DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 412, 413, 414, 424, 485, 489, and 505

[CMS-1488-F; CMS-1287-F; CMS-1320-F; and CMS-1325-IFC4]

RINs 0938-AO12; 0938-AO03; 0938-AN93; and 0938-AN58

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Fiscal Year 2007 Occupational Mix Adjustment to Wage Index; Health Care Infrastructure Improvement Program; Selection Criteria of Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care and Forgiveness of Indebtedness; and Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)

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

ACTION: Final rules and interim final rule with comment period.

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 a number of changes made by the Deficit Reduction Act of 2005 (Pub. L. 109-171). 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. We also are setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the IPPS that are paid in full or in

part on a reasonable cost basis subject to these limits. These changes are applicable to discharges occurring on or after October 1, 2006.

In this final rule, we discuss public comments we received on our proposals to refine the diagnosis-related group (DRG) system under the IPPS to better recognize severity of illness among patients--to use a hospital-specific relative value (HSRV) cost center weighting methodology to adjust DRG relative weights; and to implement consolidated severity-adjusted DRGs or alternative severity adjustment methods.

Among the other policy changes that we are making are those changes related to: limited revisions of the reclassification of cases to DRGs; the long-term care (LTC)-DRGs and relative weights; the wage data, including the occupational mix data, used to compute the wage index; applications for new technologies and medical services add-on payments; payments to hospitals for the direct and indirect costs of graduate medical education; submission of hospital quality data; payments to sole community hospitals and Medicare-dependent, small rural hospitals; and provisions governing emergency services under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA).

We are responding to requested public comments on a number of other issues that include performance-based hospital payments for services and health information technology, as well as how to improve health data transparency for consumers.

In addition, we are responding to public comments received on a proposed rule issued in the **Federal Register** on May 17, 2006 that proposed to revise the methodology for calculating the occupational mix adjustment to the wage index for the FY 2007

hospital inpatient prospective payment system by applying an adjustment to 100 percent of the wage index using new 2006 occupational mix survey data collected from hospitals.

We are finalizing two policy documents published in the **Federal Register** relating to the implementation of the Health Care Infrastructure Improvement Program, a hospital loan program for cancer research, established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

This final rule also revises the definition of the term "unit" to specify the exclusion of units of drugs sold to approved Medicare Competitive Acquisition Program (CAP) vendors for use under the CAP from average sales price (ASP) calculations for a period of up to 3 years, at which time we will reevaluate our policy.

DATES: Effective Dates: The provisions of these final rules are effective on October 1, 2006, with the exception of the provisions in §412.8, §414.802, and the procedures for withdrawing or terminating reclassifications established in section III.H.4. of the preamble. The provisions of §412.8, §414.802, and the procedures for withdrawing or terminating reclassifications established in section II.H.4. of the preamble are effective [OFR--please insert date of publication at the Federal Register]. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to the Congress on this rule on August 1, 2006.

Comment Date: We will consider comments on the exclusion of CAP drugs from the ASP calculation (§414.802) as discussed in section XII. of the preamble of this final rule, if we receive them at one of the addresses provided below, no later than 5 p.m. on [OFR—insert date 60 days after date of display at the Federal Register.]

ADDRESSES: In commenting, on section XII. of this rule, please refer to file code CMS-1325-IFC4.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may submit electronic comments on specific issues in this regulation to http://www.cms.hhs.gov/eRulemaking. Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. By regular mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1325-IFC4,

P.O. Box 8011,

Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1325-IFC4,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201; or

7500 Security Boulevard,

Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Marc Hartstein, (410) 786-4548,	Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, Occupational Mix Adjustment, New Medical Services and Technology Add-On Payments, Hospital Geographic Reclassifications, Sole Community Hospital, Disproportionate Share Hospital, and Medicare-Dependent, Small Rural Hospital Issues
Tzvi Hefter, (410) 786-4487,	Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Critical Access Hospitals, Long-Term Care (LTC)-DRGs, and Terms of Hospital Loans under Health Care Infrastructure Improvement Program Issues
Siddhartha Mazumdar, (410) 786-6673,	Rural Community Hospital Demonstration Issues
Sheila Blackstock, (410) 786-3502,	Quality Data for Annual Payment Update Issues

Thomas Valuck, (410) 786-7479,	Hospital Value-Based Purchasing Issues
Frederick Grabau, (410) 786-0206,	Services in Foreign Hospitals Issues
Brian Reitz, (410) 786-5001,	Obsolete Paper Claims Forms Issues
Melinda Jones (410) 786-7069	Loan Forgiveness Criteria for Health Care Infrastructure Improvement Program
Corinne Axelrod (410) 786-5620	Competitive Acquisition Program (CAP) for Part B Drugs Issues
Angela Mason (410) 786-7452	Payment for Covered Outpatient Drugs and Biologicals Issues

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-1325-IFC4 and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on a public website as soon as possible after they are received: http://www.cms.hhs.gov/eRulemaking. Clink on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security

Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents' home page address is http://www.gpoaccess.gov/, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512-1661; type swais, then login as guest (no password required).

Acronyms

AHA	American Hospital Association
AHIMA	American Health Information Management Association
AHRO	Agency for Health Care Research and Quality
AMI	Acute myocardial infarction
AOA	American Osteopathic Association
APR DRG	All Patient Refined Diagnosis Related Group System
ASC	Ambulatory surgical center
ASP	Average sales price

AWP	Average wholesale price
BBA	Balanced Budget Act of 1997, Pub. L. 105-33
BBRA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106-113
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106-554
BLS	Bureau of Labor Statistics
CAH	Critical access hospital
CAP	Competitive Acquisition Program
CART	CMS Abstraction & Reporting Tool
CBSAs	Core-based statistical areas
CC	Complication or comorbidity
CDAC	Clinical Data Abstraction Center
CIPI	Capital input price index
CPI	Consumer price index
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services
CMSA	Consolidated Metropolitan Statistical Area
COBRA	Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99-272
CPI	Consumer price index
CRNA	Certified registered nurse anesthetist

CY	Calendar year
DRA	Deficit Reduction Act of 2005, Pub. L. 109-171
DRG	Diagnosis-related group
DSH	Disproportionate share hospital
ECI	Employment cost index
EMR	Electronic medical record
EMTALA	Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99-272
FDA	Food and Drug Administration
FFY	Federal fiscal year
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
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, Pub. L. 104-191
HIPC	Health Information Policy Council
HIS	Health information system
HIT	Health information technology
HMO	Health maintenance organization
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
ICU	Intensive care unit
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
IRP	Initial residency period
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LAMCs	Large area metropolitan counties
LTC-DRG	Long-term care diagnosis-related group
LTCH	Long-term care hospital
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
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173
MRHFP	Medicare Rural Hospital Flexibility Program
MSA	Metropolitan Statistical Area
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
NICU	Neonatal intensive care unit
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)
PRM	Provider Reimbursement Manual
PPI	Producer price index
PMSAs	Primary metropolitan statistical areas
PPS	Prospective payment system
PRA	Per resident amount
ProPAC	Prospective Payment Assessment Commission
PRRB	Provider Reimbursement Review Board
PS&R	Provider Statistical and Reimbursement (System)
QIG	Quality Improvement Group, CMS

QIO	Quality Improvement Organization
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
SSA	Social Security Administration
SSI	Supplemental Security Income
TAG	Technical Advisory Group
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248
UHDDS	Uniform hospital discharge data set

Table of Contents

I. Background

A. Summary

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

2. Hospitals and Hospital Units Excluded from the IPPS

a. Inpatient Rehabilitation Facilities (IRFs)

b. Long-Term Care Hospitals (LTCHs)

c. Inpatient Psychiatric Facilities (IPFs)

3. Critical Access Hospitals (CAHs)

4. Payments for Graduate Medical Education (GME)

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

C. Summary of the Provisions of the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index Proposed Rules

1. DRG Reclassifications and Recalibrations of Relative Weights

2. Changes to the Hospital Wage Index

3. Other Decisions and Changes to the IPPS for Operating Costs, GME Costs, and Promoting Hospitals' Effective Use of Health Information Technology

4. Changes to the PPS for Capital-Related Costs

5. Changes for Hospitals and Hospital Units Excluded from the IPPS

6. Payments for Services Furnished Outside the United States

7. Payment for Blood Clotting Factor Administered to Inpatients with Hemophilia

8. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

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

10. Impact Analysis

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

12. Discussion of Medicare Payment Advisory Commission Recommendations

13. Appendix C and Appendix D

D. Public Comments Received in Response to the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index Proposed Rules

E. Interim Final Rule on Selection Criteria of Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care

F. Proposed Rule on Forgiveness of Indebtedness under the Health Care Infrastructure Improvement Program

G. Interim Final Rule on the Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program for Part B Outpatient Drugs and Biologicals for the Purpose of Calculating the Average Sales Price

