.2217	17.1009	20.1799	21.9517	19.7365
180066	1.1075	22.2713	23.7860	24.9542	23.6736
180067	1.9564	26.0238	27.9852	29.6053	27.9911
180069	1.0930	26.3701	26.6714	27.6785	26.8872
180070	1.1927	20.6741	20.2189	21.3707	20.7662
180078	1.0606	27.6806	28.2762	29.2136	28.3870

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
180079	1.1480	20.2100	23.6005	24.9911	22.8634
180080	1.2670	21.5818	23.7788	25.3013	23.5878
180087	1.2279	20.8841	22.0302	22.1063	21.6774
180088	1.7064	28.0916	28.6107	30.7954	29.1750
180092	1.1672	23.7909	23.7866	25.2900	24.3108
180093	1.6156	20.5807	21.4392	22.3330	21.4598
180095	1.0121	17.9146	21.5639	21.2162	20.0753
180101	1.3165	27.4506	28.1621	28.8772	28.2018
180102	1.5022	21.0896	25.2343	27.3901	24.3947
180103	2.0478	28.4583	28.1734	29.7648	28.8052
180104	1.5660	25.6157	25.9689	27.1292	26.2421
180105	0.9512	21.6002	23.1917	24.3663	23.0872
180106	0.8902	20.2884	20.7220	21.2271	20.7449
180115	0.9051	20.5539	20.3089	22.7095	21.1836
180116	1.1820	23.5354	25.8927	26.8850	25.4596
180117	0.9402	22.8469	24.7378	24.9571	24.2083
180124	1.3256	24.8292	25.4664	27.1359	25.8369
180127	1.3575	24.6774	26.3947	28.3635	26.4562
180128	0.9391	22.6056	23.8144	23.7778	23.4112
180130	1.6732	27.8900	29.1712	29.6751	28.9409
180132	1.4341	24.5105	25.3789	29.0563	26.3811
180138	1.1857	28.1901	28.6871	29.2603	28.7294
180139	1.0073	23.3569	24.7575	26.2450	24.7768
180141	1.8613	25.3357	27.5912	28.7329	27.2564
180143	1.6811	28.1924	30.8734	28.0780	29.0041
180144	***	29.5052	*	*	29.5052
180147	***	*	31.1615	*	31.1615
180148	***	*	30.1250	*	30.1250
180149	1.0084	*	*	16.4918	16.4918
180150	1.8775	*	*	*	*
180151	1.3627	*	*	*	*
190001	1.0948	22.1394	22.1569	22.5331	22.2812
190002	1.5741	23.3368	24.6984	25.9387	24.6305
190003	1.4185	25.8294	26.7844	28.0899	26.9254
190004	1.5110	25.3473	25.0803	24.6563	25.0238
190005	1.5206	22.6029	24.2899	28.3308	24.2844
190006	1.2936	22.7979	24.8836	25.4826	24.4555
190007	1.1750	21.8205	23.1426	24.0538	23.0459
190008	1.7436	24.6074	26.3638	27.2683	26.0093
190009	1.3575	21.1005	24.0696	25.0269	23.3882
190011	1.0079	21.4052	21.6991	21.9174	21.6831
190013	1.5556	21.4573	23.7333	22.8380	22.6702
190014	1.2320	22.7151	22.6405	24.5410	23.2760

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
190015	1.3066	23.7789	25.1767	26.9591	25.3342
190017	1.4844	24.5390	24.7537	25.5477	24.9737
190019	1.7235	24.0468	25.4624	27.6057	25.7465
190020	1.2828	22.1967	23.4602	24.2361	23.3370
190025	1.3355	23.5007	24.5024	26.5949	24.8093
190026	1.6123	23.7702	24.1556	25.3752	24.4577
190027	1.6315	24.3006	26.7132	31.5047	27.4181
190034	1.2084	20.7334	21.2130	22.9920	21.6119
190036	1.6678	25.4164	25.6551	29.1818	26.6083
190037	***	19.4071	20.7271	28.0463	21.7542
190039	1.5110	24.4386	25.4003	24.6848	24.8470
190040	1.4200	28.6297	28.0169	28.2444	28.2876
190041	1.4656	28.5376	28.0050	28.7702	28.4381
190044	1.2886	20.9993	21.2604	22.2462	21.5124
190045	1.5426	25.8238	27.1996	27.5873	26.9051
190046	1.4309	23.8552	24.7370	25.1890	24.5974
190050	1.1479	21.0259	20.9142	22.7962	21.5831
190053	1.2079	17.9788	18.5819	20.6289	19.0434
190054	1.3247	23.1471	22.7011	23.5137	23.1221
190060	1.4713	23.7393	22.6291	19.8911	21.9233
190064	1.6130	23.1358	23.7298	26.9960	24.6376
190065	1.5896	22.1880	23.1202	22.9861	22.7754
190078	1.0906	22.2431	22.2346	25.6943	23.4397
190079	1.1825	24.0985	23.8192	25.3344	24.4478
190081	0.8736	20.0121	21.4510	20.4111	20.6032
190086	1.2753	22.0610	22.2895	22.2852	22.2156
190088	1.1378	23.8562	23.1638	24.7450	23.9124
190090	1.0333	23.1241	24.3303	25.8610	24.3673
190098	1.7670	25.6854	25.7449	27.5058	26.3131
190099	1.0154	22.0610	23.2343	25.7488	23.6616
190102	1.5407	27.3126	26.9700	28.3090	27.5016
190106	1.1418	23.5376	26.6227	24.2759	24.7511
190111	1.6311	25.5729	26.5722	27.3192	26.5048
190114	1.0611	17.2678	19.1586	20.3651	18.9139
190115	1.2209	28.2066	26.0797	26.0285	26.7729
190116	1.1895	22.3710	23.4013	24.2154	23.3424
190118	0.9845	22.8809	21.2580	22.6572	22.2425
190122	1.4107	22.0072	22.2371	22.8681	22.4044
190124	***	26.0032	27.9484	28.6713	27.4844
190125	1.5709	25.5463	24.8256	26.6269	25.6722
190128	1.0271	28.3257	29.6682	31.1819	29.7866
190131	1.3321	27.8465	28.6795	28.5946	28.3739
190133	0.9162	18.2045	22.4311	23.9550	22.0668

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
190135	1.6174	27.7540	30.5646	35.0547	30.2949
190140	0.9875	18.9652	23.0485	23.6713	21.8179
190144	1.2674	22.9181	23.7875	24.8866	23.8767
190145	0.9756	19.9265	20.8579	21.3988	20.7223
190146	1.5590	27.4824	28.7200	28.5984	28.2733
190151	0.9259	18.7467	18.8391	20.6970	19.4063
190152	1.1740	28.1334	30.8512	34.6508	30.9978
190158	***	26.4787	30.6450	21.5594	27.6931
190160	1.5643	22.9325	24.7822	25.8646	24.4465
190161	1.0303	22.6187	22.9035	23.8073	23.1215
190162	***	25.2953	*	*	25.2953
190164	1.1306	25.2560	26.6207	27.7265	26.5861
190167	1.2777	26.4669	25.3283	27.1981	26.3229
190175	1.2778	26.0547	27.4256	30.5948	28.0073
190176	1.7861	25.8826	26.2596	28.2192	26.7835
190177	1.6455	27.7792	28.2751	29.7252	28.5976
190182	***	27.1682	29.8656	30.7058	29.2924
190183	1.2349	22.6928	22.0119	23.3462	22.7042
190184	0.9601	24.9476	24.1626	22.6144	23.9163
190185	***	25.6394	28.9759	36.7317	29.7372
190190	0.9247	24.3327	26.7043	27.5051	26.1459
190191	1.3759	24.1923	26.1628	26.9656	25.7638
190196	0.9613	24.0385	25.8472	27.7824	25.9549
190197	***	25.8071	26.4825	28.7044	26.9787
190199	1.0984	27.3304	32.0194	36.7128	31.6425
190200	***	28.8173	27.4781	*	28.3200
190201	1.3046	25.1010	24.4563	26.8550	25.4872
190202	1.5213	27.6084	29.6612	27.6463	28.2724
190203	***	28.1832	29.9753	*	29.0343
190204	1.4425	28.1033	30.5140	32.9140	30.3818
190205	1.6698	26.6832	28.2484	30.1687	28.3939
190206	2.0426	26.7401	29.2371	32.0180	29.3059
190208	0.8465	28.7308	27.9908	24.9405	26.8783
190218	1.0287	26.7262	28.1039	26.5251	27.0956
190236	1.4581	24.7142	26.4614	26.9059	26.0712
190241	2.2057	25.2123	25.7906	26.5320	25.8668
190242	1.1739	24.8461	25.0035	26.9729	25.6630
190245	1.6657	25.5751	26.7642	26.4166	26.2442
190246	1.8506	*	22.7833	31.7158	27.5725
190247	***	32.7499	*	*	32.7499
190248	***	23.2220	*	*	23.2220
190249	1.7484	20.0468	25.2523	27.0975	23.4244
190250	2.1139	31.5101	33.3302	32.8381	32.5082

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
190251	1.3045	21.4464	23.8389	25.1594	23.4545
190252	***	23.6924	*	*	23.6924
190253	***	22.8060	23.8037	22.2227	23.0784
190254	***	32.9290	*	*	32.9290
190255	0.7692	22.2412	16.1593	23.8035	20.1022
190256	0.7962	*	25.9577	25.9365	25.9461
190257	1.6689	*	26.5505	22.7512	24.6733
190258	0.9996	31.3715	26.1141	25.1993	27.3105
190259	2.0809	*	26.5084	27.5518	27.0097
190260	***	*	29.3947	33.6227	31.1721
190261	1.3897	*	27.0441	25.4757	26.2696
190262	***	*	30.3719	*	30.3719
190263	2.3166	*	26.4202	29.7063	28.0046
190264	***	*	26.5842	*	26.5842
190265	***	*	22.6231	30.9260	27.1327
190266	2.3046	*	*	24.3809	24.3809
190267	1.3959	*	*	24.2794	24.2794
190268	1.6840	*	*	29.1425	29.1425
190270	1.8773	*	*	*	*
190272	1.2781	*	*	28.4558	28.4558
190273	1.7599	*	*	*	*
190274	1.6030	*	*	*	*
190275	1.3353	*	*	*	*
190276	0.8985	*	*	*	*
190277	0.8585	*	*	*	*
200001	1.3376	25.2542	26.3045	28.1145	26.5665
200002	1.1589	25.7212	27.1151	33.2695	28.3570
200008	1.3897	27.7137	29.1836	29.3538	28.7775
200009	1.9223	30.7510	32.5812	35.0743	32.7327
200018	1.3300	23.5632	22.5027	24.6790	23.5933
200019	1.2790	25.6649	27.7896	28.3413	27.2850
200020	1.3257	32.6436	34.0916	34.5762	33.7909
200021	1.2191	27.1381	29.2054	28.7614	28.4052
200024	1.6735	27.5410	29.7817	31.0799	29.5022
200025	1.1700	26.3124	28.5750	29.3607	28.1296
200031	1.3018	21.2370	22.2151	23.7553	22.4067
200032	1.1814	26.3322	26.8993	27.2276	26.8283
200033	1.8237	29.3108	31.7007	33.6293	31.6179
200034	1.3331	27.0582	27.0103	28.0417	27.3632
200037	1.2055	24.1732	24.9418	26.7815	25.3847
200039	1.2958	25.1179	26.6409	28.8043	26.8821
200040	1.2035	25.9893	27.8053	25.5519	26.3690
200041	1.2063	24.9670	26.6777	27.5067	26.3967

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
200050	1.2408	27.6825	29.5033	30.1473	29.1598
200052	1.1149	22.5159	24.4204	25.6238	24.1943
200063	1.1844	25.8623	27.9748	28.2203	27.3998
210001	1.3569	28.2858	29.3471	31.2355	29.6486
210002	1.9961	32.3005	33.7388	36.0252	34.1115
210003	1.6227	34.1109	30.7334	28.2566	30.8154
210004	1.4256	33.6056	31.7132	33.9037	33.0694
210005	1.2608	28.9554	29.5835	32.4081	30.3404
210006	1.0722	25.9005	27.3620	27.9859	27.0801
210007	1.8012	31.8767	30.7124	31.4125	31.3087
210008	1.4117	24.3341	28.8850	31.8535	28.2955
210009	1.6519	27.7900	30.2661	31.8273	29.9849
210011	1.3855	30.8575	31.0966	30.7547	30.9036
210012	1.5987	30.3078	31.1778	32.5327	31.3798
210013	1.1783	28.5328	28.9917	32.1180	29.7735
210015	1.2996	29.9261	32.2774	31.6903	31.3249
210016	1.6107	32.3506	33.5493	35.3253	33.6944
210017	1.2881	25.1890	26.8592	26.6208	26.2242
210018	1.2020	29.5533	29.6521	31.5460	30.2549
210019	1.7211	27.3731	28.7844	30.5485	28.9508
210022	1.4640	35.4727	37.3092	36.1833	36.3047
210023	1.4887	32.1812	33.0212	34.1664	33.1593
210024	1.8237	30.6359	32.9434	34.5548	32.7605
210025	1.2386	23.8552	24.8570	23.5175	24.0677
210027	1.4172	24.6343	24.4821	25.2143	24.7929
210028	1.0685	26.3469	26.7462	28.5214	27.2379
210029	1.2751	31.0266	31.8539	32.9100	31.9599
210030	1.1907	26.9763	32.2033	29.1790	29.4513
210032	1.1814	27.0727	27.9359	29.2785	28.1119
210033	1.1638	28.5534	29.2504	28.4350	28.7360
210034	1.2674	30.2908	32.3827	33.0407	31.9431
210035	1.3015	28.6484	27.3901	30.6692	28.8623
210037	1.2035	27.3287	27.8394	28.8708	28.0168
210038	1.1889	29.8121	32.3206	31.1563	31.0739
210039	1.1191	30.4991	32.4139	35.1172	32.6911
210040	1.2211	28.3559	29.2390	31.0882	29.5756
210043	1.3059	26.6524	32.6961	29.2762	29.4119
210044	1.3653	29.7339	30.3349	31.5463	30.5476
210045	0.9947	14.2223	16.3724	19.6112	16.8138
210048	1.3788	27.5043	26.0650	29.2464	27.5600
210049	1.2291	26.0900	27.0161	28.5970	27.3355
210051	1.2949	29.8892	29.5219	30.7954	30.0813
210054	1.2562	27.4328	27.7607	28.6905	27.9555

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
210055	1.2423	30.6941	31.4905	30.2010	30.7535
210056	1.3104	30.0810	32.3518	33.2271	31.9625
210057	1.3548	31.6787	32.8299	33.7287	32.7515
210058	1.1204	31.0873	31.1988	32.0669	31.4540
210060	1.2444	27.1764	29.9626	32.5141	29.9232
210061	1.2608	23.1645	25.0253	26.6842	25.0237
220001	1.2266	30.6070	31.2316	32.0843	31.3064
220002	1.3727	32.4356	33.6649	35.9765	34.0715
220006	***	30.7673	33.6438	*	32.1319
220008	1.2881	31.3385	34.7924	35.8680	34.0339
220010	1.2311	30.7804	32.0925	33.7392	32.2158
220011	1.1377	34.7655	36.5640	39.1234	36.8973
220012	1.4648	37.8763	39.7564	41.7080	39.8261
220015	1.2980	29.6315	32.4903	35.2373	32.4372
220016	1.1268	30.4813	32.5863	33.1424	32.0662
220017	1.3192	31.6170	33.3020	34.6575	33.1991
220019	1.0423	24.4009	25.7855	26.3018	25.5041
220020	1.1282	28.5288	30.8458	32.1528	30.5516
220024	1.2438	28.7342	31.9491	33.0415	31.2656
220025	1.0377	25.6478	30.4369	27.6973	27.7644
220028	***	31.7122	39.3089	*	35.2808
220029	1.1494	30.6935	31.6363	32.6792	31.6972
220030	1.1029	26.8849	28.1347	29.3714	28.1505
220031	1.5524	36.8477	38.9433	39.4214	38.4403
220033	1.1944	31.8249	32.3495	34.7005	33.0213
220035	1.4164	31.4470	34.8739	36.1799	35.0977
220036	1.5109	33.1436	35.9124	37.7301	35.6268
220046	1.4457	30.4460	31.4510	33.8604	31.9507
220049	1.2244	30.4740	32.4652	35.1134	32.7141
220050	1.0897	28.3434	29.5194	30.3176	29.4115
220051	1.3045	30.2552	30.1022	32.8693	31.0922
220052	1.1442	32.4130	32.3532	34.9151	33.2027
220058	1.0107	25.7247	27.8893	30.0344	27.9133
220060	1.1595	32.5477	34.7336	36.8668	34.7674
220062	0.6343	25.0766	25.4224	27.4755	26.0059
220063	1.2634	30.2866	32.9283	32.2442	31.8304
220065	1.2730	27.6009	30.1103	32.3814	30.0476
220066	1.3289	27.8073	29.9736	*	28.8792
220067	1.2422	30.2222	32.4019	33.9836	32.2190
220070	1.1474	33.1299	34.2598	35.6271	34.3621
220071	1.8377	36.5065	37.4087	40.0313	38.0126
220073	1.1883	34.2989	36.0289	37.4249	35.9328
220074[4]	1.3509	30.5607	31.4730	33.2081	31.7051

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
220B74[4]	***	*	31.4731	33.2082	32.3878
220075	1.5438	30.9175	32.2957	33.3578	32.1956
220076	***	27.5148	*	*	27.5148
220077	1.6650	31.7325	34.0168	34.7345	33.5108
220080	1.1616	29.9595	31.1268	33.1640	31.3806
220082	1.2901	30.0611	30.8230	32.2124	31.0616
220083	1.0665	34.5118	34.5969	35.2758	34.8216
220084	1.2130	30.9527	31.6955	34.6275	32.3755
220086	1.7237	34.2388	35.3451	36.2385	35.3182
220088	1.9431	35.8255	34.7637	37.0840	35.9299
220089	***	32.6305	34.8205	*	33.7125
220090	1.2399	32.9011	34.1963	35.8969	34.3707
220095	1.1538	28.0673	30.8626	31.1644	30.0341
220098	1.1402	30.5869	31.5403	31.1288	31.1006
220100	1.3065	31.9859	34.6599	35.7309	34.1819
220101	1.2969	35.3464	37.7809	37.7292	37.0043
220105	1.1819	33.2625	34.4029	35.8179	34.5236
220108	1.1980	32.6131	33.8854	35.7009	34.0761
220110	1.9977	39.2167	40.7382	43.8444	41.3138
220111	1.2195	33.6167	34.2498	35.6223	34.5178
220116	1.8717	36.4149	38.8799	40.0982	38.4137
220119	1.1330	30.9965	32.0863	33.7200	32.3374
220126	1.1789	31.4882	32.6938	35.6278	33.2725
220133	***	29.4855	34.9182	*	32.1170
220135	1.3036	36.0203	37.5189	39.0296	37.5507
220153	***	*	19.8085	20.5063	20.1966
220154	***	*	28.7898	*	28.7898
220162	1.5984	*	*	*	*
220163	1.6202	34.4874	37.4968	39.4893	37.2296
220171	1.6932	32.7414	35.9948	36.4567	35.0742
220174	1.1935	30.0406	30.9503	32.9140	31.3275
220175	1.2683	*	*	34.1572	34.1572
220176	1.6447	*	*	31.4220	31.4220
230002	1.3244	32.9010	32.7578	33.9708	33.2545
230003	1.2406	27.5824	28.4716	28.9886	28.3365
230004	1.7096	29.3934	31.5136	33.4644	31.5271
230005	1.2398	25.8768	27.7463	29.0634	27.5857
230013	1.3847	24.6511	27.2075	28.6430	26.7590
230015	1.1609	26.2782	27.2541	28.9601	27.5257
230017	1.6503	31.8821	32.5396	36.8045	33.8186
230019	1.6083	32.3401	34.3213	35.1440	33.9325
230020	1.7473	28.5646	29.5324	29.9492	29.3672
230021	1.5500	26.5659	28.6169	29.5414	28.2373

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
230022	1.2709	25.6683	30.1195	25.7846	27.0331
230024	1.6542	32.1483	32.5892	34.5278	33.1070
230029	1.6185	32.3538	32.3845	33.1482	32.6284
230030	1.2792	23.8082	25.1100	25.1929	24.7213
230031	1.3564	29.7232	30.0120	30.8870	30.2340
230034	1.3730	24.4845	24.4141	29.1098	25.8641
230035	1.1989	24.8822	25.6715	25.7099	25.4578
230036	1.4158	29.3754	29.9642	31.0938	30.1642
230037	1.3051	28.9244	28.5311	28.8547	28.7697
230038	1.7654	28.2012	29.1263	30.1040	29.2001
230040	1.1781	25.5154	26.3190	27.2850	26.3824
230041	1.5805	27.8853	27.9569	30.3082	28.7064
230046	1.9171	31.6235	32.2924	33.5304	32.5204
230047	1.4493	31.1771	31.7075	32.0248	31.6483
230053	1.6704	32.5711	32.1566	33.5440	32.7711
230054	1.8811	25.7591	26.3251	28.1229	26.7477
230055	1.2545	27.4349	28.4787	28.1881	28.0396
230058	1.1164	25.9291	27.3156	27.9643	27.0820
230059	1.5366	27.9091	28.5875	28.3602	28.2952
230060	1.2912	28.2874	27.0288	28.7760	28.0396
230065	***	32.6255	*	*	32.6255
230066	1.3089	30.6184	30.2104	32.3582	31.0743
230069	1.1826	30.2663	31.3406	31.9675	31.2230
230070	1.6496	25.6778	26.8315	28.0366	26.8669
230071	0.9448	28.3064	29.6728	28.8879	28.9591
230072	1.3631	26.2838	27.4742	28.8024	27.5413
230075	1.3503	28.2540	30.9525	32.1166	30.4329
230077	1.8833	29.8538	30.5567	31.0123	30.4735
230078	1.1919	25.6809	25.7232	27.0069	26.0997
230080	1.2677	24.1573	24.5432	25.6204	24.7909
230081	1.2315	24.7374	26.4337	27.8106	26.3293
230085	1.2326	23.4959	25.4289	27.6474	25.5352
230089	1.3431	31.0522	32.8450	32.2311	31.9441
230092	1.3974	28.6829	29.3442	30.5417	29.5455
230093	1.2157	25.5804	27.4463	27.0572	26.7244
230095	1.2747	22.8681	25.1854	25.9210	24.6704
230096	1.1759	30.6024	31.7399	29.7225	30.6729
230097	1.6914	28.2526	29.8962	31.5174	29.8789
230099	1.2187	29.0221	29.3720	29.0975	29.1635
230100	1.1912	24.1881	25.2118	25.6594	25.0496
230101	1.1683	25.4839	28.4372	28.8608	27.6209
230104[5]	1.5940	32.4634	32.4125	34.0195	32.9577
230B04[5]	***	*	*	34.0195	34.0195

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
230105	1.7840	32.4583	30.5515	32.1124	31.7064
230106	1.2377	25.3243	27.8584	30.0223	27.7696
230108	1.1612	20.2539	24.4337	25.7477	23.4440
230110	1.2547	27.0040	25.7196	27.0280	26.5815
230117	1.8428	32.7994	33.0602	33.9176	33.2771
230118	1.0097	23.6110	24.8890	24.8638	24.4402
230119	1.4376	30.7488	31.9696	33.2050	32.0135
230121	1.2617	26.4940	26.8361	27.7512	27.0484
230130	1.6808	30.1608	31.2744	32.5613	31.3621
230132	1.5390	32.3939	35.5304	38.2454	35.3559
230133	1.4288	23.9442	25.0647	25.8537	24.9779
230135	1.3171	25.9583	23.6005	31.5194	26.7533
230141	1.6162	31.6152	33.2553	36.3124	33.7180
230142	1.2682	27.8377	29.7417	29.9911	29.2242
230144	1.8275	*	*	*	*
230146	1.3747	26.8156	27.2621	29.0218	27.7286
230151	1.3315	27.4546	29.8366	28.6724	28.6318
230156	1.5952	32.3755	33.9034	34.7865	33.7050
230165	1.5981	29.6376	31.4242	32.2855	31.1351
230167	1.6102	29.8071	31.0657	32.8092	31.2497
230174	1.3695	30.0563	29.7488	31.2469	30.3411
230176	1.3111	28.1498	28.9798	29.2688	28.8195
230180	1.1203	26.0707	24.9696	24.6007	25.1973
230184	***	34.6295	*	*	34.6295
230190	***	30.7875	33.8229	33.6724	32.7910
230193	1.3564	25.1626	26.4728	28.4641	26.7224
230195	1.4220	29.5656	30.9702	32.5549	31.0484
230197	1.6024	32.0063	33.7128	34.8066	33.5218
230204	1.4319	31.5615	32.2882	30.1982	31.3400
230207	1.2447	25.4268	25.1983	26.8231	25.8122
230208	1.2210	23.7523	24.3476	25.2481	24.4572
230212	1.0430	31.9818	32.8567	33.4379	32.7607
230216	1.4797	29.0147	29.2061	28.9586	29.0592
230217	1.4000	30.1136	31.9732	33.0839	31.7836
230222	1.4250	29.9341	30.6482	32.4404	30.9832
230223	1.3050	28.6745	29.8430	31.8146	30.0918
230227	1.4805	30.8218	33.6716	34.2762	32.7529
230230	1.4789	29.8763	31.1712	31.4953	30.8603
230236	1.5420	31.3110	30.8556	31.9100	31.3748
230239	1.3017	21.0814	22.1579	23.5461	22.2561
230241	1.2014	27.6106	28.5516	30.0248	28.7411
230244	1.4612	29.6283	30.0405	32.5586	30.7596
230254	1.4848	29.2653	29.5874	31.6332	30.2120

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
230257	0.9822	29.6712	30.6372	30.0674	30.1070
230259	1.2689	27.4217	27.5982	27.9572	27.6545
230264	2.0641	22.7768	28.5416	29.2202	26.4138
230269	1.4695	31.3226	31.3800	34.2694	32.4001
230270	1.3464	28.5372	28.8173	29.2408	28.8719
230273	1.4675	31.9862	31.5396	32.5730	32.0380
230275	0.5428	23.8104	25.2133	22.3740	23.7479
230277	1.4623	29.8372	31.4023	32.2545	31.1898
230279	0.5477	27.2816	27.9726	26.8552	27.3526
230283	***	33.5531	*	*	33.5531
230294	***	31.6195	*	*	31.6195
230295	***	27.1298	*	*	27.1298
230296	***	*	34.2107	*	34.2107
230297	1.6920	*	*	*	*
230298	0.7864	*	*	*	*
230300	3.3739	*	*	*	*
230301	1.0938	*	*	*	*
240001	1.5502	33.1499	34.7673	37.2211	35.0472
240002	1.8748	31.6000	33.1051	34.6368	33.1537
240004	1.5904	32.7010	32.5777	33.4596	32.9128
240006	1.2144	31.0777	33.4777	32.8229	32.4953
240010	1.9694	33.4668	32.7261	35.9131	34.0531
240014	1.0722	29.8905	30.7519	33.4492	31.3964
240017	***	24.3596	*	*	24.3596
240018	1.2602	28.1432	29.4995	30.5645	29.4376
240019	1.0341	33.7546	32.7052	34.2547	33.5839
240020	1.1149	31.3874	33.2449	34.5703	33.0767
240022	1.0628	26.1920	27.3137	28.5905	27.3650
240030	1.3913	26.5508	27.1312	27.6596	27.1140
240036	1.6412	32.7028	34.2980	37.2207	34.8318
240038	1.4975	31.9891	33.0554	34.7357	33.2517
240040	1.0533	27.5074	28.9009	30.0255	28.8064
240043	1.2463	23.3489	24.0708	25.7424	24.4202
240044	1.0855	25.0988	26.8681	28.5705	26.7911
240047	1.5238	28.6406	29.7835	35.6763	31.1190
240050	1.0906	27.5553	30.9805	33.7964	30.9177
240052	1.2045	28.7206	29.4617	31.0934	29.7879
240053	1.5034	31.4324	33.1148	34.4210	33.0272
240056	1.3595	33.1728	34.0845	35.8603	34.4104
240057	1.7893	30.7703	33.4713	34.8374	33.0726
240059	1.0938	31.0911	32.4803	32.5958	32.0873
240061	1.8565	33.1799	32.0828	34.6031	33.3414
240063	1.5798	33.7895	35.2877	36.9822	35.4065

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
240064	1.1742	34.3757	27.2407	29.9917	30.4618
240066	1.5238	35.3441	36.0705	39.6609	37.0754
240069	1.1970	29.3718	30.9719	31.1673	30.5149
240071	1.1033	28.6950	31.7754	32.5460	30.9921
240075	1.1892	27.5039	29.1171	30.3230	29.0134
240076	1.0211	30.6936	33.1439	33.7950	32.5947
240078	1.6525	32.5785	34.6118	36.2276	34.5542
240080	1.9528	32.5725	34.8064	36.5390	34.6291
240084	1.1356	26.5975	27.0995	29.0275	27.5337
240088	1.2979	28.0603	29.1387	30.7240	29.3339
240093	1.4592	27.2928	29.1717	30.4744	29.0686
240100	1.3398	30.8391	31.5774	30.9481	31.1202
240101	1.1985	25.6963	26.8849	28.5503	27.1180
240104	1.2058	31.6511	35.0736	35.8839	34.3227
240106	1.6107	30.5927	32.8156	33.9984	32.4904
240115	1.4803	32.0107	33.5288	36.2788	33.9365
240117	1.1638	24.5750	27.6950	29.0894	27.1232
240128	***	23.3334	*	*	23.3334
240132	1.2650	32.1233	34.6191	36.4252	34.2579
240141	1.1036	31.4468	32.8689	34.2473	32.8968
240166	1.1587	27.6987	26.5328	26.1732	26.6673
240187	1.2989	27.8844	29.1582	30.9646	29.4017
240196	0.8461	31.5965	34.3743	35.0345	33.6766
240206	0.9236	*	*	*	*
240207	1.2386	32.5589	34.6792	36.4569	34.6395
240210	1.2817	32.7123	34.4184	36.5950	34.6242
240211	1.0511	22.5430	17.4044	16.6158	18.6326
240213	1.4152	33.8680	35.7818	37.4608	35.7776
250001	1.9682	23.5222	23.7773	24.3404	23.8774
250002	0.9542	23.4063	25.4201	25.0342	24.6390
250004	1.7768	24.7907	25.8722	24.8086	25.1652
250006	1.1513	24.4282	25.9199	27.0511	25.8310
250007	1.2347	24.8929	27.7665	29.3479	27.3755
250009	1.2629	23.0352	23.4866	24.9118	23.8161
250010	1.0425	21.4322	21.8665	22.7988	22.0356
250012	0.9464	21.5540	23.4837	26.4110	23.6997
250015	1.1839	22.0067	22.2803	22.3685	22.2137
250017	1.1003	22.7660	33.6840	25.7404	26.7935
250018	0.8821	17.1276	17.9025	19.1108	18.0555
250019	1.5592	25.7376	26.2199	27.7230	26.5566
250020	1.0032	22.1851	23.7245	23.1521	23.0482
250023	0.8728	18.0108	18.5067	19.5081	18.7150
250025	1.1408	22.5621	23.1738	23.0555	22.9294

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
250027	0.9506	24.4937	26.9922	32.5451	27.8439
250031	1.3442	24.8139	25.9189	26.7507	25.8097
250034	1.5344	26.1887	26.7996	27.9279	26.9954
250035	0.8644	20.1622	19.1038	20.5251	19.9111
250036	1.0489	20.3625	19.7951	22.5676	20.8309
250038	0.9524	22.2571	26.9621	30.7960	25.9491
250040	1.4900	24.5962	27.3366	26.2268	26.0467
250042	1.2561	25.6807	26.1190	27.4610	26.4131
250043	0.9856	18.8979	20.8841	21.1265	20.3159
250044	1.0366	24.0508	24.9199	26.1732	25.0761
250048	1.6484	25.2092	24.7659	27.6339	25.8354
250049	0.8724	19.1044	20.4775	24.2227	21.0942
250050	1.3100	20.8084	21.1657	22.4429	21.4806
250051	0.8661	14.3741	13.9532	14.1662	14.1690
250057	1.1729	22.7601	24.3654	22.9683	23.3321
250058	1.2368	19.2502	18.9970	19.6720	19.3083
250059	0.9337	23.8997	26.7491	25.5982	25.3589
250060	0.8114	28.1431	25.4779	27.0354	26.8922
250061	0.8863	17.8267	18.7413	25.1495	20.4689
250067	1.0933	23.1193	25.2189	23.8027	24.0647
250069	1.4409	22.6353	22.4194	23.4495	22.8355
250072	1.6773	25.8399	25.5337	27.5791	26.3185
250077	0.9730	18.3735	19.0416	19.6333	19.0452
250078	1.5862	22.1243	22.8430	23.9598	22.9835
250079	0.8929	45.5166	43.0845	46.0349	44.8461
250081	1.3673	23.9995	25.6808	24.8281	24.8312
250082	1.4108	23.0287	23.5399	25.6218	24.1474
250084	1.2524	19.6492	19.1604	19.5694	19.4644
250085	1.0180	22.5513	24.2915	24.6757	23.8556
250093	1.1828	23.0984	23.9128	26.4351	24.4989
250094	1.6985	24.1422	24.7718	25.4232	24.7898
250095	1.0319	21.7488	23.6140	25.9021	23.7849
250096	1.2039	24.9187	26.3743	27.7291	26.3766
250097	1.4883	21.8139	22.0211	22.7916	22.2478
250099	1.2765	21.1269	21.5656	27.5757	23.2187
250100	1.5246	25.6846	27.0286	27.5484	26.7626
250102	1.5941	24.6652	25.4050	25.5327	25.2042
250104	1.4412	23.4303	24.4311	25.4008	24.4456
250112	0.9611	24.3069	26.3357	27.4162	26.0544
250117	1.1579	22.2450	23.7337	24.5706	23.5014
250120	***	24.6370	26.6522	*	25.6905
250122	1.1273	27.2795	27.4424	23.4908	26.0519
250123	1.3529	26.6221	27.9058	29.8299	28.1122

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
250124	0.8374	20.4394	20.5667	21.9420	20.9865
250125	1.3784	27.5158	26.7687	32.7411	28.5838
250126	1.0188	24.4126	25.0019	25.2581	24.9086
250127	0.8041	*	*	*	*
250128	0.9646	17.7624	21.7882	23.5918	21.3640
250134	0.9305	22.2167	21.0211	22.0846	21.7641
250136	1.0279	22.9468	25.2241	27.1479	25.0267
250138	1.3086	24.3018	25.2642	27.3132	25.5727
250141	1.4788	28.5922	30.5112	33.4413	31.0012
250149	0.8777	16.8796	17.2268	17.0964	17.0715
250151	0.5535	18.8846	22.8238	.	19.4286
250152	0.8224	26.9334	26.4559	28.5526	27.2309
250155	***	22.5728	*	*	22.5728
250156	***	*	16.8659	*	16.8659
250157	***	*	29.6398	*	29.6398
250162	1.0512	*	*	*	*
260001	1.6871	27.9230	29.5271	31.1866	29.5279
260004	0.9098	20.3217	21.3629	23.9584	22.0205
260005	1.5289	27.7855	27.9477	31.1050	28.9332
260006	1.4506	30.3440	27.3754	33.8253	30.6152
260009	1.2166	24.2360	25.7546	26.6685	25.5694
260011	1.5896	25.6387	27.5762	31.2612	28.1589
260015	1.0281	24.6139	25.0640	25.0250	24.8952
260017	1.2999	23.5713	25.0461	26.2621	24.9760
260020	1.7342	27.4730	29.3080	30.9599	29.2695
260021	1.3078	29.3646	32.6735	19.5810	26.0259
260022	1.3231	23.3393	24.8713	25.9391	24.7196
260023	1.3699	24.3192	25.4314	25.5899	25.1238
260024	1.1892	19.4952	19.2199	20.7136	19.8201
260025	1.3980	22.2451	24.0358	24.5042	23.6147
260027	1.6161	26.3590	29.3811	31.0236	28.7837
260032	1.8567	25.6763	27.4857	28.7183	27.3248
260034	1.0140	25.0573	27.1685	28.7736	27.0783
260040	1.7152	24.3938	25.9074	27.3680	25.8520
260047	1.4349	25.4978	26.6343	27.2667	26.4804
260048	1.1842	27.6117	28.1515	29.6969	28.5302
260050	1.1398	25.0506	26.2346	27.8065	26.4425
260052	1.3079	26.0052	27.6360	29.6998	27.7832
260057	1.0868	20.9639	21.5925	23.8181	22.1486
260059	1.2940	22.6922	22.3885	25.3025	23.4886
260061	1.1703	22.4766	22.8589	23.6717	22.9808
260062	1.2720	28.1661	28.4975	29.6156	28.7761
260064	1.3632	22.2395	23.3498	21.4932	22.3902

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
260065	1.7932	27.1014	29.3564	28.3411	28.3047
260068	1.7302	26.0295	27.3475	28.1246	27.1648
260070	0.9675	24.6331	21.9701	25.2997	24.0400
260074	1.2162	25.6218	28.0468	28.6216	27.4576
260077	1.6215	26.7466	27.6624	28.7204	27.7270
260078	1.2704	20.1983	21.1539	23.1785	21.5536
260080	1.0067	17.9107	18.6070	18.6813	18.3880
260081	1.4919	28.1182	29.1890	32.0799	29.8100
260085	1.5522	26.6718	28.0306	29.6514	28.1053
260091	1.4875	28.0537	28.5473	30.2636	28.9683
260094	1.6131	24.1473	23.8654	25.1491	24.3847
260095	1.3880	24.2698	27.6196	29.9090	27.0428
260096	1.5235	29.7312	30.7267	32.9383	31.1677
260097	1.1870	25.0624	25.5634	27.3129	26.0310
260102	0.9832	27.2145	26.7624	30.7678	28.2429
260104	1.5805	28.6247	28.0235	29.5891	28.7625
260105	1.8545	29.8848	29.4766	32.4292	30.5773
260107	***	25.8177	27.9710	29.7775	27.7682
260108	1.8284	26.6374	27.0758	28.5654	27.4384
260110	1.6442	24.7656	26.6030	28.0381	26.5202
260113	1.1405	21.2072	21.8884	23.0826	22.0238
260115	1.2648	23.1396	24.6389	25.5658	24.4741
260116	1.0458	21.3503	20.7479	22.5536	21.5321
260119	1.2935	27.9769	31.5490	31.5003	30.2553
260137	1.7473	24.3273	27.6592	31.4091	27.8375
260138	1.8951	30.4410	30.6284	31.7582	30.9548
260141	1.8720	24.1555	25.5663	26.6684	25.5215
260142	1.0835	21.5923	21.7609	22.8205	22.0859
260147	0.9520	21.4235	22.1928	22.9689	22.1974
260159	***	22.6276	23.9515	24.3027	23.5850
260160	1.0593	23.8257	25.5096	26.6715	25.4081
260162	1.4390	27.0236	28.4660	30.5761	28.7108
260163	1.2126	21.6408	21.5566	23.8644	22.3621
260166	1.2356	29.1225	28.5858	29.5259	29.0833
260175	1.1188	25.1817	24.6064	25.7069	25.1723
260176	1.7544	29.3034	31.1056	30.6205	30.3614
260177	1.2273	27.0185	28.7942	29.0815	28.3087
260178	1.9670	25.4782	27.1201	26.9902	26.5986
260179	1.5300	26.6069	28.3234	29.6316	28.1821
260180	1.5832	28.2931	29.3820	30.7336	29.4601
260183	1.6777	27.5577	29.2684	31.4916	29.4556
260186	1.4622	26.9797	28.8610	29.1874	28.3622
260190	1.2174	27.9137	30.5343	30.9003	29.7916

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
260191	1.4425	24.6973	26.3244	27.8648	26.3560
260193	1.2316	26.8922	28.1060	29.5436	28.1858
260195	1.2493	22.6870	24.0411	25.0294	23.9197
260198	***	28.0021	27.2555	27.9093	27.7145
260200	1.2911	28.2453	27.4784	30.5032	28.7982
260207	1.1540	22.6109	22.9579	23.6392	23.1709
260209	1.1565	25.0098	25.0749	26.4203	25.5829
260210	1.3936	26.8745	30.5975	36.4055	30.6939
260211	1.4236	40.9821	35.9113	37.1557	38.3595
260213	***	*	34.8953	*	34.8953
260214	1.2285	*	*	31.0175	31.0175
260216	1.3061	*	*	*	*
260218	0.8126	*	*	*	*
260219	1.3193	*	*	*	*
260220	2.3259	*	*	*	*
270002	1.1422	24.0534	25.2907	28.3379	25.9065
270003	1.2584	28.8700	29.1938	28.0543	28.6564
270004	1.6223	26.1319	26.6779	28.5869	27.1558
270011	1.0749	22.7061	24.4696	*	23.5588
270012	1.5982	25.2914	26.5854	28.0672	26.6767
270014	1.8051	25.8231	27.4811	28.2582	27.1798
270017	1.2990	26.5404	27.4150	29.3542	27.7695
270023	1.5601	25.5682	26.3076	28.1896	26.6590
270032	1.0426	20.3469	20.4330	21.6360	20.8157
270049	1.7687	27.1634	28.6880	29.8891	28.6468
270051	1.5057	26.5621	24.9371	29.3941	26.9494
270057	1.2951	25.5811	27.1838	28.3627	27.1314
270074	0.8884	*	*	*	*
270081	1.0031	19.5612	20.0438	*	19.8033
270086	1.2445	21.0808	20.7976	21.9017	21.2346
270087	1.3320	25.9772	24.8022	24.9197	25.2102
280003	1.7657	30.6124	30.1057	32.3780	30.9977
280009	1.8339	27.0705	29.3634	28.1559	28.1948
280013	1.7229	27.0250	27.9523	30.3120	28.4722
280020	1.6557	27.3284	32.3896	29.4831	29.7225
280023	1.3212	26.7980	29.5132	30.0717	28.7823
280030	1.9457	29.5102	30.6991	31.8758	30.6846
280032	1.2934	24.3995	24.7539	25.6549	24.9370
280040	1.5775	28.7207	29.5276	30.7406	29.6454
280060	1.6610	27.7496	30.3049	30.4625	29.5114
280061	1.4485	26.0208	26.4824	28.9591	27.1709
280065	1.2531	28.0581	28.0132	29.5470	28.5379
280077	1.3603	27.0860	28.2206	29.9223	28.4622

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
280081	1.6801	28.7464	31.1212	28.9696	29.5987
280105	1.2549	27.8599	29.8488	30.0472	29.2901
280111	1.1716	24.5617	27.4853	28.3541	26.8745
280119	0.8951	*	*	*	*
280123	0.9698	15.4047	22.2185	20.2741	18.6145
280125	1.5869	22.1345	23.2900	24.7466	23.4403
280127	1.8311	29.3684	25.6806	26.5659	26.9809
280128	2.7483	28.5422	28.8734	27.1024	28.1542
280129	2.0397	*	27.8793	27.9511	27.9201
280130	1.3828	*	29.8588	29.9645	29.9170
290001	1.7733	36.3129	35.5113	33.3318	34.9953
290002	0.8643	17.3876	23.9348	22.7362	20.8857
290003	1.7936	30.3373	32.8182	34.6433	32.6128
290005	1.4659	28.3366	31.7107	34.2373	31.0988
290006	1.0859	31.7301	31.9838	33.3243	32.3927
290007	1.7328	38.1938	39.7323	41.2395	39.7814
290008	1.2096	27.3019	31.1116	33.2473	30.5254
290009	1.6411	36.2724	32.3348	34.2103	34.2313
290012	1.3318	32.3966	35.7988	38.3731	35.4928
290019	1.4597	29.3650	30.5964	32.2817	30.8014
290020	1.0263	23.2103	27.6277	27.2908	25.9794
290021	1.6712	32.7894	36.7310	36.8728	35.4897
290022	1.7123	29.9717	33.5330	38.8262	33.9045
290027	0.8935	23.9959	23.9818	29.1123	25.2227
290032	1.4431	31.6711	34.6589	36.9175	34.3272
290039	1.5448	32.1423	34.9622	34.6359	33.9800
290041	1.4915	34.2436	37.6077	38.4445	36.9271
290042	***	*	22.4859	*	22.4859
290044	***	37.1662	*	*	37.1662
290045	1.6533	33.1512	34.4584	38.2560	35.4030
290046	1.4027	*	38.7966	38.3112	38.5285
290047	1.4184	*	33.4695	35.6381	34.5617
290049	1.3300	*	26.0725	33.4278	30.0568
290051	1.8875	*	*	32.5277	32.5277
290052	1.1616	*	*	*	*
290053	1.5842	*	*	*	*
300001	1.4410	29.2260	29.8145	31.0122	30.0658
300003	2.0316	34.7900	37.0886	37.7246	36.5486
300005	1.3792	27.8000	27.8431	28.2681	27.9861
300011	1.3314	30.9403	31.8928	33.0785	31.9921
300012	1.3237	30.4972	31.2655	33.0569	31.6605
300014	1.2315	29.7667	29.1847	30.7735	29.9271
300017	1.2868	29.9560	31.6699	33.4164	31.6776

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
300018	1.3179	29.4270	31.7891	31.5028	30.9784
300019	1.2444	27.5672	28.2287	28.3114	28.0677
300020	1.1989	30.8491	30.9783	32.4655	31.4533
300023	1.4456	31.0040	31.2726	32.3202	31.5699
300029	1.8191	29.8117	31.4429	32.0033	31.1351
300034	1.8497	30.7676	31.6880	33.5537	32.0221
310001	1.7566	41.7460	39.3391	41.4946	40.8285
310002	1.7978	37.9183	37.8652	37.9484	37.9115
310003	1.1900	36.2346	39.0785	40.1543	38.5772
310005	1.3403	32.1319	33.6311	34.7657	33.5615
310006	1.4377	28.4771	28.7321	30.4296	29.2530
310008	1.3391	32.6788	33.3172	34.3268	33.4561
310009	1.3663	33.6940	33.6165	35.4624	34.2965
310010	1.2850	33.9552	33.7009	36.0823	34.6173
310011	1.2621	31.2907	34.3497	37.4855	34.3019
310012	1.5949	38.3590	39.8568	41.9630	40.0675
310013	***	31.0447	35.6260	32.9488	33.1385
310014	1.8192	30.0793	32.9016	35.0124	32.7784
310015	1.9138	36.8818	39.2928	40.8229	39.0298
310016	1.3279	35.6155	38.2740	41.0363	38.2718
310017	1.3641	32.2434	35.7308	35.9806	34.6075
310018	1.1493	30.3234	32.9704	32.6956	31.9532
310019	1.5497	30.3518	30.6369	31.8930	30.9696
310020	1.5804	33.5516	37.3372	38.4266	37.3159
310021	1.6487	32.1929	31.6562	32.2064	32.0227
310022	1.3226	30.4043	31.1951	32.8079	31.4442
310024	1.3882	33.3415	33.8622	36.8666	34.7107
310025	1.4248	34.3687	32.2630	32.1481	32.9322
310026	1.3223	29.1588	30.1392	30.1321	29.8062
310027	1.4642	29.7793	31.5967	34.6471	31.9789
310028	1.1908	32.2977	33.9911	34.8332	33.7166
310029	1.7788	32.9246	33.6695	35.2084	33.9519
310031	2.8674	37.0668	39.3783	39.5911	38.6587
310032	1.3219	30.7865	33.0258	35.2402	33.0208
310034	1.4122	31.7012	32.7523	36.8614	33.7123
310037	1.4774	38.5415	38.2865	40.4642	39.0102
310038	1.8916	35.9190	36.3344	39.8707	37.3884
310039	1.2411	31.4278	33.2100	32.6425	32.4249
310040	1.2565	33.8535	37.7945	41.2246	37.4729
310041	1.3353	32.8390	33.9799	35.2009	33.9794
310042	***	34.4986	*	*	34.4986
310044	1.3490	31.9678	33.7614	33.5868	33.0832
310045	1.6492	36.7862	38.4424	39.2097	38.1284

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
310047	1.3479	34.1520	37.3695	37.7220	36.4665
310048	1.3728	32.9681	33.9506	34.5256	33.8364
310050	1.2464	29.1732	32.3686	37.9214	32.9309
310051	1.4912	35.0121	38.1174	39.7671	37.6899
310052	1.3240	32.5778	33.5849	36.5494	34.2555
310054	1.4172	34.4431	36.9095	38.2432	36.5609
310057	1.4320	31.1268	31.8933	34.2052	32.3554
310058	1.0520	27.1555	30.4080	30.4436	29.4047
310060	1.2542	27.3415	27.8242	27.9134	27.7052
310061	1.2203	31.6648	39.0538	33.5586	34.7383
310063	1.3457	31.9247	33.8519	38.1481	34.4547
310064	1.5388	35.7607	38.6310	39.8091	38.1472
310069	1.2581	31.7642	34.4669	35.1376	33.8317
310070	1.4555	34.3225	36.3279	36.9999	35.8881
310073	1.7832	32.6733	34.2858	36.9249	34.6729
310074	1.4718	40.3494	39.6196	39.0729	39.6565
310075	1.4275	31.5226	32.5338	33.5253	32.5120
310076	1.6448	38.0643	37.5163	38.1671	37.9213
310077	***	34.6085	*	*	34.6085
310078	***	30.5761	*	*	30.5761
310081	1.2628	30.1561	31.0699	31.7981	31.0164
310083	1.3218	30.3580	31.9151	28.3406	30.1104
310084	1.2657	33.5941	32.6051	34.9626	33.7180
310086	1.2600	29.5566	29.8794	30.9467	30.1385
310088	1.1245	29.9929	30.3552	31.2437	30.5511
310090	1.2386	32.8191	33.4615	33.9174	33.3962
310091	1.1323	29.3969	31.9762	35.2913	32.2231
310092	1.4086	29.7958	32.7054	32.8431	31.7811
310093	1.2195	29.1288	30.2860	32.3860	30.5694
310096	1.9397	34.1524	35.0707	34.2014	34.4700
310105	1.1625	30.1069	32.5672	32.0277	31.5553
310108	1.4023	33.0172	34.5866	36.2848	34.6399
310110	1.3135	33.2246	33.4809	35.6825	34.1576
310111	1.2528	31.8393	34.8284	36.0748	34.2685
310112	1.3282	31.2372	32.2676	34.5337	32.6225
310113	1.2435	31.0436	33.6771	35.0245	33.3355
310115	1.3174	29.5320	31.9208	32.1197	31.2483
310116	1.2969	29.2748	29.8144	27.8677	28.9754
310118	1.3573	31.1803	31.2296	32.8286	31.7723
310119	1.8877	43.1238	41.5702	41.2997	41.9839
310120	1.0872	29.2535	33.3861	35.1661	32.4713
310122	***	*	41.9029	*	41.9029
310123	***	*	37.1022	*	37.1022

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
310124	***	*	41.8827	*	41.8827
310125	***	*	36.2186	*	36.2186
310126	***	*	*	34.3189	34.3189
320001	1.6824	29.6182	30.0077	31.4193	30.3604
320002	1.5338	32.0477	33.1342	34.1610	33.1629
320003	1.1309	27.6222	31.4473	31.5792	30.3543
320004	1.3276	24.7803	26.2073	28.2407	26.4288
320005	1.4229	24.7543	28.7893	25.2168	26.1583
320006	1.2577	26.9080	28.0964	28.5177	27.8957
320009	1.5793	32.0116	27.8084	31.3296	30.3190
320011	1.1539	25.6693	27.9522	28.9951	27.5543
320013	1.1122	22.8283	30.5865	31.2890	27.7704
320014	1.0863	27.2806	28.7089	30.4803	28.8692
320016	1.1877	25.0835	27.1492	26.6392	26.3157
320017	1.2526	31.6357	33.3496	30.5787	31.7132
320018	1.5466	26.5109	25.9248	28.3465	26.9112
320019	1.4058	27.8067	35.0217	28.7067	30.2291
320021	1.6177	26.9918	28.8504	29.6464	28.5375
320022	1.1805	23.9595	25.3707	27.5152	25.6824
320030	1.0355	21.0378	24.4497	25.5267	23.7760
320033	1.2179	31.7114	30.1471	30.1846	30.6573
320037	1.2261	24.9657	25.2876	27.8982	26.0668
320038	1.2583	21.7022	32.7192	31.6526	29.0049
320057	0.9342	*	*	*	*
320058	0.7891	*	*	*	*
320059	0.9914	*	*	*	*
320060	1.0123	*	*	*	*
320061	1.0244	*	*	*	*
320062	0.9178	*	*	*	*
320063	1.3924	25.0031	26.0104	27.4946	26.1581
320065	1.3068	27.3163	25.7945	26.9130	26.6849
320067	0.8969	24.9865	24.7025	25.4121	25.0457
320069	1.0788	22.4128	23.9863	25.3151	23.9147
320070	0.9255	*	*	*	*
320074	1.2398	31.1333	28.4396	28.8088	29.1311
320079	1.2567	26.1188	27.6877	31.5661	28.5366
320083	2.4441	26.6921	29.5483	32.9476	29.7656
320084	0.9659	17.5788	22.7706	24.2902	21.5110
320085	1.7552	27.9944	27.4100	28.4537	27.9656
320086	1.4549	*	*	*	*
320087	1.4087	*	*	*	*
330002	1.5746	30.9600	32.1956	34.7270	32.6026
330003	1.3519	24.4326	25.2223	26.8363	25.5134

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
330004	1.3486	28.0594	30.2236	30.3221	29.4844
330005	1.5906	30.3200	31.5030	33.2851	31.7057
330006	1.2777	33.6284	34.2001	36.3305	34.6909
330008	1.1661	23.4429	25.2005	26.2141	24.9418
330009	1.3679	36.2820	38.9166	41.3797	38.8021
330010	1.0125	20.7476	19.7098	20.5805	20.3268
330011	1.3769	25.1308	27.4747	26.8269	26.4855
330013	1.9457	26.4578	26.8382	28.8039	27.3887
330014	1.3340	42.1759	45.7619	46.3170	44.6766
330016	***	22.0493	23.0769	*	22.5738
330019	1.3054	38.5368	39.7429	44.5669	40.8893
330023	1.5332	35.9428	36.4736	37.5135	36.6971
330024	1.8017	42.7691	43.2342	44.8070	43.6044
330025	1.0470	21.2565	23.2424	24.2702	22.9271
330027	1.3957	42.8000	45.1920	45.9571	44.5424
330028	1.5242	36.6498	36.2901	38.0149	36.9921
330029	0.5263	23.2039	24.0679	22.9332	23.3387
330030	1.1557	24.6175	25.3454	25.5089	25.1589
330033	1.2306	24.5510	24.8022	25.0215	24.7867
330036	1.2083	29.1884	30.3757	30.4659	30.0058
330037	1.2293	22.3689	21.9246	23.4915	22.5873
330041	1.3172	37.4883	36.9934	37.1651	37.2207
330043	1.4628	39.1643	38.8060	40.6094	39.5025
330044	1.3448	26.5669	28.2293	28.2638	27.6922
330045	1.4081	38.1269	40.0326	41.6565	39.9725
330046	1.3741	50.3152	47.4975	52.2397	49.9710
330047	1.2134	24.3932	24.9934	22.9948	24.1095
330049	1.4894	29.8350	34.8585	34.9740	33.3449
330053	1.0882	20.6272	21.8383	20.1303	20.8285
330055	1.5371	41.5934	42.2007	44.2343	42.7274
330056	1.3952	36.0136	38.8910	39.9662	38.2404
330057	1.6801	26.4989	27.7121	30.1821	28.1418
330058	1.2660	22.2524	22.6852	23.6296	22.8638
330059	1.5525	41.7343	44.9162	45.3691	44.0386
330061	1.1747	36.0587	37.8828	37.8649	37.2897
330064	1.2588	38.0437	38.2332	41.5737	39.3172
330065	1.0605	25.3043	24.4004	26.2288	25.3194
330066	1.2723	29.1780	25.8174	27.2085	27.4297
330067	1.3943	27.8900	29.2571	30.7537	29.2927
330072	1.3016	37.8505	39.6996	41.4605	39.5860
330073	1.1038	22.5592	23.4020	25.1392	23.7038
330074	1.1944	22.6629	23.4576	23.1016	23.0811
330075	1.1185	23.1592	24.2552	23.7522	23.7243

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
330078	1.4694	25.8073	27.2870	27.6682	26.9480
330079	1.3803	24.6054	24.9941	27.9479	25.8292
330080	1.1780	39.1417	38.9405	40.2067	39.4434
330084	1.0863	22.5573	25.6880	27.3434	25.1538
330085	1.1548	25.3285	26.6235	27.1707	26.3816
330086	1.3186	32.7675	35.5269	40.9768	36.5732
330088	1.0081	34.0789	35.3871	37.4716	35.6517
330090	1.4585	25.5351	26.8730	27.7306	26.7370
330091	1.3835	25.9378	27.0040	28.3034	27.0888
330094	1.2594	25.7116	26.9148	28.6213	27.1131
330096	1.1975	22.7189	24.2422	24.7895	23.9180
330100	1.0911	38.3333	39.6244	39.3170	39.1012
330101	1.8981	40.1929	43.7944	45.5412	43.2290
330102	1.4092	25.3879	26.6887	27.2543	26.4455
330103	1.2001	22.8242	24.5585	25.4919	24.2908
330104	1.3423	33.7537	35.1076	36.5894	35.1635
330106	1.6920	43.8210	46.3657	48.2903	46.1855
330107	1.2342	34.9047	35.7384	38.0262	36.2534
330108	1.1276	23.2919	23.9368	25.3023	24.1897
330111	0.9664	20.3473	40.4349	23.2134	25.3146
330115	1.1983	25.2373	23.8235	24.3898	24.4747
330119	1.7295	39.0528	42.2901	41.2365	40.8433
330125	1.7387	27.2920	28.0584	29.4817	28.3197
330126	1.3052	35.2257	36.5689	37.7807	36.5517
330127	1.3108	45.3680	45.2993	45.2554	45.3073
330128	1.2260	39.5197	41.7790	43.3437	41.5733
330132	1.1197	21.0479	21.7648	22.1452	21.6693
330133	1.3681	39.3837	38.5228	39.9025	39.2587
330135	1.2098	27.9132	32.0525	33.2314	31.0904
330136	1.5310	25.8531	26.6680	25.4198	25.9630
330140	1.8047	27.6183	29.3461	31.1333	29.4088
330141	1.3185	39.4701	39.3741	39.1733	39.3359
330144	0.9870	22.9561	23.3874	24.9304	23.7659
330151	1.2181	21.7665	19.7959	21.6339	21.0262
330152	1.2985	37.6721	38.2079	39.5754	38.5010
330153	1.7178	26.4386	28.4446	28.9944	27.9872
330154	1.6910	*	*	*	*
330157	1.3789	26.5686	27.1432	29.7622	27.7887
330158	1.6698	38.2033	41.7010	39.5946	39.8288
330159	1.3560	28.2774	31.7835	33.8484	31.2093
330160	1.5496	36.6208	37.1915	39.0970	37.6431
330162	1.3350	34.9460	37.6226	38.7638	37.1399
330163	1.1200	27.1933	28.3910	28.6252	28.0762

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
330164	1.4912	27.7217	27.8746	29.8458	28.5206
330166	1.0574	20.4680	20.7121	22.8506	21.3017
330167	1.6289	36.7653	39.1251	39.2421	38.3481
330169	1.3986	45.3774	46.4939	47.5404	46.4032
330171	***	30.4005	35.1577	*	32.5880
330175	1.1294	23.8509	24.1005	26.7883	24.8942
330177	0.9937	20.6338	22.9834	23.4299	22.3277
330180	1.1910	24.3761	25.4170	26.8658	25.5784
330181	1.3026	41.4104	43.0977	46.2181	43.5492
330182	2.2884	40.9014	41.3033	42.7962	41.6653
330184	1.3684	35.8102	39.0437	39.7242	38.2068
330185	1.2655	36.3155	38.4002	39.6724	38.1541
330188	1.2407	25.1153	27.5988	29.7318	27.4390
330189	1.2886	22.3484	22.4383	25.8125	23.5451
330191	1.2849	25.5656	26.4328	28.2949	26.8179
330193	1.4321	39.9327	39.8910	40.0280	39.9502
330194	1.7935	45.5639	46.8880	49.8886	47.4712
330195	1.7073	39.7802	41.7885	43.3213	41.6784
330196	1.2869	36.7178	38.2525	38.6949	37.9132
330197	1.1136	26.8921	25.9872	26.5525	26.4721
330198	1.3912	33.4930	34.8985	35.8715	34.8139
330199	1.1935	38.6407	40.3948	39.4076	39.4837
330201	1.7804	37.2064	42.6707	46.5114	42.1342
330202	1.3955	37.4150	37.4158	38.7624	37.8761
330203	1.4160	32.1207	34.0499	34.6525	33.6392
330204	1.4430	39.6393	41.9953	39.5324	40.4256
330205	1.2294	31.9510	33.9418	35.3792	33.7857
330208	1.1943	32.1256	33.5287	37.1735	34.2445
330209	***	30.2038	*	*	30.2038
330211	1.0830	24.4470	25.8752	24.9432	25.1110
330213	1.0707	24.4049	27.4890	28.5370	26.7729
330214	1.8814	41.8719	42.1339	43.3229	42.4638
330215	1.2786	23.7361	23.9583	26.3978	24.6841
330218	1.0902	26.9638	26.9982	28.4113	27.4691
330219	1.7204	29.8889	32.5658	33.2147	31.8659
330221	1.3692	39.2080	40.0514	42.5486	40.6779
330222	1.2766	25.8507	27.7198	28.7858	27.5080
330223	0.9702	23.3669	26.1264	27.1970	25.6003
330224	1.3098	27.9231	29.1738	30.4784	29.2028
330225	1.2226	32.3585	35.7651	32.9036	33.6819
330226	1.4014	24.5646	24.8471	26.3685	25.2750
330229	1.2150	21.9356	23.0577	23.9243	22.9673
330230	1.0289	37.1298	38.6569	39.3863	38.3806

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
330231	1.1102	40.6697	44.9422	48.9021	44.9242
330232	1.2065	26.3313	27.4639	27.9615	27.2545
330233	1.5351	47.3497	52.7070	40.8539	46.1540
330234	2.3437	48.2306	49.3219	49.8804	49.1357
330235	1.1500	27.7031	29.4346	30.8034	29.3085
330236	1.5506	40.2386	42.8981	42.6205	41.9572
330238	1.2715	21.7435	21.8386	23.3953	22.3485
330239	1.2425	22.3854	23.1885	24.6391	23.4010
330240	1.4750	43.5753	40.5001	41.6132	41.8585
330241	1.8405	30.2304	32.7683	32.9275	32.0178
330242	1.3113	37.4870	36.9015	38.7875	37.7218
330245	1.7759	26.1811	27.4326	28.6698	27.4612
330246	1.3712	37.1611	35.7416	35.9577	36.2363
330247	1.1834	35.4980	39.0219	41.3465	38.4859
330249	1.3316	25.3246	24.6091	26.9856	25.6369
330250	1.3858	27.1606	29.0080	29.6186	28.6251
330259	1.5048	35.1514	36.4788	39.0213	36.8303
330261	1.2439	33.7834	40.2579	38.0216	37.2344
330263	1.0104	23.8738	24.1333	24.2125	24.0872
330264	1.3204	30.4701	31.0557	32.5050	31.6017
330265	1.2458	21.6477	23.9081	22.7433	22.7619
330267	1.3964	32.8541	34.9885	35.3907	34.4227
330268	0.9313	25.3567	23.8793	23.9135	24.3481
330270	2.0751	57.3596	55.2136	52.3154	54.6702
330273	1.3503	37.0157	35.9298	39.7880	37.6026
330276	1.1580	24.3300	26.0935	27.0445	25.8324
330277	1.2083	26.4535	30.9053	30.8156	29.1295
330279	1.6269	27.4539	29.6385	31.2393	29.4475
330285	1.9770	30.1928	31.1235	31.8987	31.0835
330286	1.3541	35.5895	37.6040	38.8556	37.3707
330290	1.6256	39.4690	40.6933	39.8036	39.9788
330304	1.3052	36.2845	37.3537	39.4632	37.8144
330306	1.4551	36.3552	38.7713	39.0409	38.0895
330307	1.3359	29.2529	29.5885	30.8121	29.9035
330314	***	26.2719	28.1788	22.6885	26.0610
330316	1.2408	34.8567	37.1766	37.9357	36.6703
330331	1.2871	39.8402	41.2694	44.1734	41.7992
330332	1.3079	35.1646	37.0111	38.6932	36.9320
330338	***	37.7497	*	*	37.7497
330339	0.7634	23.5786	24.3066	25.0057	24.2981
330340	1.2285	37.9000	37.4161	38.4726	37.9274
330350	1.5271	41.1339	44.4617	44.2389	43.3341
330353	1.2437	45.9692	45.0977	46.0215	45.7029

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
330354	2.1277	*	*	*	*
330357	1.2871	38.2286	40.3850	40.2132	39.5430
330372	1.2902	36.1840	35.1297	37.0323	36.1065
330385	1.0494	48.6175	49.0859	47.4017	48.3835
330386	1.3394	29.9366	33.3216	32.9990	32.1011
330389	1.7350	37.1862	39.6871	37.5908	38.1266
330390	1.2393	36.3842	35.5562	38.7652	36.9292
330393	1.7377	38.0619	39.2186	38.9324	38.7604
330394	1.6554	27.3388	28.4597	28.8074	28.2132
330395	1.4189	36.3921	37.5791	50.1316	40.5826
330396	1.3433	37.4998	39.4904	39.1956	38.7403
330397	1.4089	37.5682	41.4448	41.1682	39.9856
330399	1.1278	34.7394	36.7626	39.8023	37.1079
330401	1.3528	37.8559	40.4485	41.7839	40.0700
330403	0.9101	25.5163	25.2937	28.7282	26.3693
330404	0.9370	*	*	36.1069	36.1069
330405	0.9452	*	*	35.2720	35.2720
330406	0.9450	*	*	28.2733	28.2733
330407	0.9450	*	*	*	*
340001	1.4864	28.3988	29.5709	29.9718	29.3460
340002	1.7877	28.4860	29.6622	30.7403	29.6338
340003	1.2356	24.1602	26.0888	26.6831	25.7088
340004	1.4313	26.6404	27.5283	27.9200	27.3739
340008	1.2695	26.7443	27.7206	29.0661	27.8652
340010	1.3309	27.2105	28.7544	29.5232	28.5205
340011	1.1740	19.7441	22.0047	22.5152	21.4246
340012	1.2233	23.2288	24.7576	24.9271	24.3221
340013	1.2357	23.9492	26.3607	26.9152	25.7237
340014	1.6082	27.4888	27.8384	29.5350	28.3126
340015	1.3958	28.0585	28.3928	30.0979	28.8526
340016	1.3325	25.6454	27.2365	27.9651	26.9661
340017	1.2762	25.7780	27.5672	28.4866	27.2558
340020	1.1897	26.4465	27.5473	28.3461	27.4406
340021	1.3374	29.4864	29.3835	31.3630	30.1018
340023	1.3643	26.4225	26.2716	27.6921	26.8315
340024	1.1350	23.6638	26.4001	26.9001	25.6603
340025	1.2984	23.5881	24.0101	25.2846	24.3051
340027	1.2182	25.5973	26.3840	26.6528	26.2240
340028	1.5011	28.0323	30.7591	31.9872	30.2242
340030	1.9784	29.6630	30.4591	31.2051	30.4866
340032	1.4551	26.5958	28.7636	29.2080	28.2299
340035	1.0953	23.9669	24.6262	26.0846	24.8880
340036	1.3104	27.2691	27.3860	29.0646	27.9430

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
340037	1.1213	25.6262	29.0618	30.5362	28.5636
340038	1.2380	22.4829	24.2111	26.2600	24.3749
340039	1.2814	27.4457	27.8228	29.5069	28.2777
340040	1.9087	27.6626	28.7434	30.1280	28.8804
340041	1.3330	24.3595	26.8314	27.1285	26.1146
340042	1.2352	25.0110	25.6349	27.0597	25.9223
340047	1.8089	27.4022	28.4968	28.7620	28.2345
340049	1.7876	30.6791	29.6826	31.5555	30.6578
340050	1.2009	26.0365	27.5274	29.2290	27.6033
340051	1.1888	23.9612	24.4561	25.4981	24.6514
340053	1.4922	27.8577	28.9355	30.8342	29.2324
340055	1.2126	26.0647	26.5752	29.0116	27.1561
340060	1.0616	22.9097	25.1791	26.8387	24.9820
340061	1.7486	27.0089	29.8574	31.2910	29.4148
340064	1.1203	23.4233	23.9701	25.0814	24.1855
340068	1.2936	22.6814	23.6757	24.7409	23.7006
340069	1.8405	29.3439	31.4951	32.2171	31.0757
340070	1.2530	25.3226	26.6546	27.7679	26.6192
340071	1.0610	26.3921	27.9748	29.7343	28.0718
340072	1.1433	25.2493	24.1350	*	24.6895
340073	1.6533	30.9849	31.6803	33.1054	31.9638
340075	1.2351	25.1551	25.1438	26.8315	25.7438
340084	1.1232	21.1363	23.1300	25.6885	23.2801
340085	1.1499	26.5164	27.9572	29.1095	27.8498
340087	1.2332	22.4287	25.4730	23.8360	23.9117
340090	1.3077	26.4031	26.7428	28.3615	27.2242
340091	1.6024	27.1285	28.8044	30.4371	28.8169
340096	1.2334	24.9036	26.5438	26.5814	26.0415
340097	1.2445	26.2228	29.8005	27.9810	27.9553
340098	1.4675	28.2493	29.7180	31.3916	29.8233
340099	1.2911	21.8564	23.9702	26.0077	24.0253
340104	0.7848	16.1204	17.0165	19.9492	17.8311
340106	1.1410	26.0892	26.1340	24.5154	25.5147
340107	1.2007	24.1762	26.5626	27.3565	26.0755
340109	1.2446	25.4464	26.6383	26.6479	26.2348
340113	1.9481	28.5587	30.3841	32.3786	30.4669
340114	1.5308	28.3222	28.1311	30.1207	28.8795
340115	1.6263	26.7592	27.2781	28.0974	27.3867
340116	1.7456	27.5881	29.3698	29.9447	28.9459
340119	1.2857	25.6226	29.4470	27.2938	27.4288
340120	1.0687	25.9134	25.5399	26.1465	25.8653
340121	1.0926	23.1343	23.8854	25.1577	24.0802
340123	1.2775	26.0637	28.5669	28.7150	27.7869

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
340124	***	22.2988	23.5480	25.7294	23.7132
340126	1.3296	26.9866	28.2247	30.6902	28.6670
340127	1.1956	26.4746	28.2161	28.8675	27.8614
340129	1.3097	25.7976	26.7606	31.7863	27.9622
340130	1.3489	26.1717	28.1594	29.5294	27.9867
340131	1.4682	27.4750	28.8542	29.6571	28.6883
340132	1.2117	23.5856	24.6162	25.3264	24.5301
340133	1.0195	23.4678	24.8579	26.8850	25.1027
340137	***	22.1741	28.9672	27.0874	25.1889
340138	0.8951	*	*	*	*
340141	1.6760	29.3878	29.3171	29.3372	29.3473
340142	1.2125	26.6886	27.7555	28.2413	27.5943
340143	1.5510	28.0082	27.9777	29.3861	28.4863
340144	1.2179	26.1865	27.0150	27.6548	26.9378
340145	1.2181	25.8459	26.7482	28.0647	26.9036
340147	1.3028	26.9162	28.2626	29.6960	28.3104
340148	1.5007	25.3660	25.8325	27.9136	26.4054
340151	1.2158	22.7736	23.2158	24.5782	23.5277
340153	1.9228	27.6509	28.5979	29.8278	28.7241
340155	1.4754	30.3443	30.9501	31.7570	31.0375
340156	0.8726	*	*	*	*
340158	1.1298	27.7816	27.6526	29.4110	28.3019
340159	1.2138	24.2588	25.3108	28.1706	25.9718
340160	1.3517	21.7923	23.4631	24.2016	23.1722
340166	1.3499	27.1132	28.5395	29.9122	28.5241
340168	0.4196	*	*	*	*
340171	1.1180	27.8539	27.4701	31.1954	28.9097
340173	1.3292	28.3502	30.2815	30.9843	29.9362
340177	***	26.7155	*	*	26.7155
340179	***	34.1895	*	*	34.1895
340182	***	27.8071	*	*	27.8071
340183	1.1992	*	*	30.1261	30.1261
350002	1.8134	22.4307	23.5869	23.6051	23.2272
350003	1.2130	23.9639	24.9975	24.5812	24.5239
350006	1.5620	21.2726	22.4626	23.4343	22.3837
350009	1.0716	23.8681	24.5737	23.9795	24.1451
350010	1.0682	20.1290	20.4198	*	20.2749
350011	1.9173	23.8400	24.1135	26.0201	24.6628
350014	0.9542	19.1684	17.5837	*	18.3437
350015	1.5995	20.9046	21.3342	22.9120	21.7905
350017	1.2265	22.4359	21.6187	24.0968	22.7333
350019	1.6978	23.2018	24.9615	24.9890	24.4059
350030	0.9535	20.2722	22.5976	23.1023	22.0052

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
350063	0.9152	*	*	*	*
350064	0.7388	*	*	*	*
350070	1.7642	25.2365	26.2454	26.2871	25.9341
360001	1.4799	25.8669	28.8623	30.1038	28.2807
360002	1.2849	24.5155	25.4859	25.2209	25.0798
360003	1.7733	28.9672	30.7812	31.8976	30.5720
360006	1.8121	30.1363	30.9806	31.8814	31.0226
360008	1.3171	26.2632	27.5683	28.0202	27.2869
360009	1.5581	25.0007	27.0618	28.2423	26.7842
360010	1.2393	23.7825	24.7352	26.6040	25.0710
360011	1.2810	27.6036	31.5587	29.9882	29.6807
360012	1.3486	30.1416	31.0526	31.9837	31.0590
360013	1.0853	27.0893	29.8412	30.2406	29.0673
360014	1.1225	27.1017	27.0743	28.1811	27.4866
360016	1.4861	27.8031	29.6298	30.2190	29.2170
360017	1.6201	29.8525	31.7081	32.6006	31.4000
360019	1.3270	26.9178	27.2997	28.8568	27.7070
360020	1.5822	23.6400	25.6328	27.8079	25.6706
360025	1.4567	27.4533	27.1546	28.4761	27.6994
360026	1.3756	25.5379	25.2945	27.5757	26.1394
360027	1.5167	27.4454	28.2923	29.9449	28.5691
360029	1.1798	24.3216	26.4208	28.0191	26.2892
360032	1.2280	25.0034	25.9916	27.2636	26.0961
360035	1.6374	30.0172	31.3181	32.0858	31.1307
360036	1.1946	27.8343	29.3514	29.9410	29.0671
360037	1.5001	29.0046	30.0446	30.6552	29.8840
360038	1.5813	25.4274	31.0611	31.3776	29.1463
360039	1.4591	23.9783	24.7873	25.8216	24.8986
360040	1.2066	24.8569	25.5337	26.7450	25.7186
360041	1.4501	26.1522	26.6755	28.4439	27.1154
360044	1.1764	21.5619	24.3840	24.7698	23.5350
360046	1.2135	25.4673	26.2417	28.2972	26.6963
360048	1.8270	29.3415	29.4378	30.0390	29.6177
360049	***	26.2222	*	*	26.2222
360051	1.6895	26.8501	28.1167	29.4434	28.1389
360052	1.5468	26.2066	26.8806	28.4731	27.2056
360054	1.3399	22.9359	24.8248	23.6606	23.7907
360055	1.4307	27.3941	30.0143	31.4794	29.5869
360056	1.5484	26.5318	30.3677	31.3936	29.5171
360058	1.1205	23.8119	24.5003	25.9295	24.7687
360059	1.4705	29.3624	30.6173	30.6294	30.2157
360062	1.5585	31.7422	32.8893	32.9025	32.5527
360064	1.5122	25.2336	27.7795	28.6101	27.1797

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
360065	1.2711	28.0405	29.7155	31.5066	29.7624
360066	1.4333	27.1436	29.7605	30.9652	29.2904
360068	1.8611	26.2065	26.6933	28.6335	27.1933
360070	1.6707	27.2389	27.8891	28.8739	27.9944
360071	1.1464	23.4619	26.4081	25.7956	25.2138
360072	1.5261	25.9589	27.2286	29.1514	27.5017
360074	1.2807	25.8959	27.5328	28.0283	27.1689
360075	1.1977	26.8925	26.1657	28.3930	27.1862
360076	1.5138	28.1013	29.0148	29.5342	28.9094
360077	1.5015	28.4449	28.0133	28.3022	28.2551
360078	1.2809	25.7885	27.4689	27.3652	26.8578
360079	1.7281	27.2437	30.1230	31.3132	29.5591
360080	1.1029	21.4526	22.7020	21.8806	22.0300
360081	1.3038	29.8366	29.5312	31.4293	30.2595
360082	1.3717	29.2561	28.7925	30.5837	29.5284
360084	1.6305	27.3917	28.5402	29.2489	28.4186
360085	2.0543	31.5800	32.8502	33.1295	32.5915
360086	1.6511	25.4218	27.3124	29.1579	27.2845
360087	1.4327	29.6579	28.4185	28.6336	28.8854
360089	1.1322	25.3465	25.5608	28.0779	26.2939
360090	1.4636	29.0199	30.7530	29.2662	29.6809
360091	1.3410	25.8657	27.6809	28.2009	27.2637
360092	1.2543	25.4954	25.4055	28.0813	26.3117
360095	1.4831	26.4635	29.3787	30.2138	28.6213
360096	1.1357	25.9275	26.8653	27.9514	26.9257
360098	1.4299	25.5973	26.6382	26.5839	26.3006
360100	1.3412	25.4523	23.6167	25.8143	24.9654
360101	1.4828	27.6030	29.7817	30.6650	29.3474
360107	1.1819	24.6095	26.0534	26.8180	25.8590
360109	1.0414	26.3131	30.1382	30.4643	28.9118
360112	1.8517	30.5715	31.1356	32.4403	31.4046
360113	1.2810	26.6556	30.2871	30.3914	29.0679
360115	1.3316	25.9841	26.1821	27.9711	26.7177
360116	1.2075	25.1717	26.4968	26.8632	26.2118
360118	1.4770	27.3884	28.5643	29.9823	28.5729
360121	1.3030	27.4442	28.3835	31.6766	29.0947
360123	1.4055	27.1920	28.0334	28.5435	27.9304
360125	1.2068	24.1388	25.9067	27.1776	25.6998
360130	1.5015	25.6570	26.3986	28.1811	26.7607
360131	1.3699	25.3719	26.6635	27.3426	26.4485
360132	1.3752	27.7724	29.4070	29.8411	28.9954
360133	1.5964	29.8684	31.7521	33.1812	31.6383
360134	1.7720	27.7339	28.5141	29.9198	28.7671

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
360137	1.7066	26.1250	27.6894	30.3116	28.0264
360141	1.6058	29.7937	31.1778	31.9397	30.9585
360143	1.3050	28.3057	26.9394	28.0693	27.7630
360144	1.3418	28.2473	28.9177	29.6547	28.9572
360145	1.6525	27.1908	28.1835	29.3271	28.2631
360147	1.2564	25.5854	27.5548	29.2371	27.4487
360148	1.1800	26.0837	26.3399	25.7460	26.0503
360150	1.3208	25.1217	28.2561	27.8840	27.0954
360151	1.4705	25.3780	26.5636	26.9672	26.3117
360152	1.5119	29.9425	31.5377	33.1017	31.5316
360153	0.9975	19.8499	20.2147	21.8416	20.6630
360155	1.4647	26.9127	28.9521	29.1711	28.3795
360156	1.1515	24.3281	25.0833	26.2268	25.2579
360159	1.3304	29.1529	28.6174	29.0187	28.9290
360161	1.3356	25.4433	27.0875	27.7423	26.7565
360163	1.8751	28.9742	30.0724	31.2087	30.0785
360170	1.1913	28.5474	29.5954	30.0688	29.4397
360172	1.3778	27.5669	28.8283	30.2330	28.8822
360174	1.2801	26.8586	28.3143	28.3769	27.8664
360175	1.2484	28.1531	28.3054	29.7499	28.7382
360179	1.5497	30.0311	29.8299	31.3540	30.4095
360180	2.3384	29.6633	31.4342	32.0225	31.0902
360185	1.2632	25.6800	26.1080	26.4210	26.0790
360187	1.4958	24.9353	25.7600	27.3745	26.0393
360189	1.1414	26.3756	27.5097	28.3738	27.4374
360192	1.3272	26.4616	27.5991	29.1999	27.8037
360195	1.0816	25.0922	27.6155	27.2630	26.6353
360197	1.1347	28.7580	28.9207	28.5267	28.7320
360203	1.1917	24.4433	25.3692	27.7569	25.8604
360210	1.2160	28.2976	29.6476	31.8182	29.9483
360211	1.6066	25.7053	26.5459	27.5081	26.5645
360212	1.3073	25.6080	26.6976	28.5882	26.9664
360218	1.2278	29.8662	30.0101	31.1641	30.3583
360230	1.5270	28.8018	30.0661	30.5995	29.8417
360234	1.4178	25.9360	31.0656	30.7926	29.2957
360236	1.3042	25.6728	29.5321	29.9367	28.6898
360239	1.3542	27.2939	30.7728	31.7938	29.9658
360241	***	23.0662	25.7290	25.8137	24.8236
360242	1.9579	*	*	*	*
360245	0.6345	20.6504	20.3426	20.4589	20.4760
360247	0.4196	19.3677	*	*	19.3677
360253	2.2685	33.2371	34.3347	34.6887	34.1008
360259	1.2289	25.9878	27.2902	28.0886	27.1594

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
360261	1.3786	22.3614	25.6332	26.6262	24.8465
360262	1.2971	28.6995	30.1559	31.5637	30.2324
360263	1.9434	25.1652	25.4864	28.1671	26.3880
360264	***	36.0754	*	*	36.0754
360265	***	36.6265	*	*	36.6265
360266	2.1579	*	31.7565	29.8385	30.6504
360267	***	*	34.0936	*	34.0936
360268	***	*	34.0526	*	34.0526
360269	1.6786	*	24.8552	25.5191	25.2444
360270	1.1268	*	*	28.8677	28.8677
360271	3.3666	*	*	28.4353	28.4353
360272	***	*	*	38.1014	38.1014
360273	***	*	*	37.6645	37.6645
360274	1.5099	*	*	*	*
360275	2.9455	*	*	*	*
360276	1.1398	*	*	*	*
370001	1.6500	26.0194	26.8884	28.4907	27.1489
370002	1.1283	22.0476	23.6886	26.2486	23.9832
370004	1.1122	26.7434	26.8521	28.2804	27.2961
370006	1.2357	22.4802	23.9935	25.2307	23.8429
370007	1.0267	19.4036	20.3706	21.1260	20.2913
370008	1.4427	25.3352	26.6563	27.9944	26.6857
370011	1.0064	21.9649	22.3391	23.1761	22.5133
370013	1.5425	26.5364	27.2667	28.3502	27.4250
370014	1.0687	25.9393	26.4488	28.8962	27.1132
370015	1.0271	24.7547	25.5815	27.8061	26.1036
370016	1.5737	26.7938	29.8284	30.4672	28.9281
370018	1.5019	25.3573	24.6868	31.2335	27.0627
370019	1.1996	22.0221	25.2814	26.7613	24.7202
370020	1.4078	20.8723	22.7566	24.7520	22.7944
370022	1.1936	24.6099	22.2289	26.4836	24.3187
370023	1.2829	23.5170	24.0376	24.9580	24.1639
370025	1.3456	23.9873	24.5547	24.8336	24.4546
370026	1.4491	25.8428	25.5172	26.0203	25.7958
370028	1.9488	27.8621	28.5619	29.9849	28.8120
370029	1.1361	26.8508	28.5309	30.0134	28.4170
370030	1.0167	24.1483	25.8212	26.0831	25.3424
370032	1.4760	24.8626	26.2642	28.0739	26.3357
370034	1.2657	19.5099	20.4106	23.2192	21.1228
370036	1.0933	19.2318	19.8162	21.1544	20.1516
370037	1.6163	24.9553	25.2350	26.8992	25.7116
370039	1.0405	23.0254	23.5745	25.3422	23.9679
370040	0.9726	22.8356	26.7395	19.7644	23.1717

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
370041	0.8882	22.6731	22.9834	29.5074	24.8468
370047	1.4257	24.1991	24.4766	27.8937	25.5718
370048	1.0283	21.4543	22.0627	23.4848	22.3180
370049	1.3019	23.8844	22.8755	24.2099	23.6444
370051	1.0508	19.8329	19.3222	21.8716	20.3137
370054	1.2413	22.4652	25.2142	23.4644	23.6684
370056	1.8680	24.3986	25.5453	27.6178	25.8235
370057	1.0265	19.8683	22.1337	23.1814	21.6645
370060	1.0459	19.9025	23.3858	25.5571	22.9760
370065	1.0143	21.2343	23.5815	24.0062	22.9091
370072	0.8303	11.7942	13.0963	22.8598	14.5182
370078	1.5375	27.8611	26.6972	30.4837	28.2981
370080	0.9491	19.9595	22.4113	23.7231	22.0525
370083	0.9505	19.2568	20.9878	21.9162	20.6846
370084	1.0061	19.6230	20.7326	17.4202	19.1737
370089	1.4208	20.6153	22.1523	22.0607	21.6436
370091	1.6034	24.1438	25.8697	28.0487	26.0383
370093	1.6604	26.0459	27.5356	26.7272	26.7697
370094	1.3758	24.5555	26.5265	28.3512	26.4238
370097	1.2824	26.3168	26.8138	28.0911	27.0820
370099	1.0542	24.9971	26.7206	30.5437	27.4902
370100	0.9055	17.9732	19.4002	20.6298	19.4039
370103	1.0410	18.8933	19.4273	22.2675	20.0896
370105	2.0249	26.7973	26.6399	30.5438	27.9858
370106	1.4205	27.8979	28.5957	29.6797	28.7258
370112	0.9286	16.0592	16.7888	19.0130	17.3059
370113	1.1290	26.9720	26.4608	30.0061	27.8043
370114	1.5749	23.0006	25.9841	27.1348	25.3838
370138	1.0939	20.2528	22.1675	23.6348	21.8809
370139	0.9156	19.4287	20.5156	21.0759	20.3639
370148	1.5358	27.0904	28.1933	29.3447	28.2975
370149	1.3333	23.3493	23.3423	23.0764	23.2547
370153	1.1065	23.2778	24.1667	25.9238	24.4637
370156	1.0054	25.2562	23.0104	22.7140	23.5681
370158	0.9397	20.7641	21.5228	22.0056	21.4294
370166	0.8551	25.1107	24.7251	26.3420	25.3952
370169	0.9454	16.8252	16.6752	24.5389	19.7623
370170	0.9037	*	*	*	*
370171	0.9688	*	*	*	*
370172	0.8566	*	*	*	*
370173	0.9839	*	*	*	*
370174	0.9087	*	*	*	*
370176	1.3162	24.7655	24.9650	26.6687	25.4764

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
370178	0.9115	16.0179	16.0747	15.6720	15.9157
370180	1.1405	*	*	*	*
370183	0.9675	24.7103	23.8419	30.3850	26.4222
370190	1.5008	29.1568	34.6942	32.5635	32.3675
370192	1.9589	27.6367	19.0638	19.1346	21.1814
370196	***	22.3498	20.8296	24.6984	22.8184
370199	0.9156	23.3989	23.7412	23.9376	23.7092
370200	1.0550	20.5175	21.7153	19.7060	20.6654
370201	1.7010	23.8090	24.2364	25.5882	24.5327
370202	1.4932	26.1132	25.7966	25.8261	25.9089
370203	1.9335	22.8869	25.7770	30.3641	26.3107
370206	1.7567	26.0353	27.5752	30.8151	28.1718
370210	2.1596	23.3786	27.2111	25.7905	25.4315
370211	1.1754	27.8737	28.6537	30.9656	29.3416
370212	1.8346	19.1720	20.3495	20.0919	19.8985
370214	0.8938	20.6217	21.0732	20.1495	20.5860
370215	2.3012	31.5652	32.4087	32.0950	32.0525
370216	2.0087	27.2429	25.8260	29.6658	27.5901
370217	***	26.8677	*	*	26.8677
370218	1.9642	*	30.3445	23.7517	26.4626
370219	***	*	*	41.4392	41.4392
370220	2.2977	*	*	21.3168	21.3168
370222	1.8772	*	*	26.9175	26.9175
370223	0.8701	*	*	24.0154	24.0154
370226	1.4674	*	*	*	*
370227	0.9360	*	*	*	*
370228	1.2380	*	*	*	*
380001	1.2934	29.5842	32.0770	33.8490	31.8559
380002	1.2138	30.3385	31.5246	32.6830	31.5506
380004	1.6436	32.6901	34.5432	36.1021	34.4662
380005	1.4169	30.9087	33.2849	33.5765	32.5883
380007	1.9731	33.9601	35.1697	36.4222	35.2090
380009	2.0902	32.4016	34.5635	36.5688	34.5656
380010	***	34.4208	*	*	34.4208
380014	1.8829	33.6078	33.1928	35.7101	34.1748
380017	1.7874	34.2605	35.3734	36.8103	35.5005
380018	1.8534	30.9923	31.8181	32.4884	31.7968
380020	1.4565	29.6053	34.6183	35.7392	32.9987
380021	1.4960	29.2164	32.6142	33.0628	31.5752
380022	1.3514	30.1742	29.6224	30.9181	30.2428
380025	1.1713	35.5084	36.4910	38.1507	36.7342
380027	1.3803	26.4982	28.0247	31.4398	28.6437
380029	1.2643	28.7994	29.4461	33.3368	30.6613

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
380033	1.7387	33.4828	34.0094	36.0798	34.5620
380037	1.3323	32.4033	32.7922	34.0321	33.1184
380038	1.2769	34.5971	35.1105	35.0350	34.9151
380039	***	38.0989	*	*	38.0989
380040	1.4589	31.2286	32.9081	34.4500	32.9490
380047	1.8055	31.0584	32.8188	35.8165	33.3102
380050	1.4233	27.1814	29.7329	31.3088	29.4435
380051	1.7208	30.8891	32.8545	35.0114	32.9636
380052	1.2617	25.6085	28.6119	27.7656	27.2630
380056	1.1176	27.7253	29.1686	31.0210	29.2593
380060	1.5000	32.0101	33.8863	35.1106	33.6775
380061	1.6410	32.3699	34.5230	35.8922	34.2580
380071	1.3772	31.7761	31.0901	31.6821	31.5140
380075	1.3485	33.8962	31.6884	34.0197	33.2058
380081	***	26.8149	*	*	26.8149
380082	1.2959	35.6708	35.7821	37.7268	36.4079
380089	1.3304	34.6015	35.4850	37.0017	35.7207
380090	1.3419	33.0990	35.5535	41.4540	36.7281
380091	1.4177	39.9703	40.5066	39.7431	40.0820
380100	***	*	*	45.3882	45.3882
380101	1.8685	*	*	*	*
390001	1.5671	23.6075	24.3251	25.4188	24.4578
390002	1.3393	24.7867	25.0860	25.9827	25.3000
390003	1.2164	23.3672	24.5099	26.2872	24.7254
390004	1.6102	24.4068	25.2424	26.5054	25.3615
390006	1.9516	26.8581	28.6926	30.9914	28.9690
390008	1.1400	22.8042	22.6297	22.9417	22.7923
390009	1.8056	26.7462	26.7234	29.0286	27.5290
390010	1.1909	24.5785	24.8196	26.0966	25.1628
390011	***	21.4856	20.2291	*	20.8697
390012	1.1860	30.7542	32.4856	34.2004	32.4301
390013	1.3643	25.0037	26.2323	28.3039	26.5756
390016	1.2421	23.2095	24.3488	26.1802	24.5419
390019	1.1202	24.0538	25.7515	25.3185	24.9937
390022	***	30.3565	29.6308	*	29.9808
390023	1.2628	35.4452	34.7787	36.2618	35.4929
390024	***	33.5186	38.8750	37.4815	36.5109
390025	0.4304	19.1362	20.3878	*	19.7743
390026	1.3104	31.8512	31.8309	36.0608	33.1373
390027	1.6507	35.5692	39.2158	40.9110	38.5961
390028	1.5805	27.1869	27.1451	29.6218	27.9538
390030	1.1867	23.6063	24.6343	26.5678	24.9946
390031	1.2119	26.2654	27.2033	26.1258	26.5391

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
390032	1.2693	23.9466	24.5243	25.3756	24.6177
390035	1.1793	28.4564	29.5417	27.2130	28.3547
390036	1.4871	21.6358	24.4917	26.1956	24.0505
390037	1.4579	25.4290	25.2296	27.0788	25.9187
390039	1.2528	22.0208	23.2300	22.1531	22.4614
390041	1.3061	22.9814	24.2257	25.1190	24.1291
390042	1.3629	28.3633	28.0996	29.6213	28.7208
390043	1.1963	23.2378	24.2087	24.3590	23.9396
390044	1.5577	28.7758	29.4057	29.9959	29.4221
390045	1.4855	23.9343	24.6495	25.8800	24.8311
390046	1.6668	29.6574	30.5115	32.5273	30.9445
390048	1.1237	28.5342	28.3152	28.4563	28.4342
390049	1.5809	29.6121	30.7431	31.0290	30.4803
390050	2.0173	27.2599	27.3481	29.6715	28.1215
390052	1.1459	24.9510	25.1462	26.3700	25.5007
390054	***	24.4435	27.4805	27.5696	26.3439
390056	1.1116	23.5077	23.5821	24.7038	23.9363
390057	1.3310	29.7982	30.9198	31.0279	30.6018
390058	1.3061	26.9546	27.7296	29.6620	28.1048
390061	1.5160	29.1318	30.0597	30.9208	29.9897
390062	1.1404	21.2999	21.0713	22.8856	21.7738
390063	1.8383	26.4998	26.8381	28.3987	27.2934
390065	1.3170	27.6249	29.5654	31.8841	29.7498
390066	1.3875	25.9645	25.4407	29.0033	26.8311
390067	1.7879	29.7234	30.6128	32.2891	30.8953
390068	1.3409	26.7358	29.0962	29.6984	28.5421
390070	1.3537	33.3185	34.4935	34.5501	34.1267
390071	1.0067	24.6462	24.8467	26.3830	25.3090
390072	1.0690	25.3029	26.2568	28.8145	26.7359
390073	1.6912	25.7822	26.4083	27.0876	26.5004
390074	***	23.6500	25.4098	*	24.5222
390076	1.3187	31.8500	32.7671	33.9908	32.8750
390079	1.8477	22.5607	24.4452	26.0199	24.3381
390080	1.3935	28.7063	29.2645	31.6210	29.8848
390081	1.2384	31.7569	33.6247	36.4788	33.9951
390084	1.1283	23.2039	24.3372	24.3191	23.9423
390086	1.6174	23.5141	25.0992	24.7454	24.4728
390090	1.9163	27.3528	27.0122	30.1256	28.1619
390091	1.1768	21.7010	23.3562	23.2118	22.7621
390093	1.1903	22.6082	22.6023	23.8846	23.0315
390095	1.1696	22.6150	24.6290	25.3859	24.2115
390096	1.6038	28.8258	28.6055	30.3910	29.2651
390097	1.2503	26.1741	27.9858	28.1285	27.3790

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
390100	1.6435	30.0132	30.0234	32.7836	31.0014
390101	1.2845	23.1497	24.8377	25.9850	24.6920
390102	1.4756	24.8369	24.4589	25.5336	24.9498
390103	***	20.5741	20.4446	*	20.5090
390104	1.1048	19.2326	19.6630	20.4552	19.7624
390107	1.5869	24.1159	24.6565	25.6790	24.8682
390108	1.2071	27.8171	28.5928	34.3066	30.2004
390110	1.5938	27.7311	25.3407	25.7159	26.1484
390111	2.1585	34.2990	34.8756	37.7322	35.7285
390112	1.3263	20.2380	21.5439	18.4185	19.9666
390113	1.3338	23.3686	24.2593	24.8669	24.1709
390114	1.6383	26.9620	27.9184	28.5336	27.8266
390115	1.4264	29.6905	30.8063	32.5058	31.0531
390116	1.2616	32.2513	33.2562	33.9295	33.1586
390117	1.1772	20.7821	21.5038	22.2327	21.5359
390118	1.1741	20.5614	21.8917	23.6535	22.0853
390119	1.2813	23.0928	24.3245	25.3907	24.2634
390121	***	25.4826	*	*	25.4826
390122	1.1069	23.1866	23.3220	24.6434	23.7142
390123	1.1989	32.4528	34.0062	35.1244	33.8969
390125	1.2501	22.4033	22.8816	24.0199	23.1236
390127	1.3566	31.9091	33.6557	33.1227	32.8966
390128	1.2329	24.1628	24.1390	25.1858	24.5042
390130	1.2051	23.0592	23.2504	30.7083	25.4530
390131	1.3539	23.0577	23.5783	27.7146	24.8839
390132	1.4532	29.6396	31.1168	30.0751	30.2701
390133	1.7588	31.1083	32.9812	33.0604	32.4225
390136	***	23.9813	*	*	23.9813
390137	1.4546	24.2878	26.1457	26.9156	25.8037
390138	1.1933	25.3410	27.4231	27.7565	26.8686
390139	1.3513	34.1447	34.0836	36.5001	34.9231
390142	1.5277	33.8224	34.5773	33.3509	33.9114
390145	1.5634	24.6672	25.6980	26.9212	25.7786
390146	1.1821	22.6752	25.1805	23.9878	23.9699
390147	1.3777	26.8522	28.6606	29.0995	28.1888
390150	1.1316	22.8228	22.7668	22.6483	22.7485
390151	1.3423	29.9254	31.4067	31.8967	31.1176
390153	1.3709	32.8234	33.2427	36.0287	34.1055
390154	1.2181	22.8391	23.3559	23.9785	23.4011
390156	1.3560	32.2688	32.8999	33.7057	32.9638
390157	1.3263	21.5923	22.1112	23.0989	22.2739
390160	1.3333	24.0208	22.9696	25.2043	24.0533
390162	1.5038	35.5057	34.5809	35.1844	35.0927

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
390163	1.2348	23.2055	22.8341	24.8761	23.6457
390164	2.1316	26.3087	27.1950	29.7778	27.7690
390166	***	20.9272	23.3255	28.2178	23.9473
390168	1.4936	26.1365	26.9816	27.3674	26.8311
390169	1.4117	26.5514	26.2643	26.6063	26.4727
390173	1.2356	23.9927	25.6455	27.6039	25.7724
390174	1.6826	34.2069	34.8999	35.1118	34.7519
390176	1.1316	23.9779	24.1247	*	24.0545
390178	1.3243	22.6006	23.1452	23.9166	23.2195
390179	1.4258	28.0688	30.1219	31.5498	29.9844
390180	1.3924	34.9832	35.5291	38.2997	36.3046
390181	***	25.9871	26.6021	27.8833	26.8195
390183	1.1442	27.0122	27.8358	28.2211	27.6773
390184	1.1122	22.7451	23.9736	23.9973	23.5374
390185	1.2585	25.4256	27.1119	25.5318	25.9883
390189	1.1469	22.6796	23.6215	23.4902	23.2867
390192	1.0397	20.5459	23.6171	23.7958	22.6677
390194	1.2048	27.5890	26.3152	23.7367	25.7642
390195	1.6572	34.2980	34.5594	37.2504	35.3808
390196	1.6451	*	*	*	*
390197	1.4166	26.8270	27.2455	27.7303	27.2757
390198	1.1271	20.5979	20.4350	21.0861	20.7064
390199	1.1363	22.3224	23.0046	24.5469	23.3010
390201	1.3573	27.0054	27.3542	28.5668	27.6595
390203	1.5284	29.4930	29.1370	30.7244	29.8050
390204	1.2928	29.5251	30.7346	32.0242	30.7960
390211	1.2850	25.1689	26.5052	27.7875	26.4997
390217	1.2307	23.5879	24.1886	26.2706	24.6774
390219	1.3587	25.4886	26.1196	26.3263	25.9701
390220	1.0763	28.9128	30.7435	32.0891	30.6092
390222	1.2662	30.9464	31.7361	32.7077	31.8280
390223	1.9832	30.2523	34.3280	36.5784	33.7268
390225	1.1816	27.5803	27.2555	26.3642	26.9597
390226	1.7115	32.6658	32.6508	35.4683	33.6054
390228	1.3605	23.9845	24.2242	25.5120	24.5899
390231	1.4010	30.9339	32.8353	35.2312	33.0480
390233	1.3801	25.6904	27.2597	28.3660	27.1368
390236	0.9816	22.1144	23.1290	24.5574	23.2396
390237	1.5871	27.4944	28.4337	29.9748	28.6624
390246	1.1781	25.1956	26.0179	*	25.6189
390256	2.0015	28.0617	28.8970	28.5887	28.5308
390258	1.4644	30.4142	31.7164	32.0551	31.4310
390263	1.5202	28.5864	29.9850	30.2069	29.6617

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
390265	1.5374	24.0675	25.0166	27.7795	25.6291
390266	1.1886	20.8789	22.2228	23.0142	22.0428
390267	1.2765	24.2428	24.8309	25.7571	24.9527
390268	1.4057	25.6643	26.7342	28.4200	27.0044
390270	1.6182	24.9510	26.5010	27.0301	26.2573
390272	0.6048	*	*	32.9918	32.9918
390278	0.6015	26.6664	28.6323	28.8318	28.0569
390285	1.4914	36.7163	37.6669	38.4703	37.6186
390286	1.2122	29.5281	31.3393	31.7337	30.8710
390287	***	39.3176	42.2401	*	40.3959
390288	***	30.9701	*	*	30.9701
390289	***	30.7583	*	*	30.7583
390290	1.8018	38.3776	41.1426	47.7663	42.3002
390302	0.8675	.	*	*	.
390303	***	27.5580	*	*	27.5580
390304	1.2937	30.4832	32.1633	33.4134	32.1090
390305	***	*	29.3217	*	29.3217
390306	***	*	40.3789	*	40.3789
390307	2.0387	*	24.5393	22.9474	23.6870
390308	***	*	36.1737	*	36.1737
390309	***	*	37.8924	*	37.8924
390310	***	*	44.3991	*	44.3991
390311	***	*	*	49.9027	49.9027
390312	1.2872	*	*	51.3372	51.3372
390313	1.1630	*	*	*	*
390314	1.9352	*	*	*	*
390315	1.7233	*	*	*	*
390316	1.8448	*	*	*	*
390317	0.7628	*	*	*	*
390318	1.0143	*	*	*	*
400001	1.3297	13.9386	14.9151	15.4249	14.7738
400002	1.9377	15.3833	12.9440	12.9793	13.6878
400003	1.3772	13.9258	15.7906	14.6859	14.8163
400004	1.2149	12.0923	12.5928	13.5197	12.7363
400005	1.2533	10.3505	11.1152	11.7590	11.0791
400006	1.1625	8.1841	8.1381	*	8.1610
400007	1.1609	11.8203	12.0743	10.4934	11.4512
400009	0.9811	9.3834	9.5114	10.1212	9.6760
400010	0.9080	9.8132	10.7993	10.4206	10.3257
400011	1.1071	9.6641	8.5503	9.4068	9.2137
400012	1.4868	12.3362	10.1156	*	11.0797
400013	1.3647	11.1414	11.4222	12.3073	11.6478
400014	1.3826	10.5286	9.9395	12.3301	10.8954

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
400015	1.4611	13.7043	22.2017	21.9225	18.9477
400016	1.4695	16.6472	16.1931	17.9107	16.9081
400017	0.8958	10.3123	9.9185	10.0590	10.0982
400018	1.1074	11.9184	12.3942	13.1572	12.5003
400019	1.5139	12.8380	14.7133	15.2364	14.0765
400021	1.3617	14.4549	13.9217	14.9779	14.4495
400022	1.4493	14.9089	15.3625	15.2124	15.1641
400024	0.8933	10.8439	12.6226	13.7215	12.2509
400026	1.1336	9.9262	7.1179	8.9064	8.4876
400028	1.1913	11.3260	10.6711	9.6941	10.5465
400032	1.1453	10.3736	10.7141	10.7844	10.6282
400044	1.4874	14.6420	11.3551	12.1393	12.5279
400048	1.3115	9.6416	9.6860	10.5176	9.9690
400061	2.2000	18.1303	18.0093	17.4504	17.8502
400079	1.2270	9.5296	10.4599	10.6127	10.2201
400087	1.3361	11.0377	11.4162	12.0034	11.4591
400098	1.3454	13.8034	13.7878	12.8756	13.4676
400102	1.1903	10.5879	12.1761	12.1257	11.5564
400103	1.9277	10.6971	11.7488	11.3314	11.2619
400104	1.2160	11.4322	12.8404	12.6934	12.3297
400105	1.2760	15.6626	16.9029	17.0463	16.5429
400106	1.1079	13.4097	12.9272	14.8544	13.7090
400109	1.4318	14.4386	14.8208	14.5713	14.6116
400110	1.2138	11.1812	9.9278	10.8214	10.6068
400111	1.2269	14.1718	10.2141	10.7892	11.5140
400112	1.2467	10.1512	13.5177	11.2303	11.5795
400113	1.1770	10.5305	10.9503	11.5948	11.0441
400114	1.1727	10.1379	10.8913	11.6872	10.9258
400115	1.0803	12.0713	9.6200	10.6809	10.8174
400117	1.1343	9.5929	11.6258	12.1540	11.0020
400118	1.2644	12.8692	12.7861	12.6199	12.7540
400120	1.3346	13.4069	14.0817	14.5205	14.0201
400121	1.1126	9.7427	9.1826	9.9713	9.6244
400122	1.8905	8.9478	9.5814	10.0966	9.5555
400123	1.2352	12.8317	12.5609	13.8601	13.0764
400124	2.7001	17.2139	17.9140	19.1704	18.1030
400125	1.2074	11.9787	13.5394	13.1078	12.8847
400126	1.2882	14.1062	16.5726	*	15.3043
400127	2.0895	17.8303	20.7775	*	19.5304
400128	1.0169	*	12.3520	*	12.3520
410001	1.3143	29.0877	30.0315	30.5865	29.9107
410004	1.3126	29.4953	31.3023	35.2384	31.9958
410005	1.2532	28.1141	31.4387	34.2846	31.1692

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
410006	1.3896	30.1855	32.8456	33.9961	32.3410
410007	1.6123	33.2896	32.0730	34.4774	33.2675
410008	1.3231	30.9505	32.5889	33.6384	32.3892
410009	1.2367	31.7300	32.8422	34.3427	32.9955
410010	1.1284	32.0704	32.7379	34.9330	33.2768
410011	1.4939	33.8781	30.1941	36.7668	33.5140
410012	1.5736	33.6072	37.0299	36.5207	35.7411
410013	1.2032	35.8075	41.0010	39.8659	38.8824
420002	1.5660	29.5592	30.5111	31.2247	30.4477
420004	1.9785	28.1455	28.9250	30.0764	29.0572
420005	1.1686	25.0420	24.6968	26.5044	25.3755
420006	***	26.3293	27.7764	29.1404	27.7494
420007	1.6348	26.8165	29.0901	28.9557	28.2952
420009	1.4150	27.0147	29.9378	28.6648	28.5287
420010	1.1445	25.1452	25.5710	26.5523	25.7619
420011	1.1811	22.1787	25.5130	26.0585	24.6061
420015	1.3156	24.1685	26.3499	27.4929	26.0293
420016	0.9718	21.6266	22.5681	23.4323	22.5466
420018	1.8353	25.6687	27.5563	29.0923	27.4862
420019	1.1038	22.5489	25.4954	25.8119	24.4096
420020	1.3450	28.4344	27.5000	29.2935	28.4131
420023	1.7184	27.4589	28.9321	30.4492	28.9948
420026	1.8734	27.8986	28.0647	29.5066	28.4734
420027	1.5782	26.4472	28.5621	31.3797	28.7409
420030	1.3246	27.8435	28.4433	30.3424	28.8727
420033	1.1836	30.4162	31.1608	32.4287	31.3443
420036	1.2541	23.8742	24.6505	26.3480	24.9671
420037	1.3444	29.8321	30.9556	32.7124	31.1325
420038	1.2870	24.6642	26.6435	27.1524	26.1472
420039	1.0548	28.2220	26.5582	26.3127	26.9783
420043	1.1171	24.0971	25.7951	25.8366	25.2419
420048	1.2737	25.9610	26.9625	27.4353	26.8151
420049	1.2602	26.0953	25.7060	28.0920	26.6563
420051	1.7177	25.9056	26.4710	27.6130	26.6671
420053	1.2411	23.2246	24.4793	25.4820	24.4055
420054	1.1192	25.6779	25.6444	26.7900	26.0199
420055	1.0971	24.0965	25.1738	25.3144	24.8608
420056	1.3511	27.7250	28.4512	29.7774	28.7574
420057	1.2119	24.9313	26.2489	27.7137	26.2671
420062	1.1082	26.7467	25.9569	27.2263	26.6405
420064	1.2644	24.3540	24.6507	25.0654	24.6908
420065	1.4204	25.5483	26.8118	28.1896	26.8680
420066	0.9999	25.1062	25.0932	20.5743	23.2330

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
420067	1.3729	25.8561	26.5658	27.7167	26.7386
420068	1.3793	25.6857	27.7315	28.0316	27.1436
420069	1.2067	22.3445	23.7494	24.4656	23.5601
420070	1.3185	24.7899	27.5988	27.6431	26.7226
420071	1.4354	25.2862	27.6371	28.1099	27.0466
420072	1.1668	17.8019	21.6587	20.7716	19.9751
420073	1.3847	25.5204	26.1120	28.2671	26.7154
420078	1.8622	29.5135	30.9001	32.8731	31.0942
420079	1.5095	27.5439	28.6374	30.5981	28.9429
420080	1.4362	28.6060	31.5670	32.8712	30.8894
420082	1.5176	31.2671	33.9874	34.8864	33.3525
420083	1.4533	26.4932	28.9007	29.6587	28.4201
420085	1.5950	27.8386	29.1127	29.9085	28.9697
420086	1.4631	28.0485	27.9523	29.6349	28.5681
420087	1.8117	25.4697	26.8409	28.4632	26.9059
420089	1.3791	28.1855	29.5862	31.7367	29.8353
420091	1.4556	26.0592	27.2520	27.9062	27.0847
420093	***	28.0765	33.0474	*	30.2237
420098	1.2068	30.7532	27.1939	27.6722	28.2074
420099	***	*	30.3089	*	30.3089
420100	***	*	*	29.2979	29.2979
420101	1.2082	*	*	33.1995	33.1995
420102	1.7065	*	*	*	*
430005	1.3354	22.4111	23.8694	25.4385	23.9209
430008	1.1164	24.4277	26.0873	27.2275	25.9007
430012	1.3022	24.0326	25.2030	27.0195	25.4029
430013	1.2025	25.9828	27.0427	28.4962	27.1842
430014	1.4124	26.8752	27.9288	28.9295	27.9163
430015	1.1983	23.6296	26.5787	28.0414	26.1014
430016	1.5978	28.9376	32.8765	31.1336	30.9589
430027	1.7447	26.6044	27.5759	29.2617	27.8489
430048	1.2682	24.1969	25.1715	25.6428	25.0139
430060	0.9428	13.2618	*	*	13.2618
430064	0.9849	18.3125	16.4916	17.7334	17.4430
430077	1.7214	25.8572	27.2116	31.1945	28.0488
430081	0.9424	*	*	*	*
430082	0.8381	*	*	*	*
430083	0.8441	*	*	*	*
430084	0.9069	*	*	*	*
430085	0.8878	*	*	*	*
430089	1.8628	22.3335	23.2467	24.9060	23.5435
430090	1.6005	26.4862	29.0197	32.7395	29.5047
430091	2.2308	25.1105	24.7274	26.7258	25.5168

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
430092	1.8871	21.6478	21.9197	23.2527	22.2953
430093	1.3555	27.5326	26.0232	24.7426	26.0961
430094	1.7383	22.9091	23.2894	23.6624	23.3069
430095	2.4765	31.3409	32.2326	32.5881	32.0547
430096	1.9114	21.6713	24.6041	24.9623	23.8075
440001	1.1589	21.2398	21.5755	25.4855	22.7822
440002	1.7216	25.7434	26.3802	26.9133	26.3588
440003	1.3386	28.4862	28.3557	26.0115	27.4330
440006	1.4562	29.7146	31.5533	31.7394	31.0135
440007	0.9825	19.9754	18.8273	22.7571	20.4816
440008	0.9673	23.2126	27.3732	26.8857	25.9987
440009	1.1668	23.9279	23.8148	24.4423	24.0657
440010	0.9491	19.3669	19.6231	20.2497	19.7446
440011	1.3628	23.6154	23.6698	24.8300	24.0422
440012	1.5037	24.0169	23.7871	24.9261	24.2670
440015	1.8279	25.0430	26.0601	27.1603	26.1002
440016	1.0462	23.0350	24.5812	25.2512	24.2769
440017	1.7694	25.0588	24.6707	26.1820	25.3220
440018	1.1090	23.2107	25.0780	24.8568	24.4213
440019	1.6927	25.3592	25.2230	26.2464	25.5929
440020	1.0908	24.0995	24.7785	27.5626	25.4794
440024	1.1324	23.9745	24.7705	26.2534	25.0629
440025	1.1247	22.5407	22.6571	24.0289	23.0933
440026	***	28.0349	26.8153	28.4615	27.7731
440029	1.4645	30.1204	31.2310	31.4652	30.9565
440030	1.2880	23.7670	22.2607	22.3144	22.8057
440031	1.1271	20.8964	22.6790	22.0711	21.8518
440032	1.1627	19.7150	21.0380	23.8030	21.5387
440033	1.0635	21.1087	22.7991	23.9792	22.5857
440034	1.6340	24.6994	25.5061	25.9138	25.3767
440035	1.3931	25.9613	26.2451	27.9217	26.6997
440039	2.1117	29.8611	30.1790	30.1918	30.0902
440040	0.9214	20.8637	20.8817	21.1288	20.9643
440046	1.3052	27.9539	29.7377	30.7334	29.5277
440047	0.9611	21.7892	22.8323	25.2150	23.3138
440048	1.8066	29.4789	29.3187	30.6725	29.8255
440049	1.6753	26.4772	28.8742	29.8623	28.4469
440050	1.2833	24.4616	24.9694	26.3825	25.3090
440051	0.9335	23.9253	23.4866	23.6560	23.6743
440052	1.0035	22.8016	22.6128	24.4071	23.2436
440053	1.2706	27.1197	27.8180	30.3907	28.4332
440054	1.0947	23.5137	23.7931	21.9641	23.0468
440056	1.2125	22.7820	23.2313	24.0635	23.3527

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
440057	1.1046	16.6346	17.2176	19.3546	17.6959
440058	1.2002	24.3522	26.0706	29.1184	26.6032
440059	1.4854	28.3565	27.9467	29.4532	28.5995
440060	1.1402	24.1024	25.0795	26.5867	25.2907
440061	1.1320	23.9678	23.7360	25.4134	24.3714
440063	1.6189	24.2566	23.9644	26.0763	24.7984
440064	0.9989	23.7176	26.1246	26.7957	25.5518
440065	1.2419	24.6169	25.8536	25.6111	25.3750
440067	1.1894	24.4772	24.6553	26.0866	25.0971
440068	1.1819	24.8146	26.1071	27.9082	26.2728
440070	1.0009	20.0938	21.9166	23.2228	21.7289
440072	1.0393	23.9563	25.7089	26.1661	25.2972
440073	1.4454	26.3570	27.6154	27.5133	27.1573
440081	1.1687	20.7125	20.7688	21.9681	21.1576
440082	1.9906	30.6115	32.2479	32.8941	31.8799
440083	0.9576	25.6099	23.6356	25.7074	24.9682
440084	1.1767	18.6043	18.8699	19.8950	19.1301
440091	1.7554	26.5687	28.1989	28.9697	27.9321
440102	1.0789	20.7363	21.6762	22.1114	21.5219
440104	1.7770	26.5741	27.9756	28.0905	27.5205
440105	0.9088	22.9372	22.7962	23.7154	23.1605
440109	1.0164	20.8924	21.4629	22.5878	21.7087
440110	1.1160	20.9179	22.5929	23.6275	22.5564
440111	1.2833	29.0975	28.8453	29.7461	29.2218
440115	0.9661	23.1409	23.7107	24.9778	23.9354
440120	1.4948	25.7161	24.7572	26.0621	25.5182
440125	1.6504	22.8097	23.6328	24.0934	23.4919
440130	1.1218	23.9955	25.1262	26.3192	25.1414
440131	1.1733	25.6666	26.9649	28.3162	26.9311
440132	1.2282	23.9410	24.0708	29.3377	25.7510
440133	1.7065	29.2829	29.6093	32.5726	30.4223
440135	0.6898	28.1925	27.7037	27.2094	27.7049
440137	1.0639	22.2538	22.9547	24.6143	23.2376
440141	0.9917	24.2406	24.9917	24.8737	24.6803
440144	1.2547	23.9241	25.2293	26.3225	25.2061
440147	***	33.1756	34.8199	36.6978	34.8983
440148	1.1235	23.9810	22.6188	28.0708	24.8108
440150	1.4315	28.1012	29.4381	30.5513	29.3884
440151	1.1658	27.1729	28.2203	28.6585	27.9979
440152	1.9950	27.1877	28.4612	29.0588	28.2868
440153	1.0490	23.6473	24.9388	23.3790	23.9597
440156	1.6461	27.7309	28.5645	30.5161	28.9643
440159	1.4825	26.9098	25.8289	27.2785	26.6813

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
440161	1.9248	28.7074	29.9894	31.0667	29.9306
440162	***	27.6837	24.8705	*	25.6907
440166	***	35.3064	*	*	35.3064
440168	1.0457	28.1215	29.4028	31.3316	29.7030
440173	1.4354	23.1167	24.0621	23.1370	23.4179
440174	0.8824	25.4829	26.2087	27.4579	26.4459
440175	1.0111	24.4848	24.7869	26.7705	25.3298
440176	1.3299	22.9631	23.7695	24.9420	23.9379
440180	1.3444	24.9841	22.3070	24.3376	23.7703
440181	0.9004	24.8857	25.9450	26.4763	25.8147
440182	0.9536	24.3302	25.0111	24.9899	24.8045
440183	1.6236	29.1982	30.6599	30.9923	30.2954
440184	1.1303	24.5786	23.3970	26.9086	24.9785
440185	1.1883	25.3817	26.7473	26.3974	26.1845
440186	0.9920	27.3733	28.9124	28.2840	28.1940
440187	1.0974	24.0723	25.8238	27.4034	25.7688
440189	1.4146	28.2621	28.8974	30.5786	29.1879
440192	1.0761	27.3917	29.6272	30.6533	29.2794
440193	1.3106	24.3622	25.2124	25.9726	25.1849
440194	1.2908	29.4706	30.8593	32.3020	30.9194
440197	1.3967	29.4275	30.1184	31.4317	30.3071
440200	0.9824	21.1860	23.8654	23.8288	22.9589
440203	***	23.7451	17.9041	*	20.6007
440217	1.3765	28.8641	29.8888	31.6650	30.1333
440218	2.0179	23.7257	18.7275	36.9273	25.9474
440222	1.0096	28.4664	29.0062	30.5148	29.3492
440225	0.8077	24.8328	27.8860	26.9687	26.4729
440226	1.5696	26.5831	27.1348	28.3199	27.3325
440227	1.3050	*	30.7785	31.9119	31.3755
440228	1.5737	*	28.3687	29.5372	29.0099
450002	1.4425	28.0936	28.8521	29.7180	28.8522
450005	1.2418	24.4933	24.5405	27.3473	25.4552
450007	1.3346	23.0026	23.9490	24.4630	23.8047
450008	1.3767	24.4701	24.5965	24.4372	24.5021
450010	1.5945	25.5503	25.5582	30.1034	27.0862
450011	1.6551	26.7418	28.5329	29.9302	28.4354
450015	1.5906	29.9193	29.4919	30.3168	29.9215
450018	1.5342	30.2383	30.7852	31.3131	30.7842
450021	1.8927	29.5658	31.3107	31.7360	30.8759
450023	1.4132	25.4450	25.5346	25.1683	25.3825
450024	1.5715	26.9113	28.2047	27.3814	27.5118
450028	1.5776	29.1438	29.5792	29.5689	29.4322
450029	1.6183	25.0602	26.9361	28.6465	26.7642

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450031	1.4439	29.0824	30.3542	29.2141	29.5397
450032	1.2559	21.5084	25.5785	26.3159	24.2727
450033	1.5964	29.2468	27.8680	29.7668	28.9235
450034	1.5314	26.5313	27.6929	29.6309	28.1127
450035	1.5410	28.0668	28.8049	30.3369	29.0814
450037	1.5869	26.6207	28.3403	28.2622	27.7354
450039	1.5943	26.7503	28.2081	29.8145	28.2732
450040	1.7548	25.4734	26.8412	28.5469	26.9591
450042	1.7467	26.6382	26.5429	27.6131	26.9561
450044	1.6922	31.0381	29.4293	32.9921	31.1706
450046	1.5786	24.8947	25.5903	27.2439	25.9775
450047	0.8561	21.8824	23.8457	24.9670	23.5092
450051	1.9265	28.8829	29.9038	30.3976	29.7573
450052	0.9850	22.6448	23.0007	24.3964	23.3482
450054	1.7903	27.5399	26.5599	30.2211	28.0406
450055	1.0446	22.9245	23.6382	24.1418	23.5763
450056	1.6850	28.3092	31.4971	32.0902	30.6442
450058	1.5738	26.6926	26.9918	27.7318	27.1594
450059	1.2991	26.8325	27.3856	28.5645	27.5870
450064	1.5124	26.8355	28.2786	29.0495	28.0423
450068	2.0493	29.5876	30.5001	32.0372	30.7388
450072	1.2140	25.8619	27.1081	28.0921	27.0436
450073	0.8914	26.9446	26.1567	22.2322	25.0644
450076	1.6922	*	*	*	*
450078	0.8999	21.4716	20.0758	20.7800	20.7563
450079	1.6790	30.2420	30.5968	36.8936	32.4461
450080	1.2480	27.9191	26.2439	26.8111	27.0304
450082	1.1594	23.9025	24.2018	25.5654	24.5571
450083	1.7516	27.4955	32.6462	30.2054	29.9870
450085	1.0822	24.3637	25.6440	26.3610	25.4426
450087	1.3987	30.0095	31.2668	32.6556	31.3370
450090	1.2605	21.3837	21.8839	22.7822	22.0414
450092	1.2122	24.9917	26.2781	28.2278	26.4939
450096	***	26.5103	28.1902	*	27.3122
450097	1.4586	29.0142	29.8734	31.9782	30.2419
450099	1.3018	31.3495	31.7829	29.8491	30.9853
450101	1.6152	25.4409	26.7457	28.4220	26.8733
450102	1.7086	25.6318	26.4161	27.3364	26.4786
450104	1.1856	24.6169	28.8063	27.7851	26.9845
450107	1.5824	27.6064	27.8177	29.0328	28.1655
450108	1.1912	21.6557	19.3245	22.4293	21.1096
450119	1.3180	27.8027	31.1026	34.4161	30.7688
450121	***	29.1296	27.7472	*	28.4439

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450123	1.3318	24.9674	26.2469	24.0433	24.9410
450124	1.7521	28.2571	30.9140	31.9797	30.4259
450126	1.3993	29.3768	30.5540	32.0370	30.6765
450128	1.2368	25.1122	26.3296	28.3171	26.5699
450130	1.1973	24.3295	24.3842	26.9208	25.2416
450131	***	25.9494	*	*	25.9494
450132	1.6337	30.1620	31.9981	31.1361	31.0947
450133	1.5306	28.4647	30.0648	30.9622	29.8085
450135	1.6392	27.8983	30.1385	30.7909	29.6284
450137	1.6760	31.4950	31.9644	35.7775	33.2281
450143	1.0287	23.4592	23.6834	24.4346	23.8659
450144	1.0094	26.2881	29.2987	31.1552	28.7444
450147	1.4566	24.3562	24.7221	26.3032	25.1667
450148	1.2114	27.0894	29.6777	30.0542	28.8677
450151	***	23.9558	26.2011	22.8768	24.2775
450152	1.2562	23.3428	23.1056	24.3442	23.6081
450154	1.3300	21.7237	22.9357	24.2582	22.9599
450155	1.1235	21.7604	24.8052	24.8773	23.6643
450162	1.3283	33.3285	32.9317	33.7823	33.3242
450163	1.0640	24.1267	24.7857	27.0967	25.3189
450165	1.1443	28.6490	29.1839	30.2236	29.3465
450176	1.4001	23.1284	24.4338	25.8587	24.4748
450177	1.0905	23.7624	24.4064	26.0895	24.7684
450178	0.9980	27.8405	27.1184	28.5990	27.8379
450184	1.5687	28.5399	29.5940	30.9726	29.6901
450187	1.2145	28.3243	27.7374	29.2749	28.4476
450188	0.9241	23.0595	23.2280	24.6823	23.6819
450191	1.1277	26.5863	28.3937	31.1339	28.6339
450192	1.1180	24.1186	26.4722	26.9884	25.8925
450193	2.0355	34.4545	36.4793	37.1906	36.0660
450194	1.2637	22.9605	24.3531	30.4381	25.7171
450196	1.4598	24.0161	23.4577	25.4842	24.2969
450200	1.6018	23.5012	25.6413	27.9843	25.4507
450201	0.9702	23.2510	23.2800	22.5464	22.9963
450203	1.2118	26.5237	27.8795	28.0986	27.5113
450209	1.8271	27.5668	30.6146	31.9882	29.9989
450210	1.0180	21.8722	22.5736	22.9055	22.4488
450211	1.3447	28.4581	28.3770	28.8485	28.5697
450213	1.7937	25.9169	26.8566	28.0307	26.9452
450214	1.2282	27.4357	27.9913	28.2261	27.8834
450219	0.9663	21.9207	23.9636	24.7274	23.5186
450221	1.1109	19.3793	21.3721	20.7118	20.5037
450222	1.6856	30.0314	30.3801	31.9255	30.7851

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450224	1.3126	26.8302	28.4382	28.7931	28.0125
450229	1.6537	24.4450	25.1370	26.8039	25.3965
450231	1.6721	27.1674	26.9783	27.0545	27.0675
450234	1.0202	20.6889	20.4659	21.6799	21.1357
450235	1.0055	23.5212	21.8967	23.8001	23.0638
450236	1.1337	23.5426	22.9622	24.5942	23.6940
450237	1.6522	25.7939	30.5885	31.2197	28.9564
450239	0.9774	21.2586	19.1359	18.4234	19.4676
450241	1.0209	20.8732	21.3641	28.4948	23.5112
450243	1.0024	15.4510	17.2966	19.0180	17.2996
450253	0.9328	24.2435	24.1056	22.9918	23.7732
450270	1.2212	15.2190	19.8180	12.9999	15.5385
450271	1.2771	22.7035	24.1269	23.9534	23.6290
450272	1.2088	26.2576	27.0521	29.0917	27.4848
450280	1.4612	29.9730	31.6575	34.9349	32.1874
450283	1.0893	22.7938	24.1754	28.2094	24.8176
450289	1.4686	32.2645	32.6533	32.6137	32.5230
450292	1.2736	26.3242	26.8110	29.0243	27.3784
450293	0.8913	23.6413	24.0827	24.1556	23.9553
450296	1.0440	30.4324	31.5596	33.4545	31.7851
450299	1.6013	27.5797	28.4171	29.4593	28.5050
450306	0.9802	21.4558	22.9486	22.6818	22.3401
450315	2.4408	37.1721	*	31.4227	33.9629
450324	1.5230	25.1633	26.6093	27.9899	26.5493
450330	1.2541	26.0771	27.1100	27.7419	26.9935
450340	1.4106	25.0344	25.6791	29.6617	26.7074
450346	1.4337	23.6072	23.8720	24.8434	24.1230
450347	1.2209	28.7667	30.7825	28.5789	29.3914
450348	1.0017	21.6787	21.0484	22.6828	21.8122
450351	1.2736	26.5388	29.2560	29.9598	28.5847
450352	1.1060	26.2281	27.2983	27.6480	27.0619
450353	***	27.0248	27.9576	*	27.5079
450358	1.9699	31.4926	32.5922	33.9103	32.6884
450369	0.9277	19.9148	22.8525	24.1953	22.2634
450370	1.2585	25.5834	26.3235	29.0816	27.0012
450372	1.4544	30.8886	29.5022	30.9345	30.4459
450373	0.9159	24.8286	27.0726	27.4251	26.4837
450378	1.3151	30.3883	32.2278	33.0583	31.9030
450379	1.4002	33.7521	35.3807	35.0637	34.7101
450388	1.7009	27.4328	27.8155	29.5386	28.2783
450389	1.1705	25.6732	26.9638	26.8499	26.4866
450393	0.7662	21.9347	*	39.0266	28.4489
450395	1.0721	27.5189	26.7743	28.4272	27.6025

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450399	0.8925	20.3528	22.1731	20.6307	21.0335
450400	1.0655	23.6358	26.2871	29.5020	26.1114
450403	1.3178	29.0359	29.8643	31.7065	30.2589
450411	1.0062	20.9372	21.5746	21.7877	21.4276
450418	***	28.4362	*	*	28.4362
450419	1.3156	31.9966	34.2427	34.9972	33.8172
450422	1.2786	34.4331	31.3454	32.4669	32.6986
450424	1.3568	28.2463	30.7228	29.8290	29.5969
450431	1.6076	26.3263	27.3926	28.5289	27.4182
450438	1.1492	27.8659	26.5223	27.7734	27.3854
450446	0.7135	17.0691	17.2871	15.4641	16.6068
450447	1.3542	25.4200	26.5238	28.3724	26.7885
450451	1.0755	24.6201	26.5477	25.8836	25.6949
450460	0.9426	22.4227	24.9870	25.2165	24.1529
450462	1.7250	29.6069	30.1466	30.6516	30.1373
450465	1.1258	26.2759	27.0835	28.1853	27.2045
450469	1.4614	26.3262	26.3445	31.1348	27.8729
450475	1.1940	23.0942	24.5176	24.7037	24.0838
450484	1.4984	26.7242	28.3913	27.7792	27.6353
450488	1.1174	22.3981	23.7985	24.9109	23.7096
450489	0.9843	23.4806	25.2680	26.9543	25.1940
450497	0.9960	22.0918	23.1860	23.0712	22.7801
450498	0.9864	18.6563	20.2475	20.6873	19.8493
450508	1.4511	28.4471	27.2850	29.1519	28.3024
450514	***	26.3704	27.3043	26.4196	26.6988
450518	1.4410	28.1755	29.1322	27.5880	28.1834
450530	1.2669	29.1349	29.9720	30.7745	29.9526
450537	1.5138	27.7757	28.7448	30.9167	29.1369
450539	1.2192	23.1829	24.2151	25.0191	24.1140
450547	0.9744	23.7820	34.3349	25.4140	27.1659
450558	1.7701	26.9407	28.0655	28.7747	27.9454
450563	1.5309	30.8332	32.0507	32.6875	31.9174
450565	1.3281	26.7942	28.1741	27.4774	27.4809
450571	1.6223	25.2108	27.4605	26.5313	26.3744
450573	1.0820	22.0797	22.1492	24.6750	22.9819
450578	0.9615	22.5167	25.0498	25.2478	24.2618
450580	1.0518	22.3886	23.9004	25.9881	23.9918
450584	1.0826	20.5257	22.5204	23.6044	22.1622
450586	1.0239	18.9107	20.6699	18.3289	19.3040
450587	1.2254	23.1202	25.0174	25.9364	24.6520
450591	1.1880	25.7031	27.1744	27.9867	26.9272
450596	1.1854	27.4011	29.8462	31.6590	29.6792
450597	0.9959	24.7853	24.2586	24.8443	24.6217

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450604	1.3401	24.4743	25.9133	29.1543	26.5825
450605	0.9811	20.9276	23.9332	14.8039	19.8573
450610	1.6030	27.7317	28.3713	30.5977	28.8800
450615	0.9984	21.8442	24.1902	22.6331	22.8682
450617	1.5832	28.0225	28.8323	30.2923	29.0544
450620	0.9657	18.6183	20.3723	21.2535	20.0801
450630	1.5095	29.1462	29.8431	31.8014	30.2299
450634	1.6212	28.7312	30.3274	31.8008	30.2941
450638	1.6006	30.6572	32.4911	33.3237	32.0997
450639	1.4824	30.4019	32.6255	34.3754	32.4480
450641	0.9826	19.4389	20.2483	21.7292	20.4548
450643	1.3353	22.7355	24.4999	27.2538	24.7940
450644	1.5457	29.7918	30.7815	31.6874	30.7923
450646	1.4522	25.6313	26.8060	27.4631	26.6298
450647	1.8759	30.6924	32.4236	34.1016	32.4022
450651	1.5363	30.4484	31.9261	33.6498	32.0236
450653	1.1587	25.2144	26.1756	26.5361	25.9887
450654	0.9051	21.5002	22.5447	25.0755	23.0147
450656	1.4209	25.5050	28.1493	29.7290	27.7371
450658	0.9793	22.2293	24.7856	22.7090	23.2039
450659	1.4013	31.5024	34.2380	34.2657	33.2718
450661	1.4595	30.2610	30.0751	29.2381	29.8382
450662	1.6467	29.0535	29.0532	30.9630	29.6832
450668	1.5422	28.8635	30.6114	30.2083	29.8666
450669	1.2197	27.9796	30.2374	32.1244	30.1390
450670	1.4377	25.9638	26.4266	26.2954	26.2320
450672	1.8339	30.1191	31.8420	33.0858	31.7663
450674	0.9478	28.7101	29.8971	31.9316	30.1858
450675	1.4560	28.9005	30.9562	32.6380	30.8662
450677	1.3165	25.9555	27.2760	27.1603	26.8129
450678	1.4190	31.1563	33.3386	33.5513	32.6562
450683	1.2013	27.4925	21.1737	24.8440	24.2911
450684	1.2816	29.3025	30.2139	31.2765	30.2646
450686	1.6151	24.2331	25.8530	26.4871	25.5762
450688	1.2724	26.8599	26.9897	29.4393	27.7082
450690	1.3405	26.5528	26.1743	30.0577	27.4942
450694	1.1748	23.9961	24.0031	27.0862	24.8820
450697	1.4746	24.8667	26.4132	28.3002	26.4751
450698	0.9155	20.0955	21.5742	23.3062	21.6142
450702	1.6144	26.8384	26.3696	27.1318	26.7841
450709	1.3968	26.8146	27.1077	31.3239	28.4264
450711	1.4833	26.7472	27.5622	28.1040	27.5207
450713	1.5561	28.8285	29.4980	30.4933	29.6232

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450715	1.3145	17.3991	17.0235	*	17.2098
450716	1.4084	32.3960	33.7096	33.9926	33.3809
450718	1.4664	27.3215	28.1560	29.7609	28.4475
450723	1.4497	28.5103	30.1704	31.0481	29.9622
450730	1.3786	31.3324	32.7293	32.8920	32.3012
450742	1.1753	27.2023	30.0583	30.4204	29.2920
450743	1.4525	28.3362	28.4736	29.5098	28.8200
450746	0.8769	20.6343	22.7873	23.3484	22.2429
450747	1.1962	23.8314	25.8175	28.3935	25.8477
450749	0.9370	20.0487	22.1562	23.9269	21.9555
450751	***	18.7456	21.4223	*	20.1469
450754	0.9447	22.1819	24.7797	22.8572	23.2196
450755	0.9660	19.8988	22.2006	24.7428	22.1319
450758	***	28.7342	28.2803	28.3305	28.4888
450760	1.0061	24.7489	25.1637	23.7157	24.5608
450766	2.0281	30.8004	30.2341	31.2084	30.7532
450770	1.1699	24.1647	24.3244	23.6093	24.0132
450771	1.7112	30.7105	32.0500	32.5014	31.7661
450774	1.7639	27.2080	25.7436	27.5065	26.8207
450775	1.3931	28.1428	29.8230	31.6656	29.9055
450779	1.2875	29.9674	31.8403	32.0770	31.3358
450780	2.5251	26.7611	27.0084	28.5560	27.4513
450788	1.5301	26.2840	28.3759	29.7667	28.1306
450795	1.1736	25.2007	32.9803	43.8574	34.0301
450796	1.8173	36.4073	37.6274	39.4762	37.9827
450797	1.2450	24.8950	24.8598	26.0302	25.2374
450801	1.4993	24.6328	23.6072	25.6379	24.6374
450803	1.2115	28.9235	29.0106	28.7041	28.8866
450804	2.0320	27.8775	29.1282	31.1891	29.4377
450808	1.8935	21.9793	23.0312	29.6476	24.9247
450809	1.6569	26.4223	27.3080	29.4696	27.7563
450811	1.7205	27.2584	31.2208	31.3007	29.7758
450813	1.1338	20.1710	22.9289	26.5803	23.2369
450820	1.4208	31.4666	33.9030	34.7445	33.5477
450822	1.3260	32.2968	32.2145	34.4060	33.0005
450824	2.6720	31.2375	33.3653	31.8413	32.1653
450825	1.4725	20.6457	25.1521	25.8006	23.7852
450827	1.4431	23.7554	24.1984	24.3659	24.1146
450828	1.3767	24.4740	24.8236	26.9553	25.5740
450829	***	20.6016	19.5842	*	20.0933
450830	1.0106	28.5902	27.8005	28.4007	28.2671
450831	0.9898	23.3880	23.9467	24.4141	23.8676
450832	1.3192	26.5229	27.3290	28.1389	27.3880