II. Changes to DRG Classifications and Relative Weights

A. Background

B. DRG Reclassifications

1. General

2. Yearly Review for Making DRG Changes

C. Revisions to the DRG System Used Under the IPPS

1. MedPAC Recommendations

2. Refinement of the Relative Weight Calculation

3. Refinement of DRGs Based on Severity of Illness

a. Comparison of the CMS DRG System and the APR DRG System

b. CS DRGs for Use in the IPPS

c. Changes to CMI from a New DRG System

4. Effect of CS DRGs on the Outlier Threshold

5. Impact of Refinement of DRG System on Payments

6. Conclusions

7. Severity Refinement to CMS DRGs

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

b. MDC 4 (Diseases and Disorders of the Respiratory System): Respiratory System Diagnosis with Ventilator Support

c. MDC 6 (Diseases and Disorders of the Digestive System)

d. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Major Bladder Procedures

e. MDC 16 (Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders): Major Hematological and Immunological Diagnoses

f. MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)): O.R. Procedure for Patients with Infectious and Parasitic Diseases

g. Severe Sepsis

D. Changes to Specific DRG Classifications

1. Pre-MDCs

a. Heart Transplant or Implant of Heart Assist System: Addition of Procedure to DRG 103

b. Pancreas Transplants

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

a. Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (DBS)

b. Carotid Artery Stents

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

a. Insertion of Epicardial Leads for Defibrillator Devices

b. Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs

4. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Hip and Knee Replacements

b. Spinal Fusion

c. CHARITE™ Spinal Disc Replacement Device

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

6. Medicare Code Editor (MCE) Changes

a. Edit: Newborn Diagnoses

b. Edit: Diagnoses for Pediatric – Age 0-17 Years Old

c. Edit: Maternity Diagnoses - Age 12 through 55

d. Edit: Diagnoses Allowed for Females Only

e. Edit: Diagnoses Allowed for Males Only

f. Edit: Procedures Allowed for Females Only

g. Edit: Manifestations Not Allowed as Principal Diagnosis

h. Edit: Nonspecific Principal Diagnosis

i. Edit: Unacceptable Principal Diagnosis

j. Edit: Nonspecific O.R. Procedures

k. Edit: Noncovered Procedures

l. Edit: Bilateral Procedure

7. Surgical Hierarchies

8. Refinement of Complications and Comorbidities (CC) List

a. Background

b. Comprehensive Review of the CC List

c. CC Exclusions List for FY 2007

9. Review of Procedure Codes in DRGs 468, 476, and 477

a. Moving Procedure Codes from DRG 468 or DRG 477 to MDCs

b. Reassignment of Procedures among DRGs 468, 476, and 477

c. Adding Diagnosis or Procedure Codes to MDCs

10. Changes to the ICD-9-CM Coding System

11. Other Issues

a. Chronic Kidney Disease

b. Bronchial Valve

c. Female Reproductive System Reconstruction Procedures

d. Devices That are Replaced Without Cost or Where Credit for a Replaced Device is Furnished to the Hospital

E. Recalibration of DRG Weights

F. LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2007

1. Background

2. Changes in the LTC-DRG Classifications

a. Background

b. Patient Classifications into DRGs

3. Development of the FY 2007 LTC-DRG Relative Weights

a. General Overview of Development of the LTC-DRG Relative Weights

b. Data

c. Hospital-Specific Relative Value Methodology

d. Low-Volume LTC-DRGs

4. Steps for Determining the FY 2007 LTC-DRG Relative Weights

5. Summary of Public Comments and Departmental Responses

G. Add-On Payments for New Services and Technologies

1. Background

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

3. FY 2007 Status of Technologies Approved for FY 2006 Add-On Payments

a. Kinetra® Implantable Neurostimulator (Kinetra®) for Deep Brain Stimulation

b. Endovascular Graft Repair of the Thoracic Aorta

c. Restore® Rechargeable Implantable Neurostimulator

4. FY 2007 Applications for New Technology Add-On Payments

a. C-Port® Distal Anastomosis System

b. NovoSeven® for Intracerebral Hemorrhage

c. X STOP Interspinous Process Decompression System

5. Interim and Final Cost Threshold Tables Due to Changes to Wage Index and Budget Neutrality Factors

III. Changes to the Hospital Wage Index

A. Background

B. Core-Based Statistical Areas for the Hospital Wage Index

C. Occupational Mix Adjustment to the FY 2007 Wage Index

1. Development of Data for the FY 2007 Occupational Mix Adjustment

2. Timeline for the Collection, Review, and Correction of the Occupational Mix Data

3. Calculation of the Occupational Mix Adjustment

D. Worksheet S-3 Wage Data for the FY 2007 Wage Index Update

E. Verification of Worksheet S-3 Wage Data

F. Computation of the FY 2007 Unadjusted Wage Index

G. Implementation of the FY 2007 Occupational Mix Adjustment to the Wage Index

H. Revisions to the Wage Index Based on Hospital Redesignations

1. General

2. Effects of Reclassification/Redesignation

3. FY 2007 MGCRB Reclassifications

4. Procedures for Hospitals Applying for Reclassification Effective in FY 2008 and Reinstating Reclassifications in FY 2008

5. FY 2007 Redesignations Under Section 1886(d)(8)(B) of the Act

6. Reclassifications Under Section 508 of Pub. L. 108-173

7. Wage Indices for Reclassified Hospitals and Reclassification Budget Neutrality Factor

I. FY 2007 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

J. Process for Requests for Wage Index Data Corrections

K. Labor-Related Share for the Wage Index for FY 2007

L. Proxy for the Hospital Market Basket

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

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update

1. Background

2. New Procedures for Hospital Reporting of Quality Data

a. Two Percentage Point Reduction

b. New Procedures

c. Expanded Quality Measures

d. HCAHPS® Survey

e. Data Submission

f. RHQDAPU Program Withdrawal and Chart Validation Requirements

g. Data Validation and Attestation

h. Public Display and Reconsideration Procedures

i. Conclusion

3. Electronic Medical Records

B. Value-Based Purchasing

1. Introduction

2. Premier Hospital Quality Incentive Demonstration

3. RHQDAPU Program

a. Section 501(b) of Pub. L. 108-173 (MMA)

b. Section 5001(a) of Pub. L. 109-171 (DRA)

4. Plan for Implementing Hospital Value-Based Purchasing Beginning with FY 2009

a. Measure Development and Refinement

b. Data Infrastructure

c. Incentive Methodology

d. Public Reporting

5. Considerations Related to Certain Conditions, Including Hospital-Acquired Infections

6. Promoting Effective Use of Health Information Technology

C. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

1. Background

2. Volume Decrease Adjustment for SCHs and MDHs

a. HAS/Monitrend Data

b. HAS/Monitrend Data Book Replacement Alternative

3. Mandatory Reporting Requirements for Any Changes in the Circumstances Under Which a Hospital Was Designated as an SCH or MDH

4. Payment Changes for MDHs under the DRA of 2005

a. Background

b. Regulation Changes

5. Technical Change

D. Rural Referral Centers

1. Case-Mix Index

2. Discharges

E. Indirect Medical Education (IME) Adjustment

1. Background

2. IME Adjustment Factor for FY 2007

3. Technical Change to Revise Cross-Reference

F. Payment Adjustment for Disproportionate Share Hospitals (DSHs)

1. Background

2. Technical Corrections

3. Reinstatement of Inadvertently Deleted Provisions on DSH Payment Adjustment Factors

4. Enhanced DSH Adjustment for MDHs

G. Geographic Reclassifications

1. Background

2. Reclassifications under Section 508 of Pub. L. 108-173

3. Multicampus Hospitals

4. Urban Group Hospital Reclassifications

5. Effect of Change of Ownership on Urban County Group Reclassifications

6. Requested Reclassification for Hospitals Located in a Single Hospital MSA Surrounded by Rural Counties

7. Special Adjustment for the Hospital Group Reclassification Denied on the Basis of Incomplete CSA Listing

H. Payment for Direct Graduate Medical Education

1. Background

2. Determination of Weighted Average Per Resident Amounts (PRAs) for Merged Teaching Hospitals

3. Determination of Per Resident Amounts (PRAs) for New Teaching Hospitals

4. Requirements for Counting and Appropriate Documentation of FTE Residents: Clarification

5. Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Programs

6. Medicare GME Affiliated Groups: Technical Changes to Regulations

I. Payment for the Costs of Nursing and Allied Health Education Activities: Clarification

J. Hospital Emergency Services under EMTALA

1. Background

2. Role of the EMTALA Technical Advisory Group (TAG)

3. Definition of "Labor"

4. Application of EMTALA Requirements to Hospitals Without Dedicated Emergency Departments

5. Clarification of Reference to "Referral Centers"

K. Other Technical Changes

1. Cross-Reference Correction in Regulations on Limitations on Beneficiary Charges

2. Cross-Reference Corrections in Regulations on Payment Denials Based on Admissions and Quality Reviews

3. Cross-Reference Correction in Regulations on Outlier Payments

4. Removing References to Two Paper Claims Forms

L. Rural Community Hospital Demonstration Program

M. Health Care Information Transparency Initiative

V. Changes to the PPS for Capital-Related Costs

A. Background

B. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

C. Other Technical Corrections Relating to the Capital PPS Geographic Adjustment Factors

VI. Changes for Hospitals and Hospital Units Excluded from the IPPS

A. Payments to Excluded Hospitals and Hospital Units

1. Payments to Existing Excluded and New Hospitals and Hospital Units

2. Separate PPS for IRFs

3. Separate PPS for LTCHs

4. Separate PPS for IPFs

5. Grandfathering of Hospitals-Within-Hospitals (HwHs) and Satellite Facilities

6. Changes to the Methodology for Determining LTCH Cost-to-Charge Ratios (CCRs) and the Reconciliation of High-Cost and Short-Stay Outlier Payments under the LTCH PPS

a. Background

b. High-Cost Outliers

c. Short-Stay Outliers

d. CCR Ceiling

e. Statewide Average CCRs

f. Data Used to Determine a CCR

g. Reconciliation of Outlier Payments Upon Cost report Settlement

7. Technical Corrections Relating to LTCHs

8. Cross-Reference Correction in Authority Citations for 42 CFR 412 and 413

9. Report of Adjustment (Exceptions) Payments

B. Critical Access Hospitals (CAHs)

1. Background

2. Sunset of Designation of CAHs as Necessary Providers: Technical Correction

VII. Payment for Services Furnished Outside the United States

A. Background

B. Proposed Clarification of Regulations

VIII. Payment for Blood Clotting Factor Administered to Inpatients with Hemophilia

IX. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

A. Background

B. Changes Made by Section 5004 of Pub. L. 109-171

C. Proposed Regulation Changes

X. MedPAC Recommendations

XI. Health Care Infrastructure Improvement Program: Selection Criteria for Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care and Forgiveness of Indebtedness

A. Background

B. Issuance of an Interim Final Rule with Comment Period and a Proposed Regulation

C. Provisions of the Interim Final Rule With Comment Period

1. Loan Qualifying Criteria

2. Selection Criteria

3. Terms of the Loan

4. Public Comments Received on the Interim Final Rule With Comment Period

5. Provisions of this Final Rule

D. Proposed Rule on Forgiveness of Indebtedness

1. Conditions for Loan Forgiveness

2. Plan Criteria for Meeting the Conditions for Loan Forgiveness

3. Public Comments Received on the Proposed Rule and Our Responses

4. Provisions of the Final Rule

E. Statutory Requirements for Issuance of Regulations

XII. Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)

A. Background

1. Average Sales Price (ASP)

2. Competitive Acquisition Program (CAP)

3. Regulatory History

B. Regulation Change

XIII. Other Required Information

A. Requests for Data from the Public

B. Collection of Information Requirements

C. Waiver of Proposed Rulemaking and Delay in the Effective Date

D. Response to Comments

Regulation Text

Addendum—Schedule of Tentative Standardized Amounts, Tentative Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2006

I. Summary and Background

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs

A. Calculation of the Tentative Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

2. Computing the Tentative Average Standardized Amount

3. Updating the Tentative Average Standardized Amount

4. Other Adjustments to the Average Standardized Amount

a. Recalibration of DRG Weights and Updated Wage Index--Budget Neutrality Adjustment

b. Reclassified Hospitals--Tentative Budget Neutrality Adjustment

c. Outliers

d. Tentative Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108-173)

5. Tentative FY 2007 Standardized Amount

B. Tentative Adjustments for Area Wage Levels and Cost-of-Living

1. Tentative Adjustment for Area Wage Levels

2. Final Adjustment for Cost-of-Living in Alaska and Hawaii

C. DRG Relative Weights

D. Calculation of the Prospective Payment Rates

1. Federal Rate

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2007

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2006, and Before October 1, 2007

a. Puerto Rico Rate

b. National Rate

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2007

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

b. Comparison of CMS and MedPAC Update Recommendation

2. Outlier Payment Adjustment Factor

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

4. Exceptions Payment Adjustment Factor

5. Capital Standard Federal Rate for FY 2007

6. Special Capital Rate for Puerto Rico Hospitals

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2007

C. Capital Input Price Index

1. Background

2. Forecast of the CIPI for FY 2007

IV. Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

A. Payments to Existing Excluded Hospitals and Units

B. New Excluded Hospitals and Units

V. Payment for Blood Clotting Factor Administered to Inpatients with Hemophilia

Tables

The following tables are included as part of this final rule:

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) (Tentative)

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) (Tentative)

Table 1C--Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor (Tentative)

Table 1D--Capital Standard Federal Payment Rate (Tentative)

Table 4J--Out-Migration Wage Adjustment--FY 2007 (Tentative)

Table 5--List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS) (Tentative)

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 6G--Additions to the CC Exclusions List

Table 6H--Deletions from the CC Exclusions List

Table 7A--Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V23.0

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V24.0

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--July 2006

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--July 2006

Table 8C-- Statewide Average Total Cost-to-Charge Ratios for LTCHs--July 2006

Table 9A--Hospital Reclassifications and Redesignations by Individual Hospital and CBSA for FY 2007 (Tentative)

Table 9B--Hospital Reclassifications and Redesignation by Individual Hospital Under Section 508 of Pub. L. 108-173 for FY 2007 (Tentative)

Table 9C--Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act for FY 2007 (Tentative)

Table 10--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 Diagnosis-Related Group (DRG)--July 2006 (Tentative)

Table 11--FY 2007 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

Appendix A – Regulatory Impact Analysis

I. Overall Impact

II. Objectives

III. Limitations on Our Analysis

IV. Hospitals Included In and Excluded From the IPPS

V. Effects on Excluded Hospitals and Hospital Units

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

B. Analysis of Table I

C. Effects on the Hospitals that Failed the Quality Data Submission Process (Column 2)

D. Effects of the DRA Provision Related to MDHs (Column 3)

E. Effects of the Changes to the DRG Reclassifications and Relative Cost-Based Weights (Column 4)

F. Effects of Wage Index Changes (Column 5)

G. Combined Effects of DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 6)

H. Effects of the 3-Year Provision Allowing Urban Hospitals that Were Converted to Rural as a Result of the FY 2005 Labor Market Area Changes to Maintain the Wage Index of the Urban Labor Market Area in Which They Were Formerly Located (Column 7)

I. Effects of MGCRB Reclassifications (Column 8)

J. Effects of the Wage Index Adjustment for Out-Migration (Column 9)

K. Effects of All Changes (Column 10)

L. Effects of Policy on Payment Adjustments for Low-Volume Hospitals

M. Impact Analysis of Table II

VII. Effects of Other Policy Changes

A. Effects of LTC-DRG Reclassifications and Relative Weights for LTCHs

B. Effects of New Technology Add-On Payments

C. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

D. Effects of Other Policy Changes Affecting Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

E. Effects of Policy on Payment for Direct Costs of Graduate Medical Education

1. Determination of Weighted Average GME PRAs for Merged Teaching Hospitals

2. Determination of PRAs for New Teaching Hospitals

3. Requirements for Counting and Appropriate Documentation of FTE Residents

4. Resident Time Spent in Nonpatient Care Activities as Part of an Approved Residency Program

F. Effects of Policy Changes Relating to Emergency Services under EMTALA

G. Effects of Policy on Rural Community Hospital Demonstration Program

H. Effects of Policy on Hospitals-within-Hospitals and Satellite Facilities

I. Effects of Policy Changes to the Methodology for Determining LTCH CCRs and the Reconciliation of LTCH PPS Outlier Payments

J. Effects of Policy on Payment for Services Furnished Outside the United States

K. Effects of Final Policy on Limitation on Payments to SNFs

L. Effects of Policy on CAP for Outpatient Drugs and Biologicals under Part B for the Purpose of Calculating the ASP

VIII. Impact of Changes in the Capital PPS

A. General Considerations

B. Results

IX. Impact of Changes Relating to the Loan Program for Capital Cost under the Health Care Infrastructure Improvement Program

A. Effects on Hospitals

B. Effects on the Medicare and Medicaid Programs

X. Alternatives Considered

XI. Overall Conclusion

XII. Accounting Statement

XIII. Executive Order 12866

Appendix B--Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

II. Secretary's Final Recommendation for Updating the Prospective Payment System Standardized Amounts

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units

IV. Secretary's Recommendation for Updating the Capital Prospective Payment Amounts

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; and 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 the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, FY 1996, or FY 2002) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded special payment protection in order to maintain access to services for beneficiaries. (Through FY 2007, an MDH receives the IPPS rate plus 50 percent of the difference between the IPPS rate and its hospital-specific rate if the hospital-specific rate is higher than the IPPS rate. In addition, an MDH may not use FY 1996 as its base year for the hospital-specific 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.)

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 PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital PPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. 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: inpatient rehabilitation hospitals and units (commonly referred to as inpatient rehabilitation facilities (IRFs); long-term care hospitals (LTCHs); inpatient psychiatric hospitals and units (commonly referred to as inpatient psychiatric facilities (IPFs); 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 IRFs, LTCHs, and 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, IRFs have been transitioned from payment based on a blend of reasonable cost reimbursement and the adjusted IRF 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 Pub. L. 106-113 and section 307(b)(1) of Pub. L. 106-554, LTCHs that do not meet the definition of "new" under §412.23(e)(4) are being transitioned from being paid for inpatient hospital services based on a blend of reasonable cost-based reimbursement under section 1886(b) of the Act to 100 percent of the Federal rate during a 5-year period with cost reporting periods

beginning on or after October 1, 2002. Those LTCHs that do not meet the definition of "new" may 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, LTCHs will be 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 Pub. L. 106-113, IPFs are paid under the IPF PPS. Under the IPF PPS, some IPFs are transitioning from being paid for inpatient hospital services based on a blend of reasonable cost-based payment to a Federal per diem payment rate, effective for cost reporting periods beginning on or after January 1, 2005 (November 15, 2004 IPF PPS final rule (69 FR 66922) and May 9, 2006 IPF PPS final rule (71 FR 27040)). For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount. 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 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)

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, was enacted. Pub. L. 109-171 made a number of changes to the Act relating to prospective payments to hospitals and other providers for inpatient services. This final rule implements amendments made by the following sections of Pub. L. 109-171:

- Section 5001(a), which, effective for FY 2007 and subsequent years, allows for expansion of the requirements for hospital quality data reporting.

- Section 5003, which makes several changes to the MDH program. It extends special payment provisions, requires MDHs to use FY 2002 as their base year for determining whether use of their hospital-specific rate enhances payment (but permits them to continue to use either their 1982 or 1987 hospital-specific rate if using either of those rates results in higher payments), and removes the application of the 12-percent cap on the DSH payment adjustment factor for MDHs.

- Section 5004, which reduces certain allowable SNF bad debt payments by 30 percent. Payments for the bad debts of full-benefit, dual eligible individuals are not reduced.