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450833	1.1878	27.0133	27.9649	29.0256	28.0118
450834	1.6108	20.9607	27.4844	26.7253	24.5170
450838	1.0752	19.5754	18.9620	19.2949	19.2973
450839	0.9683	25.8222	27.2199	27.5330	26.8419
450840	1.2859	30.1743	32.2538	32.4162	31.7003
450841	1.9116	20.9410	20.9424	24.4389	22.2257
450844	1.3780	30.7887	33.7978	33.0758	32.7256
450845	1.8834	29.4933	29.9265	28.5039	29.2852
450847	1.2560	28.5548	29.7356	30.7431	29.7038
450848	1.2905	29.5355	30.5546	31.1476	30.4220
450850	1.5769	21.9266	31.9606	27.2653	26.5519
450851	2.3662	32.6950	35.1102	32.8377	33.5041
450853	1.7347	36.1169	37.1043	38.3600	37.3460
450854	***	27.1868	*	*	27.1868
450855	1.6263	30.8855	32.6916	30.7353	31.4217
450856	2.0963	39.0865	37.7362	35.5006	37.3579
450857	***	30.4632	*	*	30.4632
450860	1.8529	24.0171	29.1075	33.3404	29.3087
450861	***	34.9290	*	*	34.9290
450862	1.5775	31.2224	31.8095	33.7962	32.2138
450863	***	24.8825	*	*	24.8825
450864	2.1884	23.3765	24.5049	25.3535	24.5423
450865	1.0998	29.1763	29.9559	31.9200	30.4459
450866	***	15.2959	*	*	15.2959
450867	1.1598	28.2289	29.5879	31.4953	29.7815
450868	1.7418	27.9579	25.3486	27.7501	27.0787
450869	2.1445	22.6253	26.1616	28.7422	27.5510
450870	***	37.4364	*	*	37.4364
450871	1.8776	*	28.9150	32.3990	30.6348
450872	1.3772	*	27.2833	31.7345	29.8435
450873	***	*	14.8821	*	14.8821
450874	1.6548	*	34.6083	35.6839	35.2084
450875	1.7324	*	23.2763	23.2962	23.2869
450876	1.9271	*	28.4343	30.3515	29.4584
450877	1.4989	*	26.1867	29.2353	27.6979
450878	2.5647	*	31.6750	33.6269	32.6709
450879	1.3352	*	35.5672	36.4874	36.0748
450880	1.5512	*	35.9572	32.6713	34.0919
450881	***	*	24.5464	*	24.5464
450882	***	*	26.6910	*	26.6910
450883	2.4493	*	35.2646	37.1525	36.2400
450884	1.0279	*	27.8213	23.5799	25.5505
450885	1.4524	*	34.1148	36.0954	35.1492

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
450886	1.5017	*	*	30.1571	30.1571
450887	***	*	*	25.5590	25.5590
450888	1.7096	*	*	28.5995	28.5995
450889	1.5530	*	*	35.6151	35.6151
450890	1.8250	*	*	32.2000	32.2000
450891	1.4143	*	*	39.0890	39.0890
450892	***	*	*	39.5333	39.5333
450893	1.4160	*	*	36.2660	36.2660
450894	1.7932	*	*	25.9441	25.9441
450895	***	*	18.4142	*	18.4142
460001	1.8326	28.7150	30.0040	30.7040	29.8216
460003	1.5414	31.4135	32.3427	29.6450	31.1486
460004	1.7715	28.2040	29.6342	29.8773	29.2542
460005	1.5229	25.0239	26.0731	29.4188	26.8380
460006	1.4489	27.1392	28.3678	28.9653	28.1492
460007	1.3345	27.1308	28.0035	29.1191	28.1211
460008	1.3382	29.5907	31.5485	27.6906	29.5835
460009	1.9757	27.2885	28.3836	29.4705	28.4464
460010	2.0996	29.0063	30.4606	30.9813	30.1582
460011	1.3221	24.4402	24.9677	26.5486	25.3374
460013	1.3900	27.7381	29.2731	29.7252	28.9125
460014	1.1483	28.2647	29.5963	30.6450	29.4787
460015	1.3543	27.2506	29.1318	28.8014	28.4039
460017	1.5043	24.3030	26.1589	28.7126	26.4252
460018	0.8921	22.0517	22.8028	22.0935	22.3162
460019	1.1926	24.3756	23.2202	25.1615	24.2511
460020	0.9177	18.5159	*	*	18.5159
460021	1.7960	28.0291	29.5761	29.7397	29.2078
460023	1.2086	26.9512	28.5884	28.9473	28.1985
460026	1.0733	26.9295	27.9487	29.2775	28.0640
460030	1.1564	23.5942	24.4218	26.8979	24.9669
460033	0.8688	25.3422	26.6606	27.9108	26.6495
460035	0.9620	20.6322	21.9115	23.8682	22.1205
460039	1.0970	29.5651	30.4912	30.0677	30.0675
460041	1.3700	26.4640	26.3807	26.7356	26.5291
460042	1.4992	24.9454	26.8389	36.2903	28.7526
460043	0.9926	28.2008	28.6668	29.5660	28.8145
460044	1.3233	27.4928	28.7023	29.5079	28.5649
460047	1.6851	28.2336	29.9990	31.0020	29.7629
460049	1.9911	26.6702	28.4884	28.6267	27.9969
460051	1.4083	27.0160	27.8841	28.1140	27.6926
460052	1.6508	26.1629	27.1995	28.7455	27.4118
460054	1.6941	24.9926	25.7870	26.3939	25.7332

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
460055	1.5286	*	*	*	*
470001	1.2661	28.3017	29.7540	32.2887	30.1255
470003	1.8790	28.1137	30.1973	30.0535	29.4652
470005	1.3522	30.7872	33.1981	33.9969	32.7072
470011	1.1591	28.1330	29.6269	30.8742	29.5553
470012	1.2129	26.0225	27.0751	29.8259	27.6841
470024	1.1459	27.0394	26.6351	27.3106	26.9938
490001	1.0914	23.2174	24.0368	24.6883	23.9912
490002	1.0163	20.8609	21.7092	24.0672	22.0941
490004	1.2937	27.1676	27.5890	28.8660	27.8914
490005	1.5721	29.8215	30.5349	31.4909	30.6464
490007	2.0390	27.6572	29.3098	30.7411	29.2730
490009	1.9938	30.4722	28.4642	31.4260	30.0815
490011	1.5705	26.4766	27.4764	28.8780	27.6276
490012	1.0083	21.0605	22.9922	21.8322	21.9361
490013	1.3741	24.7521	25.5560	27.3486	25.8960
490017	1.5024	25.8216	27.5902	29.6784	27.7184
490018	1.3619	26.2510	27.2644	27.8682	27.1385
490019	1.1538	25.9885	25.8264	29.8891	27.1456
490020	1.2867	27.3142	29.3468	30.6013	29.0713
490021	1.4632	25.7938	27.0641	28.1254	26.9973
490022	1.4122	32.2676	30.1203	31.7985	31.3748
490023	1.3288	30.3416	30.9920	32.6308	31.3342
490024	1.7009	26.1125	27.9689	29.0407	27.6973
490027	1.1151	24.0288	23.0017	24.3834	23.7446
490032	1.9495	25.2654	28.5897	28.0120	27.3522
490033	1.0968	31.2922	31.8282	30.9910	31.3736
490037	1.2796	24.7711	25.2859	26.2951	25.4678
490038	1.2248	21.8509	22.6504	24.0852	22.8207
490040	1.5114	32.6564	34.1841	35.6822	34.1611
490041	1.5631	26.0897	27.1613	29.1244	27.4594
490042	1.3154	24.4650	25.7333	26.6078	25.6263
490043	1.3369	33.7096	35.8872	36.5982	35.4365
490044	1.4501	23.3527	23.3793	24.1763	23.6467
490045	1.3435	32.0937	30.3772	32.8774	31.7672
490046	1.5416	26.6517	27.9604	29.3882	28.0346
490048	1.4338	26.2828	27.0620	28.0320	27.1314
490050	1.5227	31.3885	32.2993	31.1370	31.5954
490052	1.6681	23.5973	25.0046	25.4179	24.6456
490053	1.1873	23.3315	23.8004	24.6206	23.9164
490057	1.6375	26.6898	27.4918	29.0700	27.7794
490059	1.6596	27.3611	30.8669	32.1031	30.0798
490060	1.0189	23.6113	24.3192	25.7765	24.5811

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
490063	1.8769	31.3619	31.6069	34.1179	32.3888
490066	1.3933	27.8250	29.5917	31.4298	29.7038
490067	1.2869	24.9021	25.9497	26.7802	25.8589
490069	1.5350	27.3181	29.1527	30.1482	28.8664
490071	1.4075	29.7186	31.7061	33.7118	31.7120
490073	***	33.1829	34.5774	46.4210	36.1091
490075	1.3180	25.2022	25.7323	27.3424	26.0799
490077	1.4177	26.6806	28.1506	31.0016	28.6190
490079	1.2627	25.3103	25.2340	24.2066	24.9044
490084	1.1427	24.9007	25.7657	26.3234	25.6762
490088	1.0938	24.1471	25.0619	26.0285	25.0933
490089	1.1011	24.9438	25.9902	27.4587	26.1620
490090	1.0548	25.1157	25.5418	27.0760	25.9186
490092	1.0766	23.3439	25.7405	27.5277	25.4748
490093	1.5427	25.6531	26.7886	28.7122	27.0741
490094	0.9733	28.2165	28.9155	29.7990	28.9996
490097	1.0692	26.5322	27.1470	27.4608	27.0696
490098	1.2905	23.2782	25.1625	26.7152	25.0887
490101	1.4131	31.2377	32.3695	32.9516	32.2116
490104	0.7712	*	17.0548	19.0056	18.0437
490105	0.8337	25.5329	26.3827	*	25.9379
490106	0.7733	23.8334	25.7352	26.2318	25.2383
490107	1.4220	32.2672	33.5430	35.0272	33.6816
490108	1.0555	22.9076	23.3204	27.8717	24.7469
490109	0.9056	22.7854	24.2296	21.6711	22.7835
490110	1.3588	24.2887	24.9861	26.3089	25.2074
490111	1.1080	22.1476	22.7336	26.4297	23.6183
490112	1.7306	27.1932	29.0816	31.2549	29.1902
490113	1.2890	31.8177	32.4547	34.7841	33.0728
490114	1.1450	22.5255	22.1387	23.0533	22.5831
490115	1.2009	22.4058	23.5718	23.2118	23.0491
490116	1.1703	24.2258	24.3853	25.0351	24.5472
490117	1.1008	19.6398	18.1138	20.3038	19.3439
490118	1.6348	27.6749	29.0569	31.2407	29.3459
490119	1.3011	26.5756	27.8866	29.5222	28.0197
490120	1.4558	25.8795	25.9610	27.1990	26.3523
490122	1.5900	32.0743	33.3719	35.2234	33.5751
490123	1.1432	24.3490	24.2254	24.6011	24.3931
490126	1.1734	23.6690	24.0908	25.3294	24.3549
490127	1.1178	21.3735	23.5161	23.1399	22.6007
490130	1.2195	23.9982	25.3352	25.9782	25.1174
490134	0.8238	*	33.2405	31.1495	32.1164
490135	0.7505	*	25.9998	27.2795	26.6430

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
490136	1.4425	*	*	31.2911	31.2911
490138	1.9348	*	*	*	*
500001	1.6026	31.1605	33.0901	37.5323	33.7731
500002	1.3759	27.6400	29.1448	30.1872	29.0196
500003	1.3946	30.6939	32.1262	32.7983	31.8096
500005	1.8022	33.5117	35.0997	36.0918	34.9349
500007	1.3510	29.2869	30.5263	31.0313	30.3238
500008	1.9680	32.6052	33.5666	34.7810	33.6739
500011	1.3825	31.4514	32.6223	38.3979	33.9423
500012	1.7828	30.0509	33.8101	33.1685	32.2301
500014	1.6625	36.1380	36.5833	37.2698	36.6866
500015	1.4023	34.5877	37.5724	40.8683	37.5969
500016	1.6726	31.4905	32.9177	34.2828	32.9173
500019	1.2512	30.5594	31.6242	33.8882	32.0659
500021	1.3083	30.7927	32.4702	33.5610	32.3525
500024	1.7463	32.6171	36.1647	37.4529	35.4272
500025	1.9211	37.7952	40.6369	44.7105	41.0332
500026	1.4532	32.8369	34.5881	35.5080	34.3342
500027	1.5002	34.6164	39.2906	42.4974	38.7488
500030	1.6950	32.4426	34.9174	36.9489	34.7856
500031	1.2670	32.8833	33.2391	34.1651	33.4482
500033	1.2452	30.6292	31.8891	32.6753	31.7844
500036	1.3309	28.7096	30.5938	31.9164	30.4928
500037	1.0570	28.1056	31.2654	29.1773	29.5205
500039	1.5633	32.2245	33.5606	34.5739	33.5081
500041	1.4333	30.3627	34.2017	36.9273	33.8445
500044	1.8919	29.0214	31.0936	32.0743	30.6381
500049	1.3711	27.7170	29.8189	30.8135	29.5158
500050	1.5084	32.6751	33.7713	35.7254	34.0829
500051	1.7935	32.5764	34.7610	36.4764	34.6043
500052	1.4573	*	*	*	*
500053	1.2577	28.2901	30.2811	28.5664	29.0324
500054	1.9720	31.6595	32.5105	34.8114	32.9767
500058	1.6839	30.7487	30.7034	32.6843	31.4282
500060	1.3646	37.4869	38.7682	40.3040	38.9010
500064	1.8977	31.6112	32.3581	34.7925	32.9466
500072	1.2611	31.2000	32.5269	33.1148	32.3276
500077	1.4760	31.6153	33.2223	34.3114	33.0364
500079	1.3737	31.3280	32.5809	34.2420	32.6844
500084	1.2600	30.2411	32.7883	33.3072	32.1170
500088	1.4727	35.3770	36.7953	38.5194	36.8908
500108	1.6194	31.8483	34.3872	35.8918	34.0331
500119	1.3806	29.7028	31.2233	31.7125	30.8557

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
500124	1.4064	32.3505	34.4790	36.3338	34.3972
500129	1.5751	32.1102	34.4447	37.3189	34.6832
500134	0.5967	27.2428	28.1374	28.9759	28.2252
500139	1.4897	33.9739	34.6412	37.5709	35.2957
500141	1.2679	31.3308	33.7532	34.2384	33.1523
500143	0.5890	23.6766	25.3099	26.3893	25.1085
500148	1.2204	26.4206	37.7830	24.6347	30.3562
500150	1.2646	*	*	34.8480	34.8480
510001	1.9366	25.2973	25.8693	26.7924	26.0192
510002	1.2687	23.8921	23.7270	24.8846	24.1725
510006	1.3528	24.9627	24.8777	26.6421	25.4777
510007	1.6779	24.7264	27.1149	28.5783	26.8120
510008	1.3370	26.3554	27.5241	27.4709	27.1403
510012	0.9584	18.8984	20.8455	22.9038	20.8296
510013	1.1606	22.7882	22.8779	22.9612	22.8739
510018	1.0727	22.4597	23.1043	23.7736	23.1227
510022	1.8099	26.9511	26.8328	27.6119	27.1384
510023	1.2565	20.6435	21.0940	23.1461	21.6352
510024	1.7526	25.5634	26.6621	31.1327	27.8377
510026	0.9842	17.9908	19.2025	17.8275	18.3210
510029	1.3029	22.7104	24.0872	25.3925	24.0185
510030	1.1512	24.3936	24.2007	25.5600	24.7277
510031	1.4629	23.2624	24.0237	26.7872	24.6115
510033	1.5983	22.6189	24.0796	24.2839	23.6910
510038	1.0705	20.6565	20.9180	21.7545	21.1107
510039	1.3739	19.8751	20.4719	21.3819	20.5905
510046	1.3779	22.1712	22.2935	24.7187	23.0447
510047	1.2029	27.1214	27.6859	28.8794	27.9083
510048	1.1870	18.8576	22.7930	23.6396	21.5409
510050	1.5369	21.0772	21.9009	23.5794	22.1910
510053	1.0927	22.3318	21.5338	22.6288	22.1643
510055	1.5624	28.4615	29.4111	30.7382	29.5850
510058	1.3378	23.9015	25.3248	24.8770	24.7027
510059	***	22.1435	20.8847	21.9053	21.6386
510062	1.2236	26.2296	26.7066	27.7971	26.9092
510067	1.0951	25.0437	25.2130	25.2248	25.1590
510070	1.2035	23.5639	23.9742	25.4981	24.3387
510071	1.2815	23.4508	23.2954	23.4553	23.4006
510072	1.0733	20.5146	19.4370	20.2387	20.0446
510077	1.0374	24.5010	25.9515	27.1611	25.8352
510082	1.1014	19.9081	20.3279	21.1665	20.4933
510085	1.2011	26.3877	26.2617	26.8133	26.4915
510086	1.0978	19.8735	19.2606	20.1965	19.7687

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
510090	***	*	*	39.0787	39.0787
520002	1.3018	27.7705	29.0501	28.3413	28.3936
520004	1.4019	27.6530	28.9857	30.9212	29.2476
520008	1.5702	30.7553	33.8057	33.6774	32.7725
520009	1.6535	27.4044	28.8591	29.6290	28.6366
520011	1.2888	26.6268	28.0224	29.5024	28.0219
520013	1.4976	29.0018	30.1834	32.1721	30.5213
520017	1.1193	28.4699	29.3278	31.0537	29.6393
520019	1.3441	28.6971	29.8640	30.2189	29.6447
520021	1.3249	28.4182	29.1129	29.7809	29.1146
520027	1.4428	31.4284	32.4137	33.5836	32.5086
520028	1.3963	26.7260	28.0813	29.4694	28.3052
520030	1.6872	29.4678	30.5724	31.6807	30.5745
520033	1.2247	28.0662	29.0236	30.2631	29.1748
520034	1.2624	26.1094	26.8886	28.1819	27.0617
520035	1.3577	27.3276	28.1048	29.4076	28.2945
520037	1.7419	30.1799	32.2144	32.2206	31.5565
520038	1.2066	29.3134	29.6339	30.5267	29.8347
520040	***	29.1262	31.2038	35.9652	32.0427
520041	1.0807	23.5495	25.3764	26.1586	25.0726
520044	1.3629	27.3685	28.2382	28.6620	28.1198
520045	1.5908	27.3336	29.2556	30.0856	28.8911
520048	1.5290	26.8080	29.1870	30.1483	28.5894
520049	2.0443	26.9851	28.0936	29.4238	28.1988
520051	1.5367	31.9949	31.5974	32.4131	32.0747
520057	1.1891	27.7528	29.1158	29.1597	28.6722
520059	1.3571	29.5801	30.4491	31.1798	30.4098
520060	***	24.8638	*	*	24.8638
520062	1.3339	28.8510	32.8584	32.7015	31.5745
520063	1.1686	29.0993	30.3391	31.5200	30.3776
520064	1.5247	30.3225	31.5723	33.1269	31.5786
520066	1.4186	29.2088	31.0644	31.6793	30.6342
520070	1.6955	27.6771	28.2059	30.0475	28.7368
520071	1.2148	30.0262	30.6930	31.5452	30.8059
520075	1.6957	29.2920	30.1582	32.2773	30.5489
520076	1.2239	27.3335	27.4423	26.8943	27.2256
520078	1.4652	29.9837	31.6606	32.0200	31.1775
520083	1.7220	30.8826	32.7728	34.7230	32.8287
520087	1.7143	28.5810	30.5659	31.9771	30.3899
520088	1.3608	30.7450	30.6657	30.7482	30.7194
520089	1.5751	33.8793	33.4098	34.9357	34.0817
520091	1.2761	25.4593	27.3442	28.7180	27.1746
520095	1.2276	30.4216	32.0381	33.2426	31.9196

Provider No.	Case-mix index[2]	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009[1]	Average hourly wage** (3 years)
520096	1.3674	27.8896	29.5985	29.2895	28.9000
520097	1.3251	29.1479	29.9998	30.5442	29.9125
520098	2.0064	32.5785	36.5776	38.0993	35.8088
520100	1.3329	29.3243	29.9458	31.7772	30.3560
520102	1.1952	29.1680	30.7990	31.5756	30.5386
520103	1.5558	30.3165	32.6269	34.5640	32.5636
520107	1.3431	28.9878	29.4178	30.0354	29.4891
520109	1.0461	24.7228	25.0697	25.9740	25.2673
520113	1.2650	31.4708	33.3475	33.3040	32.7091
520116	1.2569	27.9688	30.2156	31.6702	29.9799
520132	***	25.0006	27.3431	*	26.0481
520136	1.6348	30.6522	32.1479	32.3504	31.7001
520138	1.8895	30.8016	31.6581	32.5677	31.6770
520139	1.3347	28.8870	30.4903	31.7086	30.3331
520140	***	31.0043	31.1315	*	31.0699
520152	***	29.7308	*	*	29.7308
520160	1.7786	27.9548	29.5582	30.3052	29.2720
520170	1.4785	30.4309	31.4710	31.7610	31.2280
520173	1.0885	29.2429	31.0599	*	30.1478
520177	1.6063	31.4555	32.5714	33.1243	32.4073
520189	1.1691	28.0014	29.0295	29.2229	28.7606
520193	1.7202	27.8113	29.2007	29.4737	28.8659
520194	1.5801	30.1668	31.4379	31.0015	30.8967
520195	0.6565	36.3116	36.2900	41.6120	37.9691
520196	1.7733	36.9266	31.1175	33.4890	33.5193
520197	***	*	30.1917	*	30.1917
520198	1.3579	*	28.5975	29.9803	29.2929
520199	2.0530	*	36.5699	37.0128	36.7956
520202	1.6558	*	*	*	*
520203	2.9989	*	*	*	*
530002	1.1966	28.3063	29.2069	29.2418	28.9308
530006	1.2334	27.2421	29.2104	30.3724	28.9047
530008	1.1648	24.0090	26.5180	30.6010	27.0167
530009	0.9639	24.6719	26.0490	27.0555	25.9198
530010	1.2084	25.9852	27.4121	28.5534	27.3474
530011	1.1291	27.8772	27.8613	31.1329	28.8660
530012	1.7047	26.9582	28.7524	30.6109	28.7896
530014	1.5591	26.7156	28.5469	29.6724	28.4448
530015	1.1730	29.8310	29.8306	33.4903	31.0908
530017	0.9154	29.8503	31.1105	25.8183	28.8540
530025	1.3016	24.4392	29.4346	28.8963	27.4715
530032	1.0516	23.9004	24.6580	25.4267	24.6848

[1.] Based on salaries adjusted for occupational mix, according to the calculation in section III.D.2 of this final rule.
[2.] The case-mix index is based on the billed MS-DRGs in the FY 2007 MedPAR file. It is not transfer-adjusted.
[3.] Provider 140010 is part of a multi-campus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 140B10, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the MCH that is allocated to CBSA 16974.
[4.] Provider 220074 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 220B74, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the MCH that is allocated to CBSA 39300.
[5.] Provider 230104 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 230B04, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the MCH that is allocated to CBSA 19804.

Notes:
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2007, 2008, and 2009.
*** Denotes MedPAR data not available for the provider for FY 2007.

TABLE 3A.--FY 2009 and 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009.]

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
10180	Abilene, TX	27.1024	25.7729
10380	Aguadilla-Isabela-San Sebastián, PR	10.6712	10.7623
10420	Akron, OH	28.5385	26.9954
10500	Albany, GA	28.2636	27.2191
10580	Albany-Schenectady-Troy, NY	28.4659	27.2230
10740	Albuquerque, NM	30.3967	29.6384
10780	Alexandria, LA	26.1893	24.7996
10900	Allentown-Bethlehem-Easton, PA-NJ	31.1892	30.7360
11020	Altoona, PA	26.7080	25.9831
11100	Amarillo, TX	29.0025	28.2625
11180	Ames, IA	30.4779	30.0909
11260	Anchorage, AK	38.0825	36.6245
11300	Anderson, IN	28.7764	27.5953
11340	Anderson, SC	31.3797	28.7409
11460	Ann Arbor, MI	33.6592	32.6586
11500	Anniston-Oxford, AL	25.8074	24.6819
11540	Appleton, WI	30.0422	29.0246
11700	Asheville, NC	29.6291	28.5524
12020	Athens-Clarke County, GA	29.4943	29.3242
12060	Atlanta-Sandy Springs-Marietta, GA	31.5032	30.3445
12100	Atlantic City-Hammonton, NJ	38.3063	36.8619
12220	Auburn-Opelika, AL	24.3622	24.4413
12260	Augusta-Richmond County, GA-SC	30.9613	29.7640
12420	Austin-Round Rock, TX	30.6927	29.3093
12540	Bakersfield, CA	36.5338	34.5864
12580	Baltimore-Towson, MD	32.1871	30.9447
12620	Bangor, ME	32.5984	30.6405
12700	Barnstable Town, MA	40.9290	39.1647
12940	Baton Rouge, LA	26.3042	25.0735
12980	Battle Creek, MI	32.3529	30.7416

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
13020	Bay City, MI	30.3082	28.7064
13140	Beaumont-Port Arthur, TX	27.7071	26.7788
13380	Bellingham, WA	36.9489	34.7856
13460	Bend, OR	35.6022	33.2548
13644	Bethesda-Frederick-Gaithersburg, MD	33.9538	32.8582
13740	Billings, MT	29.1484	27.7812
13780	Binghamton, NY	28.1046	27.6142
13820	Birmingham-Hoover, AL	28.3160	27.3829
13900	Bismarck, ND	23.2363	22.4954
13980	Blacksburg-Christiansburg-Radford, VA	26.1777	25.2605
14020	Bloomington, IN	30.3764	28.6844
14060	Bloomington-Normal, IL	30.6834	29.0692
14260	Boise City-Nampa, ID	30.0590	29.1772
14484	Boston-Quincy, MA	38.6537	36.7398
14500	Boulder, CO	32.3097	31.3059
14540	Bowling Green, KY	26.8914	25.3113
14600	Bradenton-Sarasota-Venice, FL	31.5117	30.2352
14740	Bremerton-Silverdale, WA	34.5739	33.5081
14860	Bridgeport-Stamford-Norwalk, CT	41.7715	39.7682
15180	Brownsville-Harlingen, TX	29.7402	29.0326
15260	Brunswick, GA	31.8968	31.0858
15380	Buffalo-Niagara Falls, NY	30.9144	29.5840
15500	Burlington, NC	27.7679	26.6192
15540	Burlington-South Burlington, VT	29.6994	29.1467
15764	Cambridge-Newton-Framingham, MA	35.8688	34.4385
15804	Camden, NJ	33.8360	32.5551
15940	Canton-Massillon, OH	28.5332	27.6793
15980	Cape Coral-Fort Myers, FL	30.6894	29.4311
16180	Carson City, NV	32.3146	30.2132
16220	Casper, WY	30.6109	28.7896
16300	Cedar Rapids, IA	28.3070	27.0348
16580	Champaign-Urbana, IL	30.3624	29.2524
16620	Charleston, WV	27.1214	26.3078
16700	Charleston-North Charleston-Summerville, SC	29.7203	28.3743
16740	Charlotte-Gastonia-Concord, NC-SC	30.8545	29.4546
16820	Charlottesville, VA	31.3538	29.8280

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
16860	Chattanooga, TN-GA	28.6176	27.6445
16940	Cheyenne, WY	29.6724	28.4448
16974	Chicago-Naperville-Joliet, IL	33.2392	32.5776
17020	Chico, CA	35.0721	34.2771
17140	Cincinnati-Middletown, OH-KY-IN	30.9303	29.7377
17300	Clarksville, TN-KY	26.7558	25.7483
17420	Cleveland, TN	26.2924	25.3796
17460	Cleveland-Elyria-Mentor, OH	29.9194	28.9439
17660	Coeur d'Alene, ID	29.6018	28.7264
17780	College Station-Bryan, TX	29.6338	28.1762
17820	Colorado Springs, CO	31.4392	29.6333
17860	Columbia, MO	27.2148	26.2869
17900	Columbia, SC	28.9974	27.6682
17980	Columbus, GA-AL	29.2026	27.4851
18020	Columbus, IN	31.7966	29.8988
18140	Columbus, OH	31.9765	31.0138
18580	Corpus Christi, TX	27.3812	26.2265
18700	Corvallis, OR	35.7101	34.1748
19060	Cumberland, MD-WV	24.2723	24.3757
19124	Dallas-Plano-Irving, TX	31.7562	30.5835
19140	Dalton, GA	27.5885	26.9190
19180	Danville, IL	31.2973	29.5317
19260	Danville, VA	27.3424	26.0799
19340	Davenport-Moline-Rock Island, IA-IL	27.2031	26.8972
19380	Dayton, OH	30.0707	28.7112
19460	Decatur, AL	24.8600	24.2898
19500	Decatur, IL	26.4753	25.3590
19660	Deltona-Daytona Beach-Ormond Beach, FL	28.4778	27.8491
19740	Denver-Aurora, CO	34.1462	32.7978
19780	Des Moines-West Des Moines, IA	30.6194	28.7465
19804	Detroit-Livonia-Dearborn, MI	32.4041	31.4672
20020	Dothan, AL	25.0476	23.4124
20100	Dover, DE	34.3854	32.3024
20220	Dubuque, IA	26.5578	26.9196
20260	Duluth, MN-WI	33.9001	31.7848
20500	Durham, NC	31.2465	30.0961

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
20740	Eau Claire, WI	31.0522	29.6550
20764	Edison-New Brunswick, NJ	36.1516	34.5127
20940	El Centro, CA	29.1095	28.1137
21060	Elizabethtown, KY	27.2851	26.5359
21140	Elkhart-Goshen, IN	30.7289	29.4430
21300	Elmira, NY	26.9008	25.8570
21340	El Paso, TX	28.5835	28.1103
21500	Erie, PA	28.2228	26.9656
21660	Eugene-Springfield, OR	36.0146	34.2346
21780	Evansville, IN-KY	27.4922	26.7125
21820	Fairbanks, AK	36.1911	34.2982
21940	Fajardo, PR	13.1078	12.8847
22020	Fargo, ND-MN	26.0905	24.9870
22140	Farmington, NM	25.2168	26.1583
22180	Fayetteville, NC	31.9872	30.2242
22220	Fayetteville-Springdale-Rogers, AR-MO	29.4274	27.9245
22380	Flagstaff, AZ	37.5523	35.8812
22420	Flint, MI	36.2808	34.1512
22500	Florence, SC	27.2448	26.5264
22520	Florence-Muscle Shoals, AL	25.3372	24.1012
22540	Fond du Lac, WI	30.7482	30.7194
22660	Fort Collins-Loveland, CO	30.8241	29.2771
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	31.6372	30.8493
22900	Fort Smith, AR-OK	25.2765	24.4942
23020	Fort Walton Beach-Crestview-Destin, FL	28.1077	26.8456
23060	Fort Wayne, IN	28.8971	28.1734
23104	Fort Worth-Arlington, TX	31.2158	29.8337
23420	Fresno, CA	35.7700	34.2811
23460	Gadsden, AL	25.7530	24.9692
23540	Gainesville, FL	30.4638	29.0996
23580	Gainesville, GA	30.1147	28.9199
23844	Gary, IN	29.9816	28.8373
24020	Glens Falls, NY	28.2949	26.8179
24140	Goldsboro, NC	29.5232	28.5205
24220	Grand Forks, ND-MN	24.9891	24.4059
24300	Grand Junction, CO	31.2219	29.9886

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
24340	Grand Rapids-Wyoming, MI	29.9056	29.1406
24500	Great Falls, MT	27.9357	26.5452
24540	Greeley, CO	32.4226	30.9997
24580	Green Bay, WI	30.6093	29.4827
24660	Greensboro-High Point, NC	29.4662	28.1371
24780	Greenville, NC	30.1280	28.8804
24860	Greenville-Mauldin-Easley, SC	31.4918	29.9304
25020	Guayama, PR	10.1110	09.6177
25060	Gulfport-Biloxi, MS	28.6753	27.0863
25180	Hagerstown-Martinsburg, MD-WV	29.8854	28.7647
25260	Hanford-Corcoran, CA	35.7306	33.4057
25420	Harrisburg-Carlisle, PA	29.4641	28.6488
25500	Harrisonburg, VA	28.8660	27.8914
25540	Hartford-West Hartford-East Hartford, CT	36.0215	34.1989
25620	Hattiesburg, MS	24.2857	23.4145
25860	Hickory-Lenoir-Morganton, NC	28.8373	27.7795
25980	[1]Hinesville-Fort Stewart, GA		
26100	Holland-Grand Haven, MI	29.3313	28.2611
26180	Honolulu, HI	37.3603	34.9565
26300	Hot Springs, AR	29.4752	27.9461
26380	Houma-Bayou Cane-Thibodaux, LA	25.3758	24.7948
26420	Houston- Sugar Land-Baytown, TX	31.9928	30.9876
26580	Huntington-Ashland, WV-KY-OH	29.4125	27.7650
26620	Huntsville, AL	28.9627	27.8631
26820	Idaho Falls, ID	29.3377	28.2705
26900	Indianapolis-Carmel, IN	31.6508	30.2928
26980	Iowa City, IA	30.2188	29.3123
27060	Ithaca, NY	30.8121	29.9035
27100	Jackson, MI	30.5417	29.5818
27140	Jackson, MS	25.9141	24.9693
27180	Jackson, TN	27.3093	26.6869
27260	Jacksonville, FL	29.3463	28.3877
27340	Jacksonville, NC	27.0597	25.9223
27500	Janesville, WI	31.7258	30.5060
27620	Jefferson City, MO	29.1526	27.2526
27740	Johnson City, TN	25.8735	24.6040

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
27780	Johnstown, PA	25.9720	24.9952
27860	Jonesboro, AR	26.0215	24.6495
27900	Joplin, MO	31.3044	28.6520
28020	Kalamazoo-Portage, MI	35.1615	33.2921
28100	Kankakee-Bradley, IL	33.6101	31.5905
28140	Kansas City, MO-KS	30.4808	29.0642
28420	Kennewick-Pasco-Richland, WA	31.3651	30.6569
28660	Killeen-Temple-Fort Hood, TX	28.5428	26.9560
28700	Kingsport-Bristol-Bristol, TN-VA	25.3736	24.5161
28740	Kingston, NY	30.3983	29.3498
28940	Knoxville, TN	25.4232	24.8949
29020	Kokomo, IN	29.8449	29.2851
29100	La Crosse, WI-MN	31.6314	30.0301
29140	Lafayette, IN	29.1814	27.3869
29180	Lafayette, LA	27.2470	25.9786
29340	Lake Charles, LA	24.4734	24.0438
29404	Lake County-Kenosha County, IL-WI	33.5019	32.6866
29420	Lake Havasu City-Kingman, AZ	31.7028	29.6612
29460	Lakeland-Winter Haven, FL	28.1514	27.5024
29540	Lancaster, PA	31.1896	30.0938
29620	Lansing-East Lansing, MI	31.9034	30.9922
29700	Laredo, TX	28.4169	26.3102
29740	Las Cruces, NM	28.3877	27.2933
29820	Las Vegas-Paradise, NV	37.5801	35.4839
29940	Lawrence, KS	26.8029	25.6449
30020	Lawton, OK	27.8156	26.3379
30140	Lebanon, PA	29.0033	26.8311
30300	Lewiston, ID-WA	29.8793	29.0080
30340	Lewiston-Auburn, ME	30.1114	28.7924
30460	Lexington-Fayette, KY	28.8451	27.8167
30620	Lima, OH	29.9622	28.3623
30700	Lincoln, NE	31.0031	30.3922
30780	Little Rock-North Little Rock-Conway, AR	28.3549	28.3026
30860	Logan, UT-ID	28.3557	27.8965
30980	Longview, TX	27.3064	26.9363
31020	Longview, WA	36.9273	33.8445

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
31084	Los Angeles-Long Beach-Glendale, CA	39.0659	36.6463
31140	Louisville-Jefferson County, KY-IN	29.7946	28.3276
31180	Lubbock, TX	28.0820	26.7841
31340	Lynchburg, VA	27.9849	26.7306
31420	Macon, GA	31.6319	30.3419
31460	Madera, CA	26.7733	26.0580
31540	Madison, WI	36.2647	34.3955
31700	Manchester-Nashua, NH	33.0561	31.4827
31900	Mansfield, OH	29.9823	28.5729
32420	Mayagüez, PR	12.5560	11.7172
32580	McAllen-Edinburg-Mission, TX	29.2859	27.9541
32780	Medford, OR	33.0810	32.3232
32820	Memphis, TN-MS-AR	30.0645	28.8805
32900	Merced, CA	39.1412	36.7046
33124	Miami-Miami Beach-Kendall, FL	31.8624	30.6919
33140	Michigan City-La Porte, IN	29.2050	27.7539
33260	Midland, TX	30.8221	29.7001
33340	Milwaukee-Waukesha-West Allis, WI	32.8764	31.8093
33460	Minneapolis-St. Paul-Bloomington, MN-WI	35.4401	33.7581
33540	Missoula, MT	28.2308	26.9689
33660	Mobile, AL	25.3223	24.4101
33700	Modesto, CA	39.3307	37.0596
33740	Monroe, LA	25.6687	24.6847
33780	Monroe, MI	29.0975	29.1635
33860	Montgomery, AL	26.8575	25.2612
34060	Morgantown, WV	27.8767	26.4878
34100	Morristown, TN	23.5610	23.4077
34580	Mount Vernon-Anacortes, WA	32.2078	31.3437
34620	Muncie, IN	26.7359	25.4267
34740	Muskegon-Norton Shores, MI	32.9641	31.3196
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	28.0587	27.0883
34900	Napa, CA	45.2798	42.3414
34940	Naples-Marco Island, FL	31.7192	30.5333
34980	Nashville-Davidson-Murfreesboro- Franklin, TN	30.5205	29.8362
35004	Nassau-Suffolk, NY	41.0380	39.8241
35084	Newark-Union, NJ-PA	37.3432	36.1295

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
35300	New Haven-Milford, CT	38.1872	37.0179
35380	New Orleans-Metairie-Kenner, LA	28.9665	27.0935
35644	New York-White Plains-Wayne, NY-NJ	42.0401	40.8899
35660	Niles-Benton Harbor, MI	29.3103	28.0269
35980	Norwich-New London, CT	37.0091	36.0955
36084	Oakland-Fremont-Hayward, CA	50.7485	48.0693
36100	Ocala, FL	27.4073	26.5365
36140	Ocean City, NJ	37.4855	34.3019
36220	Odessa, TX	30.3812	30.3256
36260	Ogden-Clearfield, UT	29.7877	28.2622
36420	Oklahoma City, OK	27.9946	27.1142
36500	Olympia, WA	37.0173	34.9717
36540	Omaha-Council Bluffs, NE-IA	30.2509	29.2054
36740	Orlando-Kissimmee, FL	29.6625	28.9734
36780	Oshkosh-Neenah, WI	30.0779	28.8550
36980	Owensboro, KY	28.2430	27.1334
37100	Oxnard-Thousand Oaks-Ventura, CA	37.1556	35.1804
37340	Palm Bay-Melbourne-Titusville, FL	30.3646	29.2698
37380	[2] Palm Coast, FL	28.3201	27.7205
37460	Panama City-Lynn Haven, FL	27.4737	25.9848
37620	Parkersburg-Marietta-Vienna, WV-OH	25.9298	25.2128
37700	Pascagoula, MS	25.8794	25.5018
37764	Peabody, MA	34.6242	32.8188
37860	Pensacola-Ferry Pass-Brent, FL	26.1521	24.9085
37900	Peoria, IL	29.5026	28.5643
37964	Philadelphia, PA	35.4192	33.9482
38060	Phoenix-Mesa-Scottsdale, AZ	33.0727	31.5723
38220	Pine Bluff, AR	26.6645	25.9275
38300	Pittsburgh, PA	27.8613	26.4327
38340	Pittsfield, MA	33.6610	31.7769
38540	Pocatello, ID	29.3374	28.3741
38660	Ponce, PR	13.2835	13.4725
38860	Portland-South Portland-Biddeford, ME	31.9912	30.7487
38900	Portland-Vancouver-Beaverton, OR-WA	36.1840	34.7786
38940	Port St. Lucie, FL	31.9978	30.8053
39100	Poughkeepsie-Newburgh-Middletown, NY	35.3300	34.0084

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
39140	Prescott, AZ	32.8663	30.9624
39300	Providence-New Bedford-Fall River, RI-MA	34.5062	33.0927
39340	Provo-Orem, UT	30.1054	29.2230
39380	Pueblo, CO	27.8208	26.8691
39460	Punta Gorda, FL	29.9898	29.4806
39540	Racine, WI	29.5544	29.1101
39580	Raleigh-Cary, NC	31.1989	30.0424
39660	Rapid City, SD	30.6224	27.7650
39740	Reading, PA	30.0888	29.3823
39820	Redding, CA	41.9978	39.5292
39900	Reno-Sparks, NV	33.7964	34.6460
40060	Richmond, VA	29.6630	28.3814
40140	Riverside-San Bernardino-Ontario, CA	36.4715	34.0891
40220	Roanoke, VA	28.6494	27.4639
40340	Rochester, MN	35.3925	33.7874
40380	Rochester, NY	28.7047	27.8066
40420	Rockford, IL	31.7848	30.6694
40484	Rockingham County-Strafford County, NH	31.9378	31.0995
40580	Rocky Mount, NC	29.2311	27.8758
40660	Rome, GA	31.2580	29.9024
40900	Sacramento--Arden-Arcade--Roseville, CA	42.4967	40.5779
40980	Saginaw-Saginaw Township North, MI	29.1148	28.2491
41060	St. Cloud, MN	37.2207	34.8318
41100	St. George, UT	29.7397	29.2078
41140	St. Joseph, MO-KS	33.8254	30.6152
41180	St. Louis, MO-IL	28.9933	27.8553
41420	Salem, OR	34.6240	32.5065
41500	Salinas, CA	48.0445	45.4311
41540	Salisbury, MD	29.6292	27.8991
41620	Salt Lake City, UT	29.8788	29.1430
41660	San Angelo, TX	27.4970	26.4821
41700	San Antonio, TX	28.8479	27.6673
41740	San Diego-Carlsbad-San Marcos, CA	36.3816	34.7236
41780	Sandusky, OH	28.4761	27.6994
41884	San Francisco-San Mateo-Redwood City, CA	48.9140	46.9074
41900	San Germán-Cabo Rojo, PR	14.9779	14.5348

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
41940	San Jose-Sunnyvale-Santa Clara, CA	51.2145	48.2447
41980	San Juan-Caguas-Guaynabo, PR	14.1934	13.8051
42020	San Luis Obispo-Paso Robles, CA	38.5261	36.2985
42044	Santa Ana-Anaheim-Irvine, CA	38.1854	36.0061
42060	Santa Barbara-Santa Maria-Goleta, CA	37.6831	35.1065
42100	Santa Cruz-Watsonville, CA	51.6319	48.4160
42140	Santa Fe, NM	34.1610	33.1629
42220	Santa Rosa-Petaluma, CA	49.4299	45.6809
42340	Savannah, GA	28.8197	27.8432
42540	Scranton--Wilkes-Barre, PA	26.5871	25.6845
42644	Seattle-Bellevue-Everett, WA	37.3377	35.3396
42680	Sebastian-Vero Beach, FL	30.7445	30.0451
43100	Sheboygan, WI	29.1180	28.0870
43300	Sherman-Denison, TX	29.9483	27.3069
43340	Shreveport-Bossier City, LA	27.5592	26.7868
43580	Sioux City, IA-NE-SD	28.3042	27.7787
43620	Sioux Falls, SD	30.2258	29.2205
43780	South Bend-Mishawaka, IN-MI	31.6519	30.3190
43900	Spartanburg, SC	29.1049	28.3533
44060	Spokane, WA	33.9550	32.3341
44100	Springfield, IL	29.4346	27.9096
44140	Springfield, MA	33.9403	32.0802
44180	Springfield, MO	27.5683	26.7768
44220	Springfield, OH	28.2017	26.6244
44300	State College, PA	28.4200	27.0044
44700	Stockton, CA	38.7364	36.5154
44940	Sumter, SC	27.6431	26.7226
45060	Syracuse, NY	31.7961	30.5781
45104	Tacoma, WA	35.9654	33.8974
45220	Tallahassee, FL	29.0088	27.8755
45300	Tampa-St. Petersburg-Clearwater, FL	28.9385	28.1846
45460	Terre Haute, IN	29.4516	27.6765
45500	Texarkana, TX-Texarkana, AR	26.4179	24.8367
45780	Toledo, OH	29.9035	28.9160
45820	Topeka, KS	28.5950	27.0606
45940	Trenton-Ewing, NJ	34.3723	33.3216

CBSA Code	Urban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
46060	Tucson, AZ	30.4294	29.2243
46140	Tulsa, OK	27.8430	26.3127
46220	Tuscaloosa, AL	28.2446	26.9059
46340	Tyler, TX	28.6932	27.8523
46540	Utica-Rome, NY	28.1058	27.1063
46660	Valdosta, GA	26.3071	25.6433
46700	Vallejo-Fairfield, CA	45.6967	44.8142
47020	Victoria, TX	25.6801	25.2874
47220	Vineland-Millville-Bridgeton, NJ	35.2402	33.0208
47260	Virginia Beach-Norfolk-Newport News, VA-NC	28.6099	27.3012
47300	Visalia-Porterville, CA	33.2045	31.6004
47380	Waco, TX	28.0533	26.9097
47580	Warner Robins, GA	30.6254	28.9060
47644	Warren-Troy-Farmington Hills, MI	32.1514	31.0986
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	34.4538	33.3878
47940	Waterloo-Cedar Falls, IA	28.0524	26.9033
48140	Wausau, WI	31.6807	30.5745
48260	Weirton-Steubenville, WV-OH	26.0170	24.7868
48300	Wenatchee, WA	30.3636	31.9696
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	31.0818	29.6957
48540	Wheeling, WV-OH	22.6483	21.8078
48620	Wichita, KS	28.9417	27.7971
48660	Wichita Falls, TX	29.5755	26.8205
48700	Williamsport, PA	25.8800	24.8311
48864	Wilmington, DE-MD-NJ	34.0957	32.8594
48900	Wilmington, NC	29.1391	29.0130
49020	Winchester, VA-WV	31.4909	30.6464
49180	Winston-Salem, NC	29.0528	28.2252
49340	Worcester, MA	35.2753	34.2028
49420	Yakima, WA	32.0343	30.9561
49500	Yauco, PR	10.8214	10.6068
49620	York-Hanover, PA	31.0115	29.5103
49660	Youngstown-Warren-Boardman, OH-PA	28.8083	27.5861
49700	Yuba City, CA	35.2433	33.0236
49740	Yuma, AZ	31.9162	30.1315

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.
[2] This is a new CBSA for FY 2009. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for FY 2007 and FY 2008.

TABLE 3B.--FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA

(*Based on the sum of the salaries and hours computed for Federal FYs 2007, 2008, and 2009)

CBSA Code	Nonurban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
01	Alabama	24.6429	23.6246
02	Alaska	38.4033	35.4146
03	Arizona	28.5426	27.4578
04	Arkansas	24.6214	23.3339
05	California	38.8712	35.9207
06	Colorado	30.1407	28.8071
07	Connecticut	36.0267	35.4695
08	Delaware	32.6052	30.8234
10	Florida	27.8815	26.8068
11	Georgia	25.2755	24.2911
12	Hawaii	36.0409	33.6551
13	Idaho	24.4391	24.1645
14	Illinois	27.1664	25.9713
15	Indiana	27.3843	26.4614
16	Iowa	28.1866	26.6796
17	Kansas	25.9828	24.8096
18	Kentucky	25.2883	24.2366
19	Louisiana	24.7684	23.6887
20	Maine	27.7445	26.2717
21	Maryland	28.3424	27.4615
22	Massachusetts	--	--
23	Michigan	28.6081	27.6769
24	Minnesota	29.3908	28.3130
25	Mississippi	24.6583	23.9278
26	Missouri	26.3905	25.2208
27	Montana	27.8441	26.4706
28	Nebraska	28.0133	26.9491
29	Nevada	31.7337	29.6714
30	New Hampshire	33.1415	32.7814
31	New Jersey[1]	--	--
32	New Mexico	28.5829	27.1095
33	New York	26.6169	25.7589
34	North Carolina	27.8213	26.7070
35	North Dakota	23.7308	22.7361

CBSA Code	Nonurban Area	FY 2009 Average Hourly Wage	3-Year Average Hourly Wage
36	Ohio	27.7269	26.8299
37	Oklahoma	25.6857	24.2692
38	Oregon	33.1244	30.9024
39	Pennsylvania	26.9132	25.8182
40	Puerto Rico[1]	--	--
41	Rhode Island[1]	--	--
42	South Carolina	27.7921	26.8755
43	South Dakota	27.1597	25.8864
44	Tennessee	25.6645	24.6489
45	Texas	26.2806	25.3604
46	Utah	27.0541	25.6728
47	Vermont	32.0328	30.2942
49	Virginia	25.9737	24.9980
50	Washington	32.6143	31.5036
51	West Virginia	24.6609	23.6992
52	Wisconsin	30.4170	29.6309
53	Wyoming	29.7236	28.3181

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

TABLE 4J.--OUT-MIGRATION ADJUSTMENT--FY 2009

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this final rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of this final rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attn.: Wage Index Adjustment Waivers, Division of Acute Care, Room C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010010	*	0.0296	MARSHALL	01470
010012	*	0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010021		0.0053	DALE	01220
010022	*	0.1128	CHEROKEE	01090
010027		0.0027	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0061	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046		0.0061	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0027	COFFEE	01150
010052	*	0.0103	TALLAPOOSA	01610

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
010059	*	0.0070	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350
010065	*	0.0103	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0406	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150	*	0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
050002		0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009		0.0180	NAPA	05380
050013		0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050042	*	0.0162	TEHAMA	05620
050043		0.0010	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075		0.0010	ALAMEDA	05000
050084		0.0132	SAN JOAQUIN	05490
050089		0.0011	SAN BERNARDINO	05460
050090		0.0058	SONOMA	05590
050099		0.0011	SAN BERNARDINO	05460
050101	*	0.0171	SOLANO	05580

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050129		0.0011	SAN BERNARDINO	05460
050133	*	0.0178	YUBA	05680
050136		0.0058	SONOMA	05590
050140		0.0011	SAN BERNARDINO	05460
050150	*	0.0342	NEVADA	05390
050167		0.0132	SAN JOAQUIN	05490
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050174		0.0058	SONOMA	05590
050193	*	0.0013	ORANGE	05400
050194		0.0052	SANTA CRUZ	05540
050195		0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211		0.0010	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050242		0.0052	SANTA CRUZ	05540
050245		0.0011	SAN BERNARDINO	05460
050264		0.0010	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279		0.0011	SAN BERNARDINO	05460
050283		0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291		0.0058	SONOMA	05590
050298		0.0011	SAN BERNARDINO	05460
050300		0.0011	SAN BERNARDINO	05460
050305		0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320		0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050327		0.0011	SAN BERNARDINO	05460
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050348	*	0.0013	ORANGE	05400
050366		0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385		0.0058	SONOMA	05590
050426	*	0.0013	ORANGE	05400
050444		0.0233	MERCED	05340
050476	*	0.0278	LAKE	05160

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
050488		0.0010	ALAMEDA	05000
050512		0.0010	ALAMEDA	05000
050517		0.0011	SAN BERNARDINO	05460
050526	*	0.0013	ORANGE	05400
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050547		0.0058	SONOMA	05590
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050584		0.0011	SAN BERNARDINO	05460
050586		0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667		0.0180	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0171	SOLANO	05580
050690		0.0058	SONOMA	05590
050693	*	0.0013	ORANGE	05400
050714		0.0052	SANTA CRUZ	05540
050720	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
050758		0.0011	SAN BERNARDINO	05460
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060010		0.0153	LARIMER	06340
060027	*	0.0069	BOULDER	06060
060030		0.0153	LARIMER	06340
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060119		0.0153	LARIMER	06340
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
080001	*	0.0041	NEW CASTLE	08010
080003	*	0.0041	NEW CASTLE	08010
090001	*	0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004	*	0.0033	THE DISTRICT	09000
090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000
090008		0.0033	THE DISTRICT	09000
090011	*	0.0033	THE DISTRICT	09000
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0177	FLAGLER	10170
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100252	*	0.0151	OKEECHOBEE	10460
100290		0.0339	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0805	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140116		0.0014	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161		0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176		0.0014	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150006	*	0.0113	LA PORTE	15450
150015	*	0.0113	LA PORTE	15450
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0319	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0235	JASPER	16490
160080		0.0066	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088	*	0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0075	CALDWELL	19100
190190		0.0075	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
190277		0.0387	WEBSTER	19590
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0364	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002		0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011		0.0271	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025	*	0.0072	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049		0.0271	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063		0.0271	MIDDLESEX	22090
220070		0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082		0.0271	MIDDLESEX	22090
220084		0.0271	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
220098		0.0271	MIDDLESEX	22090
220101		0.0271	MIDDLESEX	22090
220105		0.0271	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170
220171		0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220176	*	0.0072	WORCESTER	22170
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230047	*	0.0021	MACOMB	23490
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230151	*	0.0025	OAKLAND	23620
230174	*	0.0220	OTTAWA	23690
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230223	*	0.0025	OAKLAND	23620
230227	*	0.0021	MACOMB	23490
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230277	*	0.0025	OAKLAND	23620

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
230279	*	0.0210	LIVINGSTON	23460
230301		0.0025	OAKLAND	23620
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
260059		0.0077	LACLEDE	26520
260064		0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116		0.0087	ST. FRANCOIS	26930
260163		0.0087	ST. FRANCOIS	26930
280077		0.0080	DODGE	28260
280123		0.0123	GAGE	28330
290002	*	0.0277	LYON	29090
300011	*	0.0059	HILLSBOROUGH	30050
300012	*	0.0059	HILLSBOROUGH	30050
300017	*	0.0086	ROCKINGHAM	30070
300020	*	0.0059	HILLSBOROUGH	30050
300023	*	0.0086	ROCKINGHAM	30070
300029	*	0.0086	ROCKINGHAM	30070
300034	*	0.0059	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310010		0.0181	MERCER	31260
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310018	*	0.0268	ESSEX	31200
310021	*	0.0181	MERCER	31260
310031	*	0.0158	BURLINGTON	31150
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270
310044		0.0181	MERCER	31260
310050	*	0.0199	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310057		0.0158	BURLINGTON	31150
310061		0.0158	BURLINGTON	31150

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
310069		0.0087	SALEM	31340
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310091		0.0087	SALEM	31340
310092		0.0181	MERCER	31260
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310110		0.0181	MERCER	31260
310119	*	0.0268	ESSEX	31200
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
330004	*	0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027		0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103	*	0.0131	CATTARAUGUS	33040
330106		0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0055	STEUBEN	33690
330151		0.0055	STEUBEN	33690
330167		0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181		0.0123	NASSAU	33400
330182		0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198		0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225		0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259		0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0055	STEUBEN	33690

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
330331		0.0123	NASSAU	33400
330332		0.0123	NASSAU	33400
330372		0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085	*	0.0250	DAVIDSON	34280
340096	*	0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0260	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360065	*	0.0075•	HURON	36400
360070		0.0005	STARK	36770
360071		0.0035	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0186	CLARK	36110
360096	*	0.0071	COLUMBIANA	36140
360100		0.0005	STARK	36770
360107	*	0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0119	SANDUSKY	36730
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0133	ASHTABULA	36030
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030	*	0.0284	SCHUYLKILL	39650
390031	*	0.0284	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350
390146		0.0022	WARREN	39740
390150		0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390183	*	0.0284	SCHUYLKILL	39650
390201		0.1170	MONROE	39550

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
390236		0.0003	BRADFORD	39130
390313	*	0.0284	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
420002		0.0001	YORK	42450
420007	*	0.0027	SPARTANBURG	42410
420009	*	0.0113	OCONEE	42360
420019		0.0158	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027		0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0110	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420062	*	0.0109	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083	*	0.0027	SPARTANBURG	42410
420098	*	0.0008	GEORGETOWN	42210
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0144	CARROLL	44080
440017		0.0009	SULLIVAN	44810
440024	*	0.0230	BRADLEY	44050
440025	*	0.0009	GREENE	44290
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060	*	0.0338	GIBSON	44260
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440109		0.0070	HARDIN	44350

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440174		0.0312	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
450032		0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059		0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144		0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450324	*	0.0132	GRAYSON	45564
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370		0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450393	*	0.0132	GRAYSON	45564
450395	*	0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438		0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450469	*	0.0132	GRAYSON	45564
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582
450547	*	0.0195	WOOD	45974

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
450563	*	0.0024	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450615		0.0033	CASS	45260
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0126	ANDERSON	45000
450838		0.0126	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460017		0.0383	BOX ELDER	46010
460039	*	0.0383	BOX ELDER	46010
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041		0.0020	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520095		0.0193	SAUK	52550
520096	*	0.0195	RACINE	52500

Provider Number	Reclassified for FY 2009	Out-Migration Adjustment	Qualifying County Name	County Code
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
670015		0.0024	TARRANT	45910
670023		0.0024	TARRANT	45910

TABLE 5.-LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGs), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
001	No	No	PRE	SURG	Heart transplant or implant of heart assist system w MCC	23.6701	29.6	41.1
002	No	No	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC	12.8157	18.7	25.3
003	Yes	No	PRE	SURG	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	18.3694	32.6	39.8
004	Yes	No	PRE	SURG	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	11.1366	23 5	28.9
005	No	No	PRE	SURG	Liver transplant w MCC or intestinal transplant	10.8180	16.1	21.5
006	No	No	PRE	SURG	Liver transplant w/o MCC	4.8839	9.0	10.5
007	No	No	PRE	SURG	Lung transplant	9.5998	15.8	19.6
008	No	No	PRE	SURG	Simultaneous pancreas/kidney transplant	4.8811	10.1	11.9
009	No	No	PRE	SURG	Bone marrow transplant	6.6411	18.3	22.0
010	No	No	PRE	SURG	Pancreas transplant	3.7246	9.1	10.8
011	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC	4.8834	13.1	16.7
012	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w CC	3.0527	8.8	10.7
013	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	1.8966	5.9	6.9
020	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w MCC	8.2920	14.8	18.3
021	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w CC	6.3596	13.7	15.5
022	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	4.1535	7.6	9.3
023	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	5.0584	8.9	12.7
024	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w/o MCC	3.4597	6.2	9.0
025	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w MCC	5.0109	9.9	13.0
026	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w CC	3.0058	6.4	8.2
027	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC	2.1029	3.5	4.5
028	Yes	Yes	01	SURG	Spinal procedures w MCC	5.1919	10.7	14.3
029	Yes	Yes	01	SURG	Spinal procedures w CC or spinal neurostimulators	2.7943	5.1	7.1
030	Yes	Yes	01	SURG	Spinal procedures w/o CC/MCC	1.5385	2.8	3.7
031	Yes	No	01	SURG	Ventricular shunt procedures w MCC	4.3861	9.3	13.1

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
032	Yes	No	01	SURG	Ventricular shunt procedures w CC	1.9518	4.0	6.0
033	Yes	No	01	SURG	Ventricular shunt procedures w/o CC/MCC	1.3289	2.3	3.0
034	No	No	01	SURG	Carotid artery stent procedure w MCC	3.2220	4.6	7.3
035	No	No	01	SURG	Carotid artery stent procedure w CC	2.0227	2.1	3.3
036	No	No	01	SURG	Carotid artery stent procedure w/o CC/MCC	1.5673	1.3	1.6
037	No	No	01	SURG	Extracranial procedures w MCC	3.0263	5.9	8.6
038	No	No	01	SURG	Extracranial procedures w CC	1.5525	2.5	3.8
039	No	No	01	SURG	Extracranial procedures w/o CC/MCC	1.0005	1.5	1.8
040	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w MCC	3.9645	9.7	13.3
041	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	2.1518	5.3	7.2
042	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	1.6759	2.5	3.6
052	No	No	01	MED	Spinal disorders & injuries w CC/MCC	1.6216	4.8	6.7
053	No	No	01	MED	Spinal disorders & injuries w/o CC/MCC	0.8669	3.3	4.0
054	Yes	No	01	MED	Nervous system neoplasms w MCC	1.5860	5.2	7.0
055	Yes	No	01	MED	Nervous system neoplasms w/o MCC	1.0828	3.8	5.1
056	Yes	No	01	MED	Degenerative nervous system disorders w MCC	1.6349	5.7	7.8
057	Yes	No	01	MED	Degenerative nervous system disorders w/o MCC	0.8802	3.9	5.0
058	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w MCC	1.5706	5.7	7.7
059	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w CC	0.9444	4.2	5.1
060	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.6994	3.4	4.0
061	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w MCC	2.8717	6.8	8.9
062	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w CC	1.9537	5.3	6.3
063	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	1.5143	3.9	4.5
064	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w MCC	1.8450	5.5	7.5
065	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w CC	1.1760	4.3	5.2
066	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	0.8439	3.1	3.7
067	No	No	01	MED	Nonspecific CVA & precerebral occlusion w/o infarct w MCC	1.3873	4.4	5.8
068	No	No	01	MED	Nonspecific CVA & precerebral occlusion w/o infarct w/o MCC	0.8457	2.7	3 4
069	No	No	01	MED	Transient ischemia	0.7157	2.4	3.0
070	Yes	No	01	MED	Nonspecific cerebrovascular disorders w MCC	1.8246	6.0	7.9
071	Yes	No	01	MED	Nonspecific cerebrovascular disorders w CC	1.1361	4.4	5.6
072	Yes	No	01	MED	Nonspecific cerebrovascular disorders w/o CC/MCC	0.7650	2.8	3.5

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
073	No	No	01	MED	Cranial & peripheral nerve disorders w MCC	1.3082	4.7	6.2
074	No	No	01	MED	Cranial & peripheral nerve disorders w/o MCC	0.8423	3.4	4.3
075	No	No	01	MED	Viral meningitis w CC/MCC	1.6730	5.7	7.3
076	No	No	01	MED	Viral meningitis w/o CC/MCC	0.8595	3.4	4.1
077	No	No	01	MED	Hypertensive encephalopathy w MCC	1.6233	5.2	6.7
078	No	No	01	MED	Hypertensive encephalopathy w CC	1.0082	3.6	4.4
079	No	No	01	MED	Hypertensive encephalopathy w/o CC/MCC	0.7398	2.8	3.4
080	No	No	01	MED	Nontraumatic stupor & coma w MCC	1.1032	3.8	5.1
081	No	No	01	MED	Nontraumatic stupor & coma w/o MCC	0.7104	2.7	3.5
082	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w MCC	2.0201	3.7	6.4
083	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w CC	1.2993	3.7	4.9
084	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	0.8753	2.4	3.1
085	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w MCC	2.0908	5.5	7.6
086	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w CC	1.2072	3.9	5.0
087	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.8011	2.6	3.3
088	No	No	01	MED	Concussion w MCC	1.5829	4.2	5.9
089	No	No	01	MED	Concussion w CC	0.9186	3.0	3.7
090	No	No	01	MED	Concussion w/o CC/MCC	0.6751	2.0	2.5
091	Yes	No	01	MED	Other disorders of nervous system w MCC	1.5747	4.6	6.4
092	Yes	No	01	MED	Other disorders of nervous system w CC	0.9218	3.5	4.5
093	Yes	No	01	MED	Other disorders of nervous system w/o CC/MCC	0.6777	2.6	3.2
094	No	No	01	MED	Bacterial & tuberculous infections of nervous system w MCC	3.3505	9.2	11.8
095	No	No	01	MED	Bacterial & tuberculous infections of nervous system w CC	2.1935	6.9	8.6
096	No	No	01	MED	Bacterial & tuberculous infections of nervous system w/o CC/MCC	1.8217	5.0	6.2
097	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w MCC	3.2073	9.9	12.6
098	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w CC	1.8504	6.7	8.3
099	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	1.2593	4.7	5.9
100	Yes	No	01	MED	Seizures w MCC	1.5069	4.7	6.3
101	Yes	No	01	MED	Seizures w/o MCC	0.7617	2.9	3.7
102	No	No	01	MED	Headaches w MCC	0.9584	3.3	4.5
103	No	No	01	MED	Headaches w/o MCC	0.6239	2.5	3.1
113	No	No	02	SURG	Orbital procedures w CC/MCC	1.5787	3.8	5.6

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
114	No	No	02	SURG	Orbital procedures w/o CC/MCC	0.8289	1.9	2.6
115	No	No	02	SURG	Extraocular procedures except orbit	1.0675	3.3	4.3
116	No	No	02	SURG	Intraocular procedures w CC/MCC	1.1346	2.6	4.1
117	No	No	02	SURG	Intraocular procedures w/o CC/MCC	0.6699	1.6	2.2
121	No	No	02	MED	Acute major eye infections w CC/MCC	0.9590	4.3	5.5
122	No	No	02	MED	Acute major eye infections w/o CC/MCC	0.6148	3.3	4.0
123	No	No	02	MED	Neurological eye disorders	0.6876	2.3	2.9
124	No	No	02	MED	Other disorders of the eye w MCC	1.0642	3.9	5.3
125	No	No	02	MED	Other disorders of the eye w/o MCC	0.6689	2.8	3.5
129	No	No	03	SURG	Major head & neck procedures w CC/MCC or major device	2.0109	3.7	5.2
130	No	No	03	SURG	Major head & neck procedures w/o CC/MCC	1.1513	2.3	2.9
131	No	No	03	SURG	Cranial/facial procedures w CC/MCC	1.9933	4.0	5.8
132	No	No	03	SURG	Cranial/facial procedures w/o CC/MCC	1.0981	2.1	2.6
133	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	1.5552	3.6	5.3
134	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0.8213	1.7	2.2
135	No	No	03	SURG	Sinus & mastoid procedures w CC/MCC	1.6832	3.8	5.9
136	No	No	03	SURG	Sinus & mastoid procedures w/o CC/MCC	0.8974	1.7	2.3
137	No	No	03	SURG	Mouth procedures w CC/MCC	1.2619	3.8	5.4
138	No	No	03	SURG	Mouth procedures w/o CC/MCC	0.7366	1.9	2.5
139	No	No	03	SURG	Salivary gland procedures	0.8147	1.4	1.8
146	No	No	03	MED	Ear, nose, mouth & throat malignancy w MCC	2.0472	6.6	9.4
147	No	No	03	MED	Ear, nose, mouth & throat malignancy w CC	1.2450	4.3	6.1
148	No	No	03	MED	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.8206	2.7	3.8
149	No	No	03	MED	Dysequilibrium	0.6109	2.2	2.7
150	No	No	03	MED	Epistaxis w MCC	1.2254	3.7	5.2
151	No	No	03	MED	Epistaxis w/o MCC	0.6034	2.3	2.9
152	No	No	03	MED	Otitis media & URI w MCC	0.8994	3.4	4.5
153	No	No	03	MED	Otitis media & URI w/o MCC	0.5974	2.6	3.2
154	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w MCC	1.3776	4.6	6.3
155	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w CC	0.8784	3.5	4.4
156	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w/o CC/MCC	0.6312	2.5	3.2
157	No	No	03	MED	Dental & oral diseases w MCC	1.4746	4.6	6.6

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
158	No	No	03	MED	Dental & oral diseases w CC	0.8615	3.4	4.5
159	No	No	03	MED	Dental & oral diseases w/o CC/MCC	0.5966	2.4	3.0
163	Yes	No	04	SURG	Major chest procedures w MCC	4.9978	12.2	15.0
164	Yes	No	04	SURG	Major chest procedures w CC	2.5953	6.7	8.1
165	Yes	No	04	SURG	Major chest procedures w/o CC/MCC	1.8036	4.3	5.1
166	Yes	No	04	SURG	Other resp system O.R. procedures w MCC	3.6912	10.0	12.9
167	Yes	No	04	SURG	Other resp system O.R. procedures w CC	2.0264	6.3	8.0
168	Yes	No	04	SURG	Other resp system O.R. procedures w/o CC/MCC	1.3433	3.9	5.2
175	Yes	No	04	MED	Pulmonary embolism w MCC	1.5796	6.0	7.3
176	Yes	No	04	MED	Pulmonary embolism w/o MCC	1.0713	4.6	5.3
177	Yes	No	04	MED	Respiratory infections & inflammations w MCC	2.0393	7.2	9.1
178	Yes	No	04	MED	Respiratory infections & inflammations w CC	1.4983	6.0	7.4
179	Yes	No	04	MED	Respiratory infections & inflammations w/o CC/MCC	1.0419	4.5	5.6
180	No	No	04	MED	Respiratory neoplasms w MCC	1.6950	6.0	7.9
181	No	No	04	MED	Respiratory neoplasms w CC	1.2316	4 5	5.9
182	No	No	04	MED	Respiratory neoplasms w/o CC/MCC	0.8736	3.2	4.2
183	No	No	04	MED	Major chest trauma w MCC	1.5346	5.8	7.2
184	No	No	04	MED	Major chest trauma w CC	0.9458	3.8	4.6
185	No	No	04	MED	Major chest trauma w/o CC/MCC	0.6811	2.9	3.4
186	Yes	No	04	MED	Pleural effusion w MCC	1.6252	5.7	7.4
187	Yes	No	04	MED	Pleural effusion w CC	1.0942	4.1	5.3
188	Yes	No	04	MED	Pleural effusion w/o CC/MCC	0.8133	3.1	4.0
189	No	No	04	MED	Pulmonary edema & respiratory failure	1.3488	4.8	6.1
190	Yes	No	04	MED	Chronic obstructive pulmonary disease w MCC	1.3030	5.0	6.3
191	Yes	No	04	MED	Chronic obstructive pulmonary disease w CC	0.9757	4.1	5.0
192	Yes	No	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC	0.7254	3.3	4.0
193	Yes	No	04	MED	Simple pneumonia & pleurisy w MCC	1.4327	5.4	6.7
194	Yes	No	04	MED	Simple pneumonia & pleurisy w CC	1.0056	4.4	5.3
195	Yes	No	04	MED	Simple pneumonia & pleurisy w/o CC/MCC	0.7316	3.5	4.1
196	Yes	No	04	MED	Interstitial lung disease w MCC	1.6022	5.8	7.3
197	Yes	No	04	MED	Interstitial lung disease w CC	1.0992	4.4	5.4
198	Yes	No	04	MED	Interstitial lung disease w/o CC/MCC	0.8198	3.3	4.1