In this final rule, we also discuss the provisions of section 5001(b) of Pub. L. 109-171, which require us to develop a plan to implement, beginning with FY 2009, a value-based purchasing plan for section 1886(d) hospitals and summarize the public comments received in response to our invitation for public comments. This discussion also includes the provisions of section 5001(c) of Pub. L. 109-171, which requires a quality adjustment in DRG payments for certain hospital-acquired conditions, effective for FY 2008.

C. Summary of the Provisions of the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index Proposed Rules

In the FY 2007 IPPS proposed rule, we set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2007. We also set forth proposed changes relating to payments for GME costs, payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis, and payments for SCHs and MDHs. The changes were proposed to be effective for discharges occurring on or after October 1, 2006, unless otherwise noted.

After publication of the FY 2007 IPPS proposed rule, the United States Court of Appeals for the Second Circuit issued a decision in the Bellevue case that caused us to modify our proposals on the implementation of the occupational mix adjustment. As a result, we published a second proposed rule in the May 17, 2006 **Federal Register** that

superseded the occupational mix proposals that had been made in the FY 2007 IPPS proposed rule (published April 25, 2006). The following is a summary of the major changes that we proposed to make and the issues that we addressed in the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index proposed rules:

1. DRG Reclassifications and Recalibrations of Relative Weights

As required by section 1886(d)(4)(C) of the Act, we proposed limited annual revisions to the DRG classifications structure. In this section, we responded to several recommendations made by MedPAC intended to improve the DRG system. We also proposed to use, for FY 2007, hospital-specific relative values (HSRVs) for 10 cost centers to compute DRG relative weights. In addition, we proposed to use consolidated severity-adjusted DRGs or alternative severity adjustment methods in FY 2008 (if not earlier).

We presented our reevaluation of certain FY 2006 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of FY 2007 applicants (including public input, as directed by Pub. L. 108-173, obtained in a town hall meeting).

We proposed the annual update of the long-term care diagnosis-related group (LTC-DRG) classifications and relative weights for use under the LTCH PPS for FY 2007.

2. Changes to the Hospital Wage Index

We proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed include the following:

- The FY 2007 wage index update, using wage data from cost reporting periods that began during FY 2003.
- The FY 2007 occupational mix adjustment to the wage index (discussed inthe May 17, 2006 proposed rule).
- The revisions to the wage index based on hospital redesignations and reclassifications.
- The adjustment to the wage index for FY 2007 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 that will be in effect for the proposed FY 2007 wage index.
- The special timetable that will apply in FY 2007 in order to allow us to make presumptive reclassification withdrawal or termination decisions on behalf of affected hospitals which will then become final unless reversed or modified by the affected hospitals in accordance with CMS procedural rules.
- The labor-related share for the FY 2007 wage index, including the labor-related share for Puerto Rico.

3. Other Decisions and Changes to the IPPS for Operating Costs, GME Costs, and Promoting Hospitals' Effective Use of Health Information Technology

In the proposed rule, we discussed a number of provisions of the regulations in 42 CFR Parts 412 and 413 and related proposed changes, including the following:

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Changes in payments to SCHs and MDHs.
- Updated national and regional case-mix values and discharges for purposes of determining rural referral center status.
- The statutorily-required IME adjustment factor for FY 2007.
- Changes relating to hospitals' geographic classifications, including reclassifications under section 508 of Pub. L. 108-173, multicampus hospitals, urban group hospital reclassification and the effect of change in ownership on urban county group reclassifications.
- Changes and clarifications relating to GME that address determining the per resident amounts (PRAs) for merged hospitals and new teaching hospitals, counting and appropriate documentation of FTE residents, and counting of resident time spent in nonpatient care activities as part of approved residency programs.
- Changes relating to payment for costs of nursing and allied health education programs.
- Changes relating to requirements for emergency services for hospitals under EMTALA.
- Discussion of the third year of implementation of the Rural Community Hospital Demonstration Program.

We also invited comments on promoting hospitals' effective use of health information technology.

4. Changes to the PPS for Capital-Related Costs

In the proposed rule, we discussed the payment policy requirements for capital-related costs and capital payments to hospitals and proposed several technical corrections to the regulations.

5. Changes for Hospitals and Hospital Units Excluded from the IPPS

In the proposed rule, we discussed payments made to excluded hospitals and hospital units, proposed policy changes regarding decreases in square footage or decreases in the number of beds of the "grandfathering" HwHs and satellite facilities, and proposed changes to the methodology for determining LTCH CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. In addition, we proposed a technical change relating to the designation of CAHs as necessary providers.

6. Payments for Services Furnished Outside the United States

In the proposed rule, we set forth proposed changes to clarify what is considered "outside the United States" for Medicare payment purposes.

7. Payment for Blood Clotting Factor Administered to Inpatients with Hemophilia

In the proposed rule, we discussed the proposed changes in payment for blood clotting factor administered to Medicare beneficiaries with hemophilia for FY 2007.

8. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

In the proposed rule, we proposed to implement section 5004 of Pub. L. 109-171 relating to reduction in payments to SNFs for bad debt.

9. Determining 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 2007 prospective payment rates for operating costs and capital-related costs. We also proposed to establish the 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 2007 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 2007 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. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to the Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2006 recommendation concerning hospital inpatient payment policies addressed 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. This recommendation was addressed in Appendix B of the proposed rule. For further information relating specifically to the MedPAC March 2006 reports or to obtain a copy of the reports, contact MedPAC at (202) 220-3700 or visit MedPAC's Web site at: www.medpac.gov.

13. Appendix C and Appendix D

In Appendix C of the proposed rule, we listed the combinations of the consolidated severity-adjusted DRGs that we proposed to implement on FY 2008 (if not earlier), as discussed in section II.C. of the preamble of the proposed rule. In Appendix D of the proposed rule, we provided a crosswalk of the proposed consolidated severity-adjusted DRG system to the respective All Patient Related Diagnosis-Related Group (APR DRG) system.

D. Public Comments Received in Response to the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index Proposed Rules

We received over 2,300 timely items of correspondence containing multiple comments on the FY 2007 IPPS proposed rule. We also received over 100 timely items of correspondence on the FY 2007 Occupational Mix Adjustment to the Wage Index

proposed rule. Summaries of the public comments and our responses to those comments are set forth under the appropriate heading.

E. Interim Final Rule on Selection Criteria of Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care

On September 30, 2005, we published in the **Federal Register** (70 FR 57368) an interim final rule with comment period (CMS-1287-IFC) that set forth the criteria for implementing a loan program for qualifying hospitals engaged in research in the causes, prevention, and treatment of cancer, as specified in section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173). Specifically, this interim final rule established a loan application process by which qualifying hospitals, including specified entities, may apply for a loan for the capital costs of health care infrastructure improvement projects. The interim final rule was effective on November 29, 2005.

We received seven timely items of correspondence on the interim final rule. In section XI. of the preamble to this final rule, we are finalizing this interim final rule with comment period. In that section, we discuss the provisions of the program, the public comments received, our responses to those comments, and the final policy.

F. Proposed Rule on Forgiveness of Indebtedness under the Health Care Infrastructure Improvement Program

On September 30, 2005, we published in the **Federal Register** (70 FR 57376) a proposed rule (CMS-1320-P) to establish the loan forgiveness criteria for qualifying

hospitals who receive loans under the Health Care Infrastructure Improvement Program that was established under section 1016 of Pub. L. 108-173.

We received one timely item of correspondence on this proposed rule. We address the provisions of the proposed rule, a summary of the public comments received and our responses, and the provisions of the final rule in section XI. of the preamble of this final rule.

G. Interim Final Rule on the Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program for Part B Outpatient Drugs and Biologicals for the Purpose of Calculating the Average Sales Price

In November 21, 2005 **Federal Register** (70 FR 70748), we published an interim final rule with comment period (CMS-1325-IFC3) to clarify and solicit comments on the relationship between drugs supplied under the CAP for Part B Drugs and Biologicals and the calculation of the ASP.

We did not receive any timely items of correspondence on this interim final rule with comment period. We summarize the provisions of the July 6, 2005 and the November 21, 2005 interim final rules and the current interim final provisions in section XII. of the preamble of this final rule.

II. Changes to 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. DRG Reclassifications

1. General

As discussed in section II.D. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24030), for FY 2007, we are making only limited changes to the current DRG classifications that will be applicable to discharges occurring on or after October 1, 2006.

We are limiting our changes because, as discussed in detail in section II.C. of the preamble to the proposed rule and to this final rule, we are focusing our efforts on addressing the recommendations made last year by MedPAC to refine the entire CMS DRG system by taking into account severity of illness and applying hospital-specific relative value (HSRV) weights to DRGs.

Currently, cases are classified into CMS DRGs for payment under the IPPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of 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).

The process of forming the 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 formed by physician panels as the first step toward ensuring 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 DRG could contain patients in different MDCs. Most MDCs are based on a particular organ system of the body. 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 2006, cases are assigned to one of 526 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 a DRG. However, for FY 2006, there are nine DRGs to which cases are directly assigned on the basis of ICD-9-CM procedure codes. These 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 for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

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

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on the consumption of hospital resources. 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 a comorbidity (CC).

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 DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Once the medical and surgical classes for an MDC were formed, each class of diagnoses was evaluated to determine if complications, comorbidities, or the patient's age would consistently affect the consumption of hospital resources. Physician panels classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial CC. A substantial CC was defined as a condition which, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least one day in at least 75 percent of the patients. Each medical and surgical class within an MDC was tested to determine if the presence of any substantial CC would consistently affect the consumption of hospital resources.

A patient's diagnosis, procedure, discharge status, and demographic information is fed 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 a 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 DRG by the Medicare GROUPER software program. The GROUPER program was developed

as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and, for a limited number of DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to a DRG by the GROUPER, the PRICER software calculates a base DRG payment. The PRICER calculates the payment for each case covered by the IPPS based on the DRG relative weight and additional factors associated with each hospital, such as IME and DSH adjustments. These additional factors increase the payment amount to hospitals above the base 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 DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 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 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.

In the FY 2007 IPPS proposed rule, we proposed limited changes to the DRG classification system for FY 2007 for the FY 2007 GROUPER, Version 24.0 and to the methodology used to recalibrate the DRG weights. The changes we proposed, the public comments we received concerning the proposed changes, the final DRG changes, and the methodology used to calculate the DRG weights are set forth below. The changes we are implementing in this final rule will be reflected in the FY 2007 GROUPER, Version 24.0, and are effective for discharges occurring on or after October 1, 2006. Unless otherwise noted in this final rule, our DRG analysis is based on data from the March 2006 update of the FY 2005 MedPAR file, which contains hospital bills received through March 31, 2006, for discharges occurring in FY 2005.

2. Yearly Review for Making DRG Changes

Many of the changes to the DRG classifications are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible inclusion in the annual proposed rule Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the DRG recalibration process, concerns about DRG classification issues should be brought to our attention 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 DRGs was, and continues to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. For purposes of this final rule, in deciding whether to create a separate

DRG, we consider 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 existing DRG. We evaluate patient care costs using average charges and lengths of stay as proxies for costs and rely on the judgment of our medical officers to decide whether patients are clinically distinct or similar to other patients in the DRG. In evaluating resource costs, we consider both the absolute and percentage differences in average charges between the cases we are selecting for review and the remainder of cases in the DRG. We also consider variation in charges within these groups; that is, whether observed average differences are consistent across patients or attributable to cases that are extreme in terms of charges or length of stay, or both. Further, we also consider the number of patients who will have a given set of characteristics and generally prefer not to create a new DRG unless it will include a substantial number of cases.

C. Revisions to the DRG System Used Under the IPPS

1. MedPAC Recommendations

In the FY 2006 IPPS final rule, we discussed a number of recommendations made by MedPAC regarding revisions to the DRG system used under the IPPS (70 FR 47473 through 47482).

In Recommendation 1-3 in the 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that CMS refine the current DRGs to more fully capture differences in severity of illness among patients, including:

- Base the DRG relative weights on the estimated cost of providing care.

- Base the weights on the national average of the hospital-specific relative values (HSRVs) for each DRG (using hospital-specific costs to derive the HSRVs).
- Adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.
- Implement the case-mix measurement and outlier policies over a transitional period.

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. Following the publication of the FY 2006 IPPS final rule, we contracted with 3M Health Information Systems to assist us in performing this analysis.

Beginning with MedPAC's relative weight recommendations, we analyzed MedPAC's recommendations to move to a cost-based HSRV weighting methodology. In performing this portion of the analysis, we studied hospital cost report data, departmental cost-to-charge ratios (CCRs), MedPAR claims data, and HSRV weighting methodology. Our intention in undertaking this portion of the analysis was to find an administratively feasible approach to improving the accuracy of the DRG weights. As we described in the proposed rule, we believe some changes can be made to MedPAC's methodology for

determining the relative weights that will make it more feasible to replicate on an annual basis but will result in similar impacts.

In conjunction with analyzing MedPAC's relative weight recommendations, we looked at refining the current DRG system to better recognize severity of illness. Starting with the APR DRG GROUPER used by MedPAC in its analysis, we studied Medicare claims data. Based on this analysis, we developed a CS DRG GROUPER that we believe could be a better alternative for recognizing severity of illness among the Medicare population. We note that MedPAC's recommendations with regard to revising the DRGs to better recognize severity of illness may have implications for the outlier threshold, the measurement of real case-mix versus apparent case-mix, and the IME and the DSH adjustments. We discuss these implications in more detail in the following sections.

As we present below, we believe that the recommendations made by MedPAC, or some variants of them, have significant promise to improve the accuracy of the payment rates in the IPPS. We agree with MedPAC about exploring possible refinements to our payment methodology even in the absence of concerns about the proliferation of specialty hospitals. In the FY 2006 final rule, we indicated that until we had completed further analysis of the options and their effects, we could not predict the extent to which changing to APR DRGs would provide payment equity between specialty and general hospitals. In fact, we cautioned that any system that groups cases will always present some opportunities for providers to specialize in cases they believe to have higher margins. We believe that improving payment accuracy should reduce these

opportunities, and potentially reduce the incentives that Medicare payments may provide for the further development of specialty hospitals.

We considered MedPAC's recommendation to adjust the relative weights to account for differences in the prevalence of outlier cases. However, we placed most of our attention and resources on the recommendations related to refinement of the current DRGs to more fully capture differences in severity of illness among patients as we do not have the statutory authority to make the specific changes to our outlier policy that MedPAC recommended. While we have not made MedPAC's recommendation regarding outliers a central focus of our analysis, we do intend to examine this issue in more detail in the future. In sections II.C.2. through C.6. of the FY 2007 proposed rule, we discussed a number of issues related to the MedPAC recommendations. We also presented our analysis and specific proposals for FY 2007 and FY 2008 including their estimated impacts. In this final rule, we present the public comments received on the proposed rule, our responses to those comments, our final decisions for FY 2007 and our intended actions for FY 2008.

2. Refinement of the Relative Weight Calculation

MedPAC made two recommendations with respect to the DRG relative weight calculation. First, MedPAC recommended that CMS base the DRG relative weights on the estimated cost of providing care. Second, MedPAC recommended that CMS base the weights on the national average of hospitals' relative values in each DRG. Because both of these recommendations address the relative weight calculation, we are addressing them

together. The work we have done to address these recommendations was discussed in detail in the proposed rule (71 FR 24006-24011).

MedPAC recommended that CMS replace its charge-based relative weight methodology with cost-based weights as it believed that the charge-based relative weight methodology that CMS has utilized since 1985 has introduced bias into the weights due to differential markups for ancillary services among the DRGs. In analyzing claims data, it is evident to us that some hospital types (for example, teaching hospitals) are systematically more expensive overall than the average hospital and certain case types are more commonly treated at these more expensive facilities. Higher average charges for cases that are treated at more expensive hospitals may result in higher weights for these types of cases. MedPAC suggested a hospital-specific relative value (HSRV) methodology which MedPAC believed would reduce the effect of cost differences among hospitals that may be present in the national relative weights due to differences in case-mix adjusted costs.

Under the HSRV methodology recommended by MedPAC, charges are standardized for each provider by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the hospital's case-mix. The first step in this process involves dividing the charge for each case at the hospital by the average charge for all cases at the hospital in which the case was treated. The hospital-specific relative charge value, by definition, averages 1.0 for each hospital. The resulting ratio is then multiplied by the hospital's case-mix index (CMI). In this way, each hospital'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 hospitals. We discuss this issue in further detail below.

Our analysis of departmental-level CCRs from the Medicare cost report data has shown that charges for routine days, intensive care days, and various ancillary services are not marked up by a consistent amount. For example, the markup amounts for cardiology services are higher than average. Because charges are the current basis for the DRG relative weights, the practice of differential markups can lead to bias in the DRG weights because various DRGs use, on average, more or less of particular ancillary services. MedPAC believes that the bias in the national DRG relative weights that may arise as a result of differential markups across various cost centers can be removed by moving from charge-based to cost-based weights. Based on the analysis we have conducted, we agree that it is appropriate to adjust the DRG relative weights to account for the differences in charge markups across cost centers.

In the proposed rule, we indicated several concerns about the methodology used by MedPAC. MedPAC's methodology to reduce hospital charges to cost is administratively burdensome, not only to develop, but also to maintain. First, MedPAC developed CCRs for individual hospitals at the most detailed department level. Specifically, in calculating costs as the basis for the relative weights, MedPAC applied hospital-specific CCRs from each provider's cost report to the line item charges on the claims that the hospital submitted during the same time period. This methodology required matching cost report data to claims data, and because cost report data take longer to compile and file, the method necessitates using older claims data to set relative

weights. The most recent complete set of Medicare cost reports available to us is from FY 2003. Thus, if we were to model the exact approach used by MedPAC and use claims data for a matching year, we would be using claims data from FY 2003 instead of using FY 2005 claims data as we would if we were to continue with our current methodology. In addition, MedPAC's hospital-specific approach required detailed cost center distinctions for each hospital that are difficult to define, map, and apply. This approach also required the use of the Standard Analytic File (SAF) because MedPAR data that we currently use to set DRG weights did not have the necessary level of detail. Using the SAF increases processing time and adds further complexity to the process of setting the relative weights.

Second, because MedPAC applied these CCRs at the individual claim level, missing or invalid data resulted in MedPAC deleting a large number of claims (approximately 10 percent) from the relative weight calculation. Lastly, MedPAC acknowledged that its method was too difficult to replicate on an annual basis and suggested that the weights be recalculated once every 5 years with other adjustments based on charges during the intervening years.

As we explained in the FY 2007 IPPS proposed rule, we developed an alternative to MedPAC's approach that we believe achieves similar results in a more administratively feasible manner. This method involves developing hospital-specific charge relative weights at the cost center level and then scaling the weights to costs using the national cost center charge ratios developed from the cost report data. After studying Medicare cost report data, we established 10 cost center categories based upon broad

hospital accounting definitions. In our cost center categories, there are 8 ancillary cost groups in addition to routine day costs and intensive care day costs, and each category represents at least 5 percent of the charges in the claims data. The specific cost report lines that contribute to each category and the corresponding charge lines from the MedPAR claims data are itemized in Table A below.