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199	No	No	04	MED	Pneumothorax w MCC	1.7401	6.4	8.3
200	No	No	04	MED	Pneumothorax w CC	1.0107	3.9	5.1
201	No	No	04	MED	Pneumothorax w/o CC/MCC	0.7403	3.1	4.1
202	No	No	04	MED	Bronchitis & asthma w CC/MCC	0.8157	3.5	4.3
203	No	No	04	MED	Bronchitis & asthma w/o CC/MCC	0.5956	2.8	3.4
204	No	No	04	MED	Respiratory signs & symptoms	0.6548	2.2	2.9
205	Yes	No	04	MED	Other respiratory system diagnoses w MCC	1.2363	4.0	5.5
206	Yes	No	04	MED	Other respiratory system diagnoses w/o MCC	0.7289	2.7	3.4
207	Yes	No	04	MED	Respiratory system diagnosis w ventilator support 96+ hours	5.1055	12.8	15.1
208	No	No	04	MED	Respiratory system diagnosis w ventilator support <96 hours	2.1801	5.2	7.2
215	No	No	05	SURG	Other heart assist system implant	12.2516	7.6	14.0
216	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	10.0943	15.7	18 4
217	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	6.9900	10.9	12.3
218	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	5.4211	8 3	9.1
219	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	8.0329	11.4	14.0
220	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	5.2799	7.6	8.6
221	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	4.3869	6.0	6.4
222	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	8.6466	10.7	13.1
223	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	6.2865	4.6	6.3
224	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	7.9521	9.2	11.4
225	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	5.9006	4.5	5.6
226	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w MCC	6.7117	6.2	9.3
227	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w/o MCC	4.9961	1.8	2.8
228	Yes	No	05	SURG	Other cardiothoracic procedures w MCC	7.7863	12.1	14.7
229	Yes	No	05	SURG	Other cardiothoracic procedures w CC	5.0213	7.9	9.1
230	Yes	No	05	SURG	Other cardiothoracic procedures w/o CC/MCC	4.0573	5.6	6.5
231	No	No	05	SURG	Coronary bypass w PTCA w MCC	7.6438	11.2	13.4
232	No	No	05	SURG	Coronary bypass w PTCA w/o MCC	5.5291	8.2	9.2
233	Yes	No	05	SURG	Coronary bypass w cardiac cath w MCC	7.0144	12.4	14.2
234	Yes	No	05	SURG	Coronary bypass w cardiac cath w/o MCC	4.6075	8.3	8.9
235	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w MCC	5.6712	9.5	11.2
236	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w/o MCC	3.5945	6.1	6.6

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
237	No	No	05	SURG	Major cardiovasc procedures w MCC or thoracic aortic aneurysm repair	5.0741	7.5	10.8
238	No	No	05	SURG	Major cardiovasc procedures w/o MCC	2.8874	3.2	4.6
239	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w MCC	4.5044	12.0	15.4
240	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w CC	2.6674	8.3	10.4
241	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	1.5722	5.6	6.8
242	Yes	No	05	SURG	Permanent cardiac pacemaker implant w MCC	3.7029	6.7	8.8
243	Yes	No	05	SURG	Permanent cardiac pacemaker implant w CC	2.5887	3.8	5.1
244	Yes	No	05	SURG	Permanent cardiac pacemaker implant w/o CC/MCC	2.0059	2.2	2.9
245	No	No	05	SURG	AICD generator procedures	3.9842	2.1	3.2
246	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	3.1468	3.6	5.3
247	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9127	1.7	2.2
248	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	2.8046	4.2	6.0
249	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	1.6395	1.9	2.5
250	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent w MCC	2.9915	5.4	7.8
251	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent w/o MCC	1.6038	2.1	2.8
252	No	No	05	SURG	Other vascular procedures w MCC	2.9550	5.5	8.6
253	No	No	05	SURG	Other vascular procedures w CC	2.2545	4.1	6.0
254	No	No	05	SURG	Other vascular procedures w/o CC/MCC	1.5426	2.0	2.7
255	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w MCC	2.4110	7.1	9.7
256	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w CC	1.5920	5.8	7.5
257	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w/o CC/MCC	1.0257	3.7	4.9
258	No	No	05	SURG	Cardiac pacemaker device replacement w MCC	2.8325	5.4	7.4
259	No	No	05	SURG	Cardiac pacemaker device replacement w/o MCC	1.6899	2.0	2.8
260	No	No	05	SURG	Cardiac pacemaker revision except device replacement w MCC	3.4101	8.1	11.2
261	No	No	05	SURG	Cardiac pacemaker revision except device replacement w CC	1.4380	3.0	4.2
262	No	No	05	SURG	Cardiac pacemaker revision except device replacement w/o CC/MCC	1.0152	2.0	2.6
263	No	No	05	SURG	Vein ligation & stripping	1.5415	3.4	5.4
264	Yes	No	05	SURG	Other circulatory system O.R. procedures	2.5329	5.8	8.9
265	No	No	05	SURG	AICD lead procedures	2.2095	2.2	3.5
280	Yes	No	05	MED	Acute myocardial infarction, discharged alive w MCC	1.9404	5.8	7.3
281	Yes	No	05	MED	Acute myocardial infarction, discharged alive w CC	1.2213	3.9	4.8
282	Yes	No	05	MED	Acute myocardial infarction, discharged alive w/o CC/MCC	0.8696	2.6	3.2

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
283	No	No	05	MED	Acute myocardial infarction, expired w MCC	1.6925	3.3	5.4
284	No	No	05	MED	Acute myocardial infarction, expired w CC	0.9111	2.2	3.2
285	No	No	05	MED	Acute myocardial infarction, expired w/o CC/MCC	0.6053	1.7	2.2
286	No	No	05	MED	Circulatory disorders except AMI, w card cath w MCC	1.9769	5.2	6.9
287	No	No	05	MED	Circulatory disorders except AMI, w card cath w/o MCC	1.0252	2.4	3.1
288	Yes	No	05	MED	Acute & subacute endocarditis w MCC	3.0839	9.2	11.8
289	Yes	No	05	MED	Acute & subacute endocarditis w CC	1.9588	7.0	8.7
290	Yes	No	05	MED	Acute & subacute endocarditis w/o CC/MCC	1.4465	5.1	6.5
291	Yes	No	05	MED	Heart failure & shock w MCC	1.4601	5.0	6.5
292	Yes	No	05	MED	Heart failure & shock w CC	1.0069	4.1	5.0
293	Yes	No	05	MED	Heart failure & shock w/o CC/MCC	0.7220	3.1	3.7
294	No	No	05	MED	Deep vein thrombophlebitis w CC/MCC	0.9595	4.6	5.5
295	No	No	05	MED	Deep vein thrombophlebitis w/o CC/MCC	0.6408	3.7	4.3
296	No	No	05	MED	Cardiac arrest, unexplained w MCC	1.1947	2.0	3.1
297	No	No	05	MED	Cardiac arrest, unexplained w CC	0.6476	1.4	1.8
298	No	No	05	MED	Cardiac arrest, unexplained w/o CC/MCC	0.4447	1.1	1.3
299	Yes	No	05	MED	Peripheral vascular disorders w MCC	1.4370	5.0	6.7
300	Yes	No	05	MED	Peripheral vascular disorders w CC	0.9286	4.1	5.0
301	Yes	No	05	MED	Peripheral vascular disorders w/o CC/MCC	0.6606	3.0	3.7
302	No	No	05	MED	Atherosclerosis w MCC	1.0294	3.2	4.4
303	No	No	05	MED	Atherosclerosis w/o MCC	0.5668	2.0	2.5
304	No	No	05	MED	Hypertension w MCC	1.0865	3.9	5.2
305	No	No	05	MED	Hypertension w/o MCC	0.5918	2.3	2.9
306	No	No	05	MED	Cardiac congenital & valvular disorders w MCC	1.5703	4.4	6.3
307	No	No	05	MED	Cardiac congenital & valvular disorders w/o MCC	0.7502	2.7	3.5
308	No	No	05	MED	Cardiac arrhythmia & conduction disorders w MCC	1.2992	4.1	5.5
309	No	No	05	MED	Cardiac arrhythmia & conduction disorders w CC	0.8336	3.1	3.9
310	No	No	05	MED	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5843	2.3	2.8
311	No	No	05	MED	Angina pectoris	0.4972	1.9	2.3
312	No	No	05	MED	Syncope & collapse	0.7097	2.5	3.1
313	No	No	05	MED	Chest pain	0.5314	1.7	2.1
314	Yes	No	05	MED	Other circulatory system diagnoses w MCC	1.7552	5.0	7.0

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
315	Yes	No	05	MED	Other circulatory system diagnoses w CC	0.9936	3.5	4.6
316	Yes	No	05	MED	Other circulatory system diagnoses w/o CC/MCC	0.6528	2.4	3.0
326	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w MCC	5.7896	13.2	17.1
327	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w CC	2.8363	7.8	10.0
328	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC	1.4530	3.2	4.4
329	Yes	No	06	SURG	Major small & large bowel procedures w MCC	5.1666	12.8	16.0
330	Yes	No	06	SURG	Major small & large bowel procedures w CC	2.5589	8.3	9.7
331	Yes	No	06	SURG	Major small & large bowel procedures w/o CC/MCC	1.6224	5.2	5.9
332	Yes	No	06	SURG	Rectal resection w MCC	4.5243	12.0	14.4
333	Yes	No	06	SURG	Rectal resection w CC	2.4452	7.7	8.8
334	Yes	No	06	SURG	Rectal resection w/o CC/MCC	1.6221	4.7	5.5
335	Yes	No	06	SURG	Peritoneal adhesiolysis w MCC	4.0868	11.6	14.1
336	Yes	No	06	SURG	Peritoneal adhesiolysis w CC	2.2369	7.5	9.1
337	Yes	No	06	SURG	Peritoneal adhesiolysis w/o CC/MCC	1.4517	4.4	5.6
338	No	No	06	SURG	Appendectomy w complicated principal diag w MCC	3.1760	8.8	10.7
339	No	No	06	SURG	Appendectomy w complicated principal diag w CC	1.8564	6.0	7.0
340	No	No	06	SURG	Appendectomy w complicated principal diag w/o CC/MCC	1.2259	3.5	4.2
341	No	No	06	SURG	Appendectomy w/o complicated principal diag w MCC	2.1598	5.3	7.1
342	No	No	06	SURG	Appendectomy w/o complicated principal diag w CC	1.3098	3.2	4.1
343	No	No	06	SURG	Appendectomy w/o complicated principal diag w/o CC/MCC	0.9042	1.8	2.2
344	No	No	06	SURG	Minor small & large bowel procedures w MCC	3.0672	9.2	11.7
345	No	No	06	SURG	Minor small & large bowel procedures w CC	1.6346	6.1	7.2
346	No	No	06	SURG	Minor small & large bowel procedures w/o CC/MCC	1.1881	4.4	4.9
347	No	No	06	SURG	Anal & stomal procedures w MCC	2.2047	6.5	8.8
348	No	No	06	SURG	Anal & stomal procedures w CC	1.2883	4.4	5.7
349	No	No	06	SURG	Anal & stomal procedures w/o CC/MCC	0.7679	2.4	3.1
350	No	No	06	SURG	Inguinal & femoral hernia procedures w MCC	2.2608	5.8	8.0
351	No	No	06	SURG	Inguinal & femoral hernia procedures w CC	1.2597	3.4	4.5
352	No	No	06	SURG	Inguinal & femoral hernia procedures w/o CC/MCC	0.8117	2.0	2.5
353	No	No	06	SURG	Hernia procedures except inguinal & femoral w MCC	2.4859	6.4	8.4
354	No	No	06	SURG	Hernia procedures except inguinal & femoral w CC	1.4020	4.0	5.1
355	No	No	06	SURG	Hernia procedures except inguinal & femoral w/o CC/MCC	0.9648	2.4	2.9

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
356	Yes	No	06	SURG	Other digestive system O R. procedures w MCC	3.8569	9.5	12.9
357	Yes	No	06	SURG	Other digestive system O.R. procedures w CC	2.1709	6.2	8.1
358	Yes	No	06	SURG	Other digestive system O.R. procedures w/o CC/MCC	1.3474	3.3	4.5
368	No	No	06	MED	Major esophageal disorders w MCC	1.6289	5.1	6.6
369	No	No	06	MED	Major esophageal disorders w CC	1.0715	3.8	4 8
370	No	No	06	MED	Major esophageal disorders w/o CC/MCC	0.7819	2.8	3.4
371	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w MCC	1.9136	6 7	8.7
372	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w CC	1.3072	5.6	6.8
373	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	0.8684	4.2	4.9
374	Yes	No	06	MED	Digestive malignancy w MCC	1.9075	6.3	8.6
375	Yes	No	06	MED	Digestive malignancy w CC	1.2543	4.5	6.0
376	Yes	No	06	MED	Digestive malignancy w/o CC/MCC	0.8820	3.2	4.2
377	Yes	No	06	MED	G.I. hemorrhage w MCC	1.6073	4.9	6.4
378	Yes	No	06	MED	G.I. hemorrhage w CC	1.0043	3.7	4.4
379	Yes	No	06	MED	G.I. hemorrhage w/o CC/MCC	0.7565	2.9	3.4
380	Yes	No	06	MED	Complicated peptic ulcer w MCC	1.8006	5.6	7.3
381	Yes	No	06	MED	Complicated peptic ulcer w CC	1.1137	4.2	5.2
382	Yes	No	06	MED	Complicated peptic ulcer w/o CC/MCC	0.8218	3.1	3.7
383	No	No	06	MED	Uncomplicated peptic ulcer w MCC	1.1744	4.4	5.5
384	No	No	06	MED	Uncomplicated peptic ulcer w/o MCC	0.7838	3.1	3.8
385	No	No	06	MED	Inflammatory bowel disease w MCC	1.8568	6.5	8.8
386	No	No	06	MED	Inflammatory bowel disease w CC	1.0616	4.5	5.7
387	No	No	06	MED	Inflammatory bowel disease w/o CC/MCC	0.7786	3.5	4.3
388	Yes	No	06	MED	G.I. obstruction w MCC	1.5408	5.4	7.3
389	Yes	No	06	MED	G.I. obstruction w CC	0.9265	4.0	5.0
390	Yes	No	06	MED	G.I. obstruction w/o CC/MCC	0.6351	3.0	3.5
391	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w MCC	1.0856	3.9	5 2
392	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w/o MCC	0.6703	2.8	3.5
393	No	No	06	MED	Other digestive system diagnoses w MCC	1.5409	4.9	6.9
394	No	No	06	MED	Other digestive system diagnoses w CC	0.9519	3.8	4.8
395	No	No	06	MED	Other digestive system diagnoses w/o CC/MCC	0.6765	2.6	3.3
405	Yes	No	07	SURG	Pancreas, liver & shunt procedures w MCC	5.6405	12.4	17.0

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
406	Yes	No	07	SURG	Pancreas, liver & shunt procedures w CC	2.7858	7.0	9.1
407	Yes	No	07	SURG	Pancreas, liver & shunt procedures w/o CC/MCC	1.8388	4.2	5.5
408	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	4.2585	12.2	15.1
409	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	2.5649	8.3	9.8
410	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	1.6467	5.5	6.5
411	No	No	07	SURG	Cholecystectomy w c.d.e. w MCC	3.7496	10.4	12.4
412	No	No	07	SURG	Cholecystectomy w c.d.e. w CC	2.3641	7.5	8.6
413	No	No	07	SURG	Cholecystectomy w c.d.e. w/o CC/MCC	1.6877	5.0	5.9
414	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	3.5699	9.7	11.7
415	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w CC	2.0338	6.5	7.6
416	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.3289	4.1	4.8
417	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w MCC	2.4765	6.5	8.4
418	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.6507	4.5	5.6
419	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.1264	2.5	3.2
420	No	No	07	SURG	Hepatobiliary diagnostic procedures w MCC	4.1087	9.9	13.8
421	No	No	07	SURG	Hepatobiliary diagnostic procedures w CC	1.8959	5.6	7.7
422	No	No	07	SURG	Hepatobiliary diagnostic procedures w/o CC/MCC	1.2284	3.2	4.3
423	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w MCC	4.5812	11.9	16.0
424	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w CC	2.5188	7.9	10.4
425	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	1.3752	4.0	5.4
432	No	No	07	MED	Cirrhosis & alcoholic hepatitis w MCC	1.6790	5.2	7.0
433	No	No	07	MED	Cirrhosis & alcoholic hepatitis w CC	0.9394	3.8	4.9
434	No	No	07	MED	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.6550	2.9	3.7
435	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w MCC	1.7205	5.7	7.6
436	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w CC	1.1921	4.5	5.8
437	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	0.9531	3.2	4.2
438	No	No	07	MED	Disorders of pancreas except malignancy w MCC	1.7013	5.5	7.5
439	No	No	07	MED	Disorders of pancreas except malignancy w CC	1.0241	4.2	5.3
440	No	No	07	MED	Disorders of pancreas except malignancy w/o CC/MCC	0.6977	3.2	3.8
441	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w MCC	1.6639	5.1	7.0
442	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w CC	0.9830	3.9	5.1
443	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.6982	3.0	3.8

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444	No	No	07	MED	Disorders of the biliary tract w MCC	1.5583	5.0	6.6
445	No	No	07	MED	Disorders of the biliary tract w CC	1.0389	3.8	4.7
446	No	No	07	MED	Disorders of the biliary tract w/o CC/MCC	0.7231	2.6	3.3
453	No	No	08	SURG	Combined anterior/posterior spinal fusion w MCC	9.8253	12.0	15.6
454	No	No	08	SURG	Combined anterior/posterior spinal fusion w CC	6.9914	6.5	8.0
455	No	No	08	SURG	Combined anterior/posterior spinal fusion w/o CC/MCC	5.1476	3.7	4.4
456	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	8.4910	11.6	14.7
457	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	5.6459	6.2	7.5
458	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	4.6762	4.0	4.5
459	Yes	No	08	SURG	Spinal fusion except cervical w MCC	5.9587	7.6	9.5
460	Yes	No	08	SURG	Spinal fusion except cervical w/o MCC	3.5607	3.6	4.2
461	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w MCC	4.5419	6.8	8.4
462	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w/o MCC	3.1438	3.9	4.2
463	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	4.6947	12.0	16.6
464	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	2.6167	7.7	10.2
465	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	1.4966	4.4	5.8
466	Yes	No	08	SURG	Revision of hip or knee replacement w MCC	4.5431	7.4	9.2
467	Yes	No	08	SURG	Revision of hip or knee replacement w CC	3.0630	4.8	5.5
468	Yes	No	08	SURG	Revision of hip or knee replacement w/o CC/MCC	2.4500	3.6	3 9
469	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w MCC	3.2901	6.9	8.2
470	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w/o MCC	2.0077	3.6	3.9
471	No	No	08	SURG	Cervical spinal fusion w MCC	4.4122	7.0	9.8
472	No	No	08	SURG	Cervical spinal fusion w CC	2.6084	2.8	4.1
473	No	No	08	SURG	Cervical spinal fusion w/o CC/MCC	1.9140	1.6	2.0
474	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w MCC	3.4491	9.6	12.6
475	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w CC	1.9787	6.5	8.4
476	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	1.0999	3.7	4.8
477	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w MCC	3.2781	8.9	11.9
478	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w CC	2.1226	4.6	6.6
479	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.4742	1.9	2.8
480	Yes	Yes	08	SURG	Hip & femur procedures except major joint w MCC	2.8998	7.8	9.3
481	Yes	Yes	08	SURG	Hip & femur procedures except major joint w CC	1.8175	5.4	5.9

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482	Yes	Yes	08	SURG	Hip & femur procedures except major joint w/o CC/MCC	1.4949	4.5	4.8
483	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w CC/MCC	2.2508	3.4	4.2
484	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	1.7443	2.1	2.4
485	No	No	08	SURG	Knee procedures w pdx of infection w MCC	3.2959	9.8	12.1
486	No	No	08	SURG	Knee procedures w pdx of infection w CC	2.1592	6.7	8.0
487	No	No	08	SURG	Knee procedures w pdx of infection w/o CC/MCC	1.5538	4.9	5.7
488	Yes	No	08	SURG	Knee procedures w/o pdx of infection w CC/MCC	1.6805	4.1	5.2
489	Yes	No	08	SURG	Knee procedures w/o pdx of infection w/o CC/MCC	1.1601	2.6	3.0
490	No	No	08	SURG	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	1.7202	3.0	4.3
491	No	No	08	SURG	Back & neck proc exc spinal fusion w/o CC/MCC	0.9383	1.8	2.2
492	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC	2.7639	6.8	8.5
493	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w CC	1.7620	4.3	5.3
494	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1.2353	2.8	3.4
495	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w MCC	3.1741	8.1	10.9
496	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w CC	1.7722	4.6	6.0
497	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.1249	2.3	3.0
498	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w CC/MCC	2.0238	5.5	7.9
499	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w/o CC/MCC	0.9090	2.3	3.0
500	Yes	Yes	08	SURG	Soft tissue procedures w MCC	2.8415	7.8	10.8
501	Yes	Yes	08	SURG	Soft tissue procedures w CC	1.4700	4.5	6.0
502	Yes	Yes	08	SURG	Soft tissue procedures w/o CC/MCC	0.9573	2.3	2.9
503	No	No	08	SURG	Foot procedures w MCC	2.3047	7.2	9.4
504	No	No	08	SURG	Foot procedures w CC	1.4696	5.1	6.4
505	No	No	08	SURG	Foot procedures w/o CC/MCC	0.9860	2.6	3.4
506	No	No	08	SURG	Major thumb or joint procedures	1.0237	2.5	3.4
507	No	No	08	SURG	Major shoulder or elbow joint procedures w CC/MCC	1.7166	3.7	5.1
508	No	No	08	SURG	Major shoulder or elbow joint procedures w/o CC/MCC	1.1143	1.7	2.0
509	No	No	08	SURG	Arthroscopy	1.1718	2.0	3.1
510	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w MCC	1.9947	4.9	6.4
511	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.3392	3.2	4.0
512	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0.9509	1.8	2.2
513	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.2932	3.6	5.1

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514	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.8060	2.1	2.8
515	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w MCC	3.0669	7.9	10.5
516	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w CC	1.8083	4.5	6.0
517	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	1.3293	2.1	3.0
533	Yes	No	08	MED	Fractures of femur w MCC	1.4243	4.8	6.7
534	Yes	No	08	MED	Fractures of femur w/o MCC	0.7339	3.3	4.0
535	Yes	No	08	MED	Fractures of hip & pelvis w MCC	1.3409	4.8	6.2
536	Yes	No	08	MED	Fractures of hip & pelvis w/o MCC	0.6963	3.3	3.9
537	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0.8924	3.6	4.5
538	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.5808	2.7	3.2
539	Yes	No	08	MED	Osteomyelitis w MCC	2.0287	7.5	9.8
540	Yes	No	08	MED	Osteomyelitis w CC	1.3481	5.7	7.1
541	Yes	No	08	MED	Osteomyelitis w/o CC/MCC	0.9265	4.2	5.3
542	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w MCC	1.9045	6.7	8.8
543	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w CC	1.1302	4.8	5.9
544	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	0.7698	3.7	4.4
545	Yes	No	08	MED	Connective tissue disorders w MCC	2.3499	6.4	9.1
546	Yes	No	08	MED	Connective tissue disorders w CC	1.0969	4 4	5.5
547	Yes	No	08	MED	Connective tissue disorders w/o CC/MCC	0.7231	3.1	3.8
548	No	No	08	MED	Septic arthritis w MCC	1.8769	6.7	8.9
549	No	No	08	MED	Septic arthritis w CC	1.1618	5 1	6.4
550	No	No	08	MED	Septic arthritis w/o CC/MCC	0.8073	3.7	4.5
551	Yes	No	08	MED	Medical back problems w MCC	1.5323	5.4	7.1
552	Yes	No	08	MED	Medical back problems w/o MCC	0.7657	3.4	4.1
553	No	No	08	MED	Bone diseases & arthropathies w MCC	1.1068	4.7	6.0
554	No	No	08	MED	Bone diseases & arthropathies w/o MCC	0.6352	3.0	3.7
555	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w MCC	1.0074	3.6	4.8
556	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	0.5767	2.5	3.1
557	Yes	No	08	MED	Tendonitis, myositis & bursitis w MCC	1.4295	5.2	6.6
558	Yes	No	08	MED	Tendonitis, myositis & bursitis w/o MCC	0.8036	3.5	4.3
559	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w MCC	1.7054	5.3	7.5
560	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w CC	0.9555	3.6	4.7

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
561	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	0.5805	2.1	2.8
562	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	1.3961	4.9	6.4
563	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	0.6783	3.1	3.7
564	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w MCC	1.4111	5.2	7.0
565	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w CC	0.8882	3.9	5.0
566	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	0.6694	3.0	3.7
573	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	3.1932	9.6	13.2
574	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1.9517	7.2	9.4
575	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	1.1216	4.7	5.8
576	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	3.4384	8.4	12.9
577	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.5775	4.2	6.1
578	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	0.9782	2.4	3.3
579	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w MCC	2.7946	7.8	10.7
580	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w CC	1.4110	3.7	5.5
581	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w/o CC/MCC	0.8595	1.9	2.6
582	No	No	09	SURG	Mastectomy for malignancy w CC/MCC	0.9649	2.1	2.8
583	No	No	09	SURG	Mastectomy for malignancy w/o CC/MCC	0.7480	1.6	1.8
584	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w CC/MCC	1.4329	4.0	6.0
585	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0.8036	1.7	2.2
592	Yes	No	09	MED	Skin ulcers w MCC	1.7515	6.6	8.9
593	Yes	No	09	MED	Skin ulcers w CC	1.1080	5.2	6.5
594	Yes	No	09	MED	Skin ulcers w/o CC/MCC	0.7910	4.1	5.1
595	No	No	09	MED	Major skin disorders w MCC	1.8206	6.2	8.3
596	No	No	09	MED	Major skin disorders w/o MCC	0.8225	3.8	4.7
597	No	No	09	MED	Malignant breast disorders w MCC	1.6061	6.0	8.2
598	No	No	09	MED	Malignant breast disorders w CC	1.0808	4.3	5.7
599	No	No	09	MED	Malignant breast disorders w/o CC/MCC	0.7310	2.7	3.7
600	No	No	09	MED	Non-malignant breast disorders w CC/MCC	0.9485	4.1	5.1
601	No	No	09	MED	Non-malignant breast disorders w/o CC/MCC	0.6586	3.1	3.9
602	Yes	No	09	MED	Cellulitis w MCC	1.4033	5.5	7.0
603	Yes	No	09	MED	Cellulitis w/o MCC	0.8027	3.9	4.7
604	No	No	09	MED	Trauma to the skin, subcut tiss & breast w MCC	1.1915	4.3	5.7

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
605	No	No	09	MED	Trauma to the skin, subcut tiss & breast w/o MCC	0.6769	2.8	3.5
606	No	No	09	MED	Minor skin disorders w MCC	1.2458	4.4	6.3
607	No	No	09	MED	Minor skin disorders w/o MCC	0.6462	2.9	3.8
614	No	No	10	SURG	Adrenal & pituitary procedures w CC/MCC	2.4984	5.1	7.0
615	No	No	10	SURG	Adrenal & pituitary procedures w/o CC/MCC	1.3722	2.7	3.2
616	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	4.7068	13.3	17.1
617	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	2.1033	7.0	8.8
618	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	1.3333	5.1	6.4
619	No	No	10	SURG	O.R. procedures for obesity w MCC	3.3049	5.2	8.2
620	No	No	10	SURG	O.R. procedures for obesity w CC	1.8641	2.9	3.7
621	No	No	10	SURG	O.R. procedures for obesity w/o CC/MCC	1.4191	1.9	2.2
622	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	3.1728	9.4	13.2
623	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	1.8878	6.7	8.6
624	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	1.0946	4.8	6.0
625	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w MCC	2.1244	4.7	7.1
626	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w CC	1.1332	2.1	3.1
627	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0.7344	1.3	1.5
628	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w MCC	3.2670	7.5	11.1
629	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w CC	2.2873	6.8	8.7
630	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	1.5075	4.0	5.5
637	Yes	No	10	MED	Diabetes w MCC	1.3596	4.5	6.1
638	Yes	No	10	MED	Diabetes w CC	0.8164	3.4	4.3
639	Yes	No	10	MED	Diabetes w/o CC/MCC	0.5598	2.5	3.0
640	Yes	No	10	MED	Nutritional & misc metabolic disorders w MCC	1.1138	3.9	5.4
641	Yes	No	10	MED	Nutritional & misc metabolic disorders w/o MCC	0.6820	3.1	3.8
642	No	No	10	MED	Inborn errors of metabolism	1.0168	3.7	5.2
643	Yes	No	10	MED	Endocrine disorders w MCC	1.6464	5.8	7.6
644	Yes	No	10	MED	Endocrine disorders w CC	1.0460	4.4	5.5
645	Yes	No	10	MED	Endocrine disorders w/o CC/MCC	0.7188	3.1	3.9
652	No	No	11	SURG	Kidney transplant	2.9556	6.6	7.7
653	Yes	No	11	SURG	Major bladder procedures w MCC	5.8152	13.6	16.9
654	Yes	No	11	SURG	Major bladder procedures w CC	2.9415	8.7	9.8

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
655	Yes	No	11	SURG	Major bladder procedures w/o CC/MCC	2.0247	5.8	6.5
656	No	No	11	SURG	Kidney & ureter procedures for neoplasm w MCC	3.2782	8.0	10.1
657	No	No	11	SURG	Kidney & ureter procedures for neoplasm w CC	1.8626	5.0	6.0
658	No	No	11	SURG	Kidney & ureter procedures for neoplasm w/o CC/MCC	1.3765	3.3	3.7
659	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w MCC	3.3351	8.0	11.2
660	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w CC	1.8919	4.8	6.5
661	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1.2563	2.6	3.3
662	No	No	11	SURG	Minor bladder procedures w MCC	2.7108	7.4	10.3
663	No	No	11	SURG	Minor bladder procedures w CC	1.4429	3.6	5.3
664	No	No	11	SURG	Minor bladder procedures w/o CC/MCC	0.9922	1.6	2.1
665	No	No	11	SURG	Prostatectomy w MCC	2.5582	8.2	11.0
666	No	No	11	SURG	Prostatectomy w CC	1.5536	4.3	6.3
667	No	No	11	SURG	Prostatectomy w/o CC/MCC	0.8236	2.1	2.9
668	No	No	11	SURG	Transurethral procedures w MCC	2.2389	6.2	8.5
669	No	No	11	SURG	Transurethral procedures w CC	1.2031	3.1	4.4
670	No	No	11	SURG	Transurethral procedures w/o CC/MCC	0.7683	1.9	2.5
671	No	No	11	SURG	Urethral procedures w CC/MCC	1.4223	4.1	6.0
672	No	No	11	SURG	Urethral procedures w/o CC/MCC	0.7944	1.9	2.5
673	No	No	11	SURG	Other kidney & urinary tract procedures w MCC	2.7704	5.8	9.8
674	No	No	11	SURG	Other kidney & urinary tract procedures w CC	2.1587	4.6	7.2
675	No	No	11	SURG	Other kidney & urinary tract procedures w/o CC/MCC	1.3091	1.5	2.1
682	Yes	No	11	MED	Renal failure w MCC	1.6413	5.2	7.2
683	Yes	No	11	MED	Renal failure w CC	1.1304	4.5	5.6
684	Yes	No	11	MED	Renal failure w/o CC/MCC	0.7305	3.2	3.9
685	No	No	11	MED	Admit for renal dialysis	0.8578	2.5	3.5
686	No	No	11	MED	Kidney & urinary tract neoplasms w MCC	1.6234	5.6	7.6
687	No	No	11	MED	Kidney & urinary tract neoplasms w CC	1.0748	4.1	5.3
688	No	No	11	MED	Kidney & urinary tract neoplasms w/o CC/MCC	0.6822	2.5	3.2
689	Yes	No	11	MED	Kidney & urinary tract infections w MCC	1 2301	4.9	6.2
690	Yes	No	11	MED	Kidney & urinary tract infections w/o MCC	0.7581	3.5	4.2
691	No	No	11	MED	Urinary stones w esw lithotripsy w CC/MCC	1.4534	2.9	4.0
692	No	No	11	MED	Urinary stones w esw lithotripsy w/o CC/MCC	1.1563	1.9	2.4

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
693	No	No	11	MED	Urinary stones w/o esw lithotripsy w MCC	1.1939	3.6	4.8
694	No	No	11	MED	Urinary stones w/o esw lithotripsy w/o MCC	0.6565	2.0	2.6
695	No	No	11	MED	Kidney & urinary tract signs & symptoms w MCC	1.1711	4.2	5.5
696	No	No	11	MED	Kidney & urinary tract signs & symptoms w/o MCC	0.6322	2.6	3.3
697	No	No	11	MED	Urethral stricture	0.6931	2.4	3.1
698	Yes	No	11	MED	Other kidney & urinary tract diagnoses w MCC	1.4718	5.0	6.6
699	Yes	No	11	MED	Other kidney & urinary tract diagnoses w CC	0.9725	3.7	4.8
700	Yes	No	11	MED	Other kidney & urinary tract diagnoses w/o CC/MCC	0.6828	2.8	3.5
707	No	No	12	SURG	Major male pelvic procedures w CC/MCC	1.6199	3.4	4.4
708	No	No	12	SURG	Major male pelvic procedures w/o CC/MCC	1.1778	1.8	2.1
709	No	No	12	SURG	Penis procedures w CC/MCC	1.8864	3.8	6.6
710	No	No	12	SURG	Penis procedures w/o CC/MCC	1.2521	1.4	1.8
711	No	No	12	SURG	Testes procedures w CC/MCC	2.0238	5.5	8.1
712	No	No	12	SURG	Testes procedures w/o CC/MCC	0.8064	2.2	3.0
713	No	No	12	SURG	Transurethral prostatectomy w CC/MCC	1.1183	2.9	4.2
714	No	No	12	SURG	Transurethral prostatectomy w/o CC/MCC	0.6325	1.7	1.9
715	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w CC/MCC	1.7072	3.9	6.2
716	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	0.9636	1.2	1.4
717	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w CC/MCC	1.8087	5.1	7.2
718	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0.7809	2.2	2.8
722	No	No	12	MED	Malignancy, male reproductive system w MCC	1.5686	5.7	7.6
723	No	No	12	MED	Malignancy, male reproductive system w CC	0.9922	4.0	5.3
724	No	No	12	MED	Malignancy, male reproductive system w/o CC/MCC	0.5971	2.4	3.1
725	No	No	12	MED	Benign prostatic hypertrophy w MCC	1.0492	4.2	5.5
726	No	No	12	MED	Benign prostatic hypertrophy w/o MCC	0.6696	2.7	3.5
727	No	No	12	MED	Inflammation of the male reproductive system w MCC	1.2897	5.1	6.4
728	No	No	12	MED	Inflammation of the male reproductive system w/o MCC	0.6944	3.3	4.0
729	No	No	12	MED	Other male reproductive system diagnoses w CC/MCC	1.0995	4.0	5.6
730	No	No	12	MED	Other male reproductive system diagnoses w/o CC/MCC	0.5968	2.4	3.1
734	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	2.3472	6.0	8.0
735	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	1.1273	2.9	3.4
736	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	4.1783	11.2	13.8

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
737	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	1.9568	6.0	7.2
738	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	1.1572	3.5	3.9
739	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	3.0048	7.8	10.2
740	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	1.4641	4.3	5.2
741	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	0.9983	2.7	3.0
742	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w CC/MCC	1.3429	3.5	4.5
743	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0.8437	2.0	2.3
744	No	No	13	SURG	D&C, conization, laparoscopy & tubal interruption w CC/MCC	1.3923	4.1	5.8
745	No	No	13	SURG	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC	0.7448	2.1	2.6
746	No	No	13	SURG	Vagina, cervix & vulva procedures w CC/MCC	1.2643	3.0	4.2
747	No	No	13	SURG	Vagina, cervix & vulva procedures w/o CC/MCC	0.8370	1.6	1.9
748	No	No	13	SURG	Female reproductive system reconstructive procedures	0.8162	1.5	1.7
749	No	No	13	SURG	Other female reproductive system O.R. procedures w CC/MCC	2.4834	6.7	9.3
750	No	No	13	SURG	Other female reproductive system O.R. procedures w/o CC/MCC	0.9614	2.5	3.1
754	No	No	13	MED	Malignancy, female reproductive system w MCC	1.7546	6.2	8.3
755	No	No	13	MED	Malignancy, female reproductive system w CC	1.0780	4.3	5.7
756	No	No	13	MED	Malignancy, female reproductive system w/o CC/MCC	0.6337	2.5	3.1
757	No	No	13	MED	Infections, female reproductive system w MCC	1.5803	6.5	8.1
758	No	No	13	MED	Infections, female reproductive system w CC	1.0640	4.9	6.1
759	No	No	13	MED	Infections, female reproductive system w/o CC/MCC	0.7664	3.6	4.5
760	No	No	13	MED	Menstrual & other female reproductive system disorders w CC/MCC	0.7934	3.0	4.0
761	No	No	13	MED	Menstrual & other female reproductive system disorders w/o CC/MCC	0.5024	1.9	2.4
765	No	No	14	SURG	Cesarean section w CC/MCC	1.0536	4.0	5.0
766	No	No	14	SURG	Cesarean section w/o CC/MCC	0.7427	3.0	3.2
767	No	No	14	SURG	Vaginal delivery w sterilization &/or D&C	0.9523	2.6	3.3
768	No	No	14	SURG	Vaginal delivery w O.R. proc except steril &/or D&C	1.7319	0.0	0.0
769	No	No	14	SURG	Postpartum & post abortion diagnoses w O.R. procedure	1.2740	3.2	4.6
770	No	No	14	SURG	Abortion w D&C, aspiration curettage or hysterotomy	0.6627	1.6	2.3
774	No	No	14	MED	Vaginal delivery w complicating diagnoses	0.6511	2.6	3.2
775	No	No	14	MED	Vaginal delivery w/o complicating diagnoses	0.4800	2.0	2.2
776	No	No	14	MED	Postpartum & post abortion diagnoses w/o O.R. procedure	0.6215	2.5	3.3
777	No	No	14	MED	Ectopic pregnancy	0.7679	1.8	2.2

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
778	No	No	14	MED	Threatened abortion	0.4388	1.9	3.0
779	No	No	14	MED	Abortion w/o D&C	0.4921	1.6	2.1
780	No	No	14	MED	False labor	0.1978	1.3	1.5
781	No	No	14	MED	Other antepartum diagnoses w medical complications	0.6170	2.6	3.7
782	No	No	14	MED	Other antepartum diagnoses w/o medical complications	0.3944	1.7	2.5
789	No	No	15	MED	Neonates, died or transferred to another acute care facility	1.4226	0.0	0.0
790	No	No	15	MED	Extreme immaturity or respiratory distress syndrome, neonate	4.6911	0.0	0.0
791	No	No	15	MED	Prematurity w major problems	3.2039	0.0	0.0
792	No	No	15	MED	Prematurity w/o major problems	1.9332	0.0	0.0
793	No	No	15	MED	Full term neonate w major problems	3.2911	0.0	0.0
794	No	No	15	MED	Neonate w other significant problems	1.1648	0.0	0.0
795	No	No	15	MED	Normal newborn	0.1577	0.0	0.0
799	No	No	16	SURG	Splenectomy w MCC	4.7614	10.8	14.1
800	No	No	16	SURG	Splenectomy w CC	2.5624	6.2	7.8
801	No	No	16	SURG	Splenectomy w/o CC/MCC	1.6400	3.8	4.9
802	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w MCC	3.4208	9.0	12.3
803	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w CC	1.7652	4.7	6.7
804	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	1.0526	2.5	3.4
808	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	1.9886	6.3	8.2
809	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w CC	1.1744	4.2	5.3
810	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0.8980	3.2	4.0
811	No	No	16	MED	Red blood cell disorders w MCC	1.2753	4.0	5.7
812	No	No	16	MED	Red blood cell disorders w/o MCC	0.7630	2.8	3.7
813	No	No	16	MED	Coagulation disorders	1.3532	3.7	5.1
814	No	No	16	MED	Reticuloendothelial & immunity disorders w MCC	1.4920	5.0	6.7
815	No	No	16	MED	Reticuloendothelial & immunity disorders w CC	0.9959	3.8	5.0
816	No	No	16	MED	Reticuloendothelial & immunity disorders w/o CC/MCC	0.6994	2.8	3.5
820	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w MCC	5.6313	13.2	17.7
821	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w CC	2.2514	5.5	7.9
822	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	1.2343	2.6	3.5
823	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w MCC	4.0946	12.0	15.4
824	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w CC	2.1797	6.6	8.7

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
825	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	1.2073	3.0	4.3
826	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	4.6021	11.1	15.1
827	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	2.2712	5.9	7.9
828	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	1.2999	3.0	3.8
829	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	2.8929	7.0	10.6
830	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	1.0798	2.5	3.7
834	No	No	17	MED	Acute leukemia w/o major O.R. procedure w MCC	4.5869	9.5	15.5
835	No	No	17	MED	Acute leukemia w/o major O.R. procedure w CC	2.5814	6.2	10.4
836	No	No	17	MED	Acute leukemia w/o major O.R. procedure w/o CC/MCC	1.2117	3.4	5.2
837	No	No	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	6.3774	17.6	23.1
838	No	No	17	MED	Chemo w acute leukemia as sdx w CC or high dose chemo agent	2.9436	7.9	12.2
839	No	No	17	MED	Chemo w acute leukemia as sdx w/o CC/MCC	1.4154	5.0	6.4
840	Yes	No	17	MED	Lymphoma & non-acute leukemia w MCC	2.5965	7.6	10.4
841	Yes	No	17	MED	Lymphoma & non-acute leukemia w CC	1.5530	5.2	6.9
842	Yes	No	17	MED	Lymphoma & non-acute leukemia w/o CC/MCC	1.0258	3.4	4.5
843	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w MCC	1.8230	6.2	8.5
844	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w CC	1.2036	4.5	6.1
845	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	0.8230	3.3	4.4
846	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	2.1272	5.8	8.4
847	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	0.9421	2.7	3.4
848	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0.7970	2.5	3.1
849	No	No	17	MED	Radiotherapy	1.2094	4.4	6.0
853	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w MCC	5.4328	12.7	16.7
854	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w CC	2.9172	9.1	11.1
855	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	1.8140	5.6	7.1
856	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w MCC	4.7522	11.5	15.4
857	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w CC	2.0522	6.6	8.5
858	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	1.3595	4.5	5.7
862	Yes	No	18	MED	Postoperative & post-traumatic infections w MCC	1.9142	6.1	8.2
863	Yes	No	18	MED	Postoperative & post-traumatic infections w/o MCC	0.9605	4.2	5.2
864	No	No	18	MED	Fever	0.8257	3.2	4.1
865	No	No	18	MED	Viral illness w MCC	1.5049	4.7	6.7

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
866	No	No	18	MED	Viral illness w/o MCC	0.6708	2.8	3.5
867	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w MCC	2.3441	7.0	9.6
868	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w CC	1.0786	4.5	5.8
869	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w/o CC/MCC	0.7650	3.5	4.3
870	Yes	No	18	MED	Septicemia or severe sepsis w MV 96+ hours	5.7258	12.9	15.5
871	Yes	No	18	MED	Septicemia or severe sepsis w/o MV 96+ hours w MCC	1.8222	5.5	7.5
872	Yes	No	18	MED	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	1.1209	4.7	5.7
876	No	No	19	SURG	O.R. procedure w principal diagnoses of mental illness	2.4834	7.8	12.1
880	No	No	19	MED	Acute adjustment reaction & psychosocial dysfunction	0.5897	2.4	3.2
881	No	No	19	MED	Depressive neuroses	0.5828	3.1	4.2
882	No	No	19	MED	Neuroses except depressive	0.6115	3.1	4.4
883	No	No	19	MED	Disorders of personality & impulse control	1.0234	4.4	7.4
884	Yes	No	19	MED	Organic disturbances & mental retardation	0.8992	4.1	5.5
885	No	No	19	MED	Psychoses	0.8477	5.5	7.6
886	No	No	19	MED	Behavioral & developmental disorders	0.7549	4.0	6.0
887	No	No	19	MED	Other mental disorder diagnoses	0.7303	3.0	4.6
894	No	No	20	MED	Alcohol/drug abuse or dependence, left AMA	0.3878	2.1	2.9
895	No	No	20	MED	Alcohol/drug abuse or dependence w rehabilitation therapy	0.8902	8.1	10.5
896	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.3827	4.8	6.6
897	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.6198	3.3	4.1
901	No	No	21	SURG	Wound debridements for injuries w MCC	3.9888	10.0	15.3
902	No	No	21	SURG	Wound debridements for injuries w CC	1.7006	5.5	7.8
903	No	No	21	SURG	Wound debridements for injuries w/o CC/MCC	1.0009	3.4	4.6
904	No	No	21	SURG	Skin grafts for injuries w CC/MCC	2.9275	7.1	11.4
905	No	No	21	SURG	Skin grafts for injuries w/o CC/MCC	1.1151	3.4	4.7
906	No	No	21	SURG	Hand procedures for injuries	1.0086	2.1	3.2
907	Yes	No	21	SURG	Other O.R. procedures for injuries w MCC	3.6804	8.0	11.6
908	Yes	No	21	SURG	Other O.R. procedures for injuries w CC	1.9094	4.9	6.8
909	Yes	No	21	SURG	Other O.R. procedures for injuries w/o CC/MCC	1.1342	2.7	3.6
913	No	No	21	MED	Traumatic injury w MCC	1.2304	4.2	5.7
914	No	No	21	MED	Traumatic injury w/o MCC	0.6650	2.7	3.4
915	No	No	21	MED	Allergic reactions w MCC	1.2298	3.3	4.7

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
916	No	No	21	MED	Allergic reactions w/o MCC	0.4423	1.7	2.1
917	Yes	No	21	MED	Poisoning & toxic effects of drugs w MCC	1.4155	3.7	5.2
918	Yes	No	21	MED	Poisoning & toxic effects of drugs w/o MCC	0.5812	2.1	2.7
919	No	No	21	MED	Complications of treatment w MCC	1.5223	4.5	6.4
920	No	No	21	MED	Complications of treatment w CC	0.9234	3.3	4.4
921	No	No	21	MED	Complications of treatment w/o CC/MCC	0.6109	2.3	3.0
922	No	No	21	MED	Other injury, poisoning & toxic effect diag w MCC	1.3572	4.1	6.0
923	No	No	21	MED	Other injury, poisoning & toxic effect diag w/o MCC	0.6157	2.4	3.2
927	No	No	22	SURG	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	13.8501	23.4	31.1
928	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w CC/MCC	5.0156	11.6	15.9
929	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w/o CC/MCC	2.1444	5.3	7.7
933	No	No	22	MED	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	2 1165	2.3	4.4
934	No	No	22	MED	Full thickness burn w/o skin grft or inhal inj	1.2921	4.4	6.1
935	No	No	22	MED	Non-extensive burns	1.2213	3.6	5.4
939	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w MCC	2.6570	6.7	10.1
940	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w CC	1.6352	3.6	5.4
941	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	1.0731	2.1	2.7
945	Yes	No	23	MED	Rehabilitation w CC/MCC	1.3022	8.6	10.5
946	Yes	No	23	MED	Rehabilitation w/o CC/MCC	1.0995	6.9	7.9
947	Yes	No	23	MED	Signs & symptoms w MCC	1.0575	3.8	5.0
948	Yes	No	23	MED	Signs & symptoms w/o MCC	0.6500	2.8	3.5
949	No	No	23	MED	Aftercare w CC/MCC	0.8050	2.6	4.1
950	No	No	23	MED	Aftercare w/o CC/MCC	0.5614	2.5	3.5
951	No	No	23	MED	Other factors influencing health status	0.7616	2.2	4.8
955	No	No	24	SURG	Craniotomy for multiple significant trauma	5.0985	8.5	12.3
956	Yes	No	24	SURG	Limb reattachment, hip & femur proc for multiple significant trauma	3.5417	7.6	9.3
957	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w MCC	5.9904	10.1	14.7
958	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w CC	3.5803	7.9	10.3
959	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w/o CC/MCC	2.3913	4.9	6.4
963	No	No	24	MED	Other multiple significant trauma w MCC	2.8885	6.6	9.6
964	No	No	24	MED	Other multiple significant trauma w CC	1.6114	4.9	6.2
965	No	No	24	MED	Other multiple significant trauma w/o CC/MCC	0.9955	3.4	4.2

MS-DRG	FY09 Final Rule Post-Acute DRG	FY09 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
969	No	No	25	SURG	HIV w extensive O.R. procedure w MCC	5.3826	12.9	18.9
970	No	No	25	SURG	HIV w extensive O.R. procedure w/o MCC	2.5403	6.7	10.3
974	No	No	25	MED	HIV w major related condition w MCC	2.5656	7.3	10.4
975	No	No	25	MED	HIV w major related condition w CC	1.3612	5.3	7.0
976	No	No	25	MED	HIV w major related condition w/o CC/MCC	0.8951	3.8	4.9
977	No	No	25	MED	HIV w or w/o other related condition	1.0954	3.9	5.3
981	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w MCC	5.0238	11.8	15.2
982	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w CC	3.0783	7.6	9.7
983	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.9948	3.9	5.4
984	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	3.3177	11.8	14.6
985	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w CC	2.2035	7.3	9.6
986	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.2775	3.5	5.3
987	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	3.4406	9.8	13.0
988	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w CC	1.8792	5.8	7.8
989	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	1.1009	2.9	4.1
998	No	No		**	Principal diagnosis invalid as discharge diagnosis	0.0000	0.0	0.0
999	No	No		**	Ungroupable	0.0000	0.0	0.0

Notes:

* MS-DRGs 998 and 999 contain cases that can not be assigned to valid DRGs.

** If there is no value in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to determine a computation of these statistics.

TABLE 6A.-NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
038.12*	Methicillin resistant Staphylococcus aureus septicemia	MCC	15 18 25	791[1],793[1] 870,871,872 974,975,976
041.12*	Methicillin resistant Staphylococcus aureus in conditions classified elsewhere and of unspecified site	N	18	867,868,869
046.11	Variant Creutzfeldt-Jakob disease	CC	01	056,057
046.19	Other and unspecified Creutzfeldt-Jakob disease	CC	01	056,057
046.71	Gerstmann-Sträussler-Scheinker syndrome	CC	01 25	056,057 974,975,976
046.72	Fatal familial insomnia	CC	01 25	056,057 974,975,976
046.79	Other and unspecified prion disease of central nervous system	CC	01 25	056,057 974,975,976
051.01	Cowpox	N	18	865,866
051.02	Vaccinia not from vaccination	N	18	865,866
059.00	Orthopoxvirus infection, unspecified	N	18	865,866
059.01	Monkeypox	CC	18	865,866
059.09	Other orthopoxvirus infections	N	18	865,866
059.10	Parapoxvirus infection, unspecified	N	18	865,866
059.11	Bovine stomatitis	N	18	865,866
059.12	Sealpox	N	18	865,866
059.19	Other parapoxvirus infections	N	18	865,866
059.20*	Yatapoxvirus infection, unspecified	N	18	865,866
059.21	Tanapox	CC	18	865,866
059.22	Yaba monkey tumor virus	N	18	865,866
059.8	Other poxvirus infections	N	18	865,866
059.9	Poxvirus infections, unspecified	N	18	865,866
078.12	Plantar wart	N	09	606,607
136.21	Specific infection due to acanthamoeba	N	18	867,868,869

Diagnosis Code	Description	CC	MDC	MS-DRG
136.29	Other specific infections by free-living amebae	CC	18	867,868,869
199.2	Malignant neoplasm associated with transplant organ	CC	17	843,844,845
203.02	Multiple myeloma, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
203.12	Plasma cell leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
203.82	Other immunoproliferative neoplasms, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
204.02	Acute lymphoid leukemia, in relapse	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
204.12	Chronic lymphoid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
204.22	Subacute lymphoid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
204.82	Other lymphoid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
204.92	Unspecified lymphoid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
205.02	Acute myeloid leukemia, in relapse	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
205.12	Chronic myeloid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
205.22	Subacute myeloid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
205.32	Myeloid sarcoma, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
205.82	Other myeloid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842

Diagnosis Code	Description	CC	MDC	MS-DRG
205.92	Unspecified myeloid leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
206.02	Acute monocytic leukemia, in relapse	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
206.12	Chronic monocytic leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
206.22	Subacute monocytic leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
206.82	Other monocytic leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
206.92	Unspecified monocytic leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
207.02	Acute erythremia and erythroleukemia, in relapse	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
207.12	Chronic erythremia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
207.22	Megakaryocytic leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
207.82	Other specified leukemia, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
208.02	Acute leukemia of unspecified cell type, in relapse	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
208.12	Chronic leukemia of unspecified cell type, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
208.22	Subacute leukemia of unspecified cell type, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
208.82	Other leukemia of unspecified cell type, in relapse	CC	17	820,821,822,823,824, 825,840,841,842
208.92	Unspecified leukemia, in relapse	CC	17	820,821,822,823,824,

Diagnosis Code	Description	CC	MDC	MS-DRG
				825,840,841,842
209.00	Malignant carcinoid tumor of the small intestine, unspecified portion	CC	06	374,375,376
209.01	Malignant carcinoid tumor of the duodenum	CC	06	374,375,376
209.02	Malignant carcinoid tumor of the jejunum	CC	06	374,375,376
209.03	Malignant carcinoid tumor of the ileum	CC	06	374,375,376
209.10	Malignant carcinoid tumor of the large intestine, unspecified portion	CC	06	374,375,376
209.11	Malignant carcinoid tumor of the appendix	CC	06	338,339,340,374,375,376
209.12	Malignant carcinoid tumor of the cecum	CC	06	374,375,376
209.13	Malignant carcinoid tumor of the ascending colon	CC	06	374,375,376
209.14	Malignant carcinoid tumor of the transverse colon	CC	06	374,375,376
209.15	Malignant carcinoid tumor of the descending colon	CC	06	374,375,376
209.16	Malignant carcinoid tumor of the sigmoid colon	CC	06	374,375,376
209.17	Malignant carcinoid tumor of the rectum	CC	06	374,375,376
209.20	Malignant carcinoid tumor of unknown primary site	CC	17	843,844,845
209.21	Malignant carcinoid tumor of the bronchus and lung	CC	04	180,181,182
209.22	Malignant carcinoid tumor of the thymus	CC	17	843,844,845
209.23	Malignant carcinoid tumor of the stomach	CC	06	374,375,376
209.24	Malignant carcinoid tumor of the kidney	CC	11	656,657,658,686,687,688
209.25	Malignant carcinoid tumor of foregut, not otherwise specified	CC	06	374,375,376
209.26	Malignant carcinoid tumor of midgut, not otherwise specified	CC	06	374,375,376
209.27	Malignant carcinoid tumor of	CC	06	374,375,376

Diagnosis Code	Description	CC	MDC	MS-DRG
	hindgut, not otherwise specified			
209.29	Malignant carcinoid tumor of other sites	CC	17	843,844,845
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site	CC	17	843,844,845
209.40	Benign carcinoid tumor of the small intestine, unspecified portion	N	06	393,394,395
209.41	Benign carcinoid tumor of the duodenum	N	06	393,394,395
209.42	Benign carcinoid tumor of the jejunum	N	06	393,394,395
209.43	Benign carcinoid tumor of the ileum	N	06	393,394,395
209.50	Benign carcinoid tumor of the large intestine, unspecified portion	N	06	393,394,395
209.51	Benign carcinoid tumor of the appendix	N	06	393,394,395
209.52	Benign carcinoid tumor of the cecum	N	06	393,394,395
209.53	Benign carcinoid tumor of the ascending colon	N	06	393,394,395
209.54	Benign carcinoid tumor of the transverse colon	N	06	393,394,395
209.55	Benign carcinoid tumor of the descending colon	N	06	393,394,395
209.56	Benign carcinoid tumor of the sigmoid colon	N	06	393,394,395
209.57	Benign carcinoid tumor of the rectum	N	06	393,394,395
209.60	Benign carcinoid tumor of unknown primary site	N	17	843,844,845
209.61	Benign carcinoid tumor of the bronchus and lung	N	04	180,181,182
209.62	Benign carcinoid tumor of the thymus	N	16	814,815,816
209.63	Benign carcinoid tumor of the stomach	N	06	393,394,395
209.64	Benign carcinoid tumor of the kidney	N	11	656,657,658,686,687, 688
209.65	Benign carcinoid tumor of foregut, not otherwise specified	N	06	393,394,395
209.66	Benign carcinoid tumor of midgut,	N	06	393,394,395

Diagnosis Code	Description	CC	MDC	MS-DRG
	not otherwise specified			
209.67	Benign carcinoid tumor of hindgut, not otherwise specified	N	06	393,394,395
209.69	Benign carcinoid tumor of other sites	N	17	843,844,845
238.77	Post-transplant lymphoproliferative disorder (PTLD)	CC	21	919,920,921
249.00	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified	N	PRE 10	008,010 637,638,639
249.01	Secondary diabetes mellitus without mention of complication, uncontrolled	N	PRE 10	008,010 637,638,639
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified	MCC	PRE 10	008,010 637,638,639
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled	MCC	PRE 10	008,010 637,638,639
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified	MCC	PRE 10	008,010 637,638,639
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled	MCC	PRE 10	008,010 637,638,639
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified	MCC	PRE 10	008,010 637,638,639
249.31	Secondary diabetes mellitus with other coma, uncontrolled	MCC	PRE 10	008,010 637,638,639
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified	N	PRE 11	008,010 698,699,700
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	N	PRE 11	008,010 698,699,700
249.50	Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified	N	PRE 02	008,010 124,125
249.51	Secondary diabetes mellitus with	N	PRE	008,010

Diagnosis Code	Description	CC	MDC	MS-DRG
	ophthalmic manifestations, uncontrolled		02	124,125
249.60	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified	N	PRE 01	008,010 073,074
249.61	Secondary diabetes mellitus with neurological manifestations, uncontrolled	N	PRE 01	008,010 073,074
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified	N	PRE 05	008,010 299,300,301
249.71	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled	N	PRE 05	008,010 299,300,301
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified	N	PRE 10	008,010 637,638,639
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled	N	PRE 10	008,010 637,638,639
249.90	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified	N	PRE 10	008,010 637,638,639
249.91	Secondary diabetes mellitus with unspecified complication, uncontrolled	N	PRE 10	008,010 637,638,639
259.50	Androgen insensitivity, unspecified	N	10	643,644,645
259.51	Androgen insensitivity syndrome	N	10	643,644,645
259.52	Partial androgen insensitivity	N	10	643,644,645
275.5	Hungry bone syndrome	N	10	640,641
279.50	Graft-versus-host disease, unspecified	CC	16	808,809,810
279.51	Acute graft-versus-host disease	CC	16	808,809,810
279.52	Chronic graft-versus-host disease	CC	16	808,809,810
279.53	Acute on chronic graft-versus-host disease	CC	16	808,809,810
289.84	Heparin-induced thrombocytopenia (HIT)	N	15 16 25	791[1],793[1] 813 977

Diagnosis Code	Description	CC	MDC	MS-DRG
337.00	Idiopathic peripheral autonomic neuropathy, unspecified	N	01	073,074
337.01	Carotid sinus syndrome	N	01	073,074
337.09	Other idiopathic peripheral autonomic neuropathy	N	01	073,074
339.00	Cluster headache syndrome, unspecified	N	01	102,103
339.01	Episodic cluster headache	N	01	102,103
339.02	Chronic cluster headache	N	01	102,103
339.03	Episodic paroxysmal hemicrania	N	01	102,103
339.04	Chronic paroxysmal hemicrania	N	01	102,103
339.05	Short lasting unilateral neuralgiform headache with conjunctival injection and tearing	N	01	102,103
339.09	Other trigeminal autonomic cephalgias	N	01	102,103
339.10	Tension type headache, unspecified	N	01	102,103
339.11	Episodic tension type headache	N	01	102,103
339.12	Chronic tension type headache	N	01	102,103
339.20	Post-traumatic headache, unspecified	N	01	102,103
339.21	Acute post-traumatic headache	N	01	102,103
339.22	Chronic post-traumatic headache	N	01	102,103
339.3	Drug induced headache, not elsewhere classified	N	01	102,103
339.41	Hemicrania continua	N	01	102,103
339.42	New daily persistent headache	N	01	102,103
339.43	Primary thunderclap headache	N	01	102,103
339.44	Other complicated headache syndrome	N	01	102,103
339.81	Hypnic headache	N	01	102,103
339.82	Headache associated with sexual activity	N	01	102,103
339.83	Primary cough headache	N	01	102,103
339.84	Primary exertional headache	N	01	102,103
339.85	Primary stabbing headache	N	01	102,103
339.89	Other headache syndromes	N	01	102,103
346.02	Migraine with aura, without mention of intractable migraine with status migrainosus	N	01	102,103

Diagnosis Code	Description	CC	MDC	MS-DRG
346.03	Migraine with aura, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.12	Migraine without aura, without mention of intractable migraine with status migrainosus	N	01	102,103
346.13	Migraine without aura, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.22	Variants of migraine, not elsewhere classified, without mention of intractable migraine with status migrainosus	N	01	102,103
346.23	Variants of migraine, not elsewhere classified, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.30	Hemiplegic migraine, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.31	Hemiplegic migraine, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.32	Hemiplegic migraine, without mention of intractable migraine with status migrainosus	N	01	102,103
346.33	Hemiplegic migraine, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.40	Menstrual migraine, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.41	Menstrual migraine, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.42	Menstrual migraine, without mention of intractable migraine with status migrainosus	N	01	102,103
346.43	Menstrual migraine, with	N	01	102,103

Diagnosis Code	Description	CC	MDC	MS-DRG
	intractable migraine, so stated, with status migrainosus			
346.50	Persistent migraine aura without cerebral infarction, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.51	Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.52	Persistent migraine aura without cerebral infarction, without mention of intractable migraine with status migrainosus	N	01	102,103
346.53	Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.60	Persistent migraine aura with cerebral infarction, without mention of intractable migraine without mention of status migrainosus	CC	01	102,103
346.61	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus	CC	01	102,103
346.62	Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus	CC	01	102,103
346.63	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, with status migrainosus	CC	01	102,103
346.70	Chronic migraine without aura, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.71	Chronic migraine without aura, with intractable migraine, so stated, without mention of status	N	01	102,103

Diagnosis Code	Description	CC	MDC	MS-DRG
	migrainosus			
346.72	Chronic migraine without aura, without mention of intractable migraine with status migrainosus	N	01	102,103
346.73	Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.82	Other forms of migraine, without mention of intractable migraine with status migrainosus	N	01	102,103
346.83	Other forms of migraine, with intractable migraine, so stated, with status migrainosus	N	01	102,103
346.92*	Migraine, unspecified, without mention of intractable migraine with status migrainosus	N	01	102,103
346.93*	Migraine, unspecified, with intractable migraine, so stated, with status migrainosus	N	01	102,103
349.31*	Accidental puncture or laceration of dura during a procedure	CC	15 21	791[1],793[1] 919,920,921
349.39*	Other dural tear	CC	15 21	791[1],793[1] 919,920,921
362.20	Retinopathy of prematurity, unspecified	N	02	124,125
362.22	Retinopathy of prematurity, stage 0	N	02	124,125
362.23	Retinopathy of prematurity, stage 1	N	02	124,125
362.24	Retinopathy of prematurity, stage 2	N	02	124,125
362.25	Retinopathy of prematurity, stage 3	N	02	124,125
362.26	Retinopathy of prematurity, stage 4	N	02	124,125
362.27	Retinopathy of prematurity, stage 5	N	02	124,125
364.82	Plateau iris syndrome	N	02	124,125
372.34	Pingueculitis	N	02	124,125
414.3	Coronary atherosclerosis due to lipid rich plaque	N	05	302,303
482.42*	Methicillin resistant pneumonia due to Staphylococcus aureus	MCC	04 15 25	177,178,179 791[1],793[1] 974,975,976
511.81	Malignant pleural effusion	CC	04	180,181,182
511.89	Other specified forms of effusion,	CC	04	186,187,188

Diagnosis Code	Description	CC	MDC	MS-DRG
	except tuberculous		15	791[1],793[1]
530.13*	Eosinophilic esophagitis	N	06	391,392
535.70*	Eosinophilic gastritis, without mention of hemorrhage	N	06	391,392
535.71*	Eosinophilic gastritis, with hemorrhage	MCC	06	377,378,379
558.41*	Eosinophilic gastroenteritis	N	06 25	391,392 977
558.42*	Eosinophilic colitis	N	06 25	391,392 977
569.44	Dysplasia of anus	N	06	393,394,395
571.42	Autoimmune hepatitis	N	07	441,442,443
599.70	Hematuria, unspecified	N	11 15	695,696 791[1],793[1]
599.71	Gross hematuria	N	11 15	695,696 791[1],793[1]
599.72	Microscopic hematuria	N	11 15	695,696 791[1],793[1]
611.81	Ptosis of breast	N	09	600,601
611.82	Hypoplasia of breast	N	09	600,601
611.83	Capsular contracture of breast implant	N	09	600,601
611.89	Other specified disorders of breast	N	09	600,601
612.0	Deformity of reconstructed breast	N	09	600,601
612.1	Disproportion of reconstructed breast	N	09	600,601
625.70	Vulvodynia, unspecified	N	13	742,743,760,761
625.71	Vulvar vestibulitis	N	13	742,743,757,758,759
625.79	Other vulvodynia	N	13	742,743,760,761
649.70	Cervical shortening, unspecified as to episode of care or not applicable	CC	14	998
649.71	Cervical shortening, delivered, with or without mention of antepartum condition	CC	14	765,766,767,768,774, 775
649.73	Cervical shortening, antepartum condition or complication	CC	14	781,782
678.00	Fetal hematologic conditions,	N	14	998

Diagnosis Code	Description	CC	MDC	MS-DRG
	unspecified as to episode of care or not applicable			
678.01	Fetal hematologic conditions, delivered, with or without mention of antepartum condition	N	14	765,766,767,768,774, 775
678.03	Fetal hematologic conditions, antepartum condition or complication	N	14	781,782
678.10	Fetal conjoined twins, unspecified as to episode of care or not applicable	N	14	998
678.11	Fetal conjoined twins, delivered, with or without mention of antepartum condition	N	14	765,766,767,768,774, 775
678.13	Fetal conjoined twins, antepartum condition or complication	N	14	781,782
679.00	Maternal complications from in utero procedure, unspecified as to episode of care or not applicable	N	14	765,766,767,768,774, 775
679.01	Maternal complications from in utero procedure, delivered, with or without mention of antepartum condition	N	14	765,766,767,768,774
679.02	Maternal complications from in utero procedure, delivered, with mention of postpartum complication	N	14	765,766,767,768,774
679.03	Maternal complications from in utero procedure, antepartum condition or complication	N	14	781,782
679.04	Maternal complications from in utero procedure, postpartum condition or complication	N	14	769,776
679.10	Fetal complications from in utero procedures, unspecified as to episode of care or not applicable	N	14	998
679.11	Fetal complications from in utero procedures, delivered, with or without mention of antepartum condition	N	14	765,766,767,768,774, 775
679.12	Fetal complications from in utero procedures, delivered, with mention of postpartum	N	14	765,766,767,768,774, 775

Diagnosis Code	Description	CC	MDC	MS-DRG
	complication			
679.13	Fetal complications from in utero procedures, antepartum condition or complication	N	14	781,782
679.14	Fetal complications from in utero procedures, postpartum condition or complication	N	14	769,776
695.10	Erythema multiforme, unspecified	N	09	595,596
695.11	Erythema multiforme minor	N	09	595,596
695.12	Erythema multiforme major	CC	09	595,596
695.13	Stevens-Johnson syndrome	CC	09	595,596
695.14	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome	CC	09	595,596
695.15	Toxic epidermal necrolysis	CC	09	595,596
695.19	Other erythema multiforme	N	09	595,596
695.50	Exfoliation due to erythematous condition involving less than 10 percent of body surface	N	09	606,607
695.51	Exfoliation due to erythematous condition involving 10-19 percent of body surface	N	09	606,607
695.52	Exfoliation due to erythematous condition involving 20-29 percent of body surface	N	09	606,607
695.53	Exfoliation due to erythematous condition involving 30-39 percent of body surface	CC	09	606,607
695.54	Exfoliation due to erythematous condition involving 40-49 percent of body surface	CC	09	606,607
695.55	Exfoliation due to erythematous condition involving 50-59 percent of body surface	CC	09	606,607
695.56	Exfoliation due to erythematous condition involving 60-69 percent of body surface	CC	09	606,607
695.57	Exfoliation due to erythematous condition involving 70-79 percent of body surface	CC	09	606,607
695.58	Exfoliation due to erythematous condition involving 80-89 percent of body surface	CC	09	606,607

Diagnosis Code	Description	CC	MDC	MS-DRG
695.59	Exfoliation due to erythematous condition involving 90 percent or more of body surface	CC	09	606,607
707.20	Pressure ulcer, unspecified stage	N	09	573,574,575,592,593, 594
707.21	Pressure ulcer, stage I	N	09	573,574,575,592,593, 594
707.22	Pressure ulcer, stage II	N	09	573,574,575,592,593, 594
707.23	Pressure ulcer, stage III	MCC[3]	09	573,574,575,592,593, 594
707.24	Pressure ulcer, stage IV	MCC[3]	09	573,574,575,592,593, 594
707.25*	Pressure ulcer, unstageable	N	09	573,574,575,592,593, 594
729.90	Disorders of soft tissue, unspecified	N	08	555,556
729.91	Post-traumatic seroma	N	08	555,556
729.92	Nontraumatic hematoma of soft tissue	N	08	555,556
729.99	Other disorders of soft tissue	N	08	555,556
733.96*	Stress fracture of femoral neck	N	08	542,543,544
733.97*	Stress fracture of shaft of femur	N	08	542,543,544
733.98*	Stress fracture of pelvis	N	08	542,543,544
760.61	Newborn affected by amniocentesis	N	15	794
760.62	Newborn affected by other in utero procedure	N	15	794
760.63	Newborn affected by other surgical operations on mother during pregnancy	N	15	794
760.64	Newborn affected by previous surgical procedure on mother not associated with pregnancy	N	15	794
777.50	Necrotizing enterocolitis in newborn, unspecified	MCC	15	791[4],793[4]
777.51	Stage I necrotizing enterocolitis in	MCC	15	791[4],793[4]