In the proposed rule, we stated that this alternative approach, which we labeled as the HSRV cost center (HSRVcc) methodology, has several advantages. First, the use of national average rather than hospital-specific CCRs avoids the complexity encountered with cost center CCRs at the hospital level and allows us to retain more data for use in the relative weight calculation. In addition, the methodology eliminates the need to match claims to the time period of the CCRs, resulting in the ability to use more timely claims data. Furthermore, the alternative approach makes it more feasible to update the relative weights annually using a single methodology. We do not have to replicate the methodology once every 5 years and make adjustments based on changes in charges in the intervening years. The HSRVcc methodology is described in detail in the proposed rule (71 FR 24008 through 24011).

Comment: Several commenters supported CMS' effort to restructure the DRG relative weights based on cost. They stated that using charges as a proxy for hospital costs in determining resource utilization under the current system is inappropriate and encouraged CMS to implement a cost-based system consistent with the agency's original intent without delay.

Response: We appreciate the commenters' support of our proposal to implement a cost-based weighting methodology. We believe that adopting cost-based weights will result in significant improvements to Medicare's IPPS payments. MedPAC concluded after an extensive analysis of Medicare hospital inpatient claims and cost data that the IPPS payment rates are badly distorted, resulting in Medicare paying too much for some types of patients and too little for others. As indicated below, we are making some modifications to our proposals in response to the public comments. However, we are adopting a system of cost-based weights for FY 2007 to address the concerns raised by MedPAC. As a result, all hospitals, including specialty hospitals, will be paid more appropriately. In addition, based on our analysis, we concur with MedPAC that the current DRG system needs to be changed to better account for severity of illness among patients. This issue is discussed in more detail in the next section of this final rule.

Comment: A majority of commenters supported CMS' efforts to improve the accuracy of the DRG weights, and better reflect variations in patients' severity of illness. However, many commenters viewed the HSRVcc proposal as flawed from both a methodological and policy perspective, and believed the proposal to implement cost-based weights should be delayed for at least a year. They believed that CMS needs to further consider a number of issues raised in the public comments before such sweeping changes are implemented. In addition, the commenters indicated that CMS needs to provide hospitals with more lead-time before implementing changes so they can budget accurately. They urged CMS to use the current standardized charge-based approach in FY 2007 until these issues can be addressed. At a minimum, they believed

CMS should address what were characterized as methodological flaws and publish revised relative weights along with hospital impacts for public comment prior to implementation.

Response: We appreciate the commenters' concerns with regard to a rapid and full implementation of the changes we proposed to the relative weight methodology. However, based on our analysis and study of the MedPAC recommendations that we presented in our proposed rule, it has come to our attention that differential markups between routine and ancillary cost centers have introduced significant bias into the relative weights. In order to reduce the bias in weights and make more appropriate payments under the IPPS, we believe it is necessary to initiate the transition to a cost-based relative weight methodology in FY 2007. However, we have considered the commenters' requests to further review the HSRV methodology. Therefore, in this final rule, we are not adopting our proposal to standardize charges using the HSRV methodology. However, we are adopting our proposal to reduce charges to estimated costs prior to setting DRG weights. We will undertake further analysis of the HSRV methodology during the next year. Based on this analysis, we will consider proposing further changes to adopt the HSRV methodology for FY 2008.

Comment: Many commenters disagreed with CMS' assertion that the more administratively feasible HSRVcc approach achieves similar results to the MedPAC methodology. While they supported CMS' efforts to ensure the DRG weights are updated annually to reflect the most recent trends in inpatient care, they expressed concern with the specifics of the HSRVcc methodology.

First, they noted that CMS stated in the proposed rule that organ acquisition costs were eliminated from hospital charges before the HSRVcc weights were calculated. However, it had come to their attention that organ acquisition charges were actually included in the calculation of DRG weights under the proposed methodology. They stated that organ acquisition is reimbursed by Medicare on a cost basis and should not be included in the weight calculation. Furthermore, the commenters asserted that the inclusion of organ acquisition charges improperly overstated the transplant DRG HSRVcc weights. Commenters recommended that CMS remove the organ acquisition charges from the computation of the DRG weights if the HSRVcc methodology is to be adopted.

Second, commenters believe CMS made questionable methodological decisions when calculating the national CCRs. Under the proposed methodology, CMS calculated hospital-weighted rather than charge-weighted CCRs for each of the 10 cost centers used to scale the charge-based weights. Because the averages are unweighted, the commenters stated that the CCRs do not account for the differential contribution of each hospital to total charges. The commenters asserted that, mathematically, the only correct way to get from total hospital charges to total hospital costs is to use a charge-weighted average of hospital CCRs. Failure to use charge-weighted averages overestimates routine and ICU costs and underestimates ancillary costs, which ultimately exaggerates the shift in payments, according to the commenters. Therefore, commenters believed CMS should recalculate the mean national CCRs using a charge-weighted method.

Third, commenters believed CMS applied questionable trimming criteria in computing the cost center CCRs. They stated that trimming the cost center CCRs at 1.96 standard deviations (rather than 3 standard deviations) from the geometric mean inappropriately excluded over 200 large hospitals that account for 25 percent of routine accommodation charges. They noted that the CCRs for these hospitals appear to be predominantly correct. In addition, the commenters noted that CMS applied the CCRs to the charge data for hospitals that were excluded from the national average CCR calculation. Thus, the commenters argued there is a significant mismatch between the hospital data that was included in the CCR and HSRVcc calculations. These commenters recommended that CMS exclude hospital data from the CCRs if it is more than 3 standard deviations (rather than 1.96) from the mean CCR. Many commenters characterized these methodological decisions as errors and indicated that their combined impact is significant. If CMS is to use the HSRVcc methodology, the commenters indicated that these issues should be addressed.

A few commenters stated that we made incorrect assumptions that may have resulted in new distortions to the relative weights. Specifically, the commenters stated that we were incorrect in applying the same CCR across all hospitals for a given cost center and applying the same percent mix of services by cost center to all DRGs. The commenters recommended that we first convert charges to costs for each hospital and DRG, and then compute hospital-specific relative values. They stated that the reversal of the calculations in the HSRVcc methodology accommodates cost center mix and charge markup differences across hospitals and across DRGs.

Many commenters argued that the hospital-specific relative value methodology is unnecessary and compresses the DRG weights. Commenters cited past research indicating that HSRV has a disproportionate impact on certain types of hospitals and types of care, and reduces the range of DRG weights between the lowest and highest weight DRGs.[1] Commenters noted that the HSRV methodology "produces more compressed DRG weights" than the existing standardization methodology and that "the greater compression of the HSRV weights is counter balanced by the fact that more high-weighted cases qualify as [high cost] outlier cases." A few commenters expressed concern that adopting MedPAC's recommendation to exclude high-cost outliers in addition to statistical outliers from the computation of the DRG weights so that the weights reflect the average cost only of inlier cases would compound the DRG weight compression caused by the HSRV methodology because high-cost outlier cases occur most frequently in high-weighted DRGs. The commenters indicated that the finding raises the concern of patient access to care for services in higher cost DRGs.

Commenters also believed that the HSRV methodology fails to take into account legitimate variation in costs that occur between hospitals. Therefore, any hospital-level variation in cost that is not explained by the IPPS case mix index is simply ignored, according to the commenters. To the extent that certain services are provided most frequently in hospitals with higher than average cost, the commenters believed that the HSRV methodology will result in inappropriately lower DRG weights for these services.

---

[1] Carter, Grace, "How recalibration method, pricing, and coding affect DRG weights," Health Care Financing Review, Winter 1992)

Therefore, commenters strongly recommended that the HSRV methodology be eliminated in favor of the cost-based weighting methodology adopted under the OPPS. They stated that the main difference between these two approaches is the treatment of cost variation that is not otherwise explained with IPPS payment factors. In the standardization approach employed by OPPS, any variation in hospital costs that is not explained by CMS payment factors affects the calibration of DRG weights. They stated that the HSRV approach proposed by CMS, by contrast, ignores any hospital level variation in charges that is not explained by the case mix index. Many commenters added that CMS could propose to remove other sources of cost variation beyond its current practice of standardizing for wage index, DSH, and IME. They believed a factor-specific approach to standardization would lead to more precise and valid adjustments than those recognized under the HSRV methodology, which eliminates all sources of charge variation irrespective of whether there are legitimate differences among hospitals in costs that are not taken into account in the payment system.

Response: In preparing the FY 2007 relative weights, the costs of organ acquisition were inadvertently included in the relative weight for the calculation of "other services." The costs of organ acquisition are paid by Medicare on a cost basis and should not be included in setting the IPPS relative weights. These costs have been excluded from the IPPS relative weights calculated for this final rule.

In response to the concerns expressed regarding the CCR calculation, we proposed to establish the geometric mean CCRs using a hospital-weighted methodology because we believed that it served as an acceptable measure of central tendency. In

addition, we proposed to trim the CCRs on the basis of 1.96 standard deviations since we were using national averages and thought a more stringent statistical trim would be appropriate. In response to comments, however, we have reconsidered our approach and have implemented the 3 standard deviation statistical trim supported by commenters. Further, we are also adopting the charge-weighted method of calculating CCRs, as we now believe it may be more appropriate to apply CCRs based on aggregate costs and charges among hospitals to the charges that are aggregated by DRG and used to set the relative weights.

Although commenters asserted that the HSRV methodology exacerbates the effect of charge compression on the relative weights, we have not had sufficient time between the close of the comment period and the publication of this final rule to analyze this assertion. Therefore, in response to comments (and as stated above), we are postponing the implementation of the HSRV methodology until we can study this comment further. Instead, as suggested by many commenters, we are using an approach to calculating the IPPS relative weights that is more similar to the approach used in the OPPS. That is, rather than using a hospital-specific relative weighting methodology, we are standardizing charges to remove relevant payment factor adjustments and then adjusting those charges to costs using national cost center CCRs. As we stated in the proposed rule, it is not administratively feasible to adjust charges to cost using hospital-specific cost to charge ratios. Therefore, while we are standardizing charges for the IPPS cost-based weights using a similar process to the OPPS, we are still utilizing national average CCRs to determine cost. Specifically, we are standardizing the charges for each

DRG by cost center to remove differences in wage index, indirect medical education and disproportionate share adjustments and are then reducing the standardized charges to cost using the national average CCRs. The relative weights we are adopting in this final rule are calculated based on the average total cost for a DRG in relation to the national average total cost.

Comment: Many commenters expressed concern that CMS collapsed the full set of at least 37 cost centers into only 10. They believed this approach eliminates detail that is available on the cost report. The commenters requested that CMS elaborate on the process it went through to derive the 10 cost centers used to calculate the HSRVcc weights. Some commenters stated CMS should use all 37 cost centers that are used in calculating the OPPS relative weights for the IPPS. Other commenters suggested that CMS expand the number of cost centers used in the calculation. MedPAC found that the CCRs within the proposed 10 cost centers varied significantly in some areas and recommended that CMS expand the number to 13 by distinguishing anesthesia and labor and delivery from the operating room cost center and distinguishing inhalation therapy from the therapy services cost center. Several commenters supported MedPAC's recommendation. Further, MedPAC recommended that the CCRs be based on Medicare-specific costs and charges rather than on the costs and charges for the entire facility. Some commenters advocated that a separate cost center be added for implantable devices. They believed this additional cost center would better identify the mark-up for high cost technological devices than using the average for all supplies and equipment.

Several commenters encouraged CMS to specifically incorporate nursing costs into the weighting methodology. They stated that nursing care represents approximately 30 percent of all hospital expenditures and nearly half of all direct care costs and have been essentially ignored in the payment formula. Specifically, these commenters urged CMS to create a unique Nursing Cost Center that identifies the inpatient direct and indirect costs for registered nurses, licensed practical nurses, and unlicensed assistive personnel. They defined direct nursing costs as those associated with licensed and assistive nursing personnel assigned to care for an individual patient. Indirect nursing costs are all other salary and benefits related to licensed and assistive nursing personnel not directly assigned to care for individual patients. They suggested that the routine and intensive care cost centers in the proposed HSRVcc methodology be replaced with a nursing cost center and a separate facility cost center to identify the non-nursing cost component of care. They urged CMS to set aside funds to study and implement the above recommendation using methodologically sound research and demonstration projects.

Response: As we stated in the proposed rule, we established 10 cost center categories based upon broad hospital accounting definitions. These 10 cost center categories consist of 8 ancillary cost groups, a routine days cost group, and an intensive care days cost group. These cost centers were selected because each category represents at least 5 percent of the charges in the claims data.

We thoroughly reviewed the comments advocating that we expand the number of cost centers used in the calculation. We currently use the MedPAR data set for charge

detail. The MedPAR file does not provide enough granularity in the charge detail to support 37 different cost centers. In addition, in the proposed methodology, we eliminated claims for providers that did not have costs greater than zero for at least 8 of the 10 cost centers. At least 96 percent of the providers in the MedPAR file had charges for at least 8 of the 10 cost centers. We believe that if we were to expand to the full set of 37 cost centers outlined in the cost report, we would eliminate a greater number of claims in the calculation of the DRG relative weights.

While we do not believe expanding to 37 cost centers is feasible, we agree with MedPAC that we may have consolidated a few revenue centers that have significantly different CCRs. Upon further examination of the data, in this final rule, we are expanding the number of cost centers from 10 to 13 by creating separate cost centers for anesthesia, labor and delivery, and inhalation therapy. We also agree with MedPAC that it would be more appropriate to set the CCRs based on Medicare-specific charges and costs rather than on the costs and charges for the entire facility. Therefore, in this final rule, we are modifying our CCR calculations to incorporate Medicare-specific charge data from Worksheet D Part 4 in addition to the cost and charge data from Worksheet C Part I that we used in the proposed rule.

Other commenters suggested that we also create separate cost centers for implantable devices and nursing. As noted in the comments, the MedPAR file does not contain the necessary detail to identify a separate cost center for implantable devices or nursing. In addition, we did not have enough time to evaluate whether it would be reasonable to utilize a nursing cost center in the methodology in the future. However, we

anticipate undertaking further analysis of the relative weight methodology over the next year in conjunction with the research we are doing on charge compression to determine if additional cost centers are necessary.

Comment: Commenters, referring to Table A, "Charge Line Items from MedPAR Included in Cost Center Charge Group," noted that MedPAR charge descriptions do not match the Form CMS-2552-96 Cost Center description(s) for several cost centers. For example:

(a) MedPAR lists (18) Lithotripsy Charges where the cost reporting form lists Radioisotopes;

(b) MedPAR lists (6) Other Services where the cost reporting form lists Whole Blood and Packed Red Blood Cells

(c) MedPAR lists (19) Cardiology Charges as including line 54 of the cost report, which is Electroencephalography

(d) MedPAR lists (16) Blood Administration Charges where the cost reporting form lists ASC (Non-Distinct Part)

(e) MedPAR lists (24) Outpatient Services Charges where the cost reporting form lists Emergency

(f) MedPAR lists (25) Emergency Room Charges where the cost reporting form lists Ambulance Services

(g) MedPAR lists (26) Ambulance Charges where the cost reporting form lists Renal Dialysis

(h) MedPAR lists (29) ESRD Revenue Setting Charges where the cost reporting form lists Clinic

(i) MedPAR lists (30) Clinic Visit Charges where the cost reporting form lists Other Outpatient Services, Other Ancillary, Home Program Dialysis and Ambulance Services

(j) Ambulance Services appear to be included twice, once in (30) Clinic Visit Charges and once in (25) Emergency Room Charges

(k) Lithotripsy is included in Radiology Services

(l) Line 62 "Observation Beds" is not reflected separately in Table A.

(m) Line 68 "Other reimbursement" of the cost report is not listed in Table A.

In addition, commenters were unclear as to whether CMS accounted for subscripted lines in the cost report when calculating CCRs. The commenters noted that subscripted lines did not appear in Table A. Commenters believed this inconsistency in reporting may lead to distorted DRG weights. Therefore, commenters recommended that CMS examine this issue thoroughly before implementing cost-based weights. Several commenters requested that CMS publish a crosswalk of the revenue codes that are used for each MedPAR charge data group and require intermediaries to review cost report data to ensure that providers have reported data consistent with the mapping to the MedPAR data.

Response: We wish to clarify to the commenters that the charge description titles shown in the MedPAR charge description column in Table A were not meant to also be interpreted as the title for each of the cost report line items. That is, we were simply

using Table A to illustrate the MedPAR charge groups and the cost report line numbers that were used to create the 10 proposed cost centers. To alleviate this confusion, we are revising Table A to show both the MedPAR charge titles and the titles of the cost report line items. In response to comments (j) and (l), we note that the cost report line item number 65 for ambulance was inadvertently listed twice in the proposed rule; line item 62, observation beds, was used in establishing the CCR for the other services category. Line 65 for ambulance was only used once in the actual other services CCR calculation. Line item 62 should have appeared in the 'other services' cost center grouping printed in Table A in the proposed rule. We have corrected this error in the final version of Table A. In addition, in regards to comment (k) above, we have moved the lithotripsy charges from MedPAR to the "other services" cost center grouping and we have also revised the CCR for "other services" to include the cost report line item 43 for radioisotopes, which was formerly included in the radiology CCR.

In response to the commenters' question regarding the inclusion of subscripted lines, when we calculated the CCRs for the proposed rule and subsequently for this final rule, we relied on a HCRIS data set that contains rolled-up cost report fields such that line items which are subscripted contain the total value for the line item and any subscripted lines below. Therefore, most subscripted lines were included in the proposed rule CCRs and continue to be included in the final rule CCR calculations. However, some subscripted line items are not rolled up and continue to have their own field on the HCRIS data set that we used to calculate the CCRs. Therefore, we are now including the cost report line item 6201 for observation beds, the cost report line item 6350 for Rural

Health clinics and the cost report line item 6360 for Federally Qualified Health clinics in the other services CCR. Cost report line items 6350 and 6360 are only reported by provider-based Rural Health clinics and Federally Qualified Health clinics and are necessary in order to identify all incurred costs applicable to furnishing an observation bed prior to a decision to admit a patient to the hospital. Further, we are now including the cost report line item 68 for other reimbursement in the other services CCR, and we are including professional services charges from MedPAR in the other services charge grouping. In response to the commenters' requests that we show the revenue codes that comprise the MedPAR charges, we have also inserted an additional column in Table A that lists the revenue codes MedPAR groups into each charge field that we are using in the final 13 cost centers. The final version of Table A appears below:

Cost Center Group Name (13 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 Semi-Private Room Charges Ward Charges	011X and 014X 010X, 012X, 013X and 016X-019X 015X		Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25 C_1_C7_25	D4_HOS_C2_25 D4_HOS_C2_26
Intensive Days	Intensive Care Charges	020X		Intensive Care Unit	C_1_C5_26	C_1_C6_26 C_1_C7_26	D4_HOS_C2_26