Diagnosis Code	Description	CC	MDC	MS-DRG
	newborn			
777.52	Stage II necrotizing enterocolitis in newborn	MCC	15	791[4],793[4]
777.53	Stage III necrotizing enterocolitis in newborn	MCC	15	791[4],793[4]
780.60*	Fever, unspecified	N	18 25	864 977
780.61*	Fever presenting with conditions classified elsewhere	N	18 25	864 977
780.62*	Postprocedural fever	N	18 25	864 977
780.63*	Postvaccination fever	N	18 25	864 977
780.64*	Chills (without fever)	N	23	947,948
780.65*	Hypothermia not associated with low environmental temperature	N	23	947,948
780.72	Functional quadriplegia	MCC	01	052,053
788.91	Functional urinary incontinence	N	11	695,696
788.99	Other symptoms involving urinary system	N	11	695,696
795.07	Satisfactory cervical smear but lacking transformation zone	N	13	742,743,760,761
795.10	Abnormal glandular Papanicolaou smear of vagina	N	13	742,743,760,761
795.11	Papanicolaou smear of vagina with atypical squamous cells of undetermined significance (ASC-US)	N	13	742,743,760,761
795.12	Papanicolaou smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)	N	13	742,743,760,761
795.13	Papanicolaou smear of vagina with low grade squamous intraepithelial lesion (LGSIL)	N	13	742,743,760,761
795.14	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)	N	13	742,743,760,761
795.15	Vaginal high risk human	N	13	742,743,760,761

Diagnosis Code	Description	CC	MDC	MS-DRG
	papillomavirus (HPV) DNA test positive			
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy	N	13	742,743,760,761
795.18	Unsatisfactory vaginal cytology smear	N	13	742,743,760,761
795.19	Other abnormal Papanicolaou smear of vagina and vaginal HPV	N	13	742,743,760,761
796.70	Abnormal glandular Papanicolaou smear of anus	N	06	393,394,395
796.71	Papanicolaou smear of anus with atypical squamous cells of undetermined significance (ASC-US)	N	06	393,394,395
796.72	Papanicolaou smear of anus with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)	N	06	393,394,395
796.73	Papanicolaou smear of anus with low grade squamous intraepithelial lesion (LGSIL)	N	06	393,394,395
796.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)	N	06	393,394,395
796.75	Anal high risk human papillomavirus (HPV) DNA test positive	N	06	393,394,395
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy	N	06	393,394,395
796.77	Satisfactory anal smear but lacking transformation zone	N	06	393,394,395
796.78	Unsatisfactory anal cytology smear	N	06	393,394,395
796.79	Other abnormal Papanicolaou smear of anus and anal HPV	N	06	393,394,395
997.31	Ventilator associated pneumonia	CC	04 15	205,206 791[1],793[1]
997.39	Other respiratory complications	CC	04 15	205,206 791[1],793[1]
998.30	Disruption of wound, unspecified	CC	21	919,920,921
998.33*	Disruption of traumatic injury wound repair	CC	21	919,920,921

Diagnosis Code	Description	CC	MDC	MS-DRG
999.81	Extravasation of vesicant chemotherapy	CC	05 15	314,315,316 791[1],793[1]
999.82	Extravasation of other vesicant agent	CC	05 15	314,315,316 791[1],793[1]
999.88	Other infusion reaction	N	05 15	314,315,316 791[1],793[1]
999.89	Other transfusion reaction	N	15 16	791[1],793[1] 811,812
V02.53*	Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus	N	23	951
V02.54*	Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus	N	23	951
V07.51	Prophylactic use of selective estrogen receptor modulators (SERMs)	N	23	951
V07.52	Prophylactic use of aromatase inhibitors	N	23	951
V07.59	Prophylactic use of other agents affecting estrogen receptors and estrogen levels	N	23	951
V12.04*	Personal history of Methicillin resistant Staphylococcus aureus	N	23	951
V13.51	Personal history of pathologic fracture	N	23	951
V13.52	Personal history of stress fracture	N	23	951
V13.59	Personal history of other musculoskeletal disorders	N	23	951
V15.21	Personal history of undergoing in utero procedure during pregnancy	N	23	951
V15.22	Personal history of undergoing in utero procedure while a fetus	N	23	951
V15.29	Personal history of surgery to other organs	N	23	951
V15.51	Personal history of traumatic fracture	N	23	951
V15.59	Personal history of other injury	N	23	951
V23.85	Pregnancy resulting from assisted	N	14	998

Diagnosis Code	Description	CC	MDC	MS-DRG
	reproductive technology			
V23.86	Pregnancy with history of in utero procedure during previous pregnancy	N	14	998
V28.81	Encounter for fetal anatomic survey	N	23	951
V28.82	Encounter for screening for risk of pre-term labor	N	23	951
V28.89	Other specified antenatal screening	N	23	951
V45.11	Renal dialysis status	N	23	951
V45.12	Noncompliance with renal dialysis	N	23	951
V45.87	Transplanted organ removal status	N	23	951
V45.88*	Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility	N	23	951
V46.3	Wheelchair dependence	N	23	951
V51.0	Encounter for breast reconstruction following mastectomy	N	09	606,607
V51.8	Other aftercare involving the use of plastic surgery	N	09	606,607
V61.01*	Family disruption due to family member on military deployment	N	23	951
V61.02*	Family disruption due to return of family member from military deployment	N	23	951
V61.03*	Family disruption due to divorce or legal separation	N	23	951
V61.04*	Family disruption due to parent-child estrangement	N	23	951
V61.05*	Family disruption due to child in welfare custody	N	23	951
V61.06*	Family disruption due to child in foster care or in care of non-parental family member	N	23	951
V61.09*	Other family disruption	N	23	951
V62.21*	Personal current military deployment status	N	23	951
V62.22*	Personal history of return from military deployment	N	23	951
V62.29*	Other occupational circumstances or maladjustment	N	23	951
V87.01	Contact with and (suspected)	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
	exposure to arsenic			
V87.09	Contact with and (suspected) exposure to other hazardous metals	N	23	951
V87.11	Contact with and (suspected) exposure to aromatic amines	N	23	951
V87.12	Contact with and (suspected) exposure to benzene	N	23	951
V87.19	Contact with and (suspected) exposure to other hazardous aromatic compounds	N	23	951
V87.2	Contact with and (suspected) exposure to other potentially hazardous chemicals	N	23	951
V87.31	Contact with and (suspected) exposure to mold	N	23	951
V87.39	Contact with and (suspected) exposure to other potentially hazardous substances	N	23	951
V87.41	Personal history of antineoplastic chemotherapy	N	23	949,950
V87.42	Personal history of monoclonal drug therapy	N	23	949,950
V87.49	Personal history of other drug therapy	N	23	949,950
V88.01	Acquired absence of both cervix and uterus	N	13	742,743,760,761
V88.02	Acquired absence of uterus with remaining cervical stump	N	13	742,743,760,761
V88.03	Acquired absence of cervix with remaining uterus	N	13	742,743,760,761
V89.01	Suspected problem with amniotic cavity and membrane not found	N	23	951
V89.02	Suspected placental problem not found	N	23	951
V89.03	Suspected fetal anomaly not found	N	23	951
V89.04	Suspected problem with fetal growth not found	N	23	951
V89.05	Suspected cervical shortening not found	N	23	951
V89.09	Other suspected maternal and fetal condition not found	N	23	951

Notes:

[*] These diagnosis codes were discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2008.
[1] Secondary diagnosis of major problem
[2] Secondary diagnosis of acute leukemia
[3] The pressure ulcer site specific codes (707.00-707.09) are non-CCs. The pressure ulcer stage III and IV codes are classified as MCCs.
[4] Principal or secondary diagnosis of major problem

TABLE 6B.-NEW PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.49	SuperSaturated oxygen therapy	N		
00.58	Insertion of intra-aneurysm sac pressure monitoring device (intraoperative)	N		
00.59	Intravascular pressure measurement of coronary arteries	N		
00.67	Intravascular pressure measurement of intrathoracic arteries	N		
00.68	Intravascular pressure measurement of peripheral arteries	N		
00.69	Intravascular pressure measurement, other specified and unspecified vessels	N		
17.11	Laparoscopic repair of direct inguinal hernia with graft or prosthesis	Y	06	350,351,352
17.12	Laparoscopic repair of indirect inguinal hernia with graft or prosthesis	Y	06	350,351,352
17.13	Laparoscopic repair of inguinal hernia with graft or prosthesis, not otherwise specified	Y	06	350,351,352
17.21	Laparoscopic bilateral repair of direct inguinal hernia with graft or prosthesis	Y	06	350,351,352
17.22	Laparoscopic bilateral repair of indirect inguinal hernia with graft or prosthesis	Y	06	350,351,352
17.23	Laparoscopic bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis	Y	06	350,351,352
17.24	Laparoscopic bilateral repair of inguinal hernia with graft or prosthesis, not otherwise specified	Y	06	350,351,352
17.31	Laparoscopic multiple segmental resection of large intestine	Y	06 17 21 24	329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959

Procedure Code	Description	O.R.	MDC	MS-DRG
17.32	Laparoscopic cecectomy	Y	05 06 21 24	264 329,330,331 907,908,909 957,958,959
17.33	Laparoscopic right hemicolectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
17.34	Laparoscopic resection of transverse colon	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
17.35	Laparoscopic left hemicolectomy	Y	05 06 10 17 21 24	264 329,330,331 628,629,630 820,821,822,826,827, 828 907,908,909 957,958,959
17.36	Laparoscopic sigmoidectomy	Y	06 17 21 24	329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
17.39	Other laparoscopic partial excision of large intestine	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
17.41*	Open robotic assisted procedure	N		
17.42*	Laparoscopic robotic assisted	N		

Procedure Code	Description	O.R.	MDC	MS-DRG
	procedure			
17.43*	Percutaneous robotic assisted procedure	N		
17.44*	Endoscopic robotic assisted procedure	N		
17.45*	Thoracoscopic robotic assisted procedure	N		
17.49*	Other and unspecified robotic assisted procedure	N		
33.72*	Endoscopic pulmonary airway flow measurement	N		
37.36	Excision or destruction of left atrial appendage (LAA)	N		
37.55	Removal of internal biventricular heart replacement system	Y	05	237,238
37.60*	Implantation or insertion of biventricular external heart assist system	Y	PRE 05	001[1],002[1] 215
38.23	Intravascular spectroscopy	N		
45.81	Laparoscopic total intra-abdominal colectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827,828 907,908,909 957,958,959
45.82	Open total intra-abdominal colectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827,828 907,908,909 957,958,959
45.83	Other and unspecified total intra-abdominal colectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827,828 907,908,909 957,958,959
48.40	Pull-through resection of rectum, not otherwise specified	Y	06 17	332,333,334 820,821,822,826,827,828

Procedure Code	Description	O.R.	MDC	MS-DRG
			21 24	907,908,909 957,958,959
48.42	Laparoscopic pull-through resection of rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
48.43	Open pull-through resection of rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
48.50	Abdominoperinéal resection of the rectum, not otherwise specified	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
48.51	Laparoscopic abdominoperineal resection of the rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
48.52	Open abdominoperineal resection of the rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
48.59	Other abdominoperineal resection of the rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827,828 907,908,909 957,958,959
53.42	Laparoscopic repair of umbilical hernia with graft or prosthesis	Y	06	353,354,355
53.43	Other laparoscopic umbilical herniorrhaphy	Y	06 21	353,354,355 907,908,909

Procedure Code	Description	O.R.	MDC	MS-DRG
			24	957,958,959
53.62	Laparoscopic incisional hernia repair with graft or prosthesis	Y	06 21 24	353,354,355 907,908,909 957,958,959
53.63	Other laparoscopic repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353,354,355
53.71	Laparoscopic repair of diaphragmatic hernia, abdominal approach	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
53.72	Other and open repair of diaphragmatic hernia, abdominal approach	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
53.75	Repair of diaphragmatic hernia, abdominal approach, not otherwise specified	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
53.83	Laparoscopic repair of diaphragmatic hernia, with thoracic approach	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
53.84	Other and open repair of diaphragmatic hernia, with thoracic approach	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
80.53	Repair of the anulus fibrosus with graft or prosthesis	Y	01 08 17 21 24	028,029,030 490,491 820,821,822,826,827,828 907,908,909 957,958,959
80.54	Other and unspecified repair of the anulus fibrosus	Y	01 08	028,029,030 490,491

Procedure Code	Description	O.R.	MDC	MS-DRG
			17 21 24	820,821,822,826,827, 828 907,908,909 957,958,959
85.70*	Total reconstruction of breast, not otherwise specified	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.71*	Latissimus dorsi myocutaneous flap	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.72*	Transverse rectus abdominis myocutaneous (TRAM) flap, pedicled	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.73*	Transverse rectus abdominis myocutaneous (TRAM) flap, free	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.74*	Deep inferior epigastric artery perforator (DIEP) flap, free	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.75*	Superficial inferior epigastric artery (SIEA) flap, free	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.76*	Gluteal artery perforator (GAP) flap, free	Y	09 21 24	582,583,584,585 907,908,909 957,958,959
85.79*	Other total reconstruction of breast	Y	09 21 24	582,583,584,585 907,908,909 957,958,959

Notes:

* These procedure codes were discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2008.

[1] Assigned to MS-DRGs 001 or 002 when both 37.64 and 37.60 are reported.

TABLE 6C.-INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
046.1	Jakob-Creutzfeldt disease	CC	01	056,057
051.0	Cowpox	N	18	865,866
136.2	Specific infections by free-living amebae	MCC	18	867,868,869
259.5	Androgen insensitivity syndrome	N	10	643,644,645
337.0	Idiopathic peripheral autonomic neuropathy	CC	01	073,074
511.8	Other specified forms of pleural effusion, except tuberculous	MCC	04 15	186,187,188 791[1],793[1]
599.7	Hematuria	N	11 15	695,696 791[1],793[1]
611.8	Other specified disorders of breast	N	09	600,601
695.1	Erythema multiforme	CC	09	595,596
729.9	Other and unspecified disorders of soft tissue	N	08	555,556
760.6	Surgical operation on mother	N	15	794
777.5	Necrotizing enterocolitis in fetus or newborn	MCC	15	791[2],793[2]
780.6*	Fever	N	18 25	864 977
788.9	Other symptoms involving urinary system	N	11	695,696
795.1	Nonspecific abnormal Papanicolaou smear of other site	N	04	180,181,182
997.3	Respiratory complications	CC	04 15	205,206 791[1],793[1]
999.8	Other transfusion reaction	CC	15 16	791[1],793[1] 811,812
V13.5	Personal history of other musculoskeletal disorders	N	23	951
V15.2	Personal history of surgery to other major organs	N	23	951
V15.5	Personal history of injury	N	23	951
V28.8	Encounter for other specified antenatal screening	N	23	951
V45.1	Renal dialysis status	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
V51	Aftercare involving the use of plastic surgery	N	09	606,607
V61.0*	Family disruption	N	23	951
V62.2*	Other occupational circumstances or maladjustment	N	23	951

Notes:
* These diagnosis codes were discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be deleted on October 1, 2008.
[1] Secondary diagnosis of major problem
[2] Principal or secondary diagnosis of major problem

TABLE 6D.-INVALID PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
45.8	Total intra-abdominal colectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
48.5	Abdominoperineal resection of rectum	Y	06 17 21 24	332,333,334 820,821,822,826,827, 828 907,908,909 957,958,959
53.7	Repair of diaphragmatic hernia, abdominal approach	Y	04 06 21 24	163,164,165 326,327,328 907,908,909 957,958,959
85.7*	Total reconstruction of breast	Y	09 21 24	582,583,584,585 907,908,909 957,958,959

Notes:
* This procedure code was discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. However, it will be deleted on October 1, 2008.

TABLE 6E.-REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	MS-DRG
038.11*	Methicillin susceptible Staphylococcus aureus septicemia	MCC	15 18 25	791[1],793[1] 870,871,872 974,975,976
041.11*	Methicillin susceptible Staphylococcus aureus in conditions classified elsewhere and of unspecified site	N	18	867,868,869
203.00	Multiple myeloma, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
203.10	Plasma cell leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
203.80	Other immunoproliferative neoplasms, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
204.00	Acute lymphoid leukemia, without mention of having achieved remission	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
204.10	Chronic lymphoid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
204.20	Subacute lymphoid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
204.80	Other lymphoid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
204.90	Unspecified lymphoid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
205.00	Acute myeloid leukemia, without mention of having achieved remission	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
205.10	Chronic myeloid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
205.20	Subacute myeloid leukemia, without mention of having achieved	CC	17	820,821,822,823,824, 825,840,841,842

Diagnosis Code	Description	CC	MDC	MS-DRG
	remission			
205.30	Myeloid sarcoma, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
205.80	Other myeloid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
205.90	Unspecified myeloid leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
206.00	Acute monocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
206.10	Chronic monocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
206.20	Subacute monocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
206.80	Other monocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
206.90	Unspecified monocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
207.00	Acute erythremia and erythroleukemia, without mention of having achieved remission	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
207.10	Chronic erythremia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
207.20	Megakaryocytic leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
207.80	Other specified leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
208.00	Acute leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820,821,822,834,835, 836,837[2],838[2],839[2]
208.10	Chronic leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842

Diagnosis Code	Description	CC	MDC	MS-DRG
208.20	Subacute leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
208.80	Other leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
208.90	Unspecified leukemia, without mention of having achieved remission	CC	17	820,821,822,823,824, 825,840,841,842
346.00 •	Migraine with aura, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.01	Migraine with aura, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.10	Migraine without aura, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.11	Migraine without aura, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.20	Variants of migraine, not elsewhere classified, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.21	Variants of migraine, not elsewhere classified, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.80	Other forms of migraine, without mention of intractable migraine without mention of status migrainosus	N	01	102,103
346.81	Other forms of migraine, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
346.90*	Migraine, unspecified, without mention of intractable migraine without mention of status	N	01	102,103

Diagnosis Code	Description	CC	MDC	MS-DRG
	migrainosus			
346.91*	Migraine, unspecified, with intractable migraine, so stated, without mention of status migrainosus	N	01	102,103
386.00	Ménière's disease, unspecified	N	03	149
386.01	Active Ménière's disease, cochleovestibular	N	03	149
386.02	Active Ménière's disease, cochlear	N	03	149
386.03	Active Ménière's disease, vestibular	N	03	149
386.04	Inactive Ménière's disease	N	03	149
482.41*	Methicillin susceptible pneumonia due to Staphylococcus aureus	MCC	04 15 25	177,178,179 791[1],793[1] 974,975,976
707.00	Pressure ulcer, unspecified site	N[3]	09	573,574,575,592,593, 594
707.01	Pressure ulcer, elbow	N[3]	09	573,574,575,592,593, 594
707.02	Pressure ulcer, upper back	N[3]	09	573,574,575,592,593, 594
707.03	Pressure ulcer, lower back	N[3]	09	573,574,575,592,593, 594
707.04	Pressure ulcer, hip	N[3]	09	573,574,575,592,593, 594
707.05	Pressure ulcer, buttock	N[3]	09	573,574,575,592,593, 594
707.06	Pressure ulcer, ankle	N[3]	09	573,574,575,592,593, 594
707.07	Pressure ulcer, heel	N[3]	09	573,574,575,592,593, 594
707.09	Pressure ulcer, other site	N[3]	09	573,574,575,592,593, 594
795.08	Unsatisfactory cervical cytology	N	13	742,743,760,761

Diagnosis Code	Description	CC	MDC	MS-DRG
	smear			
998.31	Disruption of internal operation (surgical) wound	CC	21	919,920,921
998.32*	Disruption of external operation (surgical) wound	CC	21	919,920,921
V28.3	Encounter for routine screening for malformation using ultrasonics	N	23	951
V45.71	Acquired absence of breast and nipple	N	23	951

Notes:

* These diagnosis codes were discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2008.

[1] Secondary diagnosis of major problem

[2] Secondary diagnosis of acute leukemia

[3] The pressure ulcer site specific codes (707.00-707.09) are non-CCs. The pressure ulcer stage III and IV codes are classified as MCCs.

** Revised code 776.9 that was listed in the proposed rule has been deleted. There are no changes to code 776.9.

TABLE 6F.-REVISED PROCEDURE CODE TITLES

Procedure Code	Description	O.R.	MDC	MS-DRG
37.52	Implantation of total internal biventricular heart replacement system	Y	PRE	001[1],002[1]
37.53	Replacement or repair of thoracic unit of (total) replacement heart system	Y	05	215
37.54	Replacement or repair of other implantable component of (total) replacement heart system	Y	05	215
37.62*	Insertion of temporary non-implantable extracorporeal circulatory assist device	Y	05	215
37.64*	Removal of external heart assist system(s) or device(s)	Y	PRE 05	001,002 237,238
37.65*	Implant of single ventricular (extracorporeal) external heart assist system	Y	PRE 05	001,002 215
45.71	Open and other multiple segmental resection of large intestine	Y	06 17 21 24	329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
45.72	Open and other cecectomy	Y	05 06 21 24	264 329,330,331 907,908,909 957,958,959
45.73	Open and other right hemicolectomy	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
45.74	Open and other resection of transverse colon	Y	05 06 17	264 329,330,331 820,821,822,826,827, 828

Procedure Code	Description	O.R.	MDC	MS-DRG
			21 24	907,908,909 957,958,959
45.75	Open and other left hemicolectomy	Y	05 06 10 17 21 24	264 329,330,331 628,629,630 820,821,822,826,827, 828 907,908,909 957,958,959
45.76	Open and other sigmoidectomy	Y	06 17 21 24	329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
45.79	Other and unspecified partial excision of large intestine	Y	05 06 17 21 24	264 329,330,331 820,821,822,826,827, 828 907,908,909 957,958,959
53.01	Other and open repair of direct inguinal hernia	Y	06	350,351,352
53.02	Other and open repair of indirect inguinal hernia	Y	06	350,351,352
53.03	Other and open repair of direct inguinal hernia with graft or prosthesis	Y	06	350,351,352
53.04	Other and open repair of indirect inguinal hernia with graft or prosthesis	Y	06	350,351,352
53.11	Other and open bilateral repair of direct inguinal hernia	Y	06	350,351,352
53.12	Other and open bilateral repair of indirect inguinal hernia	Y	06	350,351,352
53.13	Other and open bilateral repair of inguinal hernia, one direct and one indirect	Y	06	350,351,352
53.14	Other and open bilateral repair of direct inguinal hernia with graft or	Y	06	350,351,352

Procedure Code	Description	O.R.	MDC	MS-DRG
	prosthesis			
53.15	Other and open bilateral repair of indirect inguinal hernia with graft or prosthesis	Y	06	350,351,352
53.16	Other and open bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis	Y	06	350,351,352
53.41	Other and open repair of umbilical hernia with graft or prosthesis	Y	06	353,354,355
53.49	Other open umbilical herniorrhaphy	Y	06 21 24	353,354,355 907,908,909 957,958,959
53.61	Other open incisional hernia repair with graft or prosthesis	Y	06 21 24	353,354,355 907,908,909 957,958,959
53.69	Other and open repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353,354,355
81.65	Percutaneous vertebroplasty	Y	08 21 24	515,516,517 907,908,909 957,958,959
81.66	Percutaneous vertebral augmentation	Y	08 21 24	515,516,517 907,908,909 957,958,959
84.56*	Insertion or replacement of (cement) spacer	N		
93.90*	Non-invasive mechanical ventilation	N		
96.70*	Continuous invasive mechanical ventilation of unspecified duration	N**	04	208
96.71*	Continuous invasive mechanical ventilation for less than 96 consecutive hours	N**	04	208
96.72*	Continuous invasive mechanical ventilation for 96 consecutive hours or more	N**	PRE 04 18 22	003,004 207 870 927,933

Notes:

[*] These procedure codes were discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2008.

[**] Non-O.R. procedure affects DRGs

[1] Please note MS-DRG change.

** The code title for procedure code 37.52 was revised after the publication of the proposed rule.

TABLE 7A.-MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY; FY 2007 MedPAR UPDATE-MARCH 2008 GROUPER V25.0 MS-DRGS

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	667	41.1229	12	17	31	52	85
2	295	25.2949	9	12	17	29	48
3	23,496	39.7880	16	22	32	48	69
4	21,510	28.8763	11	17	24	35	49
5	650	21.4969	7	10	15	26	43
6	233	10.5279	5	7	9	12	18
7	364	19.5797	8	10	15	22	39
8	499	11.9599	6	7	9	13	20
9	1,370	22.0350	8	16	20	25	35
10	168	10.7500	6	7	8	11	18
11	1,274	16.7190	6	9	13	20	30
12	1,926	10.6713	4	6	9	13	18
13	1,281	6.9110	3	4	6	8	11
20	899	18.3359	6	10	17	24	32
21	533	15.4597	8	11	14	19	25
22	215	9.3488	2	6	9	12	15
23	3,769	12.6758	2	5	10	17	25
24	2,107	9.0052	1	4	8	12	18
25	8,789	13.0238	4	6	10	17	25
26	11,873	8.2142	2	4	7	11	15
27	13,814	4.5398	1	2	4	6	9
28	1,682	14.3210	4	7	11	18	27
29	3,095	7.1170	1	3	6	9	14
30	3,436	3.7331	1	1	3	5	7
31	1,034	13.1228	3	6	10	18	26
32	2,811	5.9964	1	2	4	8	14
33	3,663	3.0410	1	1	2	4	6
34	770	7.2818	1	2	5	9	15
35	2,267	3.2823	1	1	2	4	8
36	7,048	1.5979	1	1	1	2	3
37	4,888	8.5978	2	3	7	11	17
38	14,279	3.7624	1	1	2	5	9
39	52,432	1.8276	1	1	1	2	3
40	4,809	13.3462	3	6	10	17	25
41	7,658	7.1940	1	3	6	9	13
42	4,907	3.6395	1	1	3	5	8
52	1,177	6.6882	2	3	5	8	14
53	588	4.0153	1	2	3	5	7
54	5,290	6.9480	2	3	5	9	14
55	16,470	5.0753	1	2	4	6	10
56	8,324	7.7639	2	3	6	9	14

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
57	47,629	4.9758	2	3	4	6	9
58	748	7.6791	2	4	6	9	15
59	2,788	5.1402	2	3	4	6	9
60	4,139	3.9618	2	2	4	5	7
61	1,600	8.9275	2	4	7	11	17
62	2,488	6.2649	3	4	5	8	11
63	1,345	4.5033	2	3	4	6	8
64	56,285	7.4572	2	3	6	10	15
65	106,112	5.2119	2	3	4	6	9
66	90,347	3.7110	1	2	3	5	7
67	1,412	5.7932	2	3	5	7	11
68	11,503	3.4478	1	2	3	4	6
69	102,863	2.9891	1	2	2	4	5
70	7,406	7.8705	2	4	6	10	15
71	9,609	5.5589	2	3	4	7	10
72	5,802	3.5400	1	2	3	4	7
73	9,320	6.2359	2	3	5	8	12
74	31,850	4.3022	1	2	3	5	8
75	1,258	7.2917	2	4	6	9	14
76	886	4.1400	2	2	4	5	7
77	1,224	6.6928	2	3	5	9	12
78	1,417	4.4192	2	2	4	6	8
79	941	3.3783	1	2	3	4	6
80	1,890	5.0979	1	2	4	6	10
81	7,219	3.5222	1	2	3	4	6
82	1,774	6.4183	1	1	4	9	15
83	2,094	4.9470	1	2	4	7	10
84	2,805	3.1241	1	1	2	4	6
85	5,944	7.6272	2	3	6	10	15
86	11,602	4.9958	1	3	4	6	9
87	13,123	3.2705	1	2	3	4	6
88	726	5.8567	1	3	4	7	12
89	2,789	3.7469	1	2	3	5	7
90	3,157	2.5353	1	1	2	3	5
91	7,691	6.3937	2	3	5	8	13
92	16,439	4.4581	1	2	4	6	8
93	16,294	3.2183	1	2	3	4	6
94	1,483	11.8307	3	6	10	15	22
95	1,045	8.6220	3	5	7	11	15
96	764	6.1675	2	4	6	8	11
97	1,201	12.5737	4	6	11	16	23
98	1,014	8.3097	3	5	7	10	15
99	660	5.8803	2	3	5	8	11
100	17,146	6.3498	2	3	5	8	12
101	57,599	3.6937	1	2	3	5	7
102	1,099	4.5177	1	2	3	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
103	13,907	3.1251	1	2	2	4	6
113	535	5.6355	1	2	4	8	12
114	557	2.6104	1	1	2	3	5
115	1,052	4.3327	1	2	4	5	8
116	548	4.0858	1	1	2	5	8
117	1,003	2.1575	1	1	1	2	3
121	543	5.4530	2	3	4	7	10
122	629	4.0270	2	2	3	5	7
123	2,811	2.8780	1	2	2	4	5
124	759	5.2885	1	2	4	7	10
125	4,708	3.5098	1	2	3	4	7
129	1,368	5.1813	1	2	4	6	11
130	1,089	2.9339	1	1	2	4	6
131	946	5.7611	1	2	4	8	12
132	901	2.6349	1	1	2	3	5
133	2,009	5.3449	1	2	4	7	11
134	3,406	2.2278	1	1	1	3	4
135	352	5.8636	1	2	4	8	12
136	475	2.3284	1	1	1	3	5
137	784	5.4056	1	2	4	7	11
138	895	2.5263	1	1	2	3	5
139	1,505	1.8425	1	1	1	2	3
146	680	9.3956	2	4	7	12	19
147	1,381	6.1224	1	2	4	8	12
148	865	3.7965	1	1	3	5	8
149	39,192	2.7195	1	1	2	3	5
150	957	5.1933	1	2	4	6	10
151	6,889	2.8924	1	1	2	4	5
152	1,742	4.4524	1	2	3	5	8
153	11,559	3.2127	1	2	3	4	6
154	1,916	6.3215	2	3	5	8	12
155	4,501	4.4095	1	2	4	6	8
156	4,882	3.1678	1	2	3	4	6
157	1,054	6.6347	1	3	5	8	14
158	3,268	4.5095	1	2	3	6	8
159	2,396	3.0447	1	1	2	4	6
163	13,765	14.9630	5	8	13	19	27
164	18,051	8.0983	3	5	7	10	15
165	13,933	5.1372	2	3	5	6	9
166	20,740	12.9311	4	7	10	16	24
167	20,704	7.9720	2	4	7	10	15
168	5,535	5.2370	1	2	4	7	10
175	12,807	7.2571	3	4	6	9	12
176	41,832	5.3202	2	3	5	7	9
177	64,269	9.0967	3	5	7	12	17
178	71,474	7.3743	3	4	6	9	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
179	26,331	5.5598	2	3	5	7	10
180	22,607	7.8953	2	4	6	10	15
181	30,602	5.9032	2	3	5	8	11
182	5,500	4.1735	1	2	3	5	8
183	1,891	7.2099	2	4	6	9	13
184	4,449	4.5817	2	3	4	6	8
185	2,572	3.4075	1	2	3	4	6
186	9,326	7.4036	2	4	6	9	14
187	10,130	5.3104	2	3	4	7	10
188	5,081	3.9904	1	2	3	5	8
189	114,036	6.1447	2	3	5	8	11
190	59,382	6.2913	2	3	5	8	12
191	119,274	5.0130	2	3	4	6	9
192	186,696	3.9669	1	2	3	5	7
193	88,184	6.7468	2	4	6	8	12
194	256,478	5.2622	2	3	4	7	9
195	134,728	4.0748	2	2	4	5	7
196	5,438	7.3453	3	4	6	9	14
197	6,856	5.3861	2	3	4	7	10
198	4,663	4.0757	1	2	3	5	7
199	3,246	8.2939	2	4	7	11	16
200	8,512	5.0759	1	2	4	7	10
201	3,513	4.0544	1	2	3	5	8
202	29,565	4.3478	1	2	4	5	8
203	37,298	3.3813	1	2	3	4	6
204	25,941	2.8749	1	1	2	4	5
205	5,920	5.4914	1	2	4	7	10
206	21,793	3.4403	1	2	3	4	6
207	39,917	15.0888	6	9	13	18	25
208	77,306	7.2193	1	3	6	10	14
215	142	14.0352	1	3	9	17	31
216	8,698	18.3819	8	11	16	23	31
217	7,294	12.3024	6	8	11	15	20
218	2,580	9.0492	5	6	8	11	14
219	10,616	13.9813	6	8	11	17	26
220	14,041	8.5532	5	6	7	10	14
221	7,103	6.4428	4	5	6	7	10
222	2,796	13.0715	5	7	11	17	23
223	5,141	6.2622	1	3	5	8	12
224	1,926	11.3764	4	6	9	14	21
225	5,117	5.6383	2	3	5	7	10
226	7,114	9.3306	1	4	7	12	19
227	43,110	2.8241	1	1	1	3	7
228	3,005	14.6869	6	8	13	18	26
229	3,623	9.1187	4	6	8	11	15
230	1,575	6.4857	3	4	6	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
231	1,463	13.3978	6	8	11	17	24
232	1,537	9.1640	5	7	8	11	14
233	16,445	14.1714	7	9	12	17	24
234	34,720	8.9220	5	6	8	11	13
235	9,726	11.2128	5	7	9	14	20
236	30,361	6.6117	4	5	6	8	10
237	22,608	10.8142	2	5	9	14	21
238	42,648	4.6409	1	2	3	6	9
239	13,430	15.4131	5	8	12	19	29
240	11,760	10.3705	3	5	8	13	19
241	2,707	6.7680	3	4	6	8	12
242	17,674	8.7783	3	4	7	11	17
243	36,409	5.0893	1	2	4	7	10
244	63,279	2.9286	1	1	2	4	6
245	5,939	3.3076	1	1	2	4	7
246	29,091	5.3367	1	2	4	7	12
247	190,632	2.1679	1	1	1	3	4
248	13,973	5.9788	1	2	4	8	12
249	70,653	2.4968	1	1	2	3	5
250	6,813	7.7813	1	3	6	10	16
251	41,998	2.8338	1	1	2	4	6
252	45,935	8.5506	1	3	6	11	18
253	45,268	6.0103	1	2	5	8	13
254	53,888	2.7300	1	1	2	3	6
255	2,551	9.6974	2	4	8	12	18
256	3,457	7.4689	2	4	6	9	13
257	713	4.8710	1	2	4	7	10
258	696	7.3736	2	3	6	9	14
259	7,331	2.8029	1	1	2	4	6
260	1,561	11.2108	3	5	8	14	22
261	3,539	4.2150	1	1	3	6	9
262	3,551	2.5917	1	1	2	3	6
263	660	5.4091	1	1	3	7	13
264	28,464	8.9145	1	3	6	11	19
280	64,213	7.3352	2	4	6	9	13
281	54,312	4.8000	2	3	4	6	9
282	55,014	3.2424	1	2	3	4	6
283	15,044	5.4388	1	1	3	7	13
284	4,176	3.2282	1	1	2	4	7
285	2,827	2.2066	1	1	1	3	5
286	23,897	6.9303	2	3	5	9	14
287	159,664	3.1467	1	1	2	4	6
288	2,983	11.7580	4	6	9	14	22
289	1,368	8.6506	3	5	7	11	15
290	481	6.5031	2	4	5	8	11
291	189,242	6.4890	2	3	5	8	12

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
292	206,400	4.9888	2	3	4	6	9
293	198,496	3.6783	1	2	3	5	6
294	1,428	5.5497	2	3	5	7	9
295	1,357	4.3324	2	3	4	6	7
296	1,943	3.0458	1	1	1	3	7
297	804	1.8035	1	1	1	2	3
298	609	1.3038	1	1	1	1	2
299	17,914	6.6566	2	3	5	8	12
300	44,997	5.0464	2	3	4	6	9
301	37,382	3.6948	1	2	3	5	7
302	7,658	4.3648	1	2	3	5	8
303	71,268	2.5293	1	1	2	3	5
304	2,105	5.1948	1	2	4	7	10
305	35,439	2.8618	1	1	2	4	5
306	1,522	6.2937	1	3	4	8	12
307	6,392	3.4529	1	2	3	4	6
308	36,062	5.5380	1	2	4	7	11
309	80,081	3.9355	1	2	3	5	7
310	160,285	2.7519	1	1	2	3	5
311	21,336	2.3079	1	1	2	3	4
312	167,491	3.1027	1	2	2	4	6
313	213,918	2.1055	1	1	2	3	4
314	62,195	7.0212	2	3	5	9	14
315	30,276	4.6006	1	2	4	6	9
316	18,186	2.9979	1	1	2	4	6
326	11,360	17.1236	5	9	14	21	32
327	10,572	10.0485	3	5	8	13	18
328	8,946	4.3592	1	2	3	6	9
329	48,640	15.9673	6	8	13	20	29
330	64,351	9.7075	4	6	8	12	17
331	28,579	5.8754	3	4	5	7	9
332	1,840	14.3462	6	8	12	18	25
333	5,987	8.8315	4	6	8	10	15
334	3,771	5.4951	2	4	5	7	9
335	7,266	14.0798	5	8	12	18	25
336	12,593	9.0903	3	5	8	11	16
337	8,675	5.5847	1	3	5	8	10
338	1,525	10.7266	4	6	9	13	19
339	3,197	7.0335	3	4	6	9	12
340	3,621	4.1527	2	2	4	5	7
341	891	7.1425	2	3	5	9	14
342	2,574	4.1340	1	2	3	5	8
343	7,104	2.1764	1	1	2	3	4
344	944	11.7172	4	6	9	15	22
345	2,955	7.2234	3	4	6	9	12
346	2,780	4.9432	2	3	5	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
347	1,643	8.8576	2	4	7	11	17
348	4,206	5.7401	2	3	5	7	11
349	5,208	3.0837	1	1	2	4	6
350	1,775	8.0045	2	3	6	10	16
351	4,330	4.5448	1	2	4	6	9
352	8,247	2.4813	1	1	2	3	5
353	3,200	8.3966	2	4	7	11	16
354	8,508	5.0803	2	3	4	6	9
355	15,471	2.8964	1	1	2	4	5
356	8,417	12.9210	3	6	10	16	25
357	7,878	8.1381	2	4	6	10	16
358	2,502	4.4700	1	2	4	6	9
368	3,608	6.6050	2	3	5	8	13
369	5,313	4.7516	2	3	4	6	9
370	3,577	3.3947	1	2	3	4	6
371	24,596	8.7500	3	4	7	11	17
372	27,326	6.8493	3	4	6	8	12
373	15,414	4.9350	2	3	4	6	8
374	9,156	8.5649	2	4	7	11	16
375	19,138	6.0246	2	3	5	8	12
376	4,320	4.1773	1	2	3	5	8
377	52,046	6.3770	2	3	5	8	12
378	111,447	4.4438	2	3	4	5	8
379	93,177	3.4057	1	2	3	4	6
380	3,049	7.2686	2	3	6	9	14
381	5,350	5.1660	2	3	4	6	9
382	4,532	3.6796	1	2	3	5	7
383	1,240	5.5024	2	3	4	7	10
384	8,179	3.7512	1	2	3	5	7
385	2,018	8.8038	3	4	6	11	18
386	7,197	5.6931	2	3	5	7	10
387	5,106	4.2934	1	2	4	5	8
388	18,713	7.3104	2	3	6	9	14
389	46,322	5.0120	2	3	4	6	9
390	46,998	3.5489	1	2	3	4	6
391	44,733	5.2391	1	2	4	6	10
392	284,997	3.4879	1	2	3	4	6
393	23,469	6.9064	2	3	5	8	14
394	46,313	4.8190	1	2	4	6	9
395	25,059	3.3330	1	2	3	4	6
405	3,996	16.9980	5	8	13	21	34
406	5,347	9.1386	2	5	7	11	17
407	2,132	5.4972	1	3	5	7	10
408	1,562	15.0583	6	8	12	18	28
409	1,749	9.8102	4	6	8	12	18
410	606	6.5215	2	4	6	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
411	961	12.3902	5	7	10	15	22
412	968	8.5702	4	6	8	11	14
413	763	5.9397	2	4	5	7	10
414	5,310	11.7320	5	7	10	14	21
415	6,209	7.6151	3	5	7	9	13
416	5,408	4.8327	2	3	4	6	8
417	16,620	8.3629	3	4	7	10	16
418	27,422	5.6310	2	3	5	7	10
419	36,311	3.1919	1	1	3	4	6
420	775	13.7535	3	6	11	17	26
421	1,060	7.6943	2	3	6	10	16
422	332	4.3464	1	2	4	6	8
423	1,548	15.9968	4	7	12	20	32
424	900	10.3978	3	5	8	14	20
425	126	5.4048	1	2	4	7	10
432	15,319	6.9599	2	3	5	9	14
433	9,804	4.8674	1	2	4	6	9
434	893	3.6719	1	2	3	4	6
435	12,239	7.5545	2	3	6	10	15
436	13,311	5.8342	2	3	5	8	11
437	3,933	4.2400	1	2	3	6	8
438	14,205	7.5159	2	3	5	9	15
439	24,645	5.3255	2	3	4	7	10
440	26,017	3.8060	1	2	3	5	7
441	13,470	7.0545	2	3	5	9	14
442	14,337	5.1004	2	2	4	6	9
443	6,635	3.7861	1	2	3	5	7
444	13,040	6.6106	2	3	5	8	13
445	16,953	4.7225	1	2	4	6	9
446	16,131	3.2615	1	2	3	4	6
453	951	15.6120	5	7	12	19	29
454	1,794	8.0334	3	4	6	10	15
455	1,999	4.4492	1	3	4	5	7
456	951	14.6866	5	7	11	18	28
457	2,436	7.4992	3	4	6	9	13
458	1,622	4.5493	2	3	4	6	7
459	3,551	9.4534	4	5	7	11	17
460	52,521	4.2154	2	3	4	5	7
461	1,030	8.4291	3	5	6	9	14
462	13,350	4.2187	3	3	4	5	6
463	5,083	16.6189	5	7	12	20	33
464	5,892	10.2223	3	5	8	12	20
465	2,426	5.8483	1	3	5	7	11
466	4,119	9.1680	3	5	7	11	16
467	14,455	5.4890	3	3	4	6	9
468	21,371	3.9269	2	3	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
469	30,884	8.1920	3	5	7	10	14
470	410,139	3.9258	3	3	3	4	6
471	2,320	9.8211	2	4	8	13	20
472	7,040	4.0892	1	1	3	5	9
473	23,193	1.9619	1	1	1	2	4
474	2,954	12.6435	4	6	10	15	24
475	3,314	8.3911	3	4	7	11	15
476	1,607	4.7828	1	2	4	6	9
477	2,610	11.9226	3	6	10	15	22
478	8,642	6.6024	1	3	6	9	13
479	11,541	2.8153	1	1	1	4	7
480	27,022	9.2834	4	5	8	11	16
481	72,869	5.9257	3	4	5	7	9
482	48,751	4.8402	3	4	4	6	7
483	7,158	4.2076	2	2	3	5	8
484	18,036	2.4278	1	2	2	3	4
485	1,195	12.1013	4	6	10	15	22
486	2,210	8.0235	3	5	7	10	14
487	1,324	5.6722	3	3	5	7	9
488	2,527	5.2228	2	3	4	6	10
489	5,842	3.0464	1	2	3	4	5
490	23,186	4.3443	1	1	3	5	9
491	53,010	2.2085	1	1	2	3	4
492	5,303	8.5288	3	4	7	11	15
493	17,135	5.2611	2	3	4	6	9
494	29,598	3.3963	1	2	3	4	6
495	1,990	10.9447	3	5	8	14	21
496	5,618	5.9676	2	3	5	7	11
497	6,732	2.9975	1	1	2	4	6
498	1,172	7.8933	2	3	6	10	16
499	1,123	2.9813	1	1	2	4	6
500	1,525	10.8157	3	5	8	14	21
501	3,925	5.9595	2	3	5	8	12
502	6,519	2.9383	1	1	2	4	6
503	847	9.4061	3	5	7	11	17
504	2,188	6.4269	2	3	6	8	12
505	3,035	3.3806	1	2	3	4	6
506	820	3.4000	1	1	2	4	7
507	846	5.1430	1	2	4	6	10
508	2,522	2.0484	1	1	1	2	3
509	635	3.0945	1	1	2	3	7
510	988	6.4180	2	3	5	8	12
511	3,988	3.9714	1	2	3	5	7
512	11,121	2.1596	1	1	2	3	4
513	1,070	5.0720	1	2	4	6	10
514	1,022	2.8112	1	1	2	3	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
515	3,864	10.4547	3	5	8	13	20
516	11,399	5.9845	1	3	5	8	11
517	17,688	3.0034	1	1	2	4	7
533	828	6.6836	2	3	5	8	12
534	3,424	4.0239	1	2	3	5	7
535	7,079	6.2393	2	3	5	8	12
536	34,043	3.9314	1	3	3	5	7
537	675	4.4785	2	3	4	5	8
538	1,064	3.2180	1	2	3	4	6
539	3,462	9.7764	3	5	8	12	17
540	4,058	7.1158	3	4	6	8	13
541	1,632	5.3419	2	3	4	6	9
542	5,770	8.7735	3	4	7	11	17
543	17,148	5.9356	2	3	5	7	11
544	10,891	4.4013	2	3	4	5	8
545	4,128	9.0821	2	4	6	11	19
546	5,626	5.5352	2	3	4	7	10
547	4,573	3.8084	1	2	3	5	7
548	589	8.9321	3	4	7	11	17
549	1,123	6.3785	2	3	5	8	12
550	864	4.4595	2	2	4	6	8
551	10,157	7.1030	2	3	6	9	14
552	86,021	4.1210	1	2	3	5	7
553	3,111	5.9817	2	3	5	7	11
554	19,344	3.6910	1	2	3	5	7
555	2,037	4.8468	1	2	4	6	9
556	18,820	3.1073	1	2	3	4	6
557	3,687	6.6035	2	3	5	8	12
558	15,241	4.2552	2	2	4	5	7
559	1,827	7.5189	2	3	6	9	15
560	4,361	4.7310	1	2	4	6	9
561	7,182	2.7680	1	1	2	3	5
562	5,516	6.3657	2	3	5	8	12
563	36,692	3.6982	1	2	3	4	6
564	1,687	7.0036	2	3	5	9	13
565	3,352	4.9806	2	3	4	6	9
566	2,652	3.6731	1	2	3	5	7
573	5,525	13.1781	4	6	9	16	26
574	11,209	9.3733	3	5	7	11	17
575	5,500	5.8496	2	3	5	7	11
576	555	12.9297	2	4	9	17	28
577	2,248	6.0974	1	2	4	8	13
578	3,097	3.3100	1	1	2	4	7
579	3,538	10.7024	3	5	8	14	21
580	10,839	5.5148	1	2	4	7	12
581	12,293	2.6107	1	1	2	3	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
582	5,389	2.8905	1	1	2	3	5
583	8,857	1.8041	1	1	1	2	3
584	677	6.0192	1	2	4	8	13
585	1,488	2.2406	1	1	1	2	4
592	4,221	8.8936	3	4	7	10	16
593	12,429	6.4515	2	3	5	8	11
594	2,785	5.0553	2	3	4	6	9
595	1,119	8.3467	2	4	6	10	16
596	5,360	4.7453	1	2	4	6	8
597	458	8.2140	2	3	6	10	16
598	1,414	5.7136	2	3	4	7	11
599	308	3.7143	1	1	3	4	6
600	691	5.0535	2	3	4	7	9
601	893	3.8611	1	2	3	5	7
602	22,323	7.0250	2	4	6	9	13
603	131,727	4.7027	2	3	4	6	8
604	2,689	5.6620	1	3	4	7	11
605	22,427	3.4569	1	2	3	4	6
606	1,358	6.3373	1	3	4	7	12
607	7,237	3.7868	1	2	3	5	7
614	1,471	7.0306	2	3	5	8	14
615	1,563	3.1567	1	2	3	4	5
616	1,103	17.0725	6	9	13	20	31
617	6,802	8.7980	3	5	7	11	15
618	262	6.3969	2	3	6	8	11
619	714	8.1625	2	3	5	9	18
620	2,235	3.6868	1	2	3	4	7
621	7,991	2.1619	1	1	2	3	4
622	1,121	13.1998	3	6	9	16	25
623	3,100	8.5719	3	4	7	10	15
624	385	6.0208	2	3	5	7	10
625	1,284	7.0826	1	2	5	9	15
626	2,573	3.1271	1	1	2	3	7
627	14,181	1.5157	1	1	1	2	2
628	3,392	11.1450	2	4	8	14	23
629	4,205	8.7087	3	5	7	11	16
630	544	5.5221	1	2	4	7	11
637	17,303	6.0618	2	3	5	7	12
638	43,111	4.2628	1	2	3	5	8
639	38,746	3.0354	1	2	2	4	5
640	61,394	5.4320	1	2	4	7	11
641	203,366	3.8212	1	2	3	5	7
642	1,504	5.1775	1	2	4	6	9
643	5,216	7.6095	2	4	6	9	14
644	11,912	5.4535	2	3	4	7	10
645	8,280	3.8907	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
652	10,308	7.7505	4	5	6	9	13
653	1,712	16.9387	7	9	13	21	31
654	3,502	9.8447	5	7	8	11	16
655	1,657	6.5244	3	5	7	8	10
656	3,958	10.1513	4	5	8	12	19
657	7,507	5.9595	3	4	5	7	10
658	8,360	3.7311	2	2	3	5	6
659	4,707	11.2044	3	5	8	14	22
660	7,668	6.5142	2	3	5	8	13
661	4,309	3.2794	1	2	3	4	6
662	955	10.2932	2	4	8	14	20
663	2,073	5.2523	1	2	4	7	11
664	4,422	2.1242	1	1	1	2	4
665	662	11.0498	3	6	9	14	21
666	2,120	6.3354	1	2	4	9	13
667	3,657	2.8679	1	1	2	3	6
668	3,871	8.5319	2	4	7	11	16
669	12,878	4.4190	1	2	3	6	9
670	11,804	2.5166	1	1	2	3	5
671	816	5.9804	1	2	4	8	12
672	950	2.5232	1	1	2	3	5
673	12,661	9.7523	1	3	7	13	21
674	11,830	7.2204	1	2	5	10	15
675	7,882	2.0669	1	1	1	2	4
682	82,890	7.1569	2	3	5	9	14
683	133,615	5.6489	2	3	5	7	10
684	45,413	3.8890	1	2	3	5	7
685	2,379	3.4582	1	1	2	4	7
686	1,612	7.5596	2	3	6	9	15
687	3,302	5.3446	2	3	4	7	10
688	1,086	3.2477	1	1	2	4	6
689	56,528	6.1996	2	3	5	8	11
690	200,099	4.2308	2	2	4	5	7
691	830	3.9506	1	2	3	5	8
692	499	2.3968	1	1	2	3	5
693	2,464	4.8373	1	2	4	6	10
694	18,275	2.5755	1	1	2	3	5
695	983	5.5107	1	3	4	7	11
696	10,671	3.2830	1	2	3	4	6
697	602	3.1063	1	1	2	4	6
698	23,565	6.6449	2	3	5	8	13
699	24,456	4.8262	1	2	4	6	9
700	12,411	3.5462	1	2	3	4	7
707	6,066	4.4052	1	2	3	5	8
708	18,317	2.1493	1	1	2	3	4
709	765	6.5660	1	2	4	8	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
710	1,850	1.7751	1	1	1	2	3
711	797	8.1292	1	3	6	10	16
712	710	3.0380	1	1	2	4	7
713	10,350	4.1905	1	2	3	5	9
714	29,172	1.9430	1	1	2	2	3
715	537	6.2439	1	2	4	8	13
716	1,282	1.4298	1	1	1	1	2
717	711	7.2293	2	3	5	9	14
718	597	2.7521	1	1	2	3	5
722	758	7.5805	2	3	6	10	14
723	1,970	5.2563	1	3	4	7	10
724	589	3.1324	1	1	2	4	6
725	769	5.4876	2	3	4	7	10
726	3,756	3.4638	1	2	3	4	6
727	1,304	6.4172	2	3	5	8	12
728	6,226	4.0379	1	2	3	5	7
729	594	5.5791	1	2	4	7	10
730	473	3.0761	1	1	2	4	6
734	1,367	7.9832	3	4	6	9	15
735	1,139	3.3582	1	2	3	4	5
736	858	13.7832	5	7	11	17	25
737	3,318	7.1823	3	4	6	8	13
738	871	3.8634	2	3	3	5	6
739	1,021	10.1704	3	5	8	12	20
740	4,368	5.2269	2	3	4	6	9
741	6,059	2.9922	1	2	3	4	5
742	11,080	4.5170	2	2	3	5	8
743	32,765	2.2617	1	2	2	3	3
744	1,527	5.8297	1	2	4	7	12
745	1,706	2.5850	1	1	2	3	5
746	2,659	4.2102	1	2	3	5	8
747	10,514	1.8844	1	1	2	2	3
748	20,075	1.7360	1	1	1	2	3
749	1,000	9.3120	2	4	7	12	19
750	439	3.1093	1	1	2	4	6
754	987	8.3171	2	4	7	11	16
755	2,964	5.6778	2	3	4	7	11
756	684	3.1228	1	1	2	4	6
757	1,404	8.1368	3	4	6	10	16
758	1,622	6.0561	2	3	5	7	11
759	1,253	4.4685	2	2	4	5	8
760	1,716	3.9610	1	2	3	5	8
761	1,777	2.4294	1	1	2	3	4
765	2,823	5.0298	2	3	4	5	7
766	2,763	3.1603	2	2	3	4	4
767	138	3.3116	2	2	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
768	6	3.5000	1	2	3	6	6
769	100	4.5500	1	2	3	5	11
770	206	2.2573	1	1	1	2	5
774	1,539	3.1780	2	2	2	3	5
775	5,884	2.2383	1	2	2	3	3
776	518	3.3282	1	2	2	4	7
777	213	2.1831	1	1	2	3	4
778	477	3.0021	1	1	2	3	5
779	116	2.1121	1	1	1	2	3
780	40	1.4500	1	1	1	1	3
781	3,070	3.7492	1	1	2	4	7
782	172	2.4942	1	1	1	2	4
790	1	25.0000	125	125	125	125	125
793	1	9.0000	9	9	9	9	9
799	572	14.1259	5	7	11	18	27
800	717	7.8466	3	4	6	9	15
801	564	4.9184	2	2	4	6	9
802	777	12.3385	3	5	9	16	25
803	1,077	6.6537	1	3	5	8	14
804	994	3.4306	1	1	3	4	7
808	6,153	8.2495	3	4	6	10	16
809	12,997	5.3239	2	3	4	7	10
810	2,812	4.0381	1	2	3	5	7
811	21,601	5.6929	1	2	4	7	11
812	90,990	3.7370	1	2	3	5	7
813	14,334	5.1703	1	2	4	6	10
814	1,580	6.7329	2	3	5	9	13
815	3,345	4.9504	1	2	4	6	9
816	2,172	3.5134	1	2	3	4	7
820	1,313	17.6740	5	8	14	22	34
821	2,504	7.8854	1	3	6	10	16
822	1,904	3.5310	1	1	3	5	7
823	2,202	15.3883	5	8	12	19	29
824	3,005	8.7331	2	4	7	11	17
825	1,771	4.3077	1	1	3	6	9
826	534	15.0581	4	7	12	19	29
827	1,269	7.9480	2	4	6	10	16
828	806	3.7903	1	2	3	5	7
829	1,178	10.6375	2	4	7	13	22
830	518	3.7297	1	1	2	4	8
834	4,058	15.5246	2	4	10	23	37
835	2,733	10.4299	2	3	6	12	28
836	1,640	5.2030	1	2	3	6	10
837	1,057	23.1249	5	10	23	31	42
838	1,333	12.2476	3	4	6	21	29
839	1,482	6.3981	3	4	5	6	10

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
840	9,758	10.4229	3	5	8	13	21
841	10,127	6.9140	2	3	5	9	13
842	5,363	4.5491	1	2	4	6	9
843	1,378	8.5348	2	4	6	11	17
844	2,440	6.0898	2	3	5	8	12
845	812	4.3608	1	2	3	6	9
846	2,133	8.4173	2	3	5	10	18
847	24,012	3.3533	1	2	3	4	6
848	1,730	3.1272	1	1	3	4	5
849	1,486	5.9764	2	3	5	6	12
853	35,145	16.6989	5	8	13	21	31
854	6,718	11.0848	4	6	9	14	20
855	470	7.0660	2	4	6	9	13
856	5,946	15.3813	4	7	12	19	29
857	9,700	8.4788	3	4	7	10	16
858	3,290	5.6729	2	3	5	7	10
862	8,020	8.1743	2	4	6	10	16
863	21,693	5.1935	2	3	4	7	9
864	19,155	4.0611	1	2	3	5	7
865	1,720	6.7209	2	3	4	8	14
866	8,252	3.5357	1	2	3	4	7
867	5,125	9.6170	2	4	7	12	19
868	2,665	5.7730	2	3	4	7	11
869	1,121	4.2926	2	2	3	5	7
870	21,358	15.4828	6	9	13	19	27
871	218,289	7.4824	2	3	6	10	14
872	91,808	5.7086	2	3	5	7	10
876	864	12.0799	2	5	9	14	24
880	9,363	3.1541	1	1	2	4	6
881	4,685	4.1836	1	2	3	5	8
882	1,582	4.4027	1	2	3	6	8
883	766	7.3668	1	2	4	8	15
884	19,202	5.4985	2	3	4	6	10
885	81,895	7.6187	2	3	6	9	14
886	408	6.0319	1	2	4	6	12
887	398	4.6131	1	2	3	5	8
894	4,401	2.9455	1	1	2	3	4
895	7,012	10.5327	3	4	6	7	9
896	5,554	6.6068	2	3	5	8	13
897	36,449	4.0573	1	2	3	5	6
901	929	15.2863	3	6	10	18	30
902	2,051	7.7699	2	3	6	9	16
903	1,513	4.5592	1	2	4	6	9
904	1,056	11.3561	2	4	7	13	23
905	817	4.6756	1	2	4	6	8
906	722	3.1953	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
907	8,577	11.6471	2	5	8	14	23
908	8,426	6.7581	2	3	5	8	13
909	5,513	3.6390	1	2	3	5	7
913	819	5.6545	1	3	4	7	11
914	6,705	3.4209	1	2	3	4	6
915	1,090	4.7174	1	2	3	6	9
916	5,559	2.1045	1	1	2	3	4
917	16,005	5.1629	1	2	4	6	11
918	36,129	2.7231	1	1	2	3	5
919	11,200	6.3668	2	3	5	8	13
920	14,131	4.3565	1	2	3	5	8
921	9,518	2.9692	1	1	2	4	6
922	1,067	5.9700	1	2	4	7	12
923	4,001	3.2254	1	1	2	4	6
927	212	31.0849	7	15	26	41	60
928	826	15.8765	4	7	12	20	30
929	439	7.6765	1	3	6	10	16
933	141	4.3830	1	1	1	5	8
934	661	6.1589	1	3	5	8	12
935	2,217	5.4285	1	2	4	6	11
939	680	10.0809	2	4	7	13	20
940	1,338	5.4215	1	2	4	7	12
941	1,734	2.7341	1	1	2	3	5
945	6,320	10.5066	4	6	8	12	15
946	3,087	7.8630	3	5	6	7	8
947	9,816	5.0145	1	2	4	6	10
948	48,248	3.4823	1	2	3	4	6
949	650	4.1015	1	1	2	4	6
950	395	3.5063	1	1	2	4	5
951	962	4.7973	1	1	2	3	6
955	455	12.2813	2	5	10	16	26
956	4,076	9.3202	4	5	7	11	17
957	1,383	14.7426	2	7	12	19	27
958	1,208	10.3377	3	5	8	13	19
959	297	6.3333	2	3	5	8	11
963	1,630	9.5521	1	4	8	13	19
964	2,686	6.2375	2	3	5	8	11
965	1,098	4.1621	1	2	4	5	7
969	643	18.8523	4	8	14	22	37
970	137	10.3358	2	3	7	12	20
974	5,981	10.3986	2	4	8	13	21
975	4,703	7.0134	2	3	5	9	13
976	2,635	4.9321	2	2	4	6	8
977	4,599	5.2768	1	2	4	6	10
981	25,685	15.1767	5	8	12	19	28
982	18,502	9.7442	3	5	8	12	18

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
983	6,149	5.3749	1	2	4	7	11
984	678	14.6637	5	8	13	18	25
985	915	9.6153	2	5	8	13	18
986	736	5.3166	1	2	3	7	12
987	8,318	13.0244	4	6	10	16	24
988	11,726	7.8083	2	3	6	10	15
989	5,878	4.0876	1	1	3	6	9
	11,507,824						

TABLE 7B.-MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY; FY 2007 MedPAR UPDATE-MARCH 2008 GROUPER V26.0 MS-DRGS

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	667	41.1229	12	17	31	52	85
2	295	25.2949	9	12	17	29	48
3	23,496	39.7880	16	22	32	48	69
4	21,510	28.8763	11	17	24	35	49
5	650	21.4969	7	10	15	26	43
6	233	10.5279	5	7	9	12	18
7	364	19.5797	8	10	15	22	39
8	499	11.9599	6	7	9	13	20
9	1,370	22.0350	8	16	20	25	35
10	168	10.7500	6	7	8	11	18
11	1,274	16.7190	6	9	13	20	30
12	1,926	10.6713	4	6	9	13	18
13	1,281	6.9110	3	4	6	8	11
20	899	18.3359	6	10	17	24	32
21	533	15.4597	8	11	14	19	25
22	215	9.3488	2	6	9	12	15
23	3,769	12.6758	2	5	10	17	25
24	2,107	9.0052	1	4	8	12	18
25	8,789	13.0238	4	6	10	17	25
26	11,873	8.2142	2	4	7	11	15
27	13,814	4.5398	1	2	4	6	9
28	1,682	14.3210	4	7	11	18	27
29	3,095	7.1170	1	3	6	9	14
30	3,436	3.7331	1	1	3	5	7
31	1,034	13.1228	3	6	10	18	26
32	2,811	5.9964	1	2	4	8	14
33	3,663	3.0410	1	1	2	4	6
34	770	7.2818	1	2	5	9	15
35	2,267	3.2823	1	1	2	4	8
36	7,048	1.5979	1	1	1	2	3
37	4,888	8.5978	2	3	7	11	17
38	14,279	3.7624	1	1	2	5	9
39	52,432	1.8276	1	1	1	2	3
40	4,808	13.3473	3	6	10	17	25
41	7,658	7.1940	1	3	6	9	13
42	4,907	3.6395	1	1	3	5	8
52	1,177	6.6882	2	3	5	8	14
53	588	4.0153	1	2	3	5	7
54	5,290	6.9480	2	3	5	9	14

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
55	16,470	5.0753	1	2	4	6	10
56	8,324	7.7639	2	3	6	9	14
57	47,629	4.9758	2	3	4	6	9
58	748	7.6791	2	4	6	9	15
59	2,788	5.1402	2	3	4	6	9
60	4,139	3.9618	2	2	4	5	7
61	1,600	8.9275	2	4	7	11	17
62	2,488	6.2649	3	4	5	8	11
63	1,345	4.5033	2	3	4	6	8
64	56,285	7.4572	2	3	6	10	15
65	106,112	5.2119	2	3	4	6	9
66	90,347	3.7110	1	2	3	5	7
67	1,412	5.7932	2	3	5	7	11
68	11,503	3.4478	1	2	3	4	6
69	102,863	2.9891	1	2	2	4	5
70	7,406	7.8705	2	4	6	10	15
71	9,609	5.5589	2	3	4	7	10
72	5,802	3.5400	1	2	3	4	7
73	9,320	6.2359	2	3	5	8	12
74	31,850	4.3022	1	2	3	5	8
75	1,258	7.2917	2	4	6	9	14
76	886	4.1400	2	2	4	5	7
77	1,224	6.6928	2	3	5	9	12
78	1,417	4.4192	2	2	4	6	8
79	941	3.3783	1	2	3	4	6
80	1,890	5.0979	1	2	4	6	10
81	7,219	3.5222	1	2	3	4	6
82	1,774	6.4183	1	1	4	9	15
83	2,094	4.9470	1	2	4	7	10
84	2,805	3.1241	1	1	2	4	6
85	5,944	7.6272	2	3	6	10	15
86	11,601	4.9960	1	3	4	6	9
87	13,123	3.2705	1	2	3	4	6
88	726	5.8567	1	3	4	7	12
89	2,789	3.7469	1	2	3	5	7
90	3,157	2.5353	1	1	2	3	5
91	7,691	6.3937	2	3	5	8	13
92	16,439	4.4581	1	2	4	6	8
93	16,294	3.2183	1	2	3	4	6
94	1,483	11.8307	3	6	10	15	22
95	1,045	8.6220	3	5	7	11	15
96	764	6.1675	2	4	6	8	11
97	1,201	12.5737	4	6	11	16	23
98	1,014	8.3097	3	5	7	10	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
99	660	5.8803	2	3	5	8	11
100	17,146	6.3498	2	3	5	8	12
101	57,599	3.6937	1	2	3	5	7
102	1,099	4.5177	1	2	3	6	9
103	13,907	3.1251	1	2	2	4	6
113	535	5.6355	1	2	4	8	12
114	557	2.6104	1	1	2	3	5
115	1,052	4.3327	1	2	4	5	8
116	548	4.0858	1	1	2	5	8
117	1,003	2.1575	1	1	1	2	3
121	543	5.4530	2	3	4	7	10
122	629	4.0270	2	2	3	5	7
123	2,811	2.8780	1	2	2	4	5
124	759	5.2885	1	2	4	7	10
125	4,708	3.5098	1	2	3	4	7
129	1,368	5.1813	1	2	4	6	11
130	1,089	2.9339	1	1	2	4	6
131	946	5.7611	1	2	4	8	12
132	901	2.6349	1	1	2	3	5
133	2,009	5.3449	1	2	4	7	11
134	3,406	2.2278	1	1	1	3	4
135	352	5.8636	1	2	4	8	12
136	475	2.3284	1	1	1	3	5
137	784	5.4056	1	2	4	7	11
138	895	2.5263	1	1	2	3	5
139	1,505	1.8425	1	1	1	2	3
146	680	9.3956	2	4	7	12	19
147	1,381	6.1224	1	2	4	8	12
148	865	3.7965	1	1	3	5	8
149	39,192	2.7195	1	1	2	3	5
150	957	5.1933	1	2	4	6	10
151	6,889	2.8924	1	1	2	4	5
152	1,742	4.4524	1	2	3	5	8
153	11,559	3.2127	1	2	3	4	6
154	1,916	6.3215	2	3	5	8	12
155	4,501	4.4095	1	2	4	6	8
156	4,882	3.1678	1	2	3	4	6
157	1,054	6.6347	1	3	5	8	14
158	3,268	4.5095	1	2	3	6	8
159	2,396	3.0447	1	1	2	4	6
163	13,765	14.9630	5	8	13	19	27
164	18,051	8.0983	3	5	7	10	15
165	13,933	5.1372	2	3	5	6	9
166	20,740	12.9311	4	7	10	16	24

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
167	20,704	7.9720	2	4	7	10	15
168	5,535	5.2370	1	2	4	7	10
175	12,807	7.2571	3	4	6	9	12
176	41,832	5.3202	2	3	5	7	9
177	64,269	9.0967	3	5	7	12	17
178	71,474	7.3743	3	4	6	9	13
179	26,331	5.5598	2	3	5	7	10
180	22,607	7.8953	2	4	6	10	15
181	30,602	5.9032	2	3	5	8	11
182	5,500	4.1735	1	2	3	5	8
183	1,891	7.2099	2	4	6	9	13
184	4,449	4.5817	2	3	4	6	8
185	2,572	3.4075	1	2	3	4	6
186	9,326	7.4036	2	4	6	9	14
187	10,130	5.3104	2	3	4	7	10
188	5,081	3.9904	1	2	3	5	8
189	114,036	6.1447	2	3	5	8	11
190	59,382	6.2913	2	3	5	8	12
191	119,274	5.0130	2	3	4	6	9
192	186,696	3.9669	1	2	3	5	7
193	88,184	6.7468	2	4	6	8	12
194	256,478	5.2622	2	3	4	7	9
195	134,728	4.0748	2	2	4	5	7
196	5,438	7.3453	3	4	6	9	14
197	6,856	5.3861	2	3	4	7	10
198	4,663	4.0757	1	2	3	5	7
199	3,246	8.2939	2	4	7	11	16
200	8,512	5.0759	1	2	4	7	10
201	3,513	4.0544	1	2	3	5	8
202	29,565	4.3478	1	2	4	5	8
203	37,298	3.3813	1	2	3	4	6
204	25,941	2.8749	1	1	2	4	5
205	5,920	5.4914	1	2	4	7	10
206	21,793	3.4403	1	2	3	4	6
207	39,917	15.0888	6	9	13	18	25
208	77,306	7.2193	1	3	6	10	14
215	142	14.0352	1	3	9	17	31
216	8,698	18.3819	8	11	16	23	31
217	7,294	12.3024	6	8	11	15	20
218	2,580	9.0492	5	6	8	11	14
219	10,616	13.9813	6	8	11	17	26
220	14,041	8.5532	5	6	7	10	14
221	7,103	6.4428	4	5	6	7	10
222	2,796	13.0715	5	7	11	17	23

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
223	5,141	6.2622	1	3	5	8	12
224	1,926	11.3764	4	6	9	14	21
225	5,117	5.6383	2	3	5	7	10
226	7,114	9.3306	1	4	7	12	19
227	43,110	2.8241	1	1	1	3	7
228	3,005	14.6869	6	8	13	18	26
229	3,623	9.1187	4	6	8	11	15
230	1,575	6.4857	3	4	6	8	11
231	1,463	13.3978	6	8	11	17	24
232	1,537	9.1640	5	7	8	11	14
233	16,445	14.1714	7	9	12	17	24
234	34,720	8.9220	5	6	8	11	13
235	9,726	11.2128	5	7	9	14	20
236	30,361	6.6117	4	5	6	8	10
237	22,608	10.8142	2	5	9	14	21
238	42,648	4.6409	1	2	3	6	9
239	13,430	15.4131	5	8	12	19	29
240	11,760	10.3705	3	5	8	13	19
241	2,707	6.7680	3	4	6	8	12
242	17,674	8.7783	3	4	7	11	17
243	36,409	5.0893	1	2	4	7	10
244	63,279	2.9286	1	1	2	4	6
245	3,956	3.2293	1	1	2	4	7
246	29,091	5.3367	1	2	4	7	12
247	190,632	2.1679	1	1	1	3	4
248	13,973	5.9788	1	2	4	8	12
249	70,653	2.4968	1	1	2	3	5
250	6,813	7.7813	1	3	6	10	16
251	41,998	2.8338	1	1	2	4	6
252	45,935	8.5506	1	3	6	11	18
253	45,268	6.0103	1	2	5	8	13
254	53,888	2.7300	1	1	2	3	6
255	2,551	9.6974	2	4	8	12	18
256	3,457	7.4689	2	4	6	9	13
257	713	4.8710	1	2	4	7	10
258	696	7.3736	2	3	6	9	14
259	7,331	2.8029	1	1	2	4	6
260	1,561	11.2108	3	5	8	14	22
261	3,539	4.2150	1	1	3	6	9
262	3,551	2.5917	1	1	2	3	6
263	660	5.4091	1	1	3	7	13
264	28,464	8.9145	1	3	6	11	19
265	1,983	3.4639	1	1	2	4	8
280	64,213	7.3352	2	4	6	9	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
281	54,312	4.8000	2	3	4	6	9
282	55,014	3.2424	1	2	3	4	6
283	15,044	5.4388	1	1	3	7	13
284	4,176	3.2282	1	1	2	4	7
285	2,827	2.2066	1	1	1	3	5
286	23,897	6.9303	2	3	5	9	14
287	159,664	3.1467	1	1	2	4	6
288	2,983	11.7580	4	6	9	14	22
289	1,368	8.6506	3	5	7	11	15
290	481	6.5031	2	4	5	8	11
291	189,242	6.4890	2	3	5	8	12
292	206,400	4.9888	2	3	4	6	9
293	198,496	3.6783	1	2	3	5	6
294	1,428	5.5497	2	3	5	7	9
295	1,357	4.3324	2	3	4	6	7
296	1,943	3.0458	1	1	1	3	7
297	804	1.8035	1	1	1	2	3
298	609	1.3038	1	1	1	1	2
299	17,914	6.6566	2	3	5	8	12
300	44,997	5.0464	2	3	4	6	9
301	37,382	3.6948	1	2	3	5	7
302	7,658	4.3648	1	2	3	5	8
303	71,268	2.5293	1	1	2	3	5
304	2,105	5.1948	1	2	4	7	10
305	35,439	2.8618	1	1	2	4	5
306	1,522	6.2937	1	3	4	8	12
307	6,392	3.4529	1	2	3	4	6
308	36,062	5.5380	1	2	4	7	11
309	80,081	3.9355	1	2	3	5	7
310	160,285	2.7519	1	1	2	3	5
311	21,336	2.3079	1	1	2	3	4
312	167,491	3.1027	1	2	2	4	6
313	213,918	2.1055	1	1	2	3	4
314	62,195	7.0212	2	3	5	9	14
315	30,276	4.6006	1	2	4	6	9
316	18,186	2.9979	1	1	2	4	6
326	11,360	17.1236	5	9	14	21	32
327	10,572	10.0485	3	5	8	13	18
328	8,946	4.3592	1	2	3	6	9
329	48,640	15.9673	6	8	13	20	29
330	64,351	9.7075	4	6	8	12	17
331	28,579	5.8754	3	4	5	7	9
332	1,840	14.3462	6	8	12	18	25
333	5,987	8.8315	4	6	8	10	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
334	3,771	5.4951	2	4	5	7	9
335	7,266	14.0798	5	8	12	18	25
336	12,593	9.0903	3	5	8	11	16
337	8,675	5.5847	1	3	5	8	10
338	1,525	10.7266	4	6	9	13	19
339	3,197	7.0335	3	4	6	9	12
340	3,621	4.1527	2	2	4	5	7
341	891	7.1425	2	3	5	9	14
342	2,574	4.1340	1	2	3	5	8
343	7,104	2.1764	1	1	2	3	4
344	944	11.7172	4	6	9	15	22
345	2,955	7.2234	3	4	6	9	12
346	2,780	4.9432	2	3	5	6	8
347	1,643	8.8576	2	4	7	11	17
348	4,206	5.7401	2	3	5	7	11
349	5,208	3.0837	1	1	2	4	6
350	1,775	8.0045	2	3	6	10	16
351	4,330	4.5448	1	2	4	6	9
352	8,247	2.4813	1	1	2	3	5
353	3,200	8.3966	2	4	7	11	16
354	8,508	5.0803	2	3	4	6	9
355	15,471	2.8964	1	1	2	4	5
356	8,416	12.9209	3	6	10	16	25
357	7,878	8.1381	2	4	6	10	16
358	2,502	4.4700	1	2	4	6	9
368	3,608	6.6050	2	3	5	8	13
369	5,313	4.7516	2	3	4	6	9
370	3,577	3.3947	1	2	3	4	6
371	24,596	8.7500	3	4	7	11	17
372	27,326	6.8493	3	4	6	8	12
373	15,414	4.9350	2	3	4	6	8
374	9,156	8.5649	2	4	7	11	16
375	19,138	6.0246	2	3	5	8	12
376	4,320	4.1773	1	2	3	5	8
377	52,046	6.3770	2	3	5	8	12
378	111,447	4.4438	2	3	4	5	8
379	93,177	3.4057	1	2	3	4	6
380	3,049	7.2686	2	3	6	9	14
381	5,350	5.1660	2	3	4	6	9
382	4,532	3.6796	1	2	3	5	7
383	1,240	5.5024	2	3	4	7	10
384	8,179	3.7512	1	2	3	5	7
385	2,018	8.8038	3	4	6	11	18
386	7,197	5.6931	2	3	5	7	10

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
387	5,106	4.2934	1	2	4	5	8
388	18,713	7.3104	2	3	6	9	14
389	46,322	5.0120	2	3	4	6	9
390	46,998	3.5489	1	2	3	4	6
391	44,733	5.2391	1	2	4	6	10
392	284,997	3.4879	1	2	3	4	6
393	23,469	6.9064	2	3	5	8	14
394	46,313	4.8190	1	2	4	6	9
395	25,059	3.3330	1	2	3	4	6
405	3,996	16.9980	5	8	13	21	34
406	5,347	9.1386	2	5	7	11	17
407	2,132	5.4972	1	3	5	7	10
408	1,562	15.0583	6	8	12	18	28
409	1,749	9.8102	4	6	8	12	18
410	606	6.5215	2	4	6	8	11
411	961	12.3902	5	7	10	15	22
412	968	8.5702	4	6	8	11	14
413	763	5.9397	2	4	5	7	10
414	5,310	11.7320	5	7	10	14	21
415	6,209	7.6151	3	5	7	9	13
416	5,408	4.8327	2	3	4	6	8
417	16,620	8.3629	3	4	7	10	16
418	27,422	5.6310	2	3	5	7	10
419	36,311	3.1919	1	1	3	4	6
420	775	13.7535	3	6	11	17	26
421	1,060	7.6943	2	3	6	10	16
422	332	4.3464	1	2	4	6	8
423	1,548	15.9968	4	7	12	20	32
424	900	10.3978	3	5	8	14	20
425	126	5.4048	1	2	4	7	10
432	15,319	6.9599	2	3	5	9	14
433	9,804	4.8674	1	2	4	6	9
434	893	3.6719	1	2	3	4	6
435	12,239	7.5545	2	3	6	10	15
436	13,311	5.8342	2	3	5	8	11
437	3,933	4.2400	1	2	3	6	8
438	14,205	7.5159	2	3	5	9	15
439	24,645	5.3255	2	3	4	7	10
440	26,017	3.8060	1	2	3	5	7
441	13,470	7.0545	2	3	5	9	14
442	14,337	5.1004	2	2	4	6	9
443	6,635	3.7861	1	2	3	5	7
444	13,040	6.6106	2	3	5	8	13
445	16,953	4.7225	1	2	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
446	16,131	3.2615	1	2	3	4	6
453	951	15.6120	5	7	12	19	29
454	1,794	8.0334	3	4	6	10	15
455	1,999	4.4492	1	3	4	5	7
456	951	14.6866	5	7	11	18	28
457	2,436	7.4992	3	4	6	9	13
458	1,622	4.5493	2	3	4	6	7
459	3,551	9.4534	4	5	7	11	17
460	52,521	4.2154	2	3	4	5	7
461	1,030	8.4291	3	5	6	9	14
462	13,350	4.2187	3	3	4	5	6
463	5,081	16.6209	5	7	12	20	33
464	5,890	10.2224	3	5	8	12	20
465	2,426	5.8483	1	3	5	7	11
466	4,119	9.1680	3	5	7	11	16
467	14,455	5.4890	3	3	4	6	9
468	21,371	3.9269	2	3	3	4	6
469	30,883	8.1918	3	5	7	10	14
470	410,139	3.9258	3	3	3	4	6
471	2,320	9.8211	2	4	8	13	20
472	7,040	4.0892	1	1	3	5	9
473	23,193	1.9619	1	1	1	2	4
474	2,954	12.6435	4	6	10	15	24
475	3,314	8.3911	3	4	7	11	15
476	1,607	4.7828	1	2	4	6	9
477	2,610	11.9226	3	6	10	15	22
478	8,642	6.6024	1	3	6	9	13
479	11,541	2.8153	1	1	1	4	7
480	27,022	9.2834	4	5	8	11	16
481	72,869	5.9257	3	4	5	7	9
482	48,751	4.8402	3	4	4	6	7
483	7,158	4.2076	2	2	3	5	8
484	18,036	2.4278	1	2	2	3	4
485	1,195	12.1013	4	6	10	15	22
486	2,210	8.0235	3	5	7	10	14
487	1,324	5.6722	3	3	5	7	9
488	2,527	5.2228	2	3	4	6	10
489	5,842	3.0464	1	2	3	4	5
490	23,186	4.3443	1	1	3	5	9
491	53,010	2.2085	1	1	2	3	4
492	5,301	8.5191	3	4	7	11	15
493	17,134	5.2611	2	3	4	6	9
494	29,598	3.3963	1	2	3	4	6
495	1,990	10.9447	3	5	8	14	21

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
496	5,618	5.9676	2	3	5	7	11
497	6,732	2.9975	1	1	2	4	6
498	1,172	7.8933	2	3	6	10	16
499	1,123	2.9813	1	1	2	4	6
500	1,524	10.8182	3	5	8	14	21
501	3,924	5.9592	2	3	5	8	12
502	6,519	2.9383	1	1	2	4	6
503	847	9.4061	3	5	7	11	17
504	2,188	6.4269	2	3	6	8	12
505	3,035	3.3806	1	2	3	4	6
506	820	3.4000	1	1	2	4	7
507	846	5.1430	1	2	4	6	10
508	2,522	2.0484	1	1	1	2	3
509	635	3.0945	1	1	2	3	7
510	988	6.4180	2	3	5	8	12
511	3,988	3.9714	1	2	3	5	7
512	11,121	2.1596	1	1	2	3	4
513	1,070	5.0720	1	2	4	6	10
514	1,022	2.8112	1	1	2	3	6
515	3,864	10.4547	3	5	8	13	20
516	11,399	5.9845	1	3	5	8	11
517	17,688	3.0034	1	1	2	4	7
533	828	6.6836	2	3	5	8	12
534	3,424	4.0239	1	2	3	5	7
535	7,079	6.2393	2	3	5	8	12
536	34,043	3.9314	1	3	3	5	7
537	675	4.4785	2	3	4	5	8
538	1,064	3.2180	1	2	3	4	6
539	3,462	9.7764	3	5	8	12	17
540	4,058	7.1158	3	4	6	8	13
541	1,632	5.3419	2	3	4	6	9
542	5,770	8.7735	3	4	7	11	17
543	17,148	5.9356	2	3	5	7	11
544	10,891	4.4013	2	3	4	5	8
545	4,128	9.0821	2	4	6	11	19
546	5,626	5.5352	2	3	4	7	10
547	4,573	3.8084	1	2	3	5	7
548	589	8.9321	3	4	7	11	17
549	1,123	6.3785	2	3	5	8	12
550	864	4.4595	2	2	4	6	8
551	10,157	7.1030	2	3	6	9	14
552	86,021	4.1210	1	2	3	5	7
553	3,111	5.9817	2	3	5	7	11
554	19,344	3.6910	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
555	2,037	4.8468	1	2	4	6	9
556	18,820	3.1073	1	2	3	4	6
557	3,687	6.6035	2	3	5	8	12
558	15,241	4.2552	2	2	4	5	7
559	1,827	7.5189	2	3	6	9	15
560	4,361	4.7310	1	2	4	6	9
561	7,182	2.7680	1	1	2	3	5
562	5,516	6.3657	2	3	5	8	12
563	36,692	3.6982	1	2	3	4	6
564	1,687	7.0036	2	3	5	9	13
565	3,352	4.9806	2	3	4	6	9
566	2,652	3.6731	1	2	3	5	7
573	5,525	13.1781	4	6	9	16	26
574	11,209	9.3733	3	5	7	11	17
575	5,500	5.8496	2	3	5	7	11
576	555	12.9297	2	4	9	17	28
577	2,248	6.0974	1	2	4	8	13
578	3,097	3.3100	1	1	2	4	7
579	3,538	10.7024	3	5	8	14	21
580	10,839	5.5148	1	2	4	7	12
581	12,293	2.6107	1	1	2	3	6
582	5,389	2.8905	1	1	2	3	5
583	8,857	1.8041	1	1	1	2	3
584	677	6.0192	1	2	4	8	13
585	1,488	2.2406	1	1	1	2	4
592	4,221	8.8936	3	4	7	10	16
593	12,429	6.4515	2	3	5	8	11
594	2,785	5.0553	2	3	4	6	9
595	1,119	8.3467	2	4	6	10	16
596	5,360	4.7453	1	2	4	6	8
597	458	8.2140	2	3	6	10	16
598	1,414	5.7136	2	3	4	7	11
599	308	3.7143	1	1	3	4	6
600	691	5.0535	2	3	4	7	9
601	893	3.8611	1	2	3	5	7
602	22,323	7.0250	2	4	6	9	13
603	131,727	4.7027	2	3	4	6	8
604	2,689	5.6620	1	3	4	7	11
605	22,427	3.4569	1	2	3	4	6
606	1,358	6.3373	1	3	4	7	12
607	7,237	3.7868	1	2	3	5	7
614	1,471	7.0306	2	3	5	8	14
615	1,563	3.1567	1	2	3	4	5
616	1,103	17.0725	6	9	13	20	31

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
617	6,802	8.7980	3	5	7	11	15
618	262	6.3969	2	3	6	8	11
619	714	8.1625	2	3	5	9	18
620	2,235	3.6868	1	2	3	4	7
621	7,991	2.1619	1	1	2	3	4
622	1,121	13.1998	3	6	9	16	25
623	3,100	8.5719	3	4	7	10	15
624	385	6.0208	2	3	5	7	10
625	1,284	7.0826	1	2	5	9	15
626	2,573	3.1271	1	1	2	3	7
627	14,181	1.5157	1	1	1	2	2
628	3,392	11.1450	2	4	8	14	23
629	4,205	8.7087	3	5	7	11	16
630	544	5.5221	1	2	4	7	11
637	17,303	6.0618	2	3	5	7	12
638	43,111	4.2628	1	2	3	5	8
639	38,746	3.0354	1	2	2	4	5
640	61,394	5.4320	1	2	4	7	11
641	203,366	3.8212	1	2	3	5	7
642	1,504	5.1775	1	2	4	6	9
643	5,216	7.6095	2	4	6	9	14
644	11,912	5.4535	2	3	4	7	10
645	8,280	3.8907	1	2	3	5	7
652	10,308	7.7505	4	5	6	9	13
653	1,712	16.9387	7	9	13	21	31
654	3,502	9.8447	5	7	8	11	16
655	1,657	6.5244	3	5	7	8	10
656	3,958	10.1513	4	5	8	12	19
657	7,507	5.9595	3	4	5	7	10
658	8,360	3.7311	2	2	3	5	6
659	4,707	11.2044	3	5	8	14	22
660	7,668	6.5142	2	3	5	8	13
661	4,309	3.2794	1	2	3	4	6
662	955	10.2932	2	4	8	14	20
663	2,073	5.2523	1	2	4	7	11
664	4,422	2.1242	1	1	1	2	4
665	662	11.0498	3	6	9	14	21
666	2,120	6.3354	1	2	4	9	13
667	3,657	2.8679	1	1	2	3	6
668	3,871	8.5319	2	4	7	11	16
669	12,878	4.4190	1	2	3	6	9
670	11,804	2.5166	1	1	2	3	5
671	816	5.9804	1	2	4	8	12
672	950	2.5232	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
673	12,661	9.7523	1	3	7	13	21
674	11,830	7.2204	1	2	5	10	15
675	7,882	2.0669	1	1	1	2	4
682	82,890	7.1569	2	3	5	9	14
683	133,615	5.6489	2	3	5	7	10
684	45,413	3.8890	1	2	3	5	7
685	2,379	3.4582	1	1	2	4	7
686	1,612	7.5596	2	3	6	9	15
687	3,302	5.3446	2	3	4	7	10
688	1,086	3.2477	1	1	2	4	6
689	56,528	6.1996	2	3	5	8	11
690	200,099	4.2308	2	2	4	5	7
691	830	3.9506	1	2	3	5	8
692	499	2.3968	1	1	2	3	5
693	2,464	4.8373	1	2	4	6	10
694	18,275	2.5755	1	1	2	3	5
695	983	5.5107	1	3	4	7	11
696	10,671	3.2830	1	2	3	4	6
697	602	3.1063	1	1	2	4	6
698	23,565	6.6449	2	3	5	8	13
699	24,456	4.8262	1	2	4	6	9
700	12,411	3.5462	1	2	3	4	7
707	6,066	4.4052	1	2	3	5	8
708	18,317	2.1493	1	1	2	3	4
709	765	6.5660	1	2	4	8	15
710	1,850	1.7751	1	1	1	2	3
711	797	8.1292	1	3	6	10	16
712	710	3.0380	1	1	2	4	7
713	10,350	4.1905	1	2	3	5	9
714	29,172	1.9430	1	1	2	2	3
715	537	6.2439	1	2	4	8	13
716	1,282	1.4298	1	1	1	1	2
717	711	7.2293	2	3	5	9	14
718	597	2.7521	1	1	2	3	5
722	758	7.5805	2	3	6	10	14
723	1,970	5.2563	1	3	4	7	10
724	589	3.1324	1	1	2	4	6
725	769	5.4876	2	3	4	7	10
726	3,756	3.4638	1	2	3	4	6
727	1,304	6.4172	2	3	5	8	12
728	6,226	4.0379	1	2	3	5	7
729	594	5.5791	1	2	4	7	10
730	473	3 0761	1	1	2	4	6
734	1,367	7.9832	3	4	6	9	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
735	1,139	3.3582	1	2	3	4	5
736	858	13.7832	5	7	11	17	25
737	3,318	7.1823	3	4	6	8	13
738	871	3.8634	2	3	3	5	6
739	1,021	10.1704	3	5	8	12	20
740	4,368	5.2269	2	3	4	6	9
741	6,059	2.9922	1	2	3	4	5
742	11,080	4.5170	2	2	3	5	8
743	32,765	2.2617	1	2	2	3	3
744	1,527	5.8297	1	2	4	7	12
745	1,706	2.5850	1	1	2	3	5
746	2,659	4.2102	1	2	3	5	8
747	10,514	1.8844	1	1	2	2	3
748	20,075	1.7360	1	1	1	2	3
749	1,000	9.3120	2	4	7	12	19
750	439	3.1093	1	1	2	4	6
754	987	8.3171	2	4	7	11	16
755	2,964	5.6778	2	3	4	7	11
756	684	3.1228	1	1	2	4	6
757	1,404	8.1368	3	4	6	10	16
758	1,622	6.0561	2	3	5	7	11
759	1,253	4.4685	2	2	4	5	8
760	1,716	3.9610	1	2	3	5	8
761	1,777	2.4294	1	1	2	3	4
765	2,823	5.0298	2	3	4	5	7
766	2,763	3.1603	2	2	3	4	4
767	138	3.3116	2	2	2	3	5
768	6	3.5000	1	2	3	6	6
769	100	4.5500	1	2	3	5	11
770	206	2.2573	1	1	1	2	5
774	1,539	3.1780	2	2	2	3	5
775	5,884	2.2383	1	2	2	3	3
776	518	3.3282	1	2	2	4	7
777	213	2.1831	1	1	2	3	4
778	477	3.0021	1	1	2	3	5
779	116	2.1121	1	1	1	2	3
780	40	1.4500	1	1	1	1	3
781	3,070	3.7492	1	1	2	4	7
782	172	2.4942	1	1	1	2	4
790	1	25.0000	125	125	125	125	125
793	1	9.0000	9	9	9	9	9
799	572	14.1259	5	7	11	18	27
800	717	7.8466	3	4	6	9	15
801	564	4.9184	2	2	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
802	777	12.3385	3	5	9	16	25
803	1,077	6.6537	1	3	5	8	14
804	994	3.4306	1	1	3	4	7
808	6,153	8.2495	3	4	6	10	16
809	12,997	5.3239	2	3	4	7	10
810	2,812	4.0381	1	2	3	5	7
811	21,601	5.6929	1	2	4	7	11
812	90,990	3.7370	1	2	3	5	7
813	14,334	5.1703	1	2	4	6	10
814	1,580	6.7329	2	3	5	9	13
815	3,345	4.9504	1	2	4	6	9
816	2,172	3.5134	1	2	3	4	7
820	1,313	17.6740	5	8	14	22	34
821	2,504	7.8854	1	3	6	10	16
822	1,904	3.5310	1	1	3	5	7
823	2,202	15.3883	5	8	12	19	29
824	3,005	8.7331	2	4	7	11	17
825	1,771	4.3077	1	1	3	6	9
826	534	15.0581	4	7	12	19	29
827	1,269	7.9480	2	4	6	10	16
828	806	3.7903	1	2	3	5	7
829	1,178	10.6375	2	4	7	13	22
830	518	3.7297	1	1	2	4	8
834	4,058	15.5246	2	4	10	23	37
835	2,733	10.4299	2	3	6	12	28
836	1,640	5.2030	1	2	3	6	10
837	1,057	23.1249	5	10	23	31	42
838	1,333	12.2476	3	4	6	21	29
839	1,482	6.3981	3	4	5	6	10
840	9,758	10.4229	3	5	8	13	21
841	10,127	6.9140	2	3	5	9	13
842	5,363	4.5491	1	2	4	6	9
843	1,378	8.5348	2	4	6	11	17
844	2,440	6.0898	2	3	5	8	12
845	812	4.3608	1	2	3	6	9
846	2,133	8.4173	2	3	5	10	18
847	24,012	3.3533	1	2	3	4	6
848	1,730	3.1272	1	1	3	4	5
849	1,486	5.9764	2	3	5	6	12
853	35,145	16.6989	5	8	13	21	31
854	6,718	11.0848	4	6	9	14	20
855	470	7.0660	2	4	6	9	13
856	5,946	15.3813	4	7	12	19	29
857	9,700	8.4788	3	4	7	10	16

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
858	3,290	5.6729	2	3	5	7	10
862	8,020	8.1743	2	4	6	10	16
863	21,693	5.1935	2	3	4	7	9
864	19,155	4.0611	1	2	3	5	7
865	1,720	6.7209	2	3	4	8	14
866	8,252	3.5357	1	2	3	4	7
867	5,125	9.6170	2	4	7	12	19
868	2,665	5.7730	2	3	4	7	11
869	1,121	4.2926	2	2	3	5	7
870	21,358	15.4828	6	9	13	19	27
871	218,289	7.4824	2	3	6	10	14
872	91,808	5.7086	2	3	5	7	10
876	864	12.0799	2	5	9	14	24
880	9,363	3.1541	1	1	2	4	6
881	4,685	4.1836	1	2	3	5	8
882	1,582	4.4027	1	2	3	6	8
883	766	7.3668	1	2	4	8	15
884	19,202	5.4985	2	3	4	6	10
885	81,895	7.6187	2	3	6	9	14
886	408	6.0319	1	2	4	6	12
887	398	4.6131	1	2	3	5	8
894	4,401	2.9455	1	1	2	3	4
895	7,012	10.5327	3	4	6	7	9
896	5,554	6.6068	2	3	5	8	13
897	36,449	4.0573	1	2	3	5	6
901	929	15.2863	3	6	10	18	30
902	2,051	7.7699	2	3	6	9	16
903	1,513	4.5592	1	2	4	6	9
904	1,055	11.3621	2	4	7	13	23
905	817	4.6756	1	2	4	6	8
906	720	3.1750	1	1	2	4	6
907	8,576	11.6483	2	5	8	14	23
908	8,426	6.7581	2	3	5	8	13
909	5,512	3.6388	1	2	3	5	7
913	819	5.6545	1	3	4	7	11
914	6,705	3.4209	1	2	3	4	6
915	1,090	4.7174	1	2	3	6	9
916	5,559	2.1045	1	1	2	3	4
917	16,005	5.1629	1	2	4	6	11
918	36,129	2 7231	1	1	2	3	5
919	11,200	6.3668	2	3	5	8	13
920	14,131	4.3565	1	2	3	5	8
921	9,518	2.9692	1	1	2	4	6
922	1,067	5.9700	1	2	4	7	12

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
923	4,001	3.2254	1	1	2	4	6
927	212	31.0849	7	15	26	41	60
928	826	15.8765	4	7	12	20	30
929	439	7.6765	1	3	6	10	16
933	141	4.3830	1	1	1	5	8
934	661	6.1589	1	3	5	8	12
935	2,217	5.4285	1	2	4	6	11
939	680	10.0809	2	4	7	13	20
940	1,338	5.4215	1	2	4	7	12
941	1,734	2.7341	1	1	2	3	5
945	6,320	10.5066	4	6	8	12	15
946	3,087	7.8630	3	5	6	7	8
947	9,816	5.0145	1	2	4	6	10
948	48,248	3.4823	1	2	3	4	6
949	650	4.1015	1	1	2	4	6
950	395	3.5063	1	1	2	4	5
951	962	4.7973	1	1	2	3	6
955	456	12.2654	2	5	10	16	26
956	4,077	9.3218	4	5	7	11	17
957	1,391	14.7390	2	7	12	19	27
958	1,210	10.3455	3	5	8	13	19
959	303	6.3762	2	3	5	8	11
963	1,630	9.5521	1	4	8	13	19
964	2,686	6.2375	2	3	5	8	11
965	1,099	4.1601	1	2	4	5	7
969	643	18.8523	4	8	14	22	37
970	137	10.3358	2	3	7	12	20
974	5,981	10.3986	2	4	8	13	21
975	4,703	7.0134	2	3	5	9	13
976	2,635	4.9321	2	2	4	6	8
977	4,599	5.2768	1	2	4	6	10
981	25,684	15.1767	5	8	12	19	28
982	18,502	9.7442	3	5	8	12	18
983	6,149	5.3749	1	2	4	7	11
984	678	14.6637	5	8	13	18	25
985	915	9.6153	2	5	8	13	18
986	736	5.3166	1	2	3	7	12
987	8,318	13.0244	4	6	10	16	24
988	11,726	7.8083	2	3	6	10	15
989	5,878	4.0876	1	1	3	6	9
	11,507,824						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—JULY 2008

State	Urban	Rural
Alabama	0.256	0.331
Alaska	0.401	0.724
Arizona	0.284	0.395
Arkansas	0.318	0.365
California	0.223	0.293
Colorado	0.276	0.434
Connecticut	0.399	0.528
Delaware	0.482	0.436
District of Columbia*	0.335	----
Florida	0.237	0.273
Georgia	0.324	0.392
Hawaii	0.387	0.504
Idaho	0.462	0.535
Illinois	0.308	0.392
Indiana	0.386	0.456
Iowa	0.342	0.439
Kansas	0.288	0.424
Kentucky	0.372	0.369
Louisiana	0.291	0.347
Maine	0.497	0.463
Maryland	0.709	0.819
Massachusetts*	0.469	----
Michigan	0.359	0.457
Minnesota	0.398	0.517
Mississippi	0.301	0.352
Missouri	0.321	0.355
Montana	0.421	0.463
Nebraska	0.334	0.454
Nevada	0.218	0.475
New Hampshire	0.442	0.43
New Jersey*	0.178	----
New Mexico	0.376	0.348
New York	0.347	0.519
North Carolina	0.398	0.396
North Dakota	0.426	0.458
Ohio	0.335	0.52

State	Urban	Rural
Oklahoma	0.293	0.381
Oregon	0.455	0.414
Pennsylvania	0.263	0.409
Puerto Rico*	0.475	----
Rhode Island*	0.388	----
South Carolina	0.285	0.301
South Dakota	0.323	0.417
Tennessee	0.29	0.363
Texas	0.253	0.339
Utah	0.416	0.581
Vermont	0.542	0.601
Virginia	0.354	0.355
Washington	0.382	0.443
West Virginia	0.468	0.445
Wisconsin	0.414	0.457
Wyoming	0.41	0.544

*All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals are located in those areas as of March 2008.

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—JULY 2008

State	Ratio
Alabama	0.024
Alaska	0.038
Arizona	0.023
Arkansas	0.025
California	0.015
Colorado	0.028
Connecticut	0.028
Delaware	0.033
District of Columbia	0.02
Florida	0.022
Georgia	0.028
Hawaii	0.03
Idaho	0.038
Illinois	0.025
Indiana	0.037
Iowa	0.027
Kansas	0.03
Kentucky	0.028
Louisiana	0.026
Maine	0.029
Maryland	0.056
Massachusetts	0.03
Michigan	0.029
Minnesota	0.028
Mississippi	0.027
Missouri	0.027
Montana	0.034
Nebraska	0.037
Nevada	0.022
New Hampshire	0.032
New Jersey	0.013
New Mexico	0.033
New York	0.026
North Carolina	0.032
North Dakota	0.035
Ohio	0.028

State	Ratio
Oklahoma	0.026
Oregon	0.032
Pennsylvania	0.021
Puerto Rico	0.042
Rhode Island	0.019
South Carolina	0.024
South Dakota	0.031
Tennessee	0.029
Texas	0.025
Utah	0.034
Vermont	0.046
Virginia	0.036
Washington	0.03
West Virginia	0.033
Wisconsin	0.037
Wyoming	0.04

TABLE 8C.—STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHs—JULY 2008

State	Urban	Rural
Alabama	0.274	0.362
Alaska	0.433	0.798
Arizona	0.307	0.422
Arkansas	0.339	0.398
California	0.238	0.312
Colorado	0.301	0.482
Connecticut	0.426	0.575
Delaware	0.514	0.472
District of Columbia*	0.356	
Florida	0.259	0.301
Georgia	0.351	0.426
Hawaii	0.415	0.538
Idaho	0.499	0.577
Illinois	0.333	0.424
Indiana	0.423	0.496
Iowa	0.366	0.476
Kansas	0.315	0.462
Kentucky	0.398	0.399
Louisiana	0.317	0.374
Maine	0.527	0.488
Maryland**	0.337	0.432
Massachusetts*	0.5	
Michigan	0.388	0.492
Minnesota	0.424	0.557
Mississippi	0.326	0.381
Missouri	0.346	0.388
Montana	0.451	0.498
Nebraska	0.368	0.499
Nevada	0.239	0.539
New Hampshire	0.474	0.463
New Jersey*	0.191	
New Mexico	0.408	0.383
New York	0.372	0.555
North Carolina	0.429	0.43
North Dakota	0.459	0.499
Ohio	0.361	0.56

State	Urban	Rural
Oklahoma	0.318	0.409
Oregon	0.488	0.442
Pennsylvania	0.282	0.44
Puerto Rico*	0.515	
Rhode Island*	0.407	
South Carolina	0.308	0.328
South Dakota	0.351	0.453
Tennessee	0.318	0.398
Texas	0.276	0.372
Utah	0.448	0.634
Vermont	0.594	0.641
Virginia	0.39	0.396
Washington	0.411	0.473
West Virginia	0.503	0.476
Wisconsin	0.45	0.496
Wyoming	0.445	0.59

*All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of July 2008.

**National average IPPS total cost-to-charge ratios, as discussed in section VI.E. of this final rule.

TABLE 9A.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS--FY 2009

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
010001	20020	10500	
010005	01	13820	
010009	19460	26620	
010010	01	13820	
010012	01	40660	
010022	01	12060	
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010052	01	33860	
010054	19460	26620	
010055	20020	37460	
010059	19460	26620	
010061	01	16860	
010065	01	13820	
010083	01	37860	
010085	19460	26620	
010090	33660	37700	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	46220	
010126	01	33860	
010143	01	13820	
010150	01	33860	
010158	01	22520	
010164	01	13820	
020008	02	11260	
030007	39140	22380	LUGAR
030033	03	22380	
030055	29420	39140	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	22220	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	32820	
040071	38220	30780	
040076	04	30780	LUGAR
040080	04	27860	
040085	04	32820	
040088	04	33740	
040091	04	45500	
040119	04	30780	
050006	05	39820	
050014	05	40900	
050022	40140	42044	
050038	41940	42100	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050125	41940	42100	
050131	41884	36084	
050133	49700	40900	
050150	05	40900	
050153	41940	42100	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050188	41940	42100	
050193	42044	31084	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050197	41884	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	
050272	40140	31084	
050292	40140	42044	
050301	05	42220	
050308	41940	42100	
050329	40140	42044	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050367	46700	36084	
050380	41940	42100	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050476	05	42220	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	31084	
050616	37100	31084	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050662	41940	42100	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050688	41940	42100	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050749	37100	31084	
060001	24540	19740	
060003	14500	19740	
060012	39380	17820	
060023	24300	19740	
060027	14500	19740	
060031	17820	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070038	35300	35004	
070039	35300	35004	
080001	48864	37964	
080003	48864	37964	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090001	47894	13644	
090004	47894	13644	
090011	47894	13644	
100002	48424	22744	
100014	19660	36740	
100017	19660	36740	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100047	39460	14600	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	14600	
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	
100109	10	36740	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100156	10	23540	
100157	29460	45300	
100160	10	33124	
100168	48424	22744	
100176	48424	22744	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
100217	42680	38940	
100232	10	23540	
100234	48424	22744	
100236	39460	14600	
100249	10	45300	
100252	10	38940	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100292	10	23020	LUGAR
110001	19140	16860	
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110095	11	10500	
110112	11	10500	
110121	11	45220	
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110146	11	27260	
110150	11	12060	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
120028	12	26180	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
130002	13	14260	
130003	30300	28420	
130049	17660	44060	
130067	13	26820	LUGAR
140012	14	16974	
140015	14	41180	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140058	14	41180	
140064	14	37900	
140110	14	16974	
140135	19500	16580	
140143	14	16974	
140155	28100	16974	
140160	14	40420	
140164	14	41180	
140186	28100	16974	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150023	45460	26900	
150030	15	26900	LUGAR
150034	23844	16974	
150035	23844	16974	
150042	15	14020	
150045	15	23060	
150048	15	17140	
150051	14020	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
150090	23844	16974	
150091	15	23060	
150102	15	23844	LUGAR
150113	11300	26900	
150115	15	21780	
150125	23844	16974	
150126	23844	16974	
150133	15	43780	
150146	15	21140	
150147	23844	16974	
160001	16	11180	
160016	16	11180	
160057	16	26980	
160064	16	24	
160089	16	26980	
160147	16	11180	
170006	17	27900	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170023	17	48620	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
170190	17	45820	
170193	17	48620	
180002	18	49	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180024	18	31140	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
180048	18	31140	
180049	18	30460	
180050	18	28700	
180066	18	34980	
180069	18	26580	
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	14	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190017	19	29180	
190086	19	33740	
190088	19	43340	
190106	19	10780	
190144	19	43340	
190164	19	45	
190167	19	29180	
190184	19	33740	
190191	19	29180	
190208	19	04	
190218	19	43340	
190257	19	33740	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
220001	49340	14484	
220008	39300	14484	
220010	37764	14484	
220019	49340	14484	
220020	39300	14484	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220058	49340	14484	
220062	49340	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220090	49340	14484	
220095	49340	14484	
220163	49340	14484	
220174	37764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	22420	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
230089	19804	11460	
230092	27100	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	13020	
230106	24340	34740	
230119	19804	11460	
230121	23	29620	LUGAR
230130	47644	22420	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230222	23	13020	
230223	47644	22420	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	22420	
230257	47644	19804	
230264	47644	19804	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	22420	
240030	24	41060	
240064	24	20260	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
240069	24	33460	
240071	24	33460	
240075	24	41060	
240088	24	41060	
240093	24	33460	
240187	24	33460	
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250044	25	22520	
250069	25	46220	
250078	25620	25060	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	28140	
260015	26	27860	
260017	26	27620	
260022	26	16	
260025	26	41180	
260050	26	41140	
260074	26	17860	
260094	26	44180	
260110	26	44180	
260113	26	14	
260119	26	27860	
260175	26	28140	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
260183	26	41180	
260186	26	27620	
270003	27	24500	
270014	33540	17660	
270017	27	33540	
270051	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280061	28	53	
280065	28	24540	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290008	29	41620	
290019	16180	39900	
300001	30	31700	
300011	31700	49340	
300012	31700	49340	
300017	40484	37764	
300019	30	15764	
300020	31700	49340	
300023	40484	37764	
300029	40484	37764	
300034	31700	49340	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310021	45940	35084	
310022	15804	37964	
310029	15804	37964	
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310039	20764	35644	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310086	15804	37964	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	35644	
330049	39100	14860	
330067	39100	14860	
330073	33	40380	LUGAR
330079	33	47	
330085	33	45060	
330090	21300	27060	
330094	33	38340	
330103	33	39	
330126	39100	35644	
330136	33	45060	
330157	33	45060	
330191	24020	10580	
330224	28740	39100	
330229	33	21500	
330239	33	21500	
330250	33	15540	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
330277	33	27060	
330386	33	35084	
340008	34	22180	
340010	24140	39580	
340013	34	16740	
340014	49180	24660	
340015	34	16740	
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340047	49180	24660	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340085	34	24660	LUGAR
340096	34	24660	LUGAR
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340148	49180	24660	
340173	39580	20500	
350003	35	13900	
350006	35	13900	
350009	35	22020	
360008	36	26580	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	26580	
360065	36	17460	
360078	10420	17460	
360086	44220	19380	
360095	36	45780	
360096	36	49660	LUGAR
360107	36	45780	
360121	36	45780	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360245	36	17460	LUGAR
360253	19380	17140	
370004	37	27900	
370006	37	48620	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370025	37	46140	
370026	37	36420	
370030	37	46140	
370047	37	36420	
370049	37	36420	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
370113	37	22220	
370149	37	36420	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	49660	
390030	39	39740	LUGAR
390031	39	39740	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	27780	
390091	39	49660	
390093	39	49660	
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390138	39	25420	
390151	39	13644	
390162	10900	35084	
390185	42540	10900	
390313	39	39740	LUGAR
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16700	
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420062	42	16740	
420067	42	42340	
420068	42	12260	
420069	42	44940	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420098	42	34820	
430012	43	43620	
430013	43	43620	
430014	43	22020	
430077	39660	16220	
440002	27180	32820	
440008	44	27180	
440020	44	26620	
440024	17420	16860	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440059	44	34980	
440060	44	27180	
440067	34100	28700	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440144	44	34980	
440148	44	34980	
440151	44	34980	
440185	17420	16860	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
440192	44	34980	
450007	45	41700	
450039	23104	19124	
450064	23104	19124	
450080	45	19124	
450087	23104	19124	
450099	45	11100	
450135	23104	19124	
450137	23104	19124	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450196	45	19124	
450211	45	30980	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450393	43300	19124	
450395	45	26420	
450419	23104	19124	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450547	45	19124	
450563	23104	19124	
450565	45	23104	
450596	45	23104	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450813	45	41700	
450830	45	36220	
450872	23104	19124	
450880	23104	19124	
450886	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460021	41100	29820	
460026	46	39340	
460039	46	30860	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	47894	
490042	13980	40220	
490043	47894	13644	
490063	47894	13644	
490079	49	24660	
490097	49	40060	
490101	47894	13644	
490107	47894	13644	
490122	47894	13644	
500002	50	28420	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
510001	34060	38300	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510024	34060	38300	
510046	51	13980	
510047	51	38300	
510050	48540	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	
520013	20740	33460	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
530014	16940	24540	
530015	53	26820	

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT--FY 2009

Provider No.	Geographic CBSA	Redesignated Rural Area
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
070036	25540	07
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170137	29940	17
180038	36980	18
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260047	27620	26
260195	44180	26
330235	33	33
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390233	49620	39
440135	34980	44
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
490116	13980	49
500148	48300	50

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG)—JULY 2008[1]

MS-DRG	Number of Cases	Threshold
1	667	$350,171
2	295	$202,084
3	23,629	$259,269
4	21,674	$156,661
5	649	$173,210
6	232	$96,668
7	364	$165,950
8	498	$96,574
9	1,369	$104,749
10	168	$77,302
11	1,276	$77,657
12	1,928	$55,711
13	1,287	$39,732
20	901	$149,415
21	535	$116,365
22	215	$80,544
23	3,780	$88,620
24	2,118	$62,903
25	8,805	$82,527
26	11,888	$56,669
27	13,830	$44,651
28	1,686	$80,525
29	3,110	$50,443
30	3,463	$32,814
31	1,034	$67,755
32	2,816	$39,037
33	3,661	$31,254
34	769	$60,924
35	2,266	$44,749
36	7,016	$38,806
37	4,889	$55,163
38	14,285	$35,669
39	52,451	$25,826

MS-DRG	Number of Cases	Threshold
40	4,812	$62,255
41	7,674	$42,111
42	4,917	$36,272
52	1,181	$32,493
53	594	$22,362
54	5,307	$32,125
55	16,514	$27,040
56	8,344	$30,017
57	47,831	$19,669
58	754	$29,924
59	2,797	$22,922
60	4,151	$17,311
61	1,605	$55,868
62	2,490	$44,516
63	1,349	$38,871
64	56,395	$35,731
65	106,265	$28,376
66	90,498	$21,585
67	1,421	$31,186
68	11,560	$23,180
69	103,051	$18,910
70	7,412	$35,099
71	9,615	$27,676
72	5,809	$20,063
73	9,327	$28,577
74	31,936	$21,420
75	1,260	$35,951
76	887	$23,229
77	1,227	$34,484
78	1,417	$25,711
79	941	$19,425
80	1,899	$26,406
81	7,255	$17,878
82	1,781	$36,791
83	2,101	$30,292
84	2,820	$22,410
85	5,961	$37,148
86	11,620	$28,113
87	13,170	$19,810
88	727	$32,061
89	2,796	$23,587

MS-DRG	Number of Cases	Threshold
90	3,162	$17,963
91	7,715	$30,844
92	16,461	$22,327
93	16,334	$17,165
94	1,486	$57,474
95	1,050	$44,361
96	768	$37,851
97	1,204	$56,727
98	1,016	$38,084
99	661	$30,789
100	17,215	$30,422
101	57,866	$19,168
102	1,105	$24,379
103	14,026	$16,829
113	537	$33,838
114	564	$20,681
115	1,066	$26,383
116	568	$26,316
117	1,148	$16,432
121	550	$22,399
122	635	$14,210
123	2,815	$18,883
124	763	$25,301
125	4,740	$16,936
129	1,374	$40,997
130	1,090	$29,785
131	950	$39,886
132	905	$28,277
133	2,016	$32,917
134	3,423	$21,230
135	353	$37,030
136	477	$24,077
137	786	$29,170
138	900	$18,695
139	1,513	$20,967
146	686	$36,930
147	1,386	$27,461
148	878	$20,950
149	39,317	$16,001
150	963	$25,693
151	6,919	$13,753

MS-DRG	Number of Cases	Threshold
152	1,751	$21,755
153	11,646	$15,269
154	1,923	$29,013
155	4,528	$21,889
156	4,915	$16,159
157	1,058	$29,493
158	3,279	$21,478
159	2,418	$15,121
163	13,773	$83,445
164	18,059	$51,123
165	13,944	$40,658
166	20,767	$60,966
167	20,722	$42,332
168	5,545	$32,465
175	12,812	$34,969
176	41,870	$26,284
177	64,396	$38,302
178	71,682	$31,933
179	26,451	$24,926
180	22,654	$35,118
181	30,679	$28,811
182	5,537	$22,800
183	1,894	$32,799
184	4,459	$23,434
185	2,587	$16,644
186	9,341	$33,304
187	10,149	$27,248
188	5,099	$20,513
189	114,170	$30,806
190	59,538	$29,124
191	119,558	$24,050
192	187,411	$18,035
193	88,534	$31,033
194	257,304	$24,721
195	135,537	$18,061
196	5,446	$33,058
197	6,882	$27,136
198	4,702	$20,751
199	3,253	$35,194
200	8,526	$24,919
201	3,521	$17,736

MS-DRG	Number of Cases	Threshold
202	29,714	$20,165
203	37,593	$14,854
204	26,050	$17,531
205	5,944	$27,675
206	21,886	$18,719
207	40,028	$87,166
208	77,522	$43,687
215	144	$172,574
216	8,722	$168,664
217	7,298	$124,604
218	2,583	$104,294
219	10,629	$136,741
220	14,050	$99,497
221	7,109	$87,581
222	2,797	$156,445
223	5,142	$119,825
224	1,927	$144,850
225	5,115	$113,577
226	7,117	$118,881
227	43,059	$93,590
228	3,006	$132,486
229	3,626	$95,599
230	1,577	$80,863
231	1,462	$149,248
232	1,538	$114,592
233	16,458	$125,765
234	34,758	$93,524
235	9,731	$99,878
236	30,389	$73,945
237	22,666	$88,554
238	42,729	$58,001
239	13,454	$62,936
240	11,788	$43,385
241	2,706	$32,369
242	17,685	$66,921
243	36,426	$53,038
244	63,236	$44,642
245	3,969	$73,696
246	29,110	$67,205
247	190,568	$48,920
248	13,985	$60,888

MS-DRG	Number of Cases	Threshold
249	70,703	$44,189
250	6,841	$59,813
251	42,071	$42,013
252	46,038	$51,851
253	45,347	$46,590
254	54,071	$37,514
255	2,555	$40,848
256	3,484	$31,822
257	715	$23,541
258	698	$53,384
259	7,345	$38,206
260	1,565	$56,328
261	3,542	$31,659
262	3,551	$25,583
263	664	$30,760
264	28,519	$42,136
265	1,985	$42,837
280	64,366	$37,612
281	54,433	$29,741
282	55,150	$22,606
283	15,083	$32,920
284	4,182	$24,080
285	2,835	$16,166
286	23,916	$42,746
287	159,829	$29,565
288	2,994	$50,513
289	1,368	$37,452
290	489	$31,372
291	189,708	$30,634
292	206,974	$23,936
293	199,315	$17,466
294	1,430	$21,913
295	1,360	$14,113
296	1,943	$29,025
297	806	$17,790
298	610	$12,320
299	17,994	$29,184
300	45,146	$21,421
301	37,566	$15,533
302	7,679	$24,678
303	71,538	$14,889

MS-DRG	Number of Cases	Threshold
304	2,117	$25,891
305	35,675	$15,250
306	1,528	$29,226
307	6,419	$18,542
308	36,157	$28,557
309	80,283	$20,644
310	160,728	$14,811
311	21,534	$13,249
312	168,023	$18,153
313	214,895	$14,816
314	62,318	$32,316
315	30,368	$24,124
316	18,297	$16,552
326	11,381	$90,549
327	10,584	$52,471
328	8,959	$34,191
329	48,723	$83,771
330	64,446	$49,891
331	28,654	$37,390
332	1,844	$76,565
333	5,991	$48,643
334	3,788	$36,452
335	7,271	$70,901
336	12,611	$45,911
337	8,691	$34,633
338	1,525	$60,299
339	3,201	$42,341
340	3,630	$31,499
341	895	$45,185
342	2,578	$33,916
343	7,118	$24,131
344	941	$54,676
345	2,959	$36,211
346	2,787	$28,028
347	1,646	$40,497
348	4,217	$30,262
349	5,234	$19,231
350	1,779	$42,942
351	4,336	$30,956
352	8,274	$20,476
353	3,207	$47,317

MS-DRG	Number of Cases	Threshold
354	8,523	$33,490
355	15,542	$23,860
356	8,439	$61,916
357	7,904	$43,014
358	2,509	$32,761
368	3,613	$34,223
369	5,316	$26,846
370	3,585	$20,025
371	24,650	$34,383
372	27,382	$28,901
373	15,460	$20,461
374	9,200	$35,945
375	19,226	$28,476
376	4,367	$22,813
377	52,154	$32,536
378	111,612	$24,182
379	93,372	$18,627
380	3,056	$35,526
381	5,361	$27,811
382	4,539	$21,033
383	1,244	$29,623
384	8,200	$21,181
385	2,020	$35,120
386	7,210	$26,911
387	5,115	$20,226
388	18,761	$31,269
389	46,428	$23,202
390	47,113	$16,365
391	44,855	$26,200
392	285,913	$17,724
393	23,543	$31,056
394	46,428	$23,924
395	25,196	$17,461
405	4,005	$86,479
406	5,350	$52,501
407	2,137	$39,504
408	1,563	$71,799
409	1,749	$50,714
410	609	$37,195
411	962	$69,359
412	974	$51,228

MS-DRG	Number of Cases	Threshold
413	767	$40,089
414	5,317	$62,925
415	6,215	$43,475
416	5,419	$32,778
417	16,630	$49,717
418	27,447	$39,388
419	36,368	$29,729
420	777	$66,595
421	1,063	$39,563
422	336	$31,203
423	1,551	$72,340
424	903	$47,699
425	127	$33,157
432	15,381	$33,214
433	9,856	$23,879
434	914	$16,997
435	12,292	$35,041
436	13,359	$28,599
437	3,958	$25,546
438	14,238	$33,743
439	24,699	$26,831
440	26,114	$18,738
441	13,517	$31,690
442	14,410	$24,001
443	6,684	$17,768
444	13,090	$33,246
445	17,029	$27,408
446	16,238	$19,788
453	953	$165,236
454	1,801	$120,755
455	2,018	$93,422
456	952	$143,751
457	2,440	$98,526
458	1,630	$82,480
459	3,559	$97,703
460	52,947	$66,668
461	1,031	$82,136
462	13,331	$63,182
463	5,089	$60,927
464	5,905	$43,652
465	2,444	$31,894

MS-DRG	Number of Cases	Threshold
466	4,120	$74,562
467	14,449	$58,001
468	21,379	$49,744
469	30,894	$59,474
470	410,820	$44,639
471	2,324	$77,997
472	7,094	$52,448
473	23,420	$43,158
474	2,960	$52,154
475	3,324	$37,334
476	1,614	$25,568
477	2,617	$58,529
478	8,655	$45,186
479	11,570	$36,065
480	27,053	$53,729
481	72,935	$40,450
482	48,828	$34,547
483	7,165	$47,806
484	18,095	$40,775
485	1,195	$60,144
486	2,213	$44,998
487	1,324	$36,256
488	2,533	$35,683
489	5,870	$27,886
490	23,297	$37,487
491	53,523	$23,730
492	5,306	$51,533
493	17,169	$39,000
494	29,667	$29,914
495	1,994	$52,679
496	5,634	$37,239
497	6,770	$28,136
498	1,176	$38,149
499	1,126	$22,343
500	1,525	$47,418
501	3,933	$32,939
502	6,548	$23,462
503	847	$42,679
504	2,197	$32,788
505	3,065	$24,230
506	825	$25,593

MS-DRG	Number of Cases	Threshold
507	848	$37,279
508	2,547	$27,727
509	635	$28,171
510	989	$40,975
511	3,994	$33,030
512	11,161	$23,793
513	1,071	$30,421
514	1,030	$20,109
515	3,866	$54,214
516	11,406	$39,779
517	17,757	$32,702
533	831	$27,834
534	3,447	$16,216
535	7,096	$27,931
536	34,111	$15,447
537	677	$21,470
538	1,067	$13,732
539	3,493	$35,324
540	4,089	$28,826
541	1,672	$21,465
542	5,784	$34,963
543	17,178	$26,885
544	10,911	$18,020
545	4,144	$36,492
546	5,639	$26,257
547	4,610	$17,885
548	594	$34,079
549	1,133	$26,887
550	871	$18,783
551	10,168	$31,064
552	86,270	$18,686
553	3,121	$25,618
554	19,458	$15,029
555	2,049	$23,834
556	18,897	$14,400
557	3,700	$30,147
558	15,306	$19,410
559	1,828	$30,458
560	4,376	$21,222
561	7,200	$13,607
562	5,535	$28,326

MS-DRG	Number of Cases	Threshold
563	36,837	$15,516
564	1,693	$28,718
565	3,376	$21,269
566	2,676	$15,978
573	5,538	$45,884
574	11,245	$34,496
575	5,515	$25,504
576	557	$51,439
577	2,253	$33,085
578	3,108	$24,189
579	3,548	$45,289
580	10,875	$31,309
581	12,342	$22,349
582	5,400	$24,302
583	8,891	$19,157
584	679	$31,624
585	1,520	$20,767
592	4,245	$31,297
593	12,494	$23,837
594	2,821	$17,108
595	1,126	$31,578
596	5,387	$19,377
597	465	$31,176
598	1,427	$25,587
599	325	$17,927
600	695	$22,518
601	903	$15,558
602	22,431	$28,563
603	132,472	$18,283
604	2,708	$27,037
605	22,539	$16,438
606	1,366	$25,865
607	7,294	$15,116
614	1,474	$47,880
615	1,567	$34,751
616	1,103	$66,053
617	6,828	$38,848
618	265	$29,599
619	714	$56,183
620	2,232	$41,615
621	7,982	$34,811

MS-DRG	Number of Cases	Threshold
622	1,122	$43,474
623	3,104	$34,554
624	389	$24,658
625	1,286	$42,095
626	2,580	$28,891
627	14,197	$19,237
628	3,397	$53,867
629	4,228	$42,515
630	549	$33,344
637	17,373	$28,240
638	43,379	$19,241
639	39,037	$13,520
640	61,619	$25,182
641	204,124	$16,426
642	1,534	$23,973
643	5,234	$32,164
644	11,958	$25,374
645	8,323	$17,940
652	10,324	$61,294
653	1,712	$89,566
654	3,508	$56,364
655	1,658	$43,100
656	3,962	$58,911
657	7,513	$41,352
658	8,380	$33,615
659	4,717	$53,896
660	7,685	$39,056
661	4,322	$31,884
662	958	$45,916
663	2,083	$32,056
664	4,439	$24,783
665	664	$47,482
666	2,122	$32,912
667	3,674	$20,129
668	3,876	$42,311
669	12,899	$30,210
670	11,840	$19,282
671	817	$31,304
672	951	$19,944
673	12,710	$45,353

MS-DRG	Number of Cases	Threshold
674	11,850	$42,036
675	7,900	$34,173
682	83,160	$31,454
683	133,885	$26,713
684	45,575	$17,784
685	2,376	$19,695
686	1,618	$32,043
687	3,307	$26,443
688	1,097	$18,106
689	56,789	$27,206
690	201,012	$18,078
691	828	$34,067
692	500	$26,870
693	2,466	$28,873
694	18,323	$17,969
695	989	$25,988
696	10,715	$15,089
697	604	$17,446
698	23,635	$29,620
699	24,530	$23,370
700	12,472	$16,830
707	6,072	$37,347
708	18,339	$30,360
709	768	$35,656
710	1,863	$29,787
711	799	$37,734
712	715	$20,245
713	10,370	$26,947
714	29,251	$15,540
715	538	$36,207
716	1,284	$29,560
717	713	$34,343
718	597	$19,177
722	767	$31,076
723	1,992	$24,859
724	597	$15,489
725	773	$24,566
726	3,774	$16,308
727	1,310	$28,041
728	6,261	$17,107

MS-DRG	Number of Cases	Threshold
729	595	$25,606
730	473	$14,674
734	1,369	$44,354
735	1,142	$28,263
736	860	$73,331
737	3,327	$41,789
738	874	$28,855
739	1,023	$53,295
740	4,380	$34,579
741	6,078	$24,751
742	11,107	$32,153
743	32,872	$21,188
744	1,534	$30,942
745	1,711	$20,171
746	2,668	$30,229
747	10,537	$21,197
748	20,134	$20,542
749	1,000	$45,268
750	441	$24,653
754	995	$33,677
755	2,985	$26,039
756	694	$16,146
757	1,410	$32,999
758	1,629	$26,491
759	1,259	$19,008
760	1,724	$19,510
761	1,800	$13,223
765	2,842	$20,303
766	2,769	$13,803
767	139	$18,450
769	100	$28,962
770	207	$16,088
774	1,550	$12,252
775	5,900	$8,742
776	520	$15,037
777	216	$20,199
778	478	$8,900
779	118	$11,225
780	41	$3,900
781	3,093	$13,141

MS-DRG	Number of Cases	Threshold
782	176	$8,662
799	572	$82,701
800	717	$50,758
801	563	$37,518
802	776	$54,151
803	1,078	$36,246
804	1,002	$27,103
808	6,157	$37,260
809	13,007	$27,679
810	2,827	$22,834
811	21,680	$27,017
812	91,413	$18,354
813	14,341	$27,292
814	1,590	$30,608
815	3,364	$25,792
816	2,179	$18,357
820	1,315	$89,923
821	2,508	$43,952
822	1,905	$30,696
823	2,206	$69,553
824	3,008	$44,477
825	1,779	$30,841
826	534	$76,503
827	1,271	$44,203
828	809	$32,205
829	1,182	$48,064
830	520	$28,448
834	4,061	$58,479
835	2,739	$37,433
836	1,641	$25,762
837	1,058	$97,066
838	1,334	$47,510
839	1,481	$30,599
840	9,783	$43,401
841	10,152	$32,377
842	5,394	$25,590
843	1,382	$34,750
844	2,442	$27,807
845	819	$21,578
846	2,137	$39,100

MS-DRG	Number of Cases	Threshold
847	24,075	$27,014
848	1,732	$23,243
849	1,486	$29,321
853	35,254	$81,039
854	6,738	$52,750
855	470	$38,833
856	5,959	$65,309
857	9,718	$37,693
858	3,302	$30,467
862	8,047	$34,483
863	21,755	$22,069
864	19,252	$20,762
865	1,722	$29,423
866	8,273	$17,147
867	5,139	$39,023
868	2,683	$25,590
869	1,158	$18,458
870	21,514	$94,861
871	218,803	$35,478
872	91,942	$27,025
876	867	$42,532
880	9,385	$15,128
881	4,721	$11,981
882	1,584	$12,543
883	767	$17,955
884	19,323	$19,171
885	82,423	$15,186
886	412	$13,839
887	404	$16,619
894	4,835	$7,585
895	10,358	$12,773
896	5,634	$27,111
897	38,721	$13,074
901	931	$54,886
902	2,056	$33,407
903	1,521	$23,581
904	1,056	$43,267
905	818	$26,134
906	726	$24,557
907	8,585	$56,211

MS-DRG	Number of Cases	Threshold
908	8,449	$37,056
909	5,535	$27,913
913	823	$27,429
914	6,752	$16,341
915	1,092	$26,255
916	5,578	$10,516
917	16,048	$29,893
918	36,232	$14,342
919	11,218	$30,534
920	14,166	$22,290
921	9,557	$14,892
922	1,075	$28,467
923	4,025	$15,386
927	214	$181,805
928	827	$64,798
929	441	$37,275
933	147	$31,876
934	666	$24,841
935	2,237	$23,085
939	682	$46,365
940	1,340	$34,109
941	1,749	$26,887
945	6,776	$20,305
946	4,409	$15,735
947	9,852	$24,763
948	48,444	$15,898
949	701	$18,398
950	430	$12,730
951	973	$15,440
955	461	$88,229
956	4,085	$57,840
957	1,398	$101,367
958	1,219	$66,924
959	307	$48,204
963	1,637	$50,370
964	2,694	$34,621
965	1,104	$25,287
969	648	$78,322
970	139	$46,231
974	6,013	$42,158

MS-DRG	Number of Cases	Threshold
975	4,739	$29,782
976	2,674	$22,442
977	4,670	$25,209
981	25,712	$78,886
982	18,528	$55,175
983	6,181	$40,288
984	678	$59,465
985	916	$42,957
986	737	$29,735
987	8,334	$55,902
988	11,755	$38,165
989	5,900	$27,663
999	26	$15,336

[1] Cases taken from the FY 2007 MedPAR file; MS-DRGs are from GROUPER Version 26.0.

* As noted in section II.J. of the preamble to this final rule, the final national adjusted operating standardized amounts as well as the final version of this table will be published in a subsequent **Federal Register** prior to October 1, 2008.

TABLE 11.--FY 2009 MS-LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
1	1	Heart transplant or implant of heart assist system w MCC	0	0.0000	0.0	0.0
2	1	Heart transplant or implant of heart assist system w/o MCC	0	0.0000	0.0	0.0
3	3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	291	4.7718	66.9	55.8
4	4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	1,211	3.0860	44.5	37.1
5	5	Liver transplant w MCC or intestinal transplant	0	0.0000	0.0	0.0
6	5	Liver transplant w/o MCC	0	0.0000	0.0	0.0
7	7	Lung transplant	0	0.0000	0.0	0.0
8	8	Simultaneous pancreas/kidney transplant	0	0.0000	0.0	0.0
9	9	Bone marrow transplant	0	1.2921	31.4	26.2
10	10	Pancreas transplant	0	0.0000	0.0	0.0
11	11	Tracheostomy for face,mouth & neck diagnoses w MCC	1	1.7960	38.2	31.8
12	11	Tracheostomy for face,mouth & neck diagnoses w CC	1	1.7960	38.2	31.8
13	11	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	0	1.7960	38.2	31.8
20	20	Intracranial vascular procedures w PDX hemorrhage w MCC	0	1.7960	38.2	31.8
21	20	Intracranial vascular procedures w PDX hemorrhage w CC	0	1.7960	38.2	31.8
22	20	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0	1.7960	38.2	31.8
23	23	Craniotomy w major device implant or acute complex CNS PDX w MCC*	2	1.2921	31.4	26.2
24	23	Craniotomy w major device implant or acute complex CNS PDX w/o MCC*	1	1.2921	31.4	26.2
25	25	Craniotomy & endovascular intracranial procedures w MCC	2	1.7960	38.2	31.8
26	25	Craniotomy & endovascular intracranial procedures w CC	3	1.7960	38.2	31.8
27	25	Craniotomy & endovascular intracranial procedures w/o CC/MCC	1	0.8819	25.2	21.0
28	28	Spinal procedures w MCC	12	1.2921	31.4	26.2
29	28	Spinal procedures w CC	9	1.2921	31.4	26.2
30	28	Spinal procedures w/o CC/MCC	1	1.2921	31.4	26.2
31	31	Ventricular shunt procedures w MCC	5	1.7960	38.2	31.8
32	31	Ventricular shunt procedures w CC	1	1.7960	38.2	31.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
33	31	Ventricular shunt procedures w/o CC/MCC	0	1.7960	38.2	31.8
34	34	Carotid artery stent procedure w MCC	0	1.2921	31.4	26.2
35	34	Carotid artery stent procedurew CC	0	1.2921	31.4	26.2
36	34	Carotid artery stent procedure w/o CC/MCC	0	1.2921	31.4	26.2
37	37	Extracranial procedures w MCC	7	1.2921	31.4	26.2
38	37	Extracranial procedures w CC*	6	1.2921	31.4	26.2
39	37	Extracranial procedures w/o CC/MCC	0	1.2921	31.4	26.2
40	40	Periph & cranial nerve & other nerv syst proc w MCC	143	1.2796	34.8	29.0
41	40	Periph & cranial nerve & other nerv syst proc w CC	88	1.1156	34.2	28.5
42	40	Periph & cranial nerve & other nerv syst proc w/o CC/MCC*	6	1.1156	34.2	28.5
52	52	Spinal disorders & injuries w CC/MCC	84	1.0515	31.6	26.3
53	52	Spinal disorders & injuries w/o CC/MCC	7	0.8819	25.2	21.0
54	54	Nervous system neoplasms w MCC	31	1.0351	26.7	22.3
55	54	Nervous system neoplasms w/o MCC	50	0.6753	21.6	18.0
56	56	Degenerative nervous system disorders w MCC	1,185	0.8232	25.3	21.1
57	56	Degenerative nervous system disorders w/o MCC	1,947	0.6204	24.0	20.0
58	58	Multiple sclerosis & cerebellar ataxia w MCC	19	0.8819	25.2	21.0
59	58	Multiple sclerosis & cerebellar ataxia w CC	24	0.6524	21.7	18.1
60	58	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	10	0.6524	21.7	18.1
61	61	Acute ischemic stroke w use of thrombolytic agent w MCC	0	0.9043	23.6	19.7
62	61	Acute ischemic stroke w use of thrombolytic agent w CC	0	0.6189	23.6	19.7
63	61	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0	0.4997	19.5	16.3
64	64	Intracranial hemorrhage or cerebral infarction w MCC	107	0.7998	24.5	20.4
65	64	Intracranial hemorrhage or cerebral infarction w CC	68	0.6357	24.0	20.0
66	64	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	24	0.4997	19.5	16.3
67	67	Nonspecific cva & precerebral occlusion w/o infarct w MCC	4	0.4997	19.5	16.3
68	67	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	4	0.4997	19.5	16.3
69	69	Transient ischemia	13	0.4997	19.5	16.3
70	70	Nonspecific cerebrovascular disorders w MCC	88	0.9043	23.6	19.7
71	70	Nonspecific cerebrovascular disorders w CC	53	0.6189	23.6	19.7
72	70	Nonspecific cerebrovascular disorders w/o CC/MCC	8	0.4997	19.5	16.3
73	73	Cranial & peripheral nerve disorders w MCC	116	0.9147	24.6	20.5
74	73	Cranial & peripheral nerve disorders w/o MCC	175	0.6277	23.3	19.4
75	75	Viral meningitis w CC/MCC	15	0.6524	21.7	18.1
76	75	Viral meningitis w/o CC/MCC	0	0.6524	21.7	18.1
77	77	Hypertensive encephalopathy w MCC	4	1.2921	31.4	26.2
78	77	Hypertensive encephalopathy w CC	1	0.6524	21.7	18.1
79	77	Hypertensive encephalopathy w/o CC/MCC	1	0.4997	19.5	16.3
80	80	Nontraumatic stupor & coma w MCC	47	0.8157	29.2	24.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
81	80	Nontraumatic stupor & coma w/o MCC	110	0.7296	28.2	23.5
82	82	Traumatic stupor & coma, coma >1 hr w MCC	9	0.8819	25.2	21.0
83	82	Traumatic stupor & coma, coma >1 hr w CC	12	0.6524	21.7	18.1
84	82	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	3	0.6524	21.7	18.1
85	85	Traumatic stupor & coma, coma <1 hr w MCC	79	0.8987	26.6	22.2
86	85	Traumatic stupor & coma, coma <1 hr w CC	81	0.6795	24.1	20.1
87	85	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	15	0.4997	19.5	16.3
88	88	Concussion w MCC	0	0.4997	19.5	16.3
89	88	Concussion w CC	1	0.4997	19.5	16.3
90	88	Concussion w/o CC/MCC	0	0.4997	19.5	16.3
91	91	Other disorders of nervous system w MCC	221	0.9504	25.9	21.6
92	91	Other disorders of nervous system w CC	141	0.7158	25.3	21.1
93	91	Other disorders of nervous system w/o CC/MCC	43	0.6224	22.0	18.3
94	94	Bacterial & tuberculous infections of nervous system w MCC	203	1.0731	29.2	24.3
95	94	Bacterial & tuberculous infections of nervous system w CC	107	0.9737	28.5	23.8
96	94	Bacterial & tuberculous infections of nervous system w/o CC/MCC	31	0.7764	27.6	23.0
97	97	Non-bacterial infect of nervous sys exc viral meningitis w MCC	49	1.0887	26.3	21.9
98	97	Non-bacterial infect of nervous sys exc viral meningitis w CC	22	0.8819	25.2	21.0
99	97	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	6	0.6524	21.7	18.1
100	100	Seizures w MCC	47	0.6543	21.8	18.2
101	100	Seizures w/o MCC	55	0.6294	25.4	21.2
102	102	Headaches w MCC	10	0.6524	21.7	18.1
103	102	Headaches w/o MCC	4	0.6524	21.7	18.1
113	113	Orbital procedures w CC/MCC	1	0.8819	25.2	21.0
114	113	Orbital procedures w/o CC/MCC	0	0.8819	25.2	21.0
115	115	Extraocular procedures except orbit	0	0.4997	19.5	16.3
116	116	Intraocular procedures w CC/MCC	1	0.8819	25.2	21.0
117	116	Intraocular procedures w/o CC/MCC	0	0.4997	19.5	16.3
121	121	Acute major eye infections w CC/MCC	10	0.6524	21.7	18.1
122	121	Acute major eye infections w/o CC/MCC	1	0.6524	21.7	18.1
123	123	Neurological eye disorders	0	0.4997	19.5	16.3
124	124	Other disorders of the eye w MCC	2	0.6524	21.7	18.1
125	124	Other disorders of the eye w/o MCC	8	0.4997	19.5	16.3
129	129	Major head & neck procedures w CC/MCC or major device	0	1.3404	29.5	24.6
130	129	Major head & neck procedures w/o CC/MCC	0	0.4997	19.5	16.3
131	131	Cranial/facial procedures w CC/MCC	0	1.7960	38.2	31.8
132	131	Cranial/facial procedures w/o CC/MCC	1	1.7960	38.2	31.8
133	133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	10	1.2921	31.4	26.2

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
134	133	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0	1.2921	31.4	26.2
135	135	Sinus & mastoid procedures w CC/MCC	2	0.4997	19.5	16.3
136	135	Sinus & mastoid procedures w/o CC/MCC*	1	0.4997	19.5	16.3
137	137	Mouth procedures w CC/MCC	1	1.7960	38.2	31.8
138	137	Mouth procedures w/o CC/MCC	0	1.7960	38.2	31.8
139	139	Salivary gland procedures	0	1.7960	38.2	31.8
146	146	Ear, nose, mouth & throat malignancy w MCC	39	1.3404	29.5	24.6
147	146	Ear, nose, mouth & throat malignancy w CC	25	1.0458	23.0	19.2
148	146	Ear, nose, mouth & throat malignancy w/o CC/MCC	6	0.4997	19.5	16.3
149	149	Dysequilibrium	11	0.4997	19.5	16.3
150	150	Epistaxis w MCC	0	0.8819	25.2	21.0
151	150	Epistaxis w/o MCC	0	0.6524	21.7	18.1
152	152	Otitis media & URI w MCC	9	0.8819	25.2	21.0
153	152	Otitis media & URI w/o MCC	23	0.6524	21.7	18.1
154	154	Nasal trauma & deformity w MCC	50	0.7922	22.0	18.3
155	154	Nasal trauma & deformity w CC	47	0.7206	21.1	17.6
156	154	Nasal trauma & deformity w/o CC/MCC	13	0.6524	21.7	18.1
157	157	Dental & Oral Diseases w MCC	12	0.6524	21.7	18.1
158	157	Dental & Oral Diseases w CC	21	0.6524	21.7	18.1
159	157	Dental & Oral Diseases w/o CC/MCC	5	0.4997	19.5	16.3
163	163	Major chest procedures w MCC	45	2.5722	33.5	27.9
164	163	Major chest procedures w CC	6	1.2921	31.4	26.2
165	163	Major chest procedures w/o CC/MCC	1	0.8819	25.2	21.0
166	166	Other resp system O.R. procedures w MCC	1,515	2.5733	41.9	34.9
167	166	Other resp system O.R. procedures w CC	213	1.9643	36.6	30.5
168	166	Other resp system O.R. procedures w/o CC/MCC	8	0.8819	25.2	21.0
175	175	Pulmonary embolism w MCC	128	0.6823	21.9	18.3
176	175	Pulmonary embolism w/o MCC	139	0.5620	20.0	16.7
177	177	Respiratory infections & inflammations w MCC	3,193	0.9087	22.9	19.1
178	177	Respiratory infections & inflammations w CC	2,340	0.7609	22.1	18.4
179	177	Respiratory infections & inflammations w/o CC/MCC	393	0.6401	19.4	16.2
180	180	Respiratory neoplasms w MCC	149	0.8188	20.9	17.4
181	180	Respiratory neoplasms w CC	109	0.6468	18.8	15.7
182	180	Respiratory neoplasms w/o CC/MCC*	11	0.6468	18.8	15.7
183	183	Major chest trauma w MCC	1	0.4997	19.5	16.3
184	183	Major chest trauma w CC	2	0.4997	19.5	16.3
185	183	Major chest trauma w/o CC/MCC	1	0.4997	19.5	16.3
186	186	Pleural effusion w MCC	121	0.7782	20.5	17.1
187	186	Pleural effusion w CC	59	0.6390	20.5	17.1
188	186	Pleural effusion w/o CC/MCC*	15	0.6390	20.5	17.1
189	189	Pulmonary edema & respiratory failure	6,613	0.9896	24.0	20.0
190	190	Chronic obstructive pulmonary disease w MCC	1,658	0.7674	20.5	17.1
191	190	Chronic obstructive pulmonary disease w CC	1,347	0.6383	19.4	16.2
192	190	Chronic obstructive pulmonary disease w/o CC/MCC	766	0.5486	17.3	14.4
193	193	Simple pneumonia & pleurisy w MCC	1,810	0.7908	21.6	18.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
194	193	Simple pneumonia & pleurisy w CC	2,028	0.6545	20.1	16.8
195	193	Simple pneumonia & pleurisy w/o CC/MCC	383	0.5524	17.4	14.5
196	196	Interstitial lung disease w MCC	109	0.7329	20.1	16.8
197	196	Interstitial lung disease w CC	85	0.5866	17.6	14.7
198	196	Interstitial lung disease w/o CC/MCC	40	0.5162	15.9	13.3
199	199	Pneumothorax w MCC	50	0.8037	22.2	18.5
200	199	Pneumothorax w CC	32	0.6066	17.8	14.8
201	199	Pneumothorax w/o CC/MCC	5	0.4997	19.5	16.3
202	202	Bronchitis & asthma w CC/MCC	88	0.6690	19.6	16.3
203	202	Bronchitis & asthma w/o CC/MCC	21	0.4997	19.5	16.3
204	204	Respiratory signs & symptoms	233	0.8567	22.8	19.0
205	205	Other respiratory system diagnoses w MCC	324	0.8494	22.4	18.7
206	205	Other respiratory system diagnoses w/o MCC	171	0.7373	21.5	17.9
207	207	Respiratory system diagnosis w ventilator support 96+ hours	13,299	2.1381	34.6	28.8
208	208	Respiratory system diagnosis w ventilator support <96 hours	1,466	1.2016	23.5	19.6
215	215	Other heart assist system implant	0	0.8819	25.2	21.0
216	216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	0	1.2921	31.4	26.2
217	216	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	0	0.8819	25.2	21.0
218	216	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	0	0.8819	25.2	21.0
219	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	0	1.2921	31.4	26.2
220	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	0	0.8819	25.2	21.0
221	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	0	0.8819	25.2	21.0
222	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	0	1.7960	38.2	31.8
223	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	0	1.7960	38.2	31.8
224	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	0	1.7960	38.2	31.8
225	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	0	1.7960	38.2	31.8
226	226	Cardiac defibrillator implant w/o cardiac cath w MCC	11	1.7960	38.2	31.8
227	226	Cardiac defibrillator implant w/o cardiac cath w/o MCC	9	1.7960	38.2	31.8
228	228	Other cardiothoracic procedures w MCC	0	1.5788	34.2	28.5
229	228	Other cardiothoracic procedures w CC	0	1.2329	28.8	24.0
230	228	Other cardiothoracic procedures w/o CC/MCC	0	0.6524	21.7	18.1
231	231	Coronary bypass w PTCA w MCC	0	1.2921	31.4	26.2
232	231	Coronary bypass w PTCA w/o MCC	0	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
233	233	Coronary bypass w cardiac cath w MCC	0	1.2921	31.4	26.2
234	233	Coronary bypass w cardiac cath w/o MCC	0	0.8819	25.2	21.0
235	235	Coronary bypass w/o cardiac cath w MCC	0	1.2921	31.4	26.2
236	235	Coronary bypass w/o cardiac cath w/o MCC	0	0.8819	25.2	21.0
237	237	Major cardiovascular procedures w MCC	8	1.2921	31.4	26.2
238	237	Major cardiovascular procedures w/o MCC	2	0.8819	25.2	21.0
239	239	Amputation for circ sys disorders exc upper limb & toe w MCC	164	1.5628	36.8	30.7
240	239	Amputation for circ sys disorders exc upper limb & toe w CC	83	1.1868	34.1	28.4
241	239	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	10	0.8819	25.2	21.0
242	242	Permanent cardiac pacemaker implant w MCC*	12	1.7960	38.2	31.8
243	242	Permanent cardiac pacemaker implant w CC	5	1.7960	38.2	31.8
244	242	Permanent cardiac pacemaker implant w/o CC/MCC	1	1.7960	38.2	31.8
245	245	AICD generator procedures	0	1.7960	38.2	31.8
246	246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	4	1.2921	31.4	26.2
247	246	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	1	1.2921	31.4	26.2
248	248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	2	1.2921	31.4	26.2
249	248	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC*	1	1.2921	31.4	26.2
250	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	3	1.7960	38.2	31.8
251	250	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0	1.7960	38.2	31.8
252	252	Other vascular procedures w MCC	136	1.5788	34.2	28.5
253	252	Other vascular procedures w CC	53	1.2329	28.8	24.0
254	252	Other vascular procedures w/o CC/MCC	3	0.6524	21.7	18.1
255	255	Upper limb & toe amputation for circ system disorders w MCC	61	1.2930	33.8	28.2
256	255	Upper limb & toe amputation for circ system disorders w CC	42	0.9685	30.0	25.0
257	255	Upper limb & toe amputation for circ system disorders w/o CC/MCC	1	0.4997	19.5	16.3
258	258	Cardiac pacemaker device replacement w MCC	0	1.2921	31.4	26.2
259	258	Cardiac pacemaker device replacement w/o MCC	1	1.2921	31.4	26.2
260	260	Cardiac pacemaker revision except device replacement w MCC	2	1.2921	31.4	26.2
261	260	Cardiac pacemaker revision except device replacement w CC*	1	0.8819	25.2	21.0
262	260	Cardiac pacemaker revision except device replacement w/o CC/MCC*	1	0.8819	25.2	21.0
263	263	Vein ligation & stripping	3	0.4997	19.5	16.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
264	264	Other circulatory system O.R. procedures	609	1.1206	31.0	25.8
265	265	AICD lead procedures	0	1.2921	31.4	26.2
280	280	Circulatory disorders w AMI, discharged alive w MCC	260	0.8051	23.0	19.2
281	280	Circulatory disorders w AMI, discharged alive w CC	112	0.5945	20.8	17.3
282	280	Circulatory disorders w AMI, discharged alive w/o CC/MCC	35	0.5201	19.9	16.6
283	283	Circulatory disorders w AMI, expired w MCC	56	0.8328	15.9	13.3
284	283	Circulatory disorders w AMI, expired w CC*	17	0.8328	15.9	13.3
285	283	Circulatory disorders w AMI, expired w/o CC/MCC	0	0.8328	15.9	13.3
286	286	Circulatory disorders except AMI, w card cath w MCC	8	1.2921	31.4	26.2
287	286	Circulatory disorders except AMI, w card cath w/o MCC	9	0.8819	25.2	21.0
288	288	Acute & subacute endocarditis w MCC	597	1.0327	26.1	21.8
289	288	Acute & subacute endocarditis w CC	217	0.8089	26.1	21.8
290	288	Acute & subacute endocarditis w/o CC/MCC	48	0.7064	24.3	20.3
291	291	Heart failure & shock w MCC	1,730	0.7949	22.0	18.3
292	291	Heart failure & shock w CC	902	0.6470	21.2	17.7
293	291	Heart failure & shock w/o CC/MCC	363	0.5312	18.8	15.7
294	294	Deep vein thrombophlebitis w CC/MCC	6	0.6524	21.7	18.1
295	294	Deep vein thrombophlebitis w/o CC/MCC	0	0.6524	21.7	18.1
296	296	Cardiac arrest, unexplained w MCC	0	0.8328	15.9	13.3
297	296	Cardiac arrest, unexplained w CC	0	0.8328	15.9	13.3
298	296	Cardiac arrest, unexplained w/o CC/MCC	0	0.8328	15.9	13.3
299	299	Peripheral vascular disorders w MCC	588	0.8019	23.4	19.5
300	299	Peripheral vascular disorders w CC	752	0.5982	22.0	18.3
301	299	Peripheral vascular disorders w/o CC/MCC	78	0.5532	20.3	16.9
302	302	Atherosclerosis w MCC	59	0.7810	21.8	18.2
303	302	Atherosclerosis w/o MCC	61	0.5850	20.1	16.8
304	304	Hypertension w MCC	6	0.4997	19.5	16.3
305	304	Hypertension w/o MCC	15	0.4997	19.5	16.3
306	306	Cardiac congenital & valvular disorders w MCC	59	0.8459	22.7	18.9
307	306	Cardiac congenital & valvular disorders w/o MCC	38	0.7581	22.9	19.1
308	308	Cardiac arrhythmia & conduction disorders w MCC	97	0.8695	25.1	20.9
309	308	Cardiac arrhythmia & conduction disorders w CC	109	0.5891	21.1	17.6
310	308	Cardiac arrhythmia & conduction disorders w/o CC/MCC	36	0.4716	19.4	16.2
311	311	Angina pectoris	7	0.4997	19.5	16.3
312	312	Syncope & collapse	57	0.5244	19.7	16.4
313	313	Chest pain	6	0.4997	19.5	16.3
314	314	Other circulatory system diagnoses w MCC	1,309	0.9026	23.0	19.2
315	314	Other circulatory system diagnoses w CC	285	0.6734	21.0	17.5
316	314	Other circulatory system diagnoses w/o CC/MCC	72	0.6194	21.0	17.5
326	326	Stomach, esophageal & duodenal proc w MCC	19	1.7960	38.2	31.8
327	326	Stomach, esophageal & duodenal proc w CC	4	1.7960	38.2	31.8
328	326	Stomach, esophageal & duodenal proc w/o CC/MCC	1	1.7960	38.2	31.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
329	329	Major small & large bowel procedures w MCC	31	2.3238	41.8	34.8
330	329	Major small & large bowel procedures w CC	12	1.7960	38.2	31.8
331	329	Major small & large bowel procedures w/o CC/MCC	1	1.7960	38.2	31.8
332	332	Rectal resection w MCC	0	1.7205	34.3	28.6
333	332	Rectal resection w CC	0	1.2024	30.0	25.0
334	332	Rectal resection w/o CC/MCC	0	1.2024	30.0	25.0
335	335	Peritoneal adhesiolysis w MCC	6	1.7960	38.2	31.8
336	335	Peritoneal adhesiolysis w CC	0	1.7960	38.2	31.8
337	335	Peritoneal adhesiolysis w/o CC/MCC	0	1.7960	38.2	31.8
338	338	Appendectomy w complicated principal diag w MCC	0	0.9929	25.1	20.9
339	338	Appendectomy w complicated principal diag w CC	0	0.7964	23.2	19.3
340	338	Appendectomy w complicated principal diag w/o CC/MCC	0	0.6113	19.6	16.3
341	341	Appendectomy w/o complicated principal diag w MCC	0	0.9929	25.1	20.9
342	341	Appendectomy w/o complicated principal diag w CC	0	0.7964	23.2	19.3
343	341	Appendectomy w/o complicated principal diag w/o CC/MCC	0	0.6113	19.6	16.3
344	344	Minor small & large bowel procedures w MCC	5	1.7960	38.2	31.8
345	344	Minor small & large bowel procedures w CC	0	1.7960	38.2	31.8
346	344	Minor small & large bowel procedures w/o CC/MCC	0	1.7960	38.2	31.8
347	347	Anal & stomal procedures w MCC	3	1.7960	38.2	31.8
348	347	Anal & stomal procedures w CC	3	1.2921	31.4	26.2
349	347	Anal & stomal procedures w/o CC/MCC	0	1.2921	31.4	26.2
350	350	Inguinal & femoral hernia procedures w MCC	0	1.2921	31.4	26.2
351	350	Inguinal & femoral hernia procedures w CC	0	1.2921	31.4	26.2
352	350	Inguinal & femoral hernia procedures w/o CC/MCC	0	1.2921	31.4	26.2
353	353	Hernia procedures except inguinal & femoral w MCC	1	1.7960	38.2	31.8
354	353	Hernia procedures except inguinal & femoral w CC	1	0.6524	21.7	18.1
355	353	Hernia procedures except inguinal & femoral w/o CC/MCC	0	0.6524	21.7	18.1
356	356	Other digestive system O.R. procedures w MCC	142	1.7205	34.3	28.6
357	356	Other digestive system O.R. procedures w CC	36	1.2024	30.0	25.0
358	356	Other digestive system O.R. procedures w/o CC/MCC*	4	1.2024	30.0	25.0
368	368	Major esophageal disorders w MCC	26	0.9419	21.1	17.6
369	368	Major esophageal disorders w CC	14	0.8819	25.2	21.0
370	368	Major esophageal disorders w/o CC/MCC	4	0.8819	25.2	21.0
371	371	Major gastrointestinal disorders & peritoneal infections w MCC	724	0.9929	25.1	20.9
372	371	Major gastrointestinal disorders & peritoneal infections w CC	351	0.7964	23.2	19.3
373	371	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	68	0.6113	19.6	16.3
374	374	Digestive malignancy w MCC	97	0.9306	21.7	18.1
375	374	Digestive malignancy w CC	88	0.8038	23.4	19.5

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
376	374	Digestive malignancy w/o CC/MCC	3	0.6524	21.7	18.1
377	377	G.I. hemorrhage w MCC	90	0.8424	23.8	19.8
378	377	G.I. hemorrhage w CC	53	0.7098	23.8	19.8
379	377	G.I. hemorrhage w/o CC/MCC	19	0.6524	21.7	18.1
380	380	Complicated peptic ulcer w MCC	22	0.8819	25.2	21.0
381	380	Complicated peptic ulcer w CC	17	0.6524	21.7	18.1
382	380	Complicated peptic ulcer w/o CC/MCC	5	0.4997	19.5	16.3
383	383	Uncomplicated peptic ulcer w MCC	0	0.8819	25.2	21.0
384	383	Uncomplicated peptic ulcer w/o MCC	7	0.8819	25.2	21.0
385	385	Inflammatory bowel disease w MCC	36	0.8288	23.3	19.4
386	385	Inflammatory bowel disease w CC	37	0.7337	23.1	19.3
387	385	Inflammatory bowel disease w/o CC/MCC	5	0.4997	19.5	16.3
388	388	G.I. obstruction w MCC	216	0.9818	22.5	18.8
389	388	G.I. obstruction w CC	97	0.7510	20.9	17.4
390	388	G.I. obstruction w/o CC/MCC	18	0.6524	21.7	18.1
391	391	Esophagitis, gastroent & misc digest disorders w MCC	255	0.8157	22.0	18.3
392	391	Esophagitis, gastroent & misc digest disorders w/o MCC	294	0.6741	20.9	17.4
393	393	Other digestive system diagnoses w MCC	783	1.0977	25.7	21.4
394	393	Other digestive system diagnoses w CC	451	0.8117	22.7	18.9
395	393	Other digestive system diagnoses w/o CC/MCC	33	0.5940	22.1	18.4
405	405	Pancreas, liver & shunt procedures w MCC	10	1.2921	31.4	26.2
406	405	Pancreas, liver & shunt procedures w CC*	2	1.2921	31.4	26.2
407	405	Pancreas, liver & shunt procedures w/o CC/MCC	0	1.2921	31.4	26.2
408	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	0	0.6524	21.7	18.1
409	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	1	0.6524	21.7	18.1
410	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	0	0.6524	21.7	18.1
411	411	Cholecystectomy w c.d.e. w MCC	1	1.7960	38.2	31.8
412	411	Cholecystectomy w c.d.e. w CC	0	1.7960	38.2	31.8
413	411	Cholecystectomy w c.d.e. w/o CC/MCC	0	1.7960	38.2	31.8
414	414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC*	2	1.7960	38.2	31.8
415	414	Cholecystectomy except by laparoscope w/o c.d.e. w CC	3	1.7960	38.2	31.8
416	414	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	0	1.7960	38.2	31.8
417	417	Laparoscopic cholecystectomy w/o c.d.e. w MCC*	11	1.7960	38.2	31.8
418	417	Laparoscopic cholecystectomy w/o c.d.e. w CC	5	1.7960	38.2	31.8
419	417	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	0	1.7960	38.2	31.8
420	420	Hepatobiliary diagnostic procedures w MCC	0	0.8819	25.2	21.0
421	420	Hepatobiliary diagnostic procedures w CC	0	0.8819	25.2	21.0
422	420	Hepatobiliary diagnostic procedures w/o CC/MCC	0	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
423	423	Other hepatobiliary or pancreas O.R. procedures w MCC	23	1.7960	38.2	31.8
424	423	Other hepatobiliary or pancreas O.R. procedures w CC	2	0.8819	25.2	21.0
425	423	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0	0.8819	25.2	21.0
432	432	Cirrhosis & alcoholic hepatitis w MCC	73	0.7175	20.9	17.4
433	432	Cirrhosis & alcoholic hepatitis w CC	24	0.6524	21.7	18.1
434	432	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0	0.6524	21.7	18.1
435	435	Malignancy of hepatobiliary system or pancreas w MCC	53	0.8448	21.7	18.1
436	435	Malignancy of hepatobiliary system or pancreas w CC	26	0.5057	17.2	14.3
437	435	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	5	0.4997	19.5	16.3
438	438	Disorders of pancreas except malignancy w MCC	244	1.1099	23.4	19.5
439	438	Disorders of pancreas except malignancy w CC	144	0.7790	22.1	18.4
440	438	Disorders of pancreas except malignancy w/o CC/MCC	24	0.6524	21.7	18.1
441	441	Disorders of liver except malig,cirr,alc hepa w MCC	123	0.8417	23.1	19.3
442	441	Disorders of liver except malig,cirr,alc hepa w CC	62	0.7326	21.7	18.1
443	441	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	14	0.4997	19.5	16.3
444	444	Disorders of the biliary tract w MCC	104	0.8562	22.7	18.9
445	444	Disorders of the biliary tract w CC	34	0.6258	21.3	17.8
446	444	Disorders of the biliary tract w/o CC/MCC*	8	0.6258	21.3	17.8
453	453	Combined anterior/posterior spinal fusion w MCC	0	1.7960	38.2	31.8
454	453	Combined anterior/posterior spinal fusion w CC	0	1.7960	38.2	31.8
455	453	Combined anterior/posterior spinal fusion w/o CC/MCC	0	1.7960	38.2	31.8
456	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC	1	1.7960	38.2	31.8
457	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	3	1.7960	38.2	31.8
458	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	0	1.7960	38.2	31.8
459	459	Spinal fusion except cervical w MCC	1	1.7960	38.2	31.8
460	459	Spinal fusion except cervical w/o MCC	0	1.7960	38.2	31.8
461	461	Bilateral or multiple major joint procs of lower extremity w MCC	0	1.7960	38.2	31.8
462	461	Bilateral or multiple major joint procs of lower extremity w/o MCC	0	0.8819	25.2	21.0
463	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	525	1.4570	38.8	32.3
464	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	313	1.0927	34.0	28.3
465	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	63	1.0113	33.9	28.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
466	466	Revision of hip or knee replacement w MCC	3	1.2921	31.4	26.2
467	466	Revision of hip or knee replacement w CC	4	1.2921	31.4	26.2
468	466	Revision of hip or knee replacement w/o CC/MCC	1	0.4997	19.5	16.3
469	469	Major joint replacement or reattachment of lower extremity w MCC*	3	1.7960	38.2	31.8
470	469	Major joint replacement or reattachment of lower extremity w/o MCC	3	1.7960	38.2	31.8
471	471	Cervical spinal fusion w MCC	2	0.8819	25.2	21.0
472	471	Cervical spinal fusion w CC	1	0.8819	25.2	21.0
473	471	Cervical spinal fusion w/o CC/MCC	0	0.8819	25.2	21.0
474	474	Amputation for musculoskeletal sys & conn tissue dis w MCC	91	1.6103	38.4	32.0
475	474	Amputation for musculoskeletal sys & conn tissue dis w CC	67	1.1441	33.9	28.3
476	474	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	4	0.8819	25.2	21.0
477	477	Biopsies of musculoskeletal system & connective tissue w MCC	22	1.7960	38.2	31.8
478	477	Biopsies of musculoskeletal system & connective tissue w CC	12	1.2921	31.4	26.2
479	477	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	0	1.2921	31.4	26.2
480	480	Hip & femur procedures except major joint w MCC	22	1.7960	38.2	31.8
481	480	Hip & femur procedures except major joint w CC	11	1.2921	31.4	26.2
482	480	Hip & femur procedures except major joint w/o CC/MCC	2	0.8819	25.2	21.0
483	483	Major joint & limb reattachment proc of upper extremity w CC/MCC	0	1.7960	38.2	31.8
484	483	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	0	0.8819	25.2	21.0
485	485	Knee procedures w pdx of infection w MCC	10	1.2921	31.4	26.2
486	485	Knee procedures w pdx of infection w CC	10	1.2921	31.4	26.2
487	485	Knee procedures w pdx of infection w/o CC/MCC*	2	1.2921	31.4	26.2
488	488	Knee procedures w/o pdx of infection w CC/MCC	1	1.7960	38.2	31.8
489	488	Knee procedures w/o pdx of infection w/o CC/MCC	1	0.6524	21.7	18.1
490	490	Back & neck procedures except spinal fusion w CC/MCC or disc devices	9	1.2921	31.4	26.2
491	490	Back & neck procedures except spinal fusion w/o CC/MCC	0	1.2921	31.4	26.2
492	492	Lower extrem & humer proc except hip,foot,femur w MCC	9	1.2921	31.4	26.2
493	492	Lower extrem & humer proc except hip,foot,femur w CC	10	1.2921	31.4	26.2
494	492	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
495	495	Local excision & removal int fix devices exc hip & femur w MCC	42	1.2376	35.0	29.2
496	495	Local excision & removal int fix devices exc hip & femur w CC*	20	1.2376	35.0	29.2
497	495	Local excision & removal int fix devices exc hip & femur w/o CC/MCC*	5	1.2376	35.0	29.2
498	498	Local excision & removal int fix devices of hip & femur w CC/MCC	9	1.7960	38.2	31.8
499	498	Local excision & removal int fix devices of hip & femur w/o CC/MCC	0	1.7960	38.2	31.8
500	500	Soft tissue procedures w MCC	68	1.3816	36.7	30.6
501	500	Soft tissue procedures w CC	29	1.1363	33.5	27.9
502	500	Soft tissue procedures w/o CC/MCC	4	0.8819	25.2	21.0
503	503	Foot procedures w MCC	15	1.2921	31.4	26.2
504	503	Foot procedures w CC	22	0.8819	25.2	21.0
505	503	Foot procedures w/o CC/MCC	4	0.8819	25.2	21.0
506	506	Major thumb or joint procedures	0	1.2921	31.4	26.2
507	507	Major shoulder or elbow joint procedures w CC/MCC	1	1.7960	38.2	31.8
508	507	Major shoulder or elbow joint procedures w/o CC/MCC	0	1.7960	38.2	31.8
509	509	Arthroscopy	0	0.8819	25.2	21.0
510	510	Shoulder,elbow or forearm proc,exc major joint proc w MCC*	1	0.8819	25.2	21.0
511	510	Shoulder,elbow or forearm proc,exc major joint proc w CC*	2	0.8819	25.2	21.0
512	510	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0	0.8819	25.2	21.0
513	513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	6	1.2921	31.4	26.2
514	513	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC*	1	1.2921	31.4	26.2
515	515	Other musculoskelet sys & conn tiss O.R. proc w MCC	61	1.4072	31.6	26.3
516	515	Other musculoskelet sys & conn tiss O.R. proc w CC	27	0.9400	28.0	23.3
517	515	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	0	0.9400	28.0	23.3
533	533	Fractures of femur w MCC	3	0.6524	21.7	18.1
534	533	Fractures of femur w/o MCC	6	0.6524	21.7	18.1
535	535	Fractures of hip & pelvis w MCC	16	0.8819	25.2	21.0
536	535	Fractures of hip & pelvis w/o MCC	25	0.6293	26.9	22.4
537	537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	1	0.4997	19.5	16.3
538	537	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0	0.4997	19.5	16.3
539	539	Osteomyelitis w MCC	1,327	1.0226	30.3	25.3
540	539	Osteomyelitis w CC	850	0.7881	27.7	23.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
541	539	Osteomyelitis w/o CC/MCC	228	0.7108	27.2	22.7
542	542	Pathological fractures & musculoskelet & conn tiss malig w MCC	23	0.8819	25.2	21.0
543	542	Pathological fractures & musculoskelet & conn tiss malig w CC	42	0.5832	20.5	17.1
544	542	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	17	0.4997	19.5	16.3
545	545	Connective tissue disorders w MCC	50	0.9338	23.5	19.6
546	545	Connective tissue disorders w CC	38	0.8719	25.5	21.3
547	545	Connective tissue disorders w/o CC/MCC	5	0.4997	19.5	16.3
548	548	Septic arthritis w MCC	174	0.9289	26.3	21.9
549	548	Septic arthritis w CC	201	0.7257	26.7	22.3
550	548	Septic arthritis w/o CC/MCC	73	0.6244	24.2	20.2
551	551	Medical back problems w MCC	84	0.9209	26.6	22.2
552	551	Medical back problems w/o MCC	157	0.6227	24.1	20.1
553	553	Bone diseases & arthropathies w MCC	15	0.6524	21.7	18.1
554	553	Bone diseases & arthropathies w/o MCC	59	0.5154	21.3	17.8
555	555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	3	0.8819	25.2	21.0
556	555	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	8	0.4997	19.5	16.3
557	557	Tendonitis, myositis & bursitis w MCC	85	0.9082	25.4	21.2
558	557	Tendonitis, myositis & bursitis w/o MCC	134	0.6692	23.0	19.2
559	559	Aftercare, musculoskeletal system & connective tissue w MCC	1,375	0.8360	26.1	21.8
560	559	Aftercare, musculoskeletal system & connective tissue w CC	1,611	0.6649	24.7	20.6
561	559	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	732	0.5725	22.8	19.0
562	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	5	0.8819	25.2	21.0
563	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	9	0.4997	19.5	16.3
564	564	Other musculoskeletal sys & connective tissue diagnoses w MCC	309	0.9071	24.3	20.3
565	564	Other musculoskeletal sys & connective tissue diagnoses w CC	198	0.6661	22.7	18.9
566	564	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	60	0.6391	22.5	18.8
573	573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1,822	1.4392	38.3	31.9
574	573	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1,770	1.1140	36.1	30.1
575	573	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	200	0.9279	30.1	25.1
576	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	27	1.8399	37.6	31.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
577	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	28	0.8318	27.3	22.8
578	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	11	0.6524	21.7	18.1
579	579	Other skin, subcut tiss & breast proc w MCC	480	1.4205	36.7	30.6
580	579	Other skin, subcut tiss & breast proc w CC	399	1.0807	33.5	27.9
581	579	Other skin, subcut tiss & breast proc w/o CC/MCC	34	0.8276	30.1	25.1
582	582	Mastectomy for malignancy w CC/MCC	1	1.7960	38.2	31.8
583	582	Mastectomy for malignancy w/o CC/MCC	0	1.7960	38.2	31.8
584	584	Breast biopsy, local excision & other breast procedures w CC/MCC	2	0.6524	21.7	18.1
585	584	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0	0.6524	21.7	18.1
592	592	Skin ulcers w MCC	3,054	0.9741	27.0	22.5
593	592	Skin ulcers w CC	2,816	0.7371	26.2	21.8
594	592	Skin ulcers w/o CC/MCC	435	0.6264	24.7	20.6
595	595	Major skin disorders w MCC	28	0.8349	25.3	21.1
596	595	Major skin disorders w/o MCC	39	0.6710	22.4	18.7
597	597	Malignant breast disorders w MCC	7	1.2921	31.4	26.2
598	597	Malignant breast disorders w CC	7	0.8819	25.2	21.0
599	597	Malignant breast disorders w/o CC/MCC*	1	0.8819	25.2	21.0
600	600	Non-malignant breast disorders w CC/MCC	17	0.8819	25.2	21.0
601	600	Non-malignant breast disorders w/o CC/MCC	6	0.4997	19.5	16.3
602	602	Cellulitis w MCC	833	0.7149	21.7	18.1
603	602	Cellulitis w/o MCC	1,637	0.5472	19.9	16.6
604	604	Trauma to the skin, subcut tiss & breast w MCC	29	0.8467	24.4	20.3
605	604	Trauma to the skin, subcut tiss & breast w/o MCC	53	0.6221	23.8	19.8
606	606	Minor skin disorders w MCC	63	0.8515	24.5	20.4
607	606	Minor skin disorders w/o MCC	93	0.5751	20.7	17.3
614	614	Adrenal & pituitary procedures w CC/MCC	0	1.0780	32.6	27.2
615	614	Adrenal & pituitary procedures w/o CC/MCC	0	0.8819	25.2	21.0
616	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	71	1.5181	38.4	32.0
617	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	131	1.1771	33.1	27.6
618	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	2	0.4997	19.5	16.3
619	619	O.R. procedures for obesity w MCC	1	1.7960	38.2	31.8
620	619	O.R. procedures for obesity w CC	0	1.7960	38.2	31.8
621	619	O.R. procedures for obesity w/o CC/MCC	0	1.7960	38.2	31.8
622	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	173	1.3628	36.2	30.2
623	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	361	1.0437	31.1	25.9
624	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	21	0.6524	21.7	18.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
625	625	Thyroid, parathyroid & thyroglossal procedures w MCC	1	1.2921	31.4	26.2
626	625	Thyroid, parathyroid & thyroglossal procedures w CC	1	0.8819	25.2	21.0
627	625	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0	0.8819	25.2	21.0
628	628	Other endocrine, nutrit & metab O.R. proc w MCC	48	1.4146	32.3	26.9
629	628	Other endocrine, nutrit & metab O.R. proc w CC	111	1.0780	32.6	27.2
630	628	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	2	0.8819	25.2	21.0
637	637	Diabetes w MCC	424	0.9525	26.6	22.2
638	637	Diabetes w CC	1,059	0.7158	24.5	20.4
639	637	Diabetes w/o CC/MCC	70	0.5965	20.8	17.3
640	640	Nutritional & misc metabolic disorders w MCC	642	0.8656	23.2	19.3
641	640	Nutritional & misc metabolic disorders w/o MCC	552	0.6400	21.5	17.9
642	642	Inborn errors of metabolism	5	0.4997	19.5	16.3
643	643	Endocrine disorders w MCC	30	0.7032	24.0	20.0
644	643	Endocrine disorders w CC	28	0.5544	21.1	17.6
645	643	Endocrine disorders w/o CC/MCC	1	0.4997	19.5	16.3
652	652	Kidney transplant	0	0.0000	0.0	0.0
653	653	Major bladder procedures w MCC	2	1.7960	38.2	31.8
654	653	Major bladder procedures w CC	0	1.7960	38.2	31.8
655	653	Major bladder procedures w/o CC/MCC	0	1.7960	38.2	31.8
656	656	Kidney & ureter procedures for neoplasm w MCC	1	1.7960	38.2	31.8
657	656	Kidney & ureter procedures forneoplasm w CC	0	1.7960	38.2	31.8
658	656	Kidney & ureter procedures for neoplasm w/o CC/MCC	0	1.7960	38.2	31.8
659	659	Kidney & ureter procedures for non-neoplasm w MCC	6	1.2921	31.4	26.2
660	659	Kidney & ureter procedures for non-neoplasm w CC	6	1.2921	31.4	26.2
661	659	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1	0.6524	21.7	18.1
662	662	Minor bladder procedures w MCC	2	1.7960	38.2	31.8
663	662	Minor bladder procedures w CC	2	0.6524	21.7	18.1
664	662	Minor bladder procedures w/o CC/MCC	0	0.6524	21.7	18.1
665	665	Prostatectomy w MCC*	2	0.8819	25.2	21.0
666	665	Prostatectomy w CC*	1	0.8819	25.2	21.0
667	665	Prostatectomy w/o CC/MCC	0	0.8819	25.2	21.0
668	668	Transurethral procedures w MCC	4	0.8819	25.2	21.0
669	668	Transurethral procedures w CC	3	0.6524	21.7	18.1
670	668	Transurethral procedures w/o CC/MCC	0	0.6524	21.7	18.1
671	671	Urethral procedures w CC/MCC	1	0.6524	21.7	18.1
672	671	Urethral procedures w/o CC/MCC	0	0.6524	21.7	18.1
673	673	Other kidney & urinary tract procedures w MCC	230	1.4875	34.0	28.3
674	673	Other kidney & urinary tract procedures w CC	67	1.1752	29.1	24.3
675	673	Other kidney & urinary tract procedures w/o CC/MCC	0	1.1752	29.1	24.3
682	682	Renal failure w MCC	1,460	0.9224	23.8	19.8
683	682	Renal failure w CC	714	0.7723	22.9	19.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
684	682	Renal failure w/o CC/MCC	91	0.6826	20.6	17.2
685	685	Admit for renal dialysis	32	0.8577	25.1	20.9
686	686	Kidney & urinary tract neoplasms w MCC	15	0.8819	25.2	21.0
687	686	Kidney & urinary tract neoplasms w CC	18	0.8819	25.2	21.0
688	686	Kidney & urinary tract neoplasms w/o CC/MCC	3	0.6524	21.7	18.1
689	689	Kidney & urinary tract infections w MCC	871	0.6922	22.6	18.8
690	689	Kidney & urinary tract infections w/o MCC	783	0.5415	20.5	17.1
691	691	Urinary stones w esw lithotripsy w CC/MCC	0	0.4997	19.5	16.3
692	691	Urinary stones w esw lithotripsy w/o CC/MCC	0	0.4997	19.5	16.3
693	693	Urinary stones w/o esw lithotripsy w MCC	3	0.8819	25.2	21.0
694	693	Urinary stones w/ot esw lithotripsy w/o MCC	5	0.4997	19.5	16.3
695	695	Kidney & urinary tract signs & symptoms w MCC	4	1.2921	31.4	26.2
696	695	Kidney & urinary tract signs & symptoms w/o MCC	7	0.6524	21.7	18.1
697	697	Urethral stricture	0	0.6524	21.7	18.1
698	698	Other kidney & urinary tract diagnoses w MCC	284	0.9862	23.6	19.7
699	698	Other kidney & urinary tract diagnoses w CC	143	0.6770	21.9	18.3
700	698	Other kidney & urinary tract diagnoses w/o CC/MCC	31	0.5830	21.0	17.5
707	707	Major male pelvic procedures w CC/MCC	0	1.2921	31.4	26.2
708	707	Major male pelvic procedures w/o CC/MCC	0	0.6524	21.7	18.1
709	709	Penis procedures w CC/MCC	15	1.7960	38.2	31.8
710	709	Penis procedures w/o CC/MCC	0	1.7960	38.2	31.8
711	711	Testes procedures w CC/MCC	6	1.2921	31.4	26.2
712	711	Testes procedures w/o CC/MCC	0	1.2921	31.4	26.2
713	713	Transurethral prostatectomy w CC/MCC	2	1.7960	38.2	31.8
714	713	Transurethral prostatectomy w/o CC/MCC	0	1.7960	38.2	31.8
715	715	Other male reproductive system O.R. proc for malignancy w CC/MCC	0	1.2921	31.4	26.2
716	715	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	0	1.2921	31.4	26.2
717	717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	11	1.2921	31.4	26.2
718	717	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0	1.2921	31.4	26.2
722	722	Malignancy, male reproductive system w MCC	15	0.6524	21.7	18.1
723	722	Malignancy, male reproductive system w CC	14	0.6524	21.7	18.1
724	722	Malignancy, male reproductive system w/o CC/MCC	0	0.6524	21.7	18.1
725	725	Benign prostatic hypertrophy w MCC	1	0.8819	25.2	21.0
726	725	Benign prostatic hypertrophy w/o MCC	2	0.4997	19.5	16.3
727	727	Inflammation of the male reproductive system w MCC	27	0.8162	23.1	19.3
728	727	Inflammation of the male reproductive system w/o MCC	53	0.5417	20.2	16.8
729	729	Other male reproductive system diagnoses w CC/MCC	48	0.9208	25.9	21.6
730	729	Other male reproductive system diagnoses w/o CC/MCC	8	0.4997	19.5	16.3
734	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	0	1.2921	31.4	26.2

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
735	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0	1.2921	31.4	26.2
736	736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	0	1.2921	31.4	26.2
737	736	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	0	0.8819	25.2	21.0
738	736	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	0	0.4997	19.5	16.3
739	739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	1	1.2921	31.4	26.2
740	739	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	0	1.2921	31.4	26.2
741	739	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	0	1.2921	31.4	26.2
742	742	Uterine & adnexa proc for non-malignancy w CC/MCC	0	0.8819	25.2	21.0
743	742	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0	0.4997	19.5	16.3
744	744	D&C, conization, laparascopy & tubal interruption w CC/MCC	1	0.8819	25.2	21.0
745	744	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0	0.8819	25.2	21.0
746	746	Vagina, cervix & vulva procedures w CC/MCC	1	1.7960	38.2	31.8
747	746	Vagina, cervix & vulva procedures w/o CC/MCC	0	1.7960	38.2	31.8
748	748	Female reproductive system reconstructive procedures	0	1.2921	31.4	26.2
749	749	Other female reproductive system O.R. procedures w CC/MCC	4	1.2921	31.4	26.2
750	749	Other female reproductive system O.R. procedures w/o CC/MCC	0	1.2921	31.4	26.2
754	754	Malignancy, female reproductive system w MCC	22	1.2921	31.4	26.2
755	754	Malignancy, female reproductive system w CC	21	0.8819	25.2	21.0
756	754	Malignancy, female reproductive system w/o CC/MCC	1	0.4997	19.5	16.3
757	757	Infections, female reproductive system w MCC	53	0.8033	24.0	20.0
758	757	Infections, female reproductive system w CC	27	0.8033	24.0	20.0
759	757	Infections, female reproductive system w/o CC/MCC*	5	0.8033	24.0	20.0
760	760	Menstrual & other female reproductive system disorders w CC/MCC	0	0.8819	25.2	21.0
761	760	Menstrual & other female reproductive system disorders w/o CC/MCC	0	0.8819	25.2	21.0
765	765	Cesarean section w CC/MCC	0	0.8819	25.2	21.0
766	765	Cesarean section w/o CC/MCC	0	0.8819	25.2	21.0
767	767	Vaginal delivery w sterilization &/or D&C	0	0.8819	25.2	21.0
768	768	Vaginal delivery w O.R. proc except steril &/or D&C	0	0.8819	25.2	21.0
769	769	Postpartum & post abortion diagnoses w O.R. procedure	0	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
770	770	Abortion w D&C, aspiration curettage or hysterotomy	0	0.8819	25.2	21.0
774	774	Vaginal delivery w complicating diagnoses	0	0.8819	25.2	21.0
775	775	Vaginal delivery w/o complicating diagnoses	0	0.8819	25.2	21.0
776	776	Postpartum & post abortion diagnoses w/o O.R. procedure	0	0.8819	25.2	21.0
777	777	Ectopic pregnancy	0	0.8819	25.2	21.0
778	778	Threatened abortion	0	0.8033	24.0	20.0
779	779	Abortion w/o D&C	0	0.8033	24.0	20.0
780	780	False labor	0	0.8033	24.0	20.0
781	781	Other antepartum diagnoses w medical complications	1	0.4997	19.5	16.3
782	782	Other antepartum diagnoses w/o medical complications	0	0.4997	19.5	16.3
789	789	Neonates, died or transferred to another acute care facility	0	0.4997	19.5	16.3
790	790	Extreme immaturity or respiratory distress syndrome, neonate	0	0.4997	19.5	16.3
791	791	Prematurity w major problems	0	0.4997	19.5	16.3
792	792	Prematurity w/o major problems	0	0.4997	19.5	16.3
793	793	Full term neonate w major problems	0	0.4997	19.5	16.3
794	794	Neonate w other significant problems	0	0.4997	19.5	16.3
795	795	Normal newborn	0	0.4997	19.5	16.3
799	799	Splenectomy w MCC	0	0.8819	25.2	21.0
800	799	Splenectomy w CC	1	0.8819	25.2	21.0
801	799	Splenectomy w/o CC/MCC	0	0.8819	25.2	21.0
802	802	Other O.R. proc of the blood & blood forming organs w MCC	4	1.2921	31.4	26.2
803	802	Other O.R. proc of the blood & blood forming organs w CC	0	1.2921	31.4	26.2
804	802	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	0	1.2921	31.4	26.2
808	808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	17	1.2921	31.4	26.2
809	808	Major hematol/immun diag exc sickle cell crisis & coagul w CC	11	0.8819	25.2	21.0
810	808	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	1	0.4997	19.5	16.3
811	811	Red blood cell disorders w MCC	44	0.8231	23.1	19.3
812	811	Red blood cell disorders w/o MCC	59	0.5476	20.4	17.0
813	813	Coagulation disorders	55	0.8633	23.2	19.3
814	814	Reticuloendothelial & immunity disorders w MCC	16	0.8819	25.2	21.0
815	814	Reticuloendothelial & immunity disorders w CC	7	0.6524	21.7	18.1
816	814	Reticuloendothelial & immunity disorders w/o CC/MCC	1	0.4997	19.5	16.3
820	820	Lymphoma & leukemia w major O.R. procedure w MCC	0	1.2921	31.4	26.2
821	820	Lymphoma & leukemia w major O.R. procedure w CC	0	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
822	820	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	0	0.8819	25.2	21.0
823	823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	11	1.2921	31.4	26.2
824	823	Lymphoma & non-acute leukemia w other O.R. proc w CC	4	0.8819	25.2	21.0
825	823	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	0	0.8819	25.2	21.0
826	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	1	1.7960	38.2	31.8
827	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	1	1.7960	38.2	31.8
828	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0	1.7960	38.2	31.8
829	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	7	1.7960	38.2	31.8
830	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	0	1.7960	38.2	31.8
834	834	Acute leukemia w/o major O.R. procedure w MCC	14	0.8819	25.2	21.0
835	834	Acute leukemia w/o major O.R. procedure w CC*	14	0.8819	25.2	21.0
836	834	Acute leukemia w/o major O.R. procedure w/o CC/MCC*	2	0.8819	25.2	21.0
837	837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	0	1.7960	38.2	31.8
838	837	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	0	1.7960	38.2	31.8
839	837	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	0	1.7960	38.2	31.8
840	840	Lymphoma & non-acute leukemia w MCC	133	0.9488	23.1	19.3
841	840	Lymphoma & non-acute leukemia w CC	63	0.7436	19.7	16.4
842	840	Lymphoma & non-acute leukemia w/o CC/MCC	7	0.6524	21.7	18.1
843	843	Other myeloprolif dis or poorly diff neopl diag w MCC	20	0.8819	25.2	21.0
844	843	Other myeloprolif dis or poorly diff neopl diag w CC	10	0.6524	21.7	18.1
845	843	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	3	0.6524	21.7	18.1
846	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	49	1.5176	30.0	25.0
847	846	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	43	1.1159	23.8	19.8
848	846	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0	1.1159	23.8	19.8
849	849	Radiotherapy	141	0.8183	21.6	18.0
853	853	Infectious & parasitic diseases w O.R. procedure w MCC	840	1.8376	37.3	31.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
854	853	Infectious & parasitic diseases w O.R. procedure w CC	104	1.1843	33.0	27.5
855	853	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC*	5	1.1843	33.0	27.5
856	856	Postoperative or post-traumatic infections w O.R. proc w MCC	303	1.6052	36.8	30.7
857	856	Postoperative or post-traumatic infections w O.R. proc w CC	213	1.1001	32.7	27.3
858	856	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	32	0.9174	26.8	22.3
862	862	Postoperative & post-traumatic infections w MCC	1,168	0.9901	25.3	21.1
863	862	Postoperative & post-traumatic infections w/o MCC	1,240	0.7241	24.0	20.0
864	864	Fever of unknown origin	11	0.4997	19.5	16.3
865	865	Viral illness w MCC	36	0.8235	22.2	18.5
866	865	Viral illness w/o MCC	14	0.6524	21.7	18.1
867	867	Other infectious & parasitic diseases diagnoses w MCC	359	1.1614	23.3	19.4
868	867	Other infectious & parasitic diseases diagnoses w CC	86	0.7627	22.6	18.8
869	867	Other infectious & parasitic diseases diagnoses w/o CC/MCC	7	0.4997	19.5	16.3
870	870	Septicemia w MV 96+ hours	902	2.2938	33.1	27.6
871	871	Septicemia w/o MV 96+ hours w MCC	4,512	0.8959	23.4	19.5
872	871	Septicemia w/o MV 96+ hours w/o MCC	1,610	0.6766	21.8	18.2
876	876	O.R. procedure w principal diagnoses of mental illness	12	0.6524	21.7	18.1
880	880	Acute adjustment reaction & psychosocial dysfunction	11	0.4997	19.5	16.3
881	881	Depressive neuroses	15	0.6524	21.7	18.1
882	882	Neuroses except depressive	16	0.4997	19.5	16.3
883	883	Disorders of personality & impulse control	12	0.8819	25.2	21.0
884	884	Organic disturbances & mental retardation	147	0.5317	25.5	21.3
885	885	Psychoses	1,220	0.4314	23.8	19.8
886	886	Behavioral & developmental disorders	18	0.4997	19.5	16.3
887	887	Other mental disorder diagnoses	0	0.6524	21.7	18.1
894	894	Alcohol/drug abuse or dependence, left ama	0	0.6524	21.7	18.1
895	895	Alcohol/drug abuse or dependence w rehabilitation therapy	2	0.4997	19.5	16.3
896	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	7	1.2921	31.4	26.2
897	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	17	0.4997	19.5	16.3
901	901	Wound debridements for injuries w MCC	220	1.5551	35.9	29.9
902	901	Wound debridements for injuries w CC	129	1.0849	30.1	25.1
903	901	Wound debridements for injuries w/o CC/MCC	23	0.8819	25.2	21.0
904	904	Skin grafts for injuries w CC/MCC	78	1.3752	35.6	29.7
905	904	Skin grafts for injuries w/o CC/MCC	6	0.8819	25.2	21.0
906	906	Hand procedures for injuries	1	1.7960	38.2	31.8
907	907	Other O.R. procedures for injuries w MCC	91	1.6745	37.5	31.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
908	907	Other O.R. procedures for injuries w CC	63	1.1596	34.1	28.4
909	907	Other O.R. procedures for injuries w/o CC/MCC*	6	1.1596	34.1	28.4
913	913	Traumatic injury w MCC	38	0.7897	25.1	20.9
914	913	Traumatic injury w/o MCC	66	0.6339	22.2	18.5
915	915	Allergic reactions w MCC	0	0.4997	19.5	16.3
916	915	Allergic reactions w/o MCC	0	0.4997	19.5	16.3
917	917	Poisoning & toxic effects of drugs w MCC	8	0.4997	19.5	16.3
918	917	Poisoning & toxic effects of drugs w/o MCC	9	0.4997	19.5	16.3
919	919	Complications of treatment w MCC	1,245	1.1250	26.9	22.4
920	919	Complications of treatment w CC	847	0.8823	26.0	21.7
921	919	Complications of treatment w/o CC/MCC	118	0.6344	20.2	16.8
922	922	Other injury, poisoning & toxic effect diag w MCC	7	0.8819	25.2	21.0
923	922	Other injury, poisoning & toxic effect diag w/o MCC	11	0.6524	21.7	18.1
927	927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	1	1.7960	38.2	31.8
928	928	Full thickness burn w skin graft or inhal inj w CC/MCC	9	1.2921	31.4	26.2
929	928	Full thickness burn w skin graft or inhal inj w/o CC/MCC	2	0.6524	21.7	18.1
933	933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	10	1.2921	31.4	26.2
934	934	Full thickness burn w/o skin grft or inhal inj	40	0.7937	24.2	20.2
935	935	Non-extensive burns	46	0.8046	24.5	20.4
939	939	O.R. proc w diagnoses of other contact w health services w MCC	270	1.3772	33.7	28.1
940	939	O.R. proc w diagnoses of other contact w health services w CC	136	1.0277	30.6	25.5
941	939	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	15	0.8819	25.2	21.0
945	945	Rehabilitation w CC/MCC	2,223	0.6307	22.1	18.4
946	945	Rehabilitation w/o CC/MCC	428	0.4426	18.9	15.8
947	947	Signs & symptoms w MCC	58	0.6660	22.1	18.4
948	947	Signs & symptoms w/o MCC	70	0.5905	22.1	18.4
949	949	Aftercare w CC/MCC	3,824	0.7232	22.5	18.8
950	949	Aftercare w/o CC/MCC	551	0.5143	19.2	16.0
951	951	Other factors influencing health status	28	1.3716	27.9	23.3
955	955	Craniotomy for multiple significant trauma	0	1.7960	38.2	31.8
956	956	Limb reattachment, hip & femur proc for multiple significant trauma	0	0.8819	25.2	21.0
957	957	Other O.R. procedures for multiple significant trauma w MCC	1	1.2921	31.4	26.2
958	957	Other O.R. procedures for multiple significant trauma w CC	1	0.4997	19.5	16.3
959	957	Other O.R. procedures for multiple significant trauma w/o CC/MCC	0	0.4997	19.5	16.3
963	963	Other multiple significant trauma w MCC	15	0.8819	25.2	21.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2007 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold [1]
964	963	Other multiple significant trauma w CC	5	0.6524	21.7	18.1
965	963	Other multiple significant trauma w/o CC/MCC	3	0.4997	19.5	16.3
969	969	HIV w extensive O.R. procedure w MCC	14	1.2921	31.4	26.2
970	969	HIV w extensive O.R. procedure w/o MCC*	3	1.2921	31.4	26.2
974	974	HIV w major related condition w MCC	196	1.0333	21.9	18.3
975	974	HIV w major related condition w CC	85	0.6617	18.3	15.3
976	974	HIV w major related condition w/o CC/MCC	16	0.6524	21.7	18.1
977	977	HIV w or w/o other related condition	45	0.7086	19.0	15.8
981	981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	1,161	2.4167	43.1	35.9
982	981	Extensive O.R. procedure unrelated to principal diagnosis w CC	293	1.5163	35.5	29.6
983	981	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	26	1.1942	31.9	26.6
984	984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	16	1.2921	31.4	26.2
985	984	Prostatic O.R. procedure unrelated to principal diagnosis w CC	9	1.2921	31.4	26.2
986	984	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	0	1.2921	31.4	26.2
987	987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	423	1.8307	36.7	30.6
988	987	Non-extensive O.R. proc unrelated to principal diagnosis w CC	219	1.1918	33.9	28.3
989	987	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	10	0.8819	25.2	21.0
998	998	Ungroupable	0	0.0000	0.0	0.0
999	999	Principal diagnosis invalid as discharge diagnosis	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529 in conjunction with §412.503).

* In determining the MS-LTC-DRG relative weights for FY 2009, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section II.I.4. (step 6) of the preamble of this final rule.

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Appendix A: Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the changes for FY 2009 operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The market basket update to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule, will result in an approximate $4.7 billion increase in FY 2009 operating and capital payments. Our impact estimate includes the −0.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts and capital Federal rates for FY 2009 in accordance with section 7 of Public Law 110–90. For purposes of the impact analysis, we also assume an additional 1.8 percent increase in case-mix between FY 2008 and FY 2009 because we believe the adoption of the MS–DRGs will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patient severity of illness. The estimates of IPPS operating payments do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $31.5 million or less in any 1 year). (For details on the latest standards for heath care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration Web site at: *http://www.sba.gov/services/*

contractingopportunities/sizestandardstopics/tableofsize/index.html.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this final rule will have a significant impact on small entities as explained in this Appendix. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule constitutes our final regulatory flexibility analysis. In the FY 2009 IPPS proposed rule, we solicited comments on our estimates and analysis of the impact of the proposed rule on those small entities. We address any public comments that we received on the impact of these changes we are finalizing in the applicable sections of this Appendix.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28 (enacted May 25, 2007), requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this final rule are available on the inpatient prospective payment system web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. We also note that the Hospital Center Web page *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $130 million. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this final rule will not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this final rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The final rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the changes in this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2009, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that implementation of the MS–DRGs would lead to increases in case-mix that do not reflect actual increases in patients' severity of illness as a result of more comprehensive documentation and coding. As explained in section II.D. of the preamble of this final rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90. Section 7 of Public Law 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. Following the enactment of Public Law 110–90, we revised the FY 2008 standardized amounts (as well as other affected payment factors and thresholds) to reflect the −0.6 percent FY 2008 documentation and coding adjustment. The tentative FY 2009 IPPS national standardized amount included in this final rule reflects the documentation and coding adjustment of −0.9 percent for FY 2009. While we have adopted the statutorily mandated documentation and coding adjustments for payment purposes, we continue to believe that an increase in case-mix of 1.8 percent between FY 2008 and FY 2009 is likely as a result of the adoption of the MS–DRGs. The impacts shown below illustrate the impact of the FY 2009 IPPS changes on hospital operating payments, including the −0.9 percent FY 2009 documentation and coding adjustment to the IPPS national standardized amounts, both prior to and following the expected 1.8 percent growth in case-mix between FY 2008 and FY 2009. As we have done in the previous rules, we solicited comments and information about the anticipated effects of the proposed changes on hospitals and our methodology for estimating them. We did not receive any public comments on the methodology for estimating the impacts.

IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass most general short-term, acute care hospitals that participate in the Medicare program. There were 35 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of July 2008, there are 3,538 IPPS hospitals to be included in our analysis. This represents about 58 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,313 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,226 specialty hospitals and 2,226 specialty units that are excluded from the IPPS. These specialty hospitals include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these specialty hospitals and units are not included in this final rule. There is also a separate rule to update and make changes to the LTCH PPS for its rate year (RY). However, we have traditionally used the IPPS rule to update the LTCH patient classifications and relative weights because the LTCH PPS uses the same DRGs as the IPPS, resulting in the LTCH relative weights being reclassified and recalibrated according to the same schedule as the IPPS (that is, for each Federal fiscal year). The impacts of our policy changes on LTCHs, where applicable, are discussed below. (We note that, as discussed in section II.I. of the preamble of this final rule, in the RY 2009 LTCH PPS final rule 73 FR 26797 through 26798), we moved the annual LTCH PPS RY

update (currently effective July 1) to be effective October 1 through September 30 (the Federal fiscal year) each year beginning October 1, 2009. Under this change, RY 2009 is extended 3 months, such that RY 2009 will be the 15-month period of July 1, 2008 through September 30, 2009.)

V. Effects on Excluded Hospitals and Hospital Units

As of July 2008, there were 1,226 hospitals excluded from the IPPS. Of these 1,226 hospitals, 56 IPFs, 78 children's hospitals, 11 cancer hospitals, and 19 RNHCIs are either being paid on a reasonable cost basis or have a portion of the PPS payment based on reasonable cost principles subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 226 IRFs, 396 LTCHs, and 440 IPFs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively, or 100 percent of the Federal per diem amount under the IPF PPS. As stated above, IRFs and IPFs are not affected by this final rule. The impacts of the changes to LTCHs are discussed separately below. In addition, there are 1,320 IPFs co-located in hospitals otherwise subject to the IPPS, 312 of which are paid on a blend of the IPF PPS per diem payment and the reasonable cost-based payment. The remaining 1,008 IPF units are paid 100 percent of the Federal amount under the IPF PPS. There are 970 IRFs (paid under the IRF PPS) co-located in hospitals otherwise subject to the IPPS.

In the past, certain hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid fully on a reasonable cost basis are subject to TEFRA limits for FY 2009. For these hospitals (cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, the update is the percentage increase in the FY 2009 IPPS operating market basket, which is estimated to be 3.6 percent, based on Global Insight, Inc.'s 2008 second quarter forecast of the IPPS operating market basket increase. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update target amounts by the rate-of-increase percentage. For RNHCIs, the update is the percentage increase in the FY 2009 IPPS operating market basket increase, which is estimated to be 3.6 percent, based on Global Insight, Inc.'s 2008 second quarter forecast of the IPPS operating market basket increase.

The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers received a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. This transitional period for a blended payment amount for IPFs ended for cost reporting periods that began on or after January 1, 2008. Because the reasonable cost-based amount is zero percent for cost reporting periods beginning during CY 2008, no IPF will have a portion of its PPS payment that is based in part on reasonable cost subject to the rate-of-increase ceiling during FY 2009. Thus, there is no longer a need for an update factor for IPFs' TEFRA target amount for FY 2009 and thereafter.

The impact on those excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit, that continue to be paid under the TEFRA system, whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the IPPS for operating costs. Changes to the capital payments are discussed in section VIII. of this Appendix. We note that, due to recently passed legislation (section 124 of Pub. L. 110–275) that extended certain special exceptions and reinstated the provisions of section 508 of Public Law 108–173 relating to the wage index reclassifications of hospitals for an additional year, through FY 2009, as discussed in section III.I. of the preamble of this final rule, we are unable to finalize the FY 2009 wage index at this time. Therefore, we are also unable to finalize budget neutrality calculations, the outlier threshold, the outlier offsets, and the standardized payment amounts. We have calculated tentative amounts for all of these factors and have based the impacts shown in the following pages on these tentative amounts. When we revise the wage index to account for the recently enacted legislation that extends certain exceptions as well as the section 508 reclassifications for an additional year through FY 2009, we will recalculate impacts and publish them in a separate **Federal Register** notice prior to October 1, 2008.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2009 operating payments will increase 4.7 percent compared to FY 2008, largely due to the statutorily mandated update to the IPPS rates. This amount also reflects the −0.9 percent FY 2009 documentation and coding adjustment to the IPPS national standardized amounts and our assumption of an additional 1.8 percent increase in case-mix between FY 2008 and FY 2009 as a result of improvements in documentation and coding that do not represent real increases in underlying resource demands and patient acuity due to the adoption of the MS–DRGs. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this final rule. However, there are other changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2007 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2007 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of FY 2009 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based DRG relative weights,
- The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2005, compared to the FY 2004 wage data.
- The effects of the recalibration of the DRG relative weights as required by section

1886(d)(4)(C) of the Act, including the wage and recalibration budget neutrality factors.

- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2009.
- The effects of the first year of the 3-year transition to apply rural floor budget neutrality adjustment at the State level. In FY 2009, hospitals will receive a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment.
- The effects of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The effect of the budget neutrality adjustment being made for the adoption of the MS–DRGs under section 1886(d)(3)(A)(iv) of the Act for the change in aggregate payments that is a result of changes in the coding or classification of discharges that do not reflect real changes in case-mix.
- The total estimated change in payments based on the FY 2009 policies relative to payments based on FY 2008 policies.

To illustrate the impacts of the FY 2009 changes, our analysis begins with an FY 2008 baseline simulation model using: The FY 2009 update of 3.6 percent; the FY 2008 DRG GROUPER (Version 25.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2008 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of Public Law 109–171, provides that for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data in a form and manner and at a time specified by the Secretary. At the time this impact was prepared, 186 hospitals did not receive the full market basket rate-of-increase for FY 2008 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the payment changes for FY 2009 using a reduced update for these 186 hospitals. However, we do not have enough information at this time to determine which hospitals will not receive the full market basket rate-of-increase for FY 2009.

Each policy change, statutorily or otherwise, is then added incrementally to this baseline, finally arriving at an FY 2009 model incorporating all of the changes. This simulation allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2008 to FY 2009. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are updating the standardized amounts for FY 2009 using the most recently forecasted hospital market basket increase for FY 2009 of 3.6 percent. (Hospitals that fail to comply with the quality data submission requirements to receive the full update will receive an update reduced by 2.0 percentage points to 1.6 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for SCHs and for MDHs are also equal to the market basket increase, or 3.6 percent.

A second significant factor that affects the changes in hospitals' payments per case from FY 2008 to FY 2009 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2008 that are no longer reclassified in FY 2009. Conversely, payments may increase for hospitals not reclassified in FY 2008 that are reclassified in FY 2009. This impact analysis was prepared under the assumption that certain special exceptions, as well as section 508 of Public Law 108–173, the reclassification provision, were to expire in FY 2009. However, legislation (section 124 of Pub. L. 110–275) enacted after preparation of this impact analysis has extended the certain special exceptions, as well as the section 508 reclassification provision for an additional year through FY 2009, and the impact of the provision will be addressed in a separate **Federal Register** notice to be published subsequent to this final rule. In the impact analysis for this final rule, the expiration of certain special exceptions as well as section 508 of Public Law 108–173 resulted in substantial impacts for a relatively small number of hospitals in a particular category because those providers would have lost their reclassification status resulting in a percentage change in payments for the category to be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2008 will be 4.7 percent of total DRG payments. When the FY 2008 final rule with comment period was published, we projected FY 2008 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2009 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2008 payments per case to estimated FY 2009 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the changes for FY 2009. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,538 hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,553 hospitals located in urban areas included in our analysis. Among these, there are 1,408 hospitals located in large urban areas (populations over 1 million), and 1,145 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 985 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2009 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the numbers of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,594, 1,430, 1,164 and 944, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,495 nonteaching hospitals in our analysis, 808 teaching hospitals with fewer than 100 residents, and 235 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 196 RRCs, 356 SCHs, 157 MDHs, 104 hospitals that are both SCHs and RRCs, and 12 hospitals that are both an MDH and an RRC.

The next series of groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2005 Medicare cost reports.

The next two groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2009. The second grouping shows the MGCRB rural reclassifications. The final category shows the impact of the policy changes on the 20 cardiac specialty hospitals in our analysis.

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TABLE I.--IMPACT ANALYSIS OF CHANGES FOR FY 2009

	Number of Hospitals[1]	FY 2009 Weights & DRG Changes[2] (1)	FY 2009 Wage Data[3] (2)	FY 2009 DRG, Rel. Wts. and Wage Index Changes[4] (3)	FY 2009 MGCRB Reclassifications[5] (4)	Transitional 1/5th Within State Rural Floor Budget Neutrality and 4/5th National Rural Floor Budget Neutrality[6] (5)	FY 2009 Out-Migration Adjustment[7] (6)	All FY 2009 Changes w/ CMI Adjustment prior to Assumed Growth[8] (7)	All FY 2009 Changes w/CMI Adjustment and Assumed Growth[9] (8)
All Hospitals	3,538	0.1	0	0	0	0	0	2.9	4.7
By Geographic Location:									
Urban hospitals	2,553	0.2	0	0.1	-0.3	0	0	3	4.8
Large urban areas	1,408	0.4	-0.1	0.3	-0.4	0	0	3.2	5
Other urban areas	1,145	-0.1	0	-0.1	0	0.1	0	2.7	4.5
Rural hospitals	985	-0.9	0	-1	2.1	-0.1	0.1	2.1	3.9
Bed Size (Urban):									
0-99 beds	643	-0.7	0	-0.8	-0.5	0.1	0	2	3.9
100-199 beds	834	0.1	0	0.1	-0.1	0.1	0.1	2.8	4.7
200-299 beds	484	0.2	0	0.2	-0.2	0	0	3	4.9
300-499 beds	407	0.3	0	0.2	-0.2	0.1	0	3.1	5
500 or more beds	185	0.4	-0.2	0.1	-0.4	-0.1	0	3	4.8
Bed Size (Rural):									
0-49 beds	339	-2.2	0	-2.3	0.7	-0.1	0.2	1.2	3.1
50-99 beds	374	-1.2	0	-1.2	1.1	-0.1	0.1	1.8	3.7
100-149 beds	164	-0.8	0.1	-0.7	2.6	-0.1	0.1	2.2	4
150-199 beds	64	-0.7	-0.1	-0.8	2.6	-0.2	0	2.3	4.1
200 or more beds	44	-0.3	-0.2	-0.5	3.6	-0.1	0	2.6	4.4
Urban by Region:									
New England	121	0	0.1	0	0.4	0.5	0.1	2.3	4.2
Middle Atlantic	349	0	-0.5	-0.5	0.1	0	0.1	1.7	3.6
South Atlantic	385	0.3	-0.2	0	-0.4	-0.1	0	3.1	4.9
East North Central	396	0.4	-0.5	-0.1	-0.3	-0.1	0	2.8	4.6
East South Central	164	-0.1	-0.1	-0.2	-0.2	-0.1	0	2.8	4.7
West North Central	158	-0.1	0.3	0	-0.7	-0.1	0	3.1	5
West South Central	374	0.3	0	0.3	-0.6	-0.1	0	3.2	5
Mountain	158	0.3	0.2	0.4	-0.1	-0.1	0	3.5	5.4
Pacific	395	0.3	1.1	1.4	-0.3	0.5	0	4.5	6.4
Puerto Rico	53	-0.1	-0.7	-0.9	-0.8	-0.1	0	1.9	3.8
Rural by Region:									
New England	23	-0.8	-0.6	-1.4	2.4	-0.3	0	1.5	3.3
Middle Atlantic	70	-0.8	-0.2	-1.1	2	-0.1	0	1.8	3.6
South Atlantic	172	-0.5	0	-0.6	2.3	-0.2	0.1	2.4	4.3
East North Central	121	-0.8	-0.3	-1.3	1.6	-0.1	0.1	1.9	3.8
East South Central	176	-1.2	0	-1.3	2.8	-0.2	0.1	2.1	4

	Number of Hospitals[1]	FY 2009 Weights & DRG Changes[2] (1)	FY 2009 Wage Data[3] (2)	FY 2009 DRG, Rel. Wts. and Wage Index Changes[4] (3)	FY 2009 MGCRB Reclassifications[5] (4)	Transitional 1/5th Within State Rural Floor Budget Neutrality and 4/5th National Rural Floor Budget Neutrality[6] (5)	FY 2009 Out-Migration Adjustment[7] (6)	All FY 2009 Changes w/ CMI Adjustment prior to Assumed Growth[8] (7)	All FY 2009 Changes w/CMI Adjustment and Assumed Growth[9] (8)
West North Central	114	-1	0.1	-0.9	1.7	-0.1	0.1	2.1	3.9
West South Central	200	-1.6	0.4	-1.3	2.7	-0.1	0.1	1.8	3.7
Mountain	75	-0.8	0	-0.9	0.5	-0.1	0.1	1.7	3.5
Pacific	34	-0.7	0.8	0	2	-0.2	0	2.7	4.6
By Payment Classification:									
Urban hospitals	2,594	0.2	-0.1	0.1	-0.2	0	0	3	4.8
Large urban areas	1,430	0.4	-0.1	0.3	-0.4	0	0	3.2	5
Other urban areas	1,164	-0.1	0	-0.1	-0	0.1	0	2.7	4.5
Rural areas	944	-1	0	-1	2	-0.1	0.1	2	3.9
Teaching Status:									
Nonteaching	2,495	-0.2	0	-0.2	0.3	0.1	0	2.7	4.6
Fewer than 100 residents	808	0.2	0	0.1	-0.2	-0.1	0	2.9	4.8
100 or more residents	235	0.4	-0.3	0.1	-0.3	0	0	3	4.8
Urban DSH:									
Non-DSH	816	-0.3	-0.1	-0.5	-0.1	0	0.1	2.3	4.2
100 or more beds	1,559	0.3	0	0.3	-0.3	0	0	3.1	5
Less than 100 beds	353	-0.7	0.1	-0.7	-0.2	0.1	0	2.2	4.1
Rural DSH:									
SCH	397	-1.4	0	-1.4	0.5	-0.1	0.1	2.1	4
RRC	207	-0.6	0	-0.6	3.4	-0.2	0	2.4	4.3
100 or more beds	37	-0.7	-0.2	-0.9	1	-0.2	0.3	1.4	3.3
Less than 100 beds	169	-1.5	0	-1.6	1.3	-0.2	0.3	1	2.9
Urban teaching and DSH:									
Both teaching and DSH	820	0.4	-0.1	0.2	-0.4	0	0	3.1	4.9
Teaching and no DSH	163	-0.2	-0.2	-0.4	0	0	0.1	2.4	4.2
No teaching and DSH	1,092	0.2	0.1	0.2	0	0.1	0	3.2	5.1
No teaching and no DSH	519	-0.2	-0.1	-0.4	-0.2	0	0	2.3	4.2
Special Hospital Types:									
RRC	196	-0.4	0	-0.4	3.3	-0.1	0	2.8	4.7
SCH	356	-1.2	0	-1.3	0.4	-0.1	0.1	1.8	3.6
MDH	157	-1.7	0.1	-1.7	0.5	-0.1	0.2	2.8	4.7
SCH and RRC	104	-0.5	0.1	-0.5	1.8	-0.1	0	2.7	4.6
MDH and RRC	12	-1.3	0.1	-1.2	0.8	-0.1	0	1.8	3.6
Type of Ownership:									

	Number of Hospitals[1]	FY 2009 Weights & DRG Changes[2] (1)	FY 2009 Wage Data[3] (2)	FY 2009 DRG, Rel. Wts. and Wage Index Changes[4] (3)	FY 2009 MGCRB Reclassifications[5] (4)	Transitional 1/5th Within State Rural Floor Budget Neutrality and 4/5th National Rural Floor Budget Neutrality[6] (5)	FY 2009 Out-Migration Adjustment[7] (6)	All FY 2009 Changes w/ CMI Adjustment prior to Assumed Growth[8] (7)	All FY 2009 Changes w/CMI Adjustment and Assumed Growth[9] (8)
Voluntary	2,035	0.1	-0.1	0	0	0	0	2.8	4.6
Proprietary	856	0	0	-0.1	0	-0.1	0	2.9	4.7
Government	586	0.1	-0.1	0	0.1	0.1	0	3.2	5.1
Medicare Utilization as a Percent of Inpatient Days:									
0-25	257	0.8	0	0.7	-0.5	0	0	3.8	5.6
25-50	1,344	0.3	0	0.3	-0.4	0	0	3.2	5
50-65	1,432	-0.1	-0.2	-0.4	0.5	0	0	2.5	4.3
Over 65	394	-0.8	-0.2	-1	0.5	0	0.1	1.7	3.6
FY 2009 Reclassifications by the Medicare Geographic Classification Review Board:									
All Reclassified Hospitals	741	0	0	0	2.3	-0.1	0	2.8	4.7
Non-Reclassified Hospitals	2,797	0.1	-0.1	0	-0.7	0	0	2.9	4.7
Urban Hospitals Reclassified	382	0.3	0.1	0.2	1.9	-0.1	0	3	4.9
Urban Nonreclassified, FY 2009:	2,149	0.2	-0.1	0.1	-0.7	0	0	2.9	4.8
All Rural Hospitals Reclassified Full Year FY 2009:	359	-0.7	0	-0.7	3.4	-0.1	0	2.4	4.2
Rural Nonreclassified Hospitals Full Year FY 2009:	565	-1.4	-0.1	-1.5	-0.3	-0.1	0.2	1.6	3.4
All Section 401 Reclassified Hospitals:	30	-1.5	0	-1.6	-0.5	0	0	1.2	3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	-0.9	-0.3	-1.3	3.2	-0.2	0	1.6	3.4
Specialty Hospitals									
Cardiac specialty Hospitals	20	-2.4	-0.2	-2.6	-0.7	0	0	0.3	2.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2007, and hospital cost report data are from reporting periods beginning in FY 2006 and FY 2005.

[2] This column displays the payment impact of the changes to the V26 GROUPER and the recalibration of the DRG weights based on FY 2007 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the payment impact of updating the wage index data to the FY 2005 cost report data.

[4] This column displays the combined payment impact of the changes in column 2 and column 3 and the budget neutrality factors for DRG and wage index changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[5] Shown here are the tentative effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2009 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2008. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991339.

[6] This column displays the tentative effects of the rural floor and the imputed floor, including the transition to the rural floor budget neutrality adjustment at the State level. Under the transition, hospitals will receive a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment.

[7] This column displays the tentative impact of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[8] This column shows tentative changes in payments from FY 2008 to FY 2009, including the FY 2009 -0.9 percent documentation and coding adjustment, but not the projected 1.8 percent increase in case-mix expected to occur in FY 2009 due to improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the FY 2009 update, and changes in hospitals' reclassification status in FY 2009 compared to FY 2008.

[9] This column shows tentative changes in payments from FY 2008 to FY 2009, including the FY 2009 -0.9 percent documentation and coding adjustment and the projected 1.8 percent increase in case-mix expected to occur in FY 2009 due to improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 ,8 (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the FY 2008 update, and changes in hospitals' reclassification status in FY 2009 compared to FY 2008. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

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C. Effects of the Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 2)

In Column 2 of Table I, we present the effects of the DRG reclassifications, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this final rule, the FY 2009 DRG relative weights will be 100 percent cost-based and 100 percent MS–DRGs, thus completing our 3-year transition to cost-based relative weights and our 2-year transition to MS–DRGs. For FY 2009, the MS–DRGs are calculated using the FY 2007 MedPAR data grouped to the Version 26.0 (FY 2009) DRGs. The methods of calculating the relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this final rule. In previous years, this column also reflected the effects of the recalibration budget neutrality factor that is applied to the hospital-specific rates and the Puerto Rico-specific standardized amount. However, for this final rule, we show the effects of the recalibration budget neutrality factor of 0.998795 in column 4. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we are applying a budget neutrality factor to the national standardized amounts to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This wage and recalibration budget neutrality factor of 0.999580 is applied to payments in Column 4 and not Column 2.

The changes to the relative weights and DRGs shown in column 2 are prior to any offset for budget neutrality. The ''All Hospitals'' line indicates that changes in this column will increase payments by 0.1 percent. However, as stated earlier, the changes shown in this column are combined with revisions to the wage index, and the budget neutrality adjustments made for these changes are shown in column 4. Thus, the impact after accounting only for budget neutrality for changes to the DRG relative weights and classification is somewhat lower than the figures shown in this column (approximately 0.1 percent).

D. Effects of Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2009 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005. The estimated impact of the wage data on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage changes in payments when going from a model using the FY 2008 wage index, based on FY 2004 wage data and having a 100-percent occupational mix adjustment applied, to a model using the FY 2009 pre-reclassification wage index, also having a 100-percent occupational mix adjustment applied, based on FY 2005 wage data (while holding other payment parameters such as use of the Version 26.0 DRG GROUPER constant). The wage data collected on the FY 2005 cost report include overhead costs for contract labor that were not collected on FY 2004 and earlier cost reports. The impacts below incorporate the effects of the FY 2005 wage data collected on hospital cost reports, including additional overhead costs for contract labor compared to the wage data from FY 2004 cost reports that were used to calculate the FY 2008 wage index.

Column 3 shows the impacts of updating the wage data using FY 2004 cost reports. Overall, the new wage data will lead to a 0.0 percent change for all hospitals before application of the wage and DRG recalibration budget neutrality adjustment shown in column 4. Thus, the figures in this column are estimated to be the same as what they otherwise would be if they also illustrated a budget neutrality adjustment solely for changes to the wage index. Among the regions, the largest increase is in the urban Pacific region, which experiences a 1.1 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in Puerto Rico (0.7 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 4.3 percent compared to FY 2008. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 4.3 percent increase in average hourly wage. Of the 3,458 hospitals with wage data for both FYs 2008 and 2009, 1,703, or 49.2 percent, experienced an average hourly wage increase of 4.3 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2009 relative to FY 2008. Among urban hospitals, 32 will experience an increase of more than 5 percent and less than 10 percent and 3 will experience an increase of more than 10 percent. Among rural hospitals, none will experience an increase of more than 5 percent and less than 10 percent, and none will experience an increase of more than 10 percent. However, 970 rural hospitals will experience increases or decreases of less than 5 percent, while 2,426 urban hospitals will experience increases or decreases of less than 5 percent. Seventeen urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Ten urban hospitals will experience decreases in their wage index values of greater than 10 percent. No rural hospitals will experience decreases of more than 5 percent. These figures reflect changes in the wage index which is an adjustment to either 69.7 percent or 62 percent of a hospital's standardized amount, depending upon whether its wage index is greater than 1.0 or less than or equal to 1.0. Therefore, these figures are illustrating a somewhat larger change in the wage index than would occur to the hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	3	0
Increase more than 5 percent and less than 10 percent	32	0
Increase or decrease less than 5 percent	2,426	970
Decrease more than 5 percent and less than 10 percent	17	0
Decrease more than 10 percent	10	0

E. Combined Effects of MS–DRG and Wage Index Changes (Column 4)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, in determining the budget neutrality factor, we equated simulated aggregate payments for FY 2008 and FY 2009 using the FY 2007 Medicare utilization data after applying the changes to the DRG relative weights and the wage index.

We computed a wage and MS–DRG recalibration budget neutrality factor of 0.999580 (which is applied to the national standardized amounts) and a recalibration budget neutrality factor 0.998795 (which is applied to the hospital-specific rates and the Puerto Rico-specific standardized amount). The 0.0 percent impact for all hospitals demonstrates that the MS–DRG and wage changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the MS–DRG reclassifications and the updated wage index are shown in Column 4. The estimated changes shown in this column reflect the combined effects of the changes in Columns 2 and 3 and the budget neutrality factors discussed previously.

We estimate that the combined impact of the changes to the relative weights and DRGs and the updated wage data with budget neutrality applied will increase payments to hospitals located in large urban areas (populations over 1 million) by approximately 0.3 percent. These changes will generally increase payments to hospitals in all urban areas (0.1 percent) and teaching hospitals (0.1 percent). Rural hospitals will generally experience a decrease in payments (−1.0 percent). Among the rural hospital categories, rural hospitals with less than 50 beds will experience the greatest decline in payment (−2.3 percent) primarily due to the changes to MS–DRGs and the relative cost weights.

F. Effects of MGCRB Reclassifications (Column 5)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The changes in Column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2009 which affect hospitals' wage index area assignments.

By Spring of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. Hospitals may appeal denials of MGCRB decisions to the CMS Administrator. Further, hospitals have 45 days from publication of the IPPS rule in the **Federal Register** to decide whether to withdraw or terminate an approved geographic reclassification for the following year. This column reflects all MGCRB decisions, Administrator appeals and decisions of hospitals for FY 2009 geographic reclassifications.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, for the purposes of this impact analysis, we are applying an adjustment of 0.991339 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this final rule.) Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 2.1 percent.

However, we note that this budget neutrality factor and this impact are both calculated using wage adjustments applied prior to legislation that extends certain special exceptions and section 508 reclassifications for an additional year through FY 2009. As noted earlier in section III.I.7. of the preamble of this final rule, for affected areas, CMS will use best efforts to apply a reclassification decision for FY 2009 on behalf of hospitals to give them the highest wage index. Hospitals will have 15 days from the date of publication to revise the decision that CMS made on their behalf. We are unable to state with certainty that all of the reclassified providers shown in tentative Table 9A of the Addendum to this final rule will retain their approved reclassifications for FY 2009 once the wage indices that account for the new legislation are known. We will include the FY 2009 wage related impacts and our reclassification decisions made on behalf of hospitals in a separate **Federal Register** notice document to be published prior to October 1, 2008.

G. Effects of the Rural Floor and Imputed Floor, Including the Transition to Apply Budget Neutrality at the State Level (Column 6)

As discussed in section III.B. of the preamble of this FY 2009 final rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 proposed rule, we had proposed to apply the rural floor budget neutrality adjustment at the State level, which will redistribute payments within the State rather than across all other providers within the Nation. In this final rule, we are finalizing the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals will receive a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. The national rural floor budget neutrality applied to the wage index is 0.996355. The within-State rural floor budget neutrality factors applied to the wage index will be available in Table 4D that will be published in a separate **Federal Register** notice before October 1, 2008. After the wage index is blended, an additional adjustment of 0.999923 is applied to the wage index to ensure that payments before the application of the rural floor are equivalent to the payments under the blended budget neutral rural floor wage index.

Furthermore, the FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed floor was established for States that do not have rural areas or rural IPPS hospitals. In the FY 2008 IPPS final rule with comment period (72 FR 47321), we finalized our rule to extend the imputed floor for 1 additional year. In this final rule, we are extending the imputed floor for an additional 3 years through FY 2011. Furthermore, in the proposed rule, we wanted the application of the imputed floor budget neutrality to be consistent with our application of the rural floor budget neutrality adjustment at the State level, so we proposed to apply the imputed floor budget neutrality adjustment to the wage index at the State level. In this final rule, we will have a 3-year transition to the rural floor budget neutrality adjustment at the State level. Therefore, we will also apply the imputed floor budget neutrality adjustment at the State level through a 3-year transition, so that wage indices adjusted for the imputed floor will be blended where 80 percent of the wage index will have the national rural and imputed floor budget neutrality factor applied and 20 percent of the wage index will have the within-State rural and imputed budget neutrality factor applied. The national rural floor budget neutrality factor listed also incorporates the imputed floor in its adjustment to the wage index. Column 6 shows the projected impact of the rural floor and the imputed floor, including the application of the transition to within-State rural and imputed floor budget neutrality. The column compares the post-reclassification FY 2009 wage index of providers before the rural floor adjustment and the post-reclassification FY 2009 wage index of providers with the rural floor and

imputed floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, in prior years, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) had experienced a decrease in payments due to the budget neutrality adjustment applied nationally. However, under this final rule, because the rural floor adjusted wage index is based on a blend where 20 percent of the wage index has a within state budget neutrality factor applied and 80 percent of the wage index has a national rural floor budget neutrality factor applied, rural hospitals and urban hospitals that do not benefit from the rural floor will continue to see decreases in payments, to a lesser extent. Conversely, all hospitals in States with hospitals receiving a rural floor will have their wage indices only partly downwardly adjusted to achieve budget neutrality within the State.

We project that, in aggregate, rural hospitals will experience a 0.1 percent decrease in payments as a result of the transition to within-State rural floor budget neutrality. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because those providers benefit from the rural floor. Rural New England hospitals can expect the greatest decrease in payment, 0.3 percent, because under the blended rural floor budget neutrality adjustment, hospitals in Vermont will receive a rural floor budget neutrality adjustment of 0.97721 or a reduction of approximately 2 percent, and hospitals in Connecticut will receive a rural floor budget neutrality adjustment of 0.98968 or a reduction of approximately 1 percent. New Jersey, which is the only State that benefits from the imputed floor, is expected to receive a rural floor budget neutrality adjustment of 0.99441, or a reduction of less than 1 percent.

We note that these wage indices and rural floor budget neutrality factors are subject to change when we revise these factors to account for the recent enacted legislation that extended certain special exceptions and section 508 reclassifications through FY 2009. In the notice that we will publish in the **Federal Register** prior to October 1, 2008, we will present the revised wage indices and rural floor budget neutrality factors and the impacts.

The table that appears in section III B.2.b. of the preamble of this final rule compares payments under our former policy of applying rural floor budget neutrality at the national level to payments under our new policy to undergo a 3-year transition to apply the rural floor budget neutrality within the State so that, for FY 2009, hospitals receive a blended wage index where 20 percent of their wage index has the within-State rural floor budget neutrality applied and 80 percent of their wage index has the national rural floor budget neutrality applied. The last column of the table shows the net effect on State payments resulting from this policy change. The table shows that, under our former policy of applying budget neutrality at the national level, States that do not have any hospitals receiving the rural floor wage index will expect a decrease in payments because, in order to maintain budget neutrality nationally, these hospitals have to pay for the hospitals in other States that do receive a rural floor. For example, States such as Arizona, New York, and Rhode Island, which do not have hospitals receiving a rural floor, will expect to lose 0.2 percent in payments under a national rural floor budget neutrality adjustment. However, under our new policy to transition to within-State rural floor budget neutrality and to have a blended budget neutral wage index for FY 2009, States with providers that receive the rural floor will expect minor decreases in their payments under blended budget neutral wage indices relative to a wage index with national rural floor budget neutrality applied. Therefore, States such as California and Connecticut, which have several hospitals that benefit from the rural floor, can expect decreases in payments by 0.2 and 0.4, respectively. States that do not have hospitals receiving a floor will see a negligible change in payments (compared with our previous policy of applying budget neutrality at the national level) because a majority of their wage index (80 percent) has a national rural floor budget neutrality applied, resulting in a zero percent change in payments relative to national rural floor budget neutrality. For States that do not have hospitals receiving a floor, their wage indices is a blend of a wage index with within-State budget neutrality applied (which is 1.0 because they do not have a rural floor) and a wage index with a national rural floor budget neutrality applied (which is 0.996355), so the blended wage index would be reduced by 0.19 percent.

H. Effects of the Wage Index Adjustment for Out-Migration (Column 7)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, rural providers will experience a 0.1 percent increase in payments in FY 2009 relative to no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $34 million.

As section 505 reclassification adjustments must be calculated using wage data after accounting for the extension of certain special exceptions and section 508 reclassifications through FY 2009, we are unable to assess whether any new counties would qualify for section 505 reclassification adjustments for FY 2009. In the notice that we will publish in the **Federal Register** prior to October 1, 2008, we will show any new counties that qualify for the section 505 reclassification adjustment for FY 2009 and any related impacts that result from application of the out-migration adjustment to the revised adjusted wage indices.

I. Effects of All Changes With CMI Adjustment Prior to Estimated Growth (Column 8)

Column 8 compares our estimate of payments per case between FY 2008 and FY 2009 with all changes reflected in this final rule for FY 2009, including a −0.9 percent documentation and coding adjustment to the FY 2009 national standardized amounts to account for anticipated improvements in documentation and coding that are expected to increase case-mix. We generally apply an adjustment to the DRGs to ensure budget neutrality assuming constant utilization. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that the adoption of MS–DRGs would lead to increases in case-mix as a result of improved documentation and coding. In the FY 2008 IPPS final rule with comment period, we had finalized a policy to apply a documentation and coding adjustment to the standardized amount of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to offset the expected increase in case-mix and achieve budget neutrality. However, in compliance with section 7 of Public Law 110–90, we reduced the documentation and coding adjustment to −0.6 percent for FY 2008. In accordance with section 7 of Public Law 110–90, for FY 2009, we are applying a documentation and coding adjustment of −0.9 percent to the FY 2009 national standardized amounts (in addition to the −0.6 percent adjustment made for FY 2008). We are not applying the documentation and coding adjustment to the FY 2009 hospital-specific rates and the FY 2009 Puerto Rico-specific standardized amount. However, we continue to believe that case-mix growth of an additional 1.8 percent compared to FY 2008 is likely to occur across all hospitals as a result of improvements in documentation and coding.

Column 8 illustrates the total payment change for FY 2009 compared to FY 2008, taking into account the −0.9 percent FY 2009 documentation and coding adjustment but not the projected 1.8 percent case-mix increase itself. Therefore, this column illustrates a total payment change that is less than what is anticipated to occur.

J. Effects of All Changes With CMI Adjustment and Estimated Growth (Column 9)

Column 9 compares our estimate of payments per case between FY 2008 and FY 2009, incorporating all changes reflected in this final rule for FY 2009 (including statutory changes). This column includes the FY 2009 documentation and coding adjustment of −0.9 percent and the projected 1.8 percent increase in case-mix from improved documentation and coding (with the 1.8 percent case-mix increase assumed to occur equally across all hospitals). We note that this impact is calculated using standardized amounts, outlier estimates, and budget neutrality factors that do not account for wage index changes due to the recently

enacted legislation that extends certain special exceptions and section 508 reclassifications for FY 2009.

Column 9 reflects the impact of all FY 2009 changes relative to FY 2008, including those shown in Columns 2 through 7. The average increase for all hospitals is approximately 4.7 percent. This increase includes the effects of the 3.6 percent market basket update. It also reflects the 0.4 percentage point difference between the projected outlier payments in FY 2008 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2008 (4.7 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 0.4 percentage points lower in FY 2008 than originally estimated, resulting in a 0.4 percentage point greater increase for FY 2009 than would otherwise occur. This analysis accounts for the impact of expiration of certain special exceptions and section 508 reclassification, a nonbudget neutral provision, which results in a decrease in estimated payments by 0.1 percent. However, recently enacted legislation has extended certain special exceptions and section 508 reclassifications for FY 2009, and a revised impacts analysis to account for this change will be published in a **Federal Register** notice prior to October 1, 2008. There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 9 may not equal the product of the percentage changes described above.

The overall change in payments per case for hospitals in FY 2009 is estimated to increase by 4.7 percent. Hospitals in urban areas will experience an estimated 4.8 percent increase in payments per case compared to FY 2008. Hospitals in large urban areas will experience an estimated 5.0 percent increase and hospitals in other urban areas will experience an estimated 4.5 percent increase in payments per case in FY 2008. Hospital payments per case in rural areas are estimated to increase 3.9 percent. The increases that are larger than the national average for larger urban areas and smaller than the national average for other urban and rural areas are largely attributed to the differential impact of adopting MS–DRGs.

Among urban census divisions, the largest estimated payment increases will be 6.4 percent in the Pacific region (generally attributed to MS–DRGs and wage data) and 5.4 percent in the Mountain region (mostly due to MS–DRGs). The smallest urban increase is estimated at 3.6 percent in the Middle Atlantic region.

Among the rural regions in Column 9, the providers in the New England region experience the smallest increase in payments (3.3 percent) primarily due to the transition to the within-State rural floor budget neutrality adjustment. The Pacific and South Atlantic regions will have the highest increases among rural regions, with 4.6 percent and 4.3 percent estimated increases, respectively. Again, increases in rural areas are generally less than the national average due to the adoption of MS–DRGs.

Among special categories of rural hospitals in Column 9, the MDH and the RRC providers will receive an estimated increase in payments of 4.7 percent, and the MDHs and RRCs will experience an estimated increase in payments by 3.6 percent.

Urban hospitals reclassified for FY 2009 are anticipated to receive an increase of 4.9 percent, while urban hospitals that are not reclassified for FY 2009 are expected to receive an increase of 4.8 percent. Rural hospitals reclassifying for FY 2009 are anticipated to receive a 4.2 percent payment increase and rural hospitals that are not reclassifying are estimated to receive a payment increase of 3.4 percent.

K. Effects of Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2009, we are continuing to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that three providers will receive the low-volume adjustment for FY 2009. We estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $22,000.

L. Impact Analysis of Table II

Table II presents the projected impact of the changes for FY 2009 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2008 with the average estimated payments per case for FY 2009, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from Column 9 of Table I.

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TABLE II.--IMPACT ANALYSIS OF CHANGES FOR FY 2009 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)

	Number of Hospitals	Average FY 2008 Payment Per Case[1] (2)	Average FY 2009 Payment Per Case[1] (3)	All FY 2009 Changes (4)
All hospitals	3,538	$9,150	$9,581	4.7
By Geographic Location:				
Urban hospitals	2,553	$9,574	$10,034	4.8
Large urban areas (populations over 1 million)	1,408	$10,046	$10,551	5
Other urban areas (populations of 1 million or fewer)	1,145	$9,005	$9,411	4.5
Rural hospitals	985	$6,700	$6,962	3.9
Bed Size (Urban):				
0-99 beds	643	$7,272	$7,557	3.9
100-199 beds	834	$8,141	$8,522	4.7
200-299 beds	484	$8,965	$9,400	4.9
300-499 beds	407	$10,002	$10,498	5
500 or more beds	185	$11,808	$12,378	4.8
Bed Size (Rural):				
0-49 beds	339	$5,465	$5,634	3.1
50-99 beds	374	$6,151	$6,379	3.7
100-149 beds	164	$6,672	$6,941	4
150-199 beds	64	$7,393	$7,700	4.1
200 or more beds	44	$8,386	$8,757	4.4
Urban by Region:				
New England	121	$9,927	$10,339	4.2
Middle Atlantic	349	$10,432	$10,805	3.6
South Atlantic	385	$9,033	$9,479	4.9
East North Central	396	$9,080	$9,501	4.6
East South Central	164	$8,654	$9,060	4.7
West North Central	158	$9,144	$9,598	5
West South Central	374	$9,044	$9,501	5
Mountain	158	$9,586	$10,105	5.4
Pacific	395	$11,591	$12,332	6.4
Puerto Rico	53	$4,713	$4,891	3.8
Rural by Region:				
New England	23	$9,083	$9,381	3.3
Middle Atlantic	70	$6,922	$7,173	3.6
South Atlantic	172	$6,523	$6,804	4.3
East North Central	121	$6,878	$7,138	3.8
East South Central	176	$6,259	$6,510	4
West North Central	114	$6,996	$7,271	3.9
West South Central	200	$6,092	$6,319	3.7
Mountain	75	$6,867	$7,110	3.5
Pacific	34	$8,179	$8,554	4.6
By Payment Classification:				

	Number of Hospitals	Average FY 2008 Payment Per Case[1] (2)	Average FY 2009 Payment Per Case[1] (3)	All FY 2009 Changes (4)
Urban hospitals	2,594	$9,553	$10,012	4.8
Large urban areas (populations over 1 million)	1,430	$10,027	$10,531	5
Other urban areas (populations of 1 million or fewer)	1,164	$8,980	$9,385	4.5
Rural areas	944	$6,732	$6,996	3.9
Teaching Status:				
Non-teaching	2,495	$7,725	$8,082	4.6
Fewer than 100 Residents	808	$9,219	$9,658	4.8
100 or more Residents	235	$13,452	$14,098	4.8
Urban DSH:				
Non-DSH	816	$8,134	$8,472	4.2
100 or more beds	1,559	$10,041	$10,540	5
Less than 100 beds	353	$6,763	$7,041	4.1
Rural DSH:				
SCH	397	$6,132	$6,374	4
RRC	207	$7,483	$7,802	4.3
100 or more beds	37	$6,057	$6,256	3.3
Less than 100 beds	169	$5,457	$5,614	2.9
Urban teaching and DSH:				
Both teaching and DSH	820	$10,973	$11,509	4.9
Teaching and no DSH	163	$8,930	$9,308	4.2
No teaching and DSH	1,092	$8,285	$8,704	5.1
No teaching and no DSH	519	$7,795	$8,122	4.2
Rural Hospital Types:				
RRC	196	$7,709	$8,069	4.7
SCH	356	$6,585	$6,823	3.6
MDH	157	$5,803	$6,076	4.7
SCH and RRC	104	$8,088	$8,461	4.6
MDH and RRC	12	$7,273	$7,538	3.6
Type of Ownership:				
Voluntary	2,035	$9,255	$9,685	4.6
Proprietary	856	$8,451	$8,851	4.7
Government	586	$9,432	$9,909	5.1
Medicare Utilization as a Percent of Inpatient Days:				
0-25	257	$13,016	$13,749	5.6
25-50	1,344	$10,349	$10,869	5
50-65	1,432	$7,964	$8,309	4.3
Over 65	394	$7,041	$7,291	3.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2009 Reclassifications:				
All Reclassified Hospitals FY 2009	741	$8,708	$9,118	4.7
All Non-Reclassified Hospitals FY 2009	2,797	$9,289	$9,726	4.7
Urban Reclassified Hospitals FY 2009:	382	$9,483	$9,948	4.9
Urban Non-reclassified Hospitals FY 2009:	2,149	$9,602	$10,062	4.8
Rural Reclassified Hospitals FY 2009:	359	$7,267	$7,574	4.2
Rural Nonreclassified Hospitals FY 2009:	565	$5,880	$6,083	3.4
All Section 401 Reclassified Hospitals:	30	$7,517	$7,744	3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	$6,542	$6,766	3.4
Specialty Hospitals				
Cardiac Specialty Hospitals	20	$10,846	$11,073	2.1

[1]These payment amounts per case do not reflect any estimates of annual case-mix increase.

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VII. Effects of Other Policy Changes

In addition to those policy changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Effects of Policy on HACs, Including Infections

In section II.F. of the preamble of this final rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision will result in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case.

The HAC payment provision will go into effect on October 1, 2008. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings (in millions)
FY 2009	$21
FY 2010	21
FY 2011	21
FY 2012	22
FY 2013	22

B. Effects of MS–LTC–DRG Reclassifications and Relative Weights for LTCHs

In section II.I. of the preamble to this final rule, we discuss the MS–LTC–DRGs (Version 26.0 of the GROUPER) and development of the relative weights for use under the LTCH PPS for FY 2009. We also discuss that when we adopted the new severity adjusted MS–LTC–DRG patient classification system under the LTCH PPS in the FY 2008 IPPS final rule with comment, we implemented a 2-year transition, in which the MS–LTC–DRG relative weights for FY 2009 will be based completely on the MS–LTC–DRG patient classification system (and no longer based in part on the former LTC–DRG patient classification system). Consistent with the requirement at § 412.517 established in the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884), the annual update to the classification and relative weights under the LTCH PPS for RY 2009 was done in a budget neutral manner, such that estimated aggregate LTCH PPS payments would be unaffected; that is, they would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes. To achieve budget neutrality under § 412.517, in determining the FY 2009 MS–LTC–DRG relative weights, we applied a factor of 1.03887 in the first step of the budget neutrality process (normalization), and we applied a budget neutrality factor of 1.04186 after normalization (see section II.I.4. (step 7) of the preamble of this final rule). These factors that were applied to maintain budget neutrality were based on the most recent available LTCH claims data (FY 2007 MedPAR files) for the 388 LTCHs in our database. Consistent with the budget neutrality requirement under § 412.517, we estimate that with the changes to the MS–LTC–DRG classifications and relative weights for FY 2009, there will be no change in aggregate LTCH PPS payments. In applying the budget neutrality adjustment described above, we assumed constant utilization.

C. Effects of Policy Change Relating to New Medical Service and Technology Add-On Payments

In section II.J. of the preamble to this final rule, we discuss add-on payments for new medical services and technologies. As explained in that section, add-on payments for new technology under section 1886(d)(5)(K) of the Act are not required to be budget neutral. As discussed in section II.J.4. of this final rule, one applicant, the CardioWest(tm) temporary Total Artificial Heart system (TAH-t) met the criteria for new technology add-on payments for FY 2009. There were no technologies receiving new technology add-on payment in FY 2008. In the proposed rule, we estimated that Medicare's new technology add-on payments would remain unchanged in FY 2009 compared to FY 2008 because we believed it was premature to predict which, if any, new technology add-on payment applications would be approved in the FY 2009 final rule. In the proposed rule, we stated that if any of the four applicants were found to be eligible for new technology add-on payments for FY 2009, in the final rule, we would discuss the estimated payment impact for FY 2009 in that final rule. As stated above, the TAH-t was approved for FY 2009 new technology add-on payments. The maximum add-on payment for the TAH-t is $53,000 per case and the applicant estimates that there will be approximately 180 cases in FY 2009. Therefore, we estimate that total new technology add-on payments will be $9.54 million in FY 2009.

D. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section IV.B. of the preamble of this final rule, we discuss the requirements for hospitals to report quality data in order for hospitals to receive the full annual hospital payment update for FY 2009 and FY 2010. We also note that, for the FY 2009 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the fourth quarter of data from CY 2006 and first three quarters of data from CY 2007. These data were due to the QIO Clinical Warehouse by May 15, 2007 (fourth quarter CY 2006 discharges), August 15, 2007 (first quarter CY 2007 discharges), November 15, 2007 (second quarter CY 2007 discharges), and February 15, 2008 (third quarter CY 2006 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. In the preamble of this final rule, we are providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per hospital will result in approximately 21,500 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 150 pages. Thus, the agency will have expenditures of approximately $597,600 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

E. Effects of Policy Change to Methodology for Computing Core Staffing Factors for Volume Decrease Adjustment for SCHs and MDHs

In section IV.D. of the preamble of this final rule, we discuss a change to the methodology we will use to compute the average nursing staff factors (nursing hours per patient days) for the volume decrease adjustment for SCHs and MDHs. If certain requirements are met, this adjustment may be made if the hospital's total discharges decrease by more than 5 percent from one cost reporting period to the next. We do not believe this change will have any significant

impact on Medicare payments to these hospitals.

F. Impact of the Policy Revisions Related to Payment to Hospitals for Direct Graduate Medical Education (GME)

As we discussed in detail in section IV.G. of the preamble of this final rule, we are finalizing the current GME regulations that were included in interim final rules with comment periods issued on April 12, 2006 (71 FR 18654) and November 27, 2007 (72 FR 66580), as they apply to emergency Medicare GME affiliated groups, with two modifications. They provide for greater flexibility in training residents in approved residency programs during times of disaster. Specifically, this final rule modifies the provision for ''emergency Medicare GME affiliated groups'' to extend the submission deadline for emergency Medicare GME affiliation agreements and also provides for home and host hospitals with valid emergency Medicare GME affiliation agreements an exemption to the application of the IRB ratio cap. That is, IME payments for home and host hospitals with valid emergency Medicare GME affiliation agreements are calculated based on the 3-year rolling average FTE resident count, subject to the hospital's FTE resident cap for IME; and the calculation is not subject to the IRB ratio cap.

We believe that there is limited, if any, impact associated with modifying the existing emergency Medicare GME affiliation regulations to extend the deadline for hospitals to submit emergency Medicare GME affiliation agreements. In estimating the impact resulting from the exemption from application of the IRB ratio cap for home and host hospitals with valid emergency Medicare GME affiliation agreements, CMS' Office of the Actuary notes that it is nearly impossible to predict the occurrence of future emergencies, the magnitude of those emergencies, or how they would affect graduate medical education programs at teaching hospitals in a declared emergency area under section 1135 of the Act. However, for purposes of estimating the impact of the change to hospitals affected by Hurricanes Katrina and Rita, the Office of the Actuary estimates that the IRB ratio cap exemption for home and host hospitals will result in an additional cost of no more than $1 million per year for the remaining 2 years for which emergency Medicare GME affiliation agreements due to Hurricanes Katrina and Rita are permitted.

G. Effects of Clarification of Policy for Collection of Risk Adjustment Data From MA Organizations

In section IV.H. of the preamble of this final rule, we discuss our revision of our regulations to clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee. The revision also clarifies that CMS will determine the formats for submitting encounter data, which may be more abbreviated than those used for the Medicare fee-for-service claims data submission process. At this time, we have not yet determined an approach for submission of the encounter data. Therefore, we are not in a position to determine the extent to which the cost impact of submitting encounter data would differ from the current costs to MA organizations of submitting risk adjustment data.

H. Effects of Policy Changes Relating to Hospital Emergency Services Under EMTALA

In section IV.I. of the preamble of this final rule, we are clarifying our policy regarding the applicability of EMTALA to hospital inpatients. We are stating that when an individual covered by EMTALA is admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities does not have an EMTALA obligation to accept that individual. In addition, we are making two changes related to the requirements for on-call physicians in hospital emergency departments. We are deleting the provision related to maintaining a list of on-call physicians from the EMTALA regulations at § 489.24(j)(1) and merging it with § 489.20(r)(2) because the requirement to maintain an on-call list is not found in the EMTALA statutory provision at section 1867 of the Act, but rather in section 1866 of the Act which outlines the requirements for provider agreements. We are incorporating the language of § 489.24(j)(1) as replacement language for the existing § 489.20(r)(2) and amending the regulatory language to make it more consistent with the statutory language found at section 1866(a)(1)(I)(iii) of the Act, which refers to provider agreements and the requirement to maintain an on-call list. These changes will make the regulations consistent with the statutory basis for maintaining an on-call list. In addition, we are amending our regulations to provide that hospitals may comply with the on-call list requirement by participating in a formal community call plan so long as the plan includes a number of elements that are specified in the final rule. Lastly, we are making a technical change to the regulations to conform them to the statutory language found in the Pandemic and All-Hazards Preparedness Act. These changes do not include any substantive new requirements. Although hospitals choosing to participate in a community call arrangement will be required to devise a formal community call plan, such a plan will increase a hospital's flexibility in meeting its on-call requirements. We are estimating no impact on Medicare expenditures and no significant impact on hospitals with emergency departments.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.K. of the preamble to this final rule, we discuss our implementation of section 410A of Public Law 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' There are currently 13 hospitals participating in the demonstration; 4 of these hospitals were selected to participate in the demonstration as of July 1, 2008, as a result of our February 6, 2008 solicitation (73 FR 6971).

As discussed in section IV.K. of the preamble to this final rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2009 that will be made to each participating hospital under the demonstration will be approximately $1,753,106. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. We estimate that the total annual impact of the demonstration program for FY 2009 for the 13 participating hospitals will be $22,790,388. The adjustment factor to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999764.

J. Effects of Policy Changes Relating to Payments to Hospitals-Within-Hospitals

In section VI.F. of the preamble of this final rule, we discuss our policy change to allow a HwH that, because of state law, cannot meet the criteria in regulations for a separate governing body solely because it is a State hospital occupying space with another State hospital or located on the same campus as another State hospital and both hospitals are under the same governing authority, or the governing authority of a third entity that controls both State hospitals, to nevertheless qualify for an exclusion from the IPPS if the hospital meets other applicable criteria for HwHs in the regulations and the specified criteria in this final rule. We are only aware of one hospital that would qualify for exclusion from the IPPS under the criteria and to expand its bed size under the provisions. Because any expansion would occur at some point in the future, we are unable to quantify the impact of this change.

K. Effects of Policy Changes Relating to Requirements for Disclosure of Physician Ownership in Hospitals

In section VII. of the preamble of this final rule, we discuss revisions to the definition of a physician-owned hospital at § 489.3 to include hospitals that have ownership or investment interests by a physician and/or by an immediate family member of a physician. We are excepting from the definition of physician-owned hospital those hospitals that do not have at least one owner/investor who is either a physician who refers patients to the hospital or an immediate family member of a referring physician. We believe that the changes to the definition of physician-owned hospital will result in no more than a *de minimis* increase in the number of hospitals that are subject to the disclosure requirements applicable to physician-owned hospitals. We believe that there will be very few hospitals that will meet the revised definition of physician-owned hospital that did not already meet the definition as set forth in the existing

regulations. That is, we believe there are very few hospitals that have no referring physician owners/investors but which have one or more owners/investors who are immediate family members of a referring physician. We note that such hospitals that have no physician owners/investors (and, thus, that are not subject to the former disclosure requirement) but do have at least one owner/investor that is the immediate family member of a referring physician will be subject to the revised disclosure requirement.

We expect that under the final policy for an exception to the definition of physician-owned hospital, the number of hospitals that now are subject to the disclosure requirement may be reduced slightly as we understand that there are some hospitals that have no referring physician owner/investors but rather have physician owner/investors who have retired from the practice of medicine. Thus, for both of our final changes to the definition of physician-owned hospital, the net result may be no change, or a minimal increase or decrease in the number of hospitals that are subject to the disclosure requirement. Finally, by changing the definition of physician-owned hospital to encompass immediate family members, we believe that some hospitals that already meet the definition based on the investment of referring physicians may have to amend their list of physician owner/investors to add immediate family members, which we believe will be a minimal burden.

As specified in section VII. of the preamble of this final rule, and in new § 489.20(u)(1), the list of the hospital's owners or investors who are physicians or immediate family members of physicians must be provided to the patient at the time the request for the list is made by or on behalf of the patient. We note that hospitals are already currently required to furnish the list of physician owners or investors and, thus, we believe that the impact of stipulating a timeframe for furnishing the list is negligible. Also specified in section VII. of this final rule, in new 489.20(u)(2), all hospitals must require that all physician owners who also are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients they refer to the hospital any ownership or investment interest that is held by themselves or by an immediate family member (as defined in § 411.351). Disclosure will be required at the time the referral is made. Both hospitals and physicians will participate in the disclosure process. We believe this requirement will have a minimal financial impact on physician-owned hospitals to the extent that it may require them to change their by-laws or make similar changes. We are collectively referring to the requirements of §§ 489.20(u)(1) and (u)(2) as ''physician ownership disclosure requirements.''

We do not anticipate that these policy changes discussed in section VII. of the preamble of this final rule will have a significant economic impact on a substantial number of physicians, other health care providers and suppliers, or the Medicare or Medicaid programs and their beneficiaries. Specifically, we believe that this final rule will affect mostly hospitals, physicians, and beneficiaries. The changes concerning both the definition of a physician-owned hospital and the disclosure of physician ownership in hospitals are consistent with the physician self-referral statute and regulations as well as the current practices of most hospitals. Thus, our requirement that the list of physician owners be provided to the patient at the time the request for the list is made by or on behalf of the patient will present a negligible economic impact on the hospital. Similarly, the cost borne by individual physicians to implement these provisions will be limited to a one-time cost associated with developing a disclosure notice that will be shared with patients at the time the referral is made in addition to the negligible time associated with providing the list to the patient and maintaining a copy of the notice in the patient's medical record.

Also specified in section VII. of the preamble of this final rule, new § 489.20(w) requires that hospitals and CAHs furnish written notice to all patients at the beginning of their hospital or outpatient visit if a physician is not available 24 hours per day, 7 days per week and describe how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when there is no physician present in the hospital. We referred to this requirement in section VII. of the preamble of this final rule as the ''physician availability disclosure requirement.'' This requirement was finalized in the FY 2008 IPPS final rule and previously located at § 489.20(v). Thus, there is no impact associated with this requirement.

In section VII. of the preamble of this final rule, we discuss revisions to § 489.53(c) to establish additional bases for terminating the Medicare provider agreement. In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u) or (w). In the case of a participating hospital, as defined at § 489.24, CMS may terminate the provider agreement if the participating hospital failed to comply with the requirements of § 489.20(w). We believe that the cost borne by hospitals to implement these requirements will be limited to a one-time cost associated with completing minor revisions to the hospital's policies and procedures to comply with the requirements of its Medicare provider agreement. Most hospitals have standard procedures to satisfy CMS by correcting deficiencies (such as the failure to furnish notice of physician ownership in the hospital to patients) before action is taken by CMS to terminate the Medicare provider agreement.

Overall, we believe that beneficiaries will be positively impacted by these provisions. Specifically, disclosure of physician ownership or investment interests equips patients to make informed decisions about where they elect to receive care. These policies make no significant changes that have the potential to impede patient access to health care facilities and services. In fact, we believe that our policies will help minimize anti-competitive behavior that can affect the decision as to where a beneficiary receives health care services and possibly the quality of the services furnished.

L. Effects of Policy Changes Relating to Physician Self-Referral Provisions

In section VIII. of the preamble of this final rule, we discuss changes in our policies pertaining to physician self-referral provisions, including: ''Stand in the shoes,'' period of disallowance, alternative method of compliance with certain exceptions, percentage-based compensation, unit of service (''per-click'') payments in lease arrangements, services provided ''under arrangements,'' exception for obstetrical malpractice insurance subsidies, ownership or investment interest in retirement plans, and burden of proof. We do not anticipate that these final policies will have a significant impact on physicians, other health care providers and suppliers, or the Medicare or Medicaid programs and their beneficiaries.

With respect to the policies pertaining to the physician ''stand in the shoes'' provisions, we do not anticipate that entities that have financial relationships with one or more physician organizations will find it necessary to restructure those relationships. We believe that compliance with the ''stand in the shoes'' provisions will be made easier by simplifying the required analysis of arrangements in which a physician organization is interposed between the referring physician and the entity furnishing DHS. We are not finalizing our proposal to make an entity ''stand in the shoes,'' whereby an entity that furnishes DHS would have been deemed to stand in the shoes of an organization in which it has a 100-percent ownership interest and would have been deemed to have the same compensation arrangements with the same parties and on the same terms as does the organization that it owns. In not finalizing this proposal, we anticipate no additional impact on the industry.

Our policy pertaining to the period of disallowance is a codification of what we believe is existing law and reflects what we believe most entities furnishing DHS are already following. Therefore, we do not anticipate a significant economic impact on the industry.

The following policies set forth in section VIII. of the preamble of this final rule pertain to the expansion of physician self-referral exceptions; exception for obstetrical malpractice insurance subsidies, ownership or investment interest in retirement plans, and alternative method of compliance with certain exceptions. To the extent that expanded exceptions permit additional legitimate arrangements to comply with the law, this rule will reduce the potential costs of restructuring such arrangements, and the consequences of noncompliance may be avoided entirely.

We anticipate that our remaining physician self-referral policies set forth in section VIII. of the preamble of this final rule will result in savings to the program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any

certainty the extent of these savings to the Medicare program.

M. Effects of Changes Relating to Reporting of Financial Relationships Between Hospitals and Physicians

As discussed in section IX. of the preamble to this final rule, 500 hospitals will be required to furnish information concerning their financial relationships with their physicians. The financial relationships include ownership and investment interests and compensation arrangements. This information will be submitted in a collection of information instrument that CMS has developed—the ''DFRR.'' We are unable to quantify the number of physicians who have ownership and investment interests and compensation arrangements with hospitals. Even if we assume that the 500 or less hospitals have a substantial number of financial relationships with physicians, we believe that, in general, the economic impact on these hospitals would not be substantial. Because the physician information requested in the DFRR will be on file at the hospital, we believe there should be negligible, if any, impact upon physicians or other health care providers or suppliers. Specifically, we believe that the cost to complete the DFRR for each hospital would be approximately $4,080, and the total cost burden for the industry would be approximately $2,040,000.

We expect that this final rule may result in savings to the Medicare program by minimizing anti-competitive business arrangements as well as financial incentives that encourage overutilization. In addition, to the extent that we determine that any arrangements are noncompliant with the physician self-referral statute and regulations, there may be monies returned to the Medicare Trust Fund. We cannot gauge with any certainty the extent of these savings to the Medicare program at this time. Finally, we do not anticipate any financial burden on beneficiaries or impact on beneficiary access to medically necessary services because the completion of the DFRR would be conducted by hospitals.

N. Effects of Policy Change Relating to Payments to SCHs

Currently, an SCH is paid under the IPPS based on whichever of the following rates yields the greatest aggregate payment for the cost reporting period: The Federal payment rate applicable to IPPS hospitals or the hospital-specific rate based on FY 1982, FY 1987, or FY 1996 updated costs per discharge. As discussed in section IV.D.2. of the preamble of this final rule, section 122 of Public Law 110–275, effective for cost reporting periods beginning on or after January 1, 2009, an SCH's hospital-specific rate will be based on its costs per discharge in FY 2006 if greater than the hospital-specific rates based on its costs in FY 1982, FY 1987, or FY 1986, or the IPPS rate based on the standardized amount.

In this final rule, we are incorporating this self-implementing provision of section 122 of Public Law 110–275 in our regulations.

At this time, many FY 2006 cost reports have not as yet been settled by the Medicare fiscal intermediary/MAC. Therefore, we are unable to determine with any degree of accuracy a hospital's FY 2006 costs per discharge. Because we cannot determine whether the use of the SCH's hospital-specific rate based on its FY 2006 cost report would yield the greatest aggregate payment for the cost reporting period, we are unable to determine which SCHs would benefit from this provision. However, we note that, in scoring the provision of section 112 of Public Law 110–275, the CMS Office of the Actuary estimated the cost of this provision to be $140 million for 2009 from its effective date in January 2009 through the end of FY 2009 (September 30, 2009) and the 5-year impact for FYs 2009 through 2013 to be $2.74 billion (per FY in millions: $140 in 2009, $550 in 2010, $640 in 2011, $680 in 2012, and $730 in 2013).

VIII. Effects of Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

The basic methodology for determining a capital IPPS payment is set forth at § 412.312. The basic methodology for calculating capital IPPS payments in FY 2009 is as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable).

We note that, in accordance with § 412.322(c), the IME adjustment factor for FY 2009 is equal to half of the current adjustment, as discussed in section V.B.2. of the preamble of this final rule. In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2008 update of the FY 2007 MedPAR file and the March 2008 update of the Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the March 2008 update of the most recently available hospital cost report data (FYs 2005 and 2006) to categorize hospitals. Our analysis has several qualifications. We use the best data available and make assumptions about case-mix and beneficiary enrollment as described below. In addition, as discussed in section III. of the Addendum to this final rule, as we established for FY 2008, we are adjusting the national capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009. (As discussed in section III.A.6. of the Addendum to this final rule, we are not adjusting the Puerto Rico specific capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009.) Furthermore, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. In addition, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2008 update of the FY 2007 MedPAR file, we simulated payments under the capital PPS for FY 2008 and FY 2009 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. As discussed in section III.A. of the Addendum to this final rule, section 124 of Public Law 110–275 extends, through FY 2009, wage index reclassifications under section 508 of Public Law 108–173 and special exceptions contained in the final rule published in the **Federal Register** on August 11, 2004 (69 FR 49105 and 49107) and extended under section 117 of the MMSEA of 2007 (Pub. L. 110–173). As a result, we cannot finalize the FY 2009 capital rates, including the GAF/DRG adjustment factor, the outlier payment adjustment factor, and the outlier threshold, until we recompute the wage indices for FY 2009 as a result of these extensions. (A complete discussion on the extension of these provisions can be found in section III.I. of the preamble to this final rule.) Therefore, the impact analysis presented below is based on the tentative capital rates and factors discussed in section III.A. of the Addendum to this final rule. (The final capital rates and factors for FY 2009 will be published in a forthcoming notice in the **Federal Register**.)

As we explain in section III.A. of the Addendum to this final rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education (which are reduced by 50 percent in FY 2009 in

accordance with § 412.322(c), as discussed in section V.B.2. of the preamble of this final rule), disproportionate share, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2008 and 2009. (We note that this does not reflect the expected growth in case-mix due to improvement in documentation and coding under the MS–DRGs, as discussed below.)
- We estimate that the Medicare discharges will be approximately 13 million in both FY 2008 and FY 2009.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section III.A.2.1. of the Addendum to this final rule, the FY 2009 update is 0.9 percent.
- In addition to the FY 2009 update factor, the FY 2009 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0010, an outlier adjustment factor of 0.9465, and an exceptions adjustment factor of 0.9999.
- For FY 2009, as discussed in section III.A. of the Addendum to this final rule, the FY 2009 national capital rate was further adjusted by a factor to account for anticipated improvements in documentation and coding that are expected to increase case-mix under the MS–DRGs. In the FY 2008 IPPS final rule with comment period (72 FR 47186), we established adjustments to the IPPS rates based on the Office of the Actuary projected case-mix growth resulting from improved documentation and coding of 1.2 percent for FY 2008, 1.8 percent for FY 2009, and 1.8 percent for FY 2010. However, we reduced the documentation and coding adjustment to −0.6 percent for FY 2008, and for FY 2009, we are applying an adjustment of 0.9 percent, consistent with section 7 of Public Law 110–90. As noted above and as discussed in section III.A.6. of the Addendum to this final rule, we are not adjusting the Puerto Rico-specific capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009.

B. Results

We used the actuarial model described above to estimate the potential impact of our changes for FY 2009 on total capital payments per case, using a universe of 3,538 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2008 update of the FY 2007 MedPAR file, the March 2008 update to the PSF, and the most recent cost report data from the March 2008 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2008 compared to FY 2009 based on the FY 2009 payment policies. Column 2 shows estimates of payments per case under our model for FY 2008. Column 3 shows estimates of payments per case under our model for FY 2009. Column 4 shows the total percentage change in payments from FY 2008 to FY 2009. The change represented in Column 4 includes the 0.9 percent update to the capital Federal rate, other changes in the adjustments to the capital Federal rate (for example, the 50 percent reduction to the teaching adjustment for FY 2009), and the additional 0.9 percent reduction to the national capital rate to account for improvements in documentation and coding (or other changes in coding that do not reflect real changes in case-mix) for implementation of the MS–DRGs). Consistent with the impact analysis for the policy changes under the IPPS for operating costs in section VI. of this Appendix, for purposes of this impact analysis, we also assume a 1.8 percent increase in case-mix growth for FY 2009, as determined by the Office of the Actuary, because we believe the adoption of the MS–DRGs will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patient severity of illness. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case in FY 2009 are expected to increase as compared to capital payments per case in FY 2008. The capital rate for FY 2009 will decrease 0.51 percent as compared to the FY 2008 capital rate, and the changes to the GAFs are expected to result in a slight decrease (0.3 percent) in capital payments. In addition, the 50 percent reduction to the teaching adjustment in FY 2009 will also result in a decrease in capital payments from FY 2008 as compared to FY 2009. Countering these factors is the projected case-mix growth as a result of improved documentation and coding (discussed above) as well as an estimated increase in outlier payments in FY 2008 as compared to FY 2009. The net result of these changes is an estimated 0.4 percent change in capital payments per discharge from FY 2008 to FY 2009 for all hospitals (as shown below in Table III).

The results of our comparisons by geographic location and by region are consistent with the results we expected with the decrease to the teaching adjustment in FY 2009 (§ 412.522(c)). The geographic comparison shows that, on average, all urban hospitals are expected to experience a 0.4 percent increase in capital IPPS payments per case in FY 2009 as compared to FY 2008, while hospitals in large urban areas are expected to experience a 0.1 percent increase in capital IPPS payments per case in FY 2009 as compared to FY 2008. Capital IPPS payments per case for rural hospitals are expected to increase 1.0 percent. These differences in payments per case by geographic location are mostly due to the decrease in the teaching adjustment. Because teaching hospitals generally tend to be located in urban or large urban areas, we expect that the 50 percent decrease in the teaching adjustment for FY 2009 will have a more significant impact on hospitals in those areas than those hospitals located in rural areas.

Most regions are estimated to experience an increase in total capital payments per case from FY 2008 to FY 2009. These increases vary by region and range from a 2.8 percent increase in the Pacific urban region to a 0.4 percent increase in the West North Central urban region. Two urban regions are projected to experience a relatively larger decrease in capital payments, with the difference mostly due to changes in the GAFs and the 50 percent reduction in the teaching adjustment for FY 2009: −2.3 percent in the Middle Atlantic urban region and −2.6 percent in the New England urban region. The East North Central urban region is also expected to experience a decrease of 0.6 percent in capital payments in FY 2009 as compared to FY 2008, mostly due to changes in the GAFs. There are two rural regions that are also expected to experience a decrease in total capital payments per case: a −3.2 percent decrease in the New England rural region and a −0.6 percent decrease in the Middle Atlantic rural region. Again, for these two rural regions, the projected decrease in capital payments is mostly due to changes in the GAF, as well as a smaller than average expected increase in payments due to the adoption of the MS–DRGs.

By type of ownership, voluntary and proprietary hospitals are estimated to experience an increase of 0.2 percent and 2.0 percent, respectively. The projected increase in capital payments per case for proprietary hospitals is mostly because these hospitals are expected to experience a smaller than average decrease in their payments due to the 50 percent teaching adjustment reduction for FY 2009. Government hospitals are estimated to experience a decrease in capital payments per case of −0.3 percent. This estimated decrease in capital payments is mostly due to a larger than average decrease in payments resulting from the 50 percent teaching adjustment reduction for FY 2009.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2009. Reclassification for wage index purposes also affects the GAFs because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2009, we show the average capital payments per case for reclassified hospitals for FY 2008. All classifications of reclassified hospitals are expected to experience an increase in payments in FY 2009 as compared to FY 2008. Rural nonreclassified hospitals are expected to have the smallest increase in capital payments of 0.3 percent, while rural reclassified hospitals are expected to have the largest increase in capital payments of 1.4 percent. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience a 1.3 percent increase in capital payment from FY 2008 to FY 2009. The large than average increase in projected changes in capital payments for rural reclassified and other reclassified hospitals is mainly due to

a smaller than average change in payments from FY 2009 as compared to FY 2008 resulting from the 50 percent reduction in the teaching adjustment in FY 2009.

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2008 Payments Compared To FY 2009 Payments]*

	Number of hospitals	Average FY 2008 payments/ case	Average FY 2009 payments/ case	Change
By Geographic Location:				
All hospitals	3,538	755	759	0.4
Large urban areas (populations over 1 million)	1,408	832	833	0.1
Other urban areas (populations of 1 million of fewer)	1,145	750	755	0.7
Rural areas	985	527	532	1.0
Urban hospitals	2,553	795	798	0.4
0-99 beds	643	628	640	1.9
100-199 beds	834	686	697	1.6
200-299 beds	484	749	759	1.4
300-499 beds	407	824	826	0.2
500 or more beds	185	965	951	-1.5
Rural hospitals	985	527	532	1.0
0-49 beds	339	425	425	0.1
50-99 beds	374	486	491	1.0
100-149 beds	164	530	539	1.6
150-199 beds	64	581	590	1.5
200 or more beds	44	649	653	0.5
By Region:				
Urban by Region	2,553	795	798	0.4
New England	121	833	812	-2.6
Middle Atlantic	349	856	837	-2.3
South Atlantic	385	754	764	1.4
East North Central	396	777	773	-0.6
East South Central	164	714	724	1.4
West North Central	158	775	778	0.4
West South Central	374	744	759	2.0
Mountain	158	807	824	2.0
Pacific	395	922	947	2.8
Puerto Rico	53	366	369	0.7
Rural by Region	985	527	532	1.0
New England	23	707	685	-3.2
Middle Atlantic	70	542	538	-0.6
South Atlantic	172	515	525	1.9
East North Central	121	554	557	0.6
East South Central	176	480	487	1.4
West North Central	114	555	563	1.4
West South Central	200	478	484	1.4
Mountain	75	533	541	1.5
Pacific	34	651	667	2.5
By Payment Classification:				
All hospitals	3,538	755	759	0.4
Large urban areas (populations over 1 million)	1,430	831	831	0.1
Other urban areas (populations of 1 million of fewer)	1,164	749	754	0.7
Rural areas	944	527	532	1.0
Teaching Status:				
Non-teaching	2,495	643	659	2.5
Fewer than 100 Residents	808	766	773	0.9
100 or more Residents	235	1,084	1,039	-4.1
Urban DSH:				
100 or more beds	1,559	819	820	0.1
Less than 100 beds	353	557	567	1.8
Rural DSH:				
Sole Community (SCH/EACH)	397	469	474	1.0
Referral Center (RRC/EACH)	207	583	590	1.2
Other Rural:				
100 or more beds	37	484	488	0.8
Less than 100 beds	169	438	440	0.6
Urban teaching and DSH:				
Both teaching and DSH	820	892	880	-1.3
Teaching and no DSH	163	789	786	-0.3
No teaching and DSH	1,092	682	703	3.0
No teaching and no DSH	519	703	719	2.3
Rural Hospital Types:				
Non special status hospitals	2,466	799	801	0.3
RRC/EACH	65	697	715	2.6
SCH/EACH	38	641	648	1.2

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2008 Payments Compared To FY 2009 Payments]*

	Number of hospitals	Average FY 2008 payments/ case	Average FY 2009 payments/ case	Change
Medicare-dependent hospitals (MDH)	10	469	471	0.4
SCH, RRC and EACH	15	753	775	2.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2009 Reclassifications:				
All Urban Reclassified	382	795	798	0.4
All Urban Non-Reclassified	2,149	796	799	0.4
All Rural Reclassified	359	572	580	1.4
All Rural Non-Reclassified	565	459	460	0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	53	536	543	1.3
Type of Ownership:				
Voluntary	2,035	769	771	0.2
Proprietary	856	700	714	2.0
Government	586	749	747	-0.3
Medicare Utilization as a Percent of Inpatient Days:				
0-25	257	988	966	-2.2
25-50	1,344	845	844	-0.1
50-65	1,432	671	680	1.3
Over 65	394	597	603	0.9

* As noted above, this impact analysis is based on the tentative capital rates and factors discussed in section III.A. of the Addendum to this final rule. As discussed in section III.A. of the Addendum to this final rule, we were unable to finalize the FY 2009 capital rates until we recompute the wage indices for FY 2009 as a result of implementing the extension of certain wage index reclassifications and special exceptions provided under section 124 of Pub. L. 110-275.

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IX. Alternatives Considered

This final rule contains a range of policies. The preamble of this final rule provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, and presents rationale for our decisions and, where relevant, alternatives that were considered.

X. Overall Conclusion

The changes we are making in this final rule will affect all classes of hospitals. Some hospitals are expected to experience significant gains and others less significant gains, but overall hospitals are projected to experience positive updates in IPPS payments in FY 2009. Table I of section VI. of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 4.7 percent in operating payments. We estimate operating payments to increase by $4.709 billion. This accounts for the projected savings associated with the HACs policy, which have an estimated savings of $21 million. In addition, this estimate includes the hospital reporting of quality data program costs for $2.39 million, the estimated new technology payments of $9.54 million, and all operating payment policies as described in section VII. of this Appendix. Capital payments are estimated to increase by 0.4 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that the increase in capital payments in FY 2009 compared to FY 2008 will be approximately $40 million. The cumulative operating and capital payments should result in a net increase of $4.749 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this final rule, constitute a regulatory impact analysis.

XI. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments to providers as a result of the changes to the IPPS presented in this final rule. All expenditures are classified as transfers to Medicare providers.

TABLE IV—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2008 TO FY 2009

Category	Transfers
Annualized Monetized Transfers.	$4.749 Billion.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$4.749 Billion.

XII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this final rule.

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary high quality care. Under section 1886(e)(5)(B) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the final recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS, as well as LTCHS, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2009

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Public Law 109–171, sets the FY 2009 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage

increase less 2.0 percentage points. Consistent with current law, based on Global Insight, Inc.'s first quarter 2008 forecast of the FY 2009 market basket increase, we stated in the proposed rule that we are estimating that the FY 2009 update to the standardized amount will be 3.0 percent (that is, the then current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we stated in the proposed rule that we are estimating that the update to the standardized amount will be 1.0 percent (that is, the then current estimate of the market basket rate-of-increase minus 2.0 percentage points).Therefore, we are adopting in this final rule, based on Global Insight, Inc.'s second quarter 2008 forecast of the FY 2009 market basket increase, a FY 2009 update to the standardized amount of 3.6 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the update to the standardized amount will be 1.6 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

This revision to the FY 2009 market basket increase is primarily due to the increase in prices associated with energy components, both primary and secondary. The price pressures with these secondary energy components (chemicals, rubber and plastics, accounting for 4.1 percent of the hospital market basket) are responsible for approximately 50 percent of the revision. Most of the increased price pressure in energy components is a result of changing fundamentals; that is, supply and demand. There is an increase in global demand for the commodity from emerging market countries, and there is an inability or lack of desire for oil-producing countries to increase supply. A secondary effect is an overall increase in many goods and commodity prices due to the weakness of the U.S. dollar, coupled with increased global demand.

Also contributing to the revision in the FY 2009 forecast of the IPPS market basket is the short-term price increase in the wages for hospital workers as a result of continued tightness in the market and pressure for providers to increase wages to keep pace with inflation. The health service sector has continued to show growth, unlike other service sectors that have seen a slackening in wage growth due to weakness in their labor markets.

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. In the proposed rule, we proposed to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Because we did not receive any public comments on this proposal, for FY 2009, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 3.6 percent.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2009 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is 3.6, or 1.6 percent, depending upon whether the hospital submits quality data.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. As discussed below, for cost reporting periods beginning on or after October 1, 2006, LTCHs that are not defined as new under § 412.23(e)(4), and that had not elected to be paid under 100 percent of the Federal rate are paid 100 percent of the adjusted Federal PPS rate. Therefore, because no portion of LTCHs' prospective payments will be based on reasonable cost concepts for cost reporting periods beginning on or after October 1, 2006, we are not establishing a rate-of-increase percentage to the reasonable cost portion for FY 2009 for LTCHs to be used under § 413.40. In addition, section 124 of Public Law 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs. Under this broad authority, IPFs that are not defined as new under § 412.426(c) are paid under a blended methodology for cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008. For cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate. Therefore, because no portion of the existing IPFs prospective payments will be based on reasonable cost concepts for cost reporting periods beginning on or after January 1, 2008, we are not establishing a rate-of-increase percentage to the reasonable cost portion for FY 2009 for IPFs to be used under § 412.428(b). New IPFs are paid based on 100 percent of the Federal per diem payment amount.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are providing our current estimate of the FY 2009 IPPS operating market basket percentage increase (3.6 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs have been paid under the LTCH PPS. Additionally, for cost reporting periods beginning on or after October 1, 2006, no portion of a LTCH's PPS payments can be based on reasonable cost concepts. Consequently, there is no need to update the target limit under § 413.40 effective October 1, 2008, for LTCHs.

In the RY 2009 LTCH PPS final rule (73 FR 26812), we established an update of 2.7 percent to the LTCH PPS Federal rate for RY 2009, which is based on a market basket increase of 3.6 percent and an adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity. The market basket of 3.6 percent used in determining this update factor is based on our final policy in the RY 2009 LTCH final rule to extend the LTCH RY 2009 by 3 months (a total of 15 months instead of 12 months) through September 30, 2009. (A full discussion of the reasons for this extension of RY 2009 can be found in the RY 2009 LTCH PPS final rule (73 FR 26797 through 26798).)

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. For cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008, existing IPFs (those not defined as ''new'' under § 412.426(c)) are paid based on a blend of the reasonable cost-based PPS payments and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate. Consequently, there is no need to update the target limit under § 413.40 effective October 1, 2008, for IPFs.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721). Section 1886(j)(3)(C) of the Act, as amended by section 115 of Public Law 110–173, sets the FY 2009 IRF PPS update factor equal to 0 percent. Thus, we are not applying an update (market basket) to the IRF PPS rates for FY 2009.

We did not receive any public comments on the market basket updates and, therefore, are finalizing the market basket updates for FY 2009.

III. Secretary's Final Recommendation

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2009. MedPAC's rationale for this update recommendation is described in more detail below. Based on the FY 2009 President's Budget, we are recommending an inpatient hospital update to the standardized amount of zero percent. We are recommending that this same update factor also apply to SCHs and MDHs.

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. As noted above, for FY 2009, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 3.6 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other types of hospitals. Consistent with the President's Budget, we are recommending an update similar to the IPPS update of zero percent for children's hospitals, cancer hospitals, and RNHCIs. As mentioned above, for cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate (and are no longer paid a blend of the reasonable cost-based PPS payments and the Federal per diem base rate). Consequently, we are no longer recommending an update factor for the portion of the payment that is based on reasonable costs. Consistent with the President's Budget, as we implemented in a **Federal Register** notice (73 FR 25709) for the RY 2009 IPF PPS, we finalized an update to the IPF PPS Federal rate for RY 2009 of 3.2 percent (which is based on Global Insight, Inc.'s first quarter 2008 forecast of the RPL market basket increase) for the Federal per diem payment amount.

In the RY 2009 LTCH PPS final rule (73 FR 26812), we established an update of 2.7 percent to the LTCH PPS Federal rate for RY 2009, which is based on a market basket increase of 3.6 percent and an adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity. The market basket of 3.6 percent used in determining this final update factor is based on our final policy in the LTCH final rule to extend the LTCH RY 2009 by 3 months (a total of 15 months instead of 12 months) through September 30, 2009. (A full discussion on the reasons for this extension of RY 2009 can be found in the RY 2009 LTCH PPS final rule (73 FR 26797 through 26798).) Finally, consistent with the President's FY 2009 Budget, we are recommending a zero percent update to the IRF PPS Federal rate for FY 2009.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its March 2008 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base, utilizing an established methodology used by MedPAC in the past several years.

MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2009, concurrent with implementation of a quality incentive program. Similar to last year, MedPAC also recommended that CMS put pressure on hospitals to control their costs rather than accommodate the current rate of cost growth, which is, in part, caused by a lack of pressure from private payers.

MedPAC noted that indicators of payment adequacy are almost uniformly positive. MedPAC expects Medicare margins to remain low in 2008. At the same time though, MedPAC's analysis finds that hospitals with low non-Medicare profit margins have below average standardized costs and most of these facilities have positive overall Medicare margins.

Response: Similar to our response last year, we agree with MedPAC that hospitals should control costs rather than accommodate the current rate of growth. An update equal to less than the market basket will motivate hospitals to control their costs, consistent with MedPAC's recommendation. As MedPAC noted, the lack of financial pressure at certain hospitals can lead to higher costs and in turn bring down the overall Medicare margin for the industry.

As discussed in section II. of the preamble of this final rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The final update to the capital rate is discussed in section III. of the Addendum to this final rule.

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