Cost Center Group Name (13 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
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27 C_1_C7_27	D4_HOS_C2_27
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28 C_1_C7_28	D4_HOS_C2_28
			Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29 C_1_C7_29	D4_HOS_C2_29
			Other Special Care Unit	C_1_C5_30	C_1_C6_30 C_1_C7_30	D4_HOS_C2_30
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48 C_1_C7_48	D4_HOS_C2_48
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56 C_1_C7_56	D4_HOS_C2_56
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55 C_1_C7_55	D4_HOS_C2_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

Cost Center Group Name (13 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
	Used Durable Medical Charges	0293		DME-Sold	C_1_C5_67	C_1_C7_66 C_1_C6_67 C_1_C7_67	D4_HOS_C2_67
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	D4_HOS_C2_38

Cost Center Group Name (13 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_38	
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	D4_HOS_C2_39
						C_1_C7_39	
	Clinic Charges	051X		Obstetrics Clinic	C_1_C5_63	C_1_C6_63	D4_HOS_C2_63
						C_1_C7_63	
Anesthesia	Anesthesia Charges	037X		Anesthesiology	C_1_C5_40	C_1_C6_40	D4_HOS_C2_40
						C_1_C7_40	
Cardiology	Cardiology Charges	048X and 073X		Electrocardiology	C_1_C5_53	C_1_C6_53	D4_HOS_C2_53
						C_1_C7_53	
				Electro-encephalography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54
						C_1_C7_54	
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X		Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44

Cost Center Group Name (13 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_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
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
Other Services	Lithotripsy Charge	079X	Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43
					C_1_C7_43	
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X	Whole Blood & Packed Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
					C_1_C7_46	
	Blood Charges	038X	Blood Storing Processing & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
					C_1_C7_47	
	Blood Administration Charges	039X	ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
					C_1_C7_58	

Cost Center Group Name (13 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
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
					C_1_C7_59	
	Emergency Room Charges	045X	Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
					C_1_C7_60	
	Ambulance Charges	054X	Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
					C_1_C7_61	
	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	
			FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
					C_1_C7_6360	
			Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
					C_1_C7_64	

Cost Center Group Name (13 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
				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

Comment: Many commenters warned that the redistribution of payments from the surgical to the medical DRGs under the proposed methodology may create unintended consequences. Several of these commenters stated that this redistribution poses a threat to patients' access to the latest medical advances and highest quality care. They feared that hospitals will invest less in new medical technologies because Medicare would not pay sufficiently for the DRGs that use them. Another commenter stated that the increased reimbursement for psychiatric DRGs may create an incentive for IPFs to decertify and become inpatient units.

Response: We appreciate the commenters' concern that payment redistribution may create the potential for unintended consequences. However, we wish to emphasize that the redistribution of payments among DRGs is necessary to improve payment accuracy and eliminate the distortions in the current IPPS payment rates. Under the methodology in this final rule, we will increase payment for relatively underpaid cases and reduce payment for relatively overpaid cases.

We are adopting a methodology that will realign payments with costs to pay more appropriately for services rendered by hospitals. Therefore, we do not believe altering the DRG relative weighting methodology will affect patients' access to quality medical care. Patients should have continued and uninterrupted access to new, innovative technologies.

We have analyzed the impact of the increased reimbursement for psychiatric DRGs in response to the commenter's concern that increased reimbursement may provide incentives for IPFs to decertify their units and be paid under the IPPS. Because of the differences in payment between the IPPS and the IPF PPS, we do not believe that the DRG relative weights we are adopting in this final rule will provide increased incentive for IPFs to decertify units. Whereas under the IPF PPS, hospitals receive a daily base rate and adjustments to account for certain patient and facility characteristics, hospitals paid under the IPPS are paid a specified amount based on the DRG for the same cases, regardless of the length of the hospital stay. Our analysis suggests that even though the average payment per day (total payment divided by average length of stay) for the psychiatric DRGs in the IPPS proposed rule may be higher than under the IPF PPS, the total average payment per episode of care remains lower (product of the average IPF payment per day and the average length of stay). Thus, because payments per episode of care remain lower under the IPPS than under the IPF PPS, we are not concerned that IPFs will decertify to get paid using the IPPS. In addition, as indicated above, we are making some modifications to our methodology in response to the public comments. Based on

these changes, the increase in the relative weights for the psychiatric DRGs presented in this final rule will not be as significant as those contained in the proposed rule.

Comment: Commenters expressed concern that because hospitals often allocate charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges on the claims to which the CCRs are later applied. Commenters expressed concern that Medicare cost report data are not detailed enough or consistently reported accurately to determine costs accurately at a DRG level since such data lack specific cost data on individual items and services. They reiterated that the Medicare cost reports, which serve as the primary source of data under the proposed system, were not designed to be used in a prospective payment system and have not been used to establish hospital rates for inpatient services for some time. They noted several limitations in using the cost reports to derive estimated costs utilized in the DRG relative weight calculations that should be carefully examined and addressed before moving forward with the proposed system of hospital-specific cost weights.

First, the commenters believed that CMS should address cost report accuracy. The commenters stated that because the cost reports have only been used for payment in limited circumstances (DSH, IME, outlier policy), hospitals have had little incentive to report accurately and completely for the services provided to Medicare beneficiaries. In addition, they claimed the cost reports do not contain the level of detail necessary to accurately determine costs at the DRG level. Instead, the cost report provides payments, costs, and some reimbursement totals by department or cost center. The commenters also

advised that CMS perform additional auditing of the cost reports to ensure accuracy. The commenters were concerned that if CMS implements a cost-based weighting methodology, the DRG weights will be based on largely un-audited cost reports since approximately 15 percent of hospital cost reports are audited each year. They noted that MedPAC estimated that a full-scale audit could require 1,000 to 2,000 hours from a fiscal intermediary, as well as additional time and resources from the hospital. In addition, a few commenters stated that CMS should only use final settled cost report data, not as-submitted data, in calculating DRG weights.

Second, some commenters contended that CMS should evaluate the overall timeliness of cost report data. They stated that cost report data used to recalibrate the DRG weights are outdated and significantly older than the charge-based data currently used to determine DRG weights under the IPPS. Under the proposed methodology, CMS used hospital claims data from FY 2005 and hospital cost reports from FY 2003. The commenters were concerned that because a lag between the cost report year and the payment year exists, the proposed methodology would rely on older data that does not reflect the costs of many newer technologies. The commenters supported an approach that uses more recent claims and cost report data and also urge CMS to explore options for using alternative data sources that include current information on the costs of inpatient care.

Third, the commenters stated that CMS should examine the comparability of cost reports due to variability in how hospitals allocate costs. Commenters explained that a cost allocation methodology must be used to estimate the cost of individual items and

services from the aggregate costs reported for each cost-center on the cost-report. They stated that the proposed methodology assumes that all hospitals consistently allocate costs to the same cost centers. However, hospitals may have inconsistent cost accounting practices or use different cost allocation methods (for example, utilization or square-footage) according to the commenters. The commenters suggested these factors and the compression of charges both within and across cost-centers, limits the usefulness of cost report data to accurately estimate costs. According to the commenters, each hospital uses its own method to allocate costs among cost centers, often resulting in cost assignments that do not reflect the departments to which charges are assigned in the MedPAR data. For example, some commenters indicated that they included cardiac catheterization in lines other than 53 and 54 that group to the cardiac cost center. In addition, several commenters noted that hospitals report medical supply costs inconsistently. While some report them in the supply cost center, others report the medical supply cost in the cost center for the procedure in which the device was used (that is, medical supplies specific to the Emergency Room are included in line 61 of the cost report). The commenters suggested that more specific cost report instructions may be necessary to ensure that hospitals report the information correctly and consistently. Some commenters believed that cost report data were not intended or designed to be used to develop accurate payment rates and suggested developing a proxy to more accurately allocate costs at the DRG level, such as collecting data from hospitals that utilize "sophisticated cost accounting tools that provide more accurate allocation of costs."

Some commenters also recommended that CMS convene an expert panel to explore ways to address the current limitations of the cost report. They stated that this effort should identify methods to better use or improve hospital cost reports for use in setting the inpatient and outpatient relative weights. The expert panel should aim to identify changes to the cost report that reduce the net information burden on hospitals, while improving overall payment accuracy. The panel should report its recommendations by April 2007 to enable CMS enough time to consider the recommendations in setting the relative weights for FY 2008. Other commenters advocated that CMS initiate a national project to correct any misalignments between cost and charges in cost reports and on the MedPAR claims. Other commenters suggested that CMS postpone the adoption of the proposed HSRVcc methodology until such time that providers improve the accuracy of the source data used in the determination of the DRG weights.

Response: With respect to the commenters' recommendation regarding the reporting of costs and charges for services, CMS requires hospitals to report their costs and charges through the cost report with sufficient specificity to support CMS' use of cost report data for monitoring and payment. Within generally accepted principles of cost accounting, CMS allows providers flexibility to accommodate the unique attributes of each institution's accounting systems. For example, providers must match the generally intended meaning of the line-item cost centers, both standard and non-standard, to the unique configuration of department and service categories used by each hospital's accounting system. Also, while the cost report provides a recommended basis of allocation for the general service cost centers, a provider is permitted, within specified

guidelines, to use an alternative basis for a general service cost if it can support to its intermediary that the alternative is more accurate than the recommended basis. This approach creates internal consistency between a hospital's accounting system and the cost report but cannot guarantee the precise comparability of costs and charges for individual cost centers across institutions.

However, we believe that achieving greater uniformity by, for example, specifying the exact components of individual cost centers, would be very burdensome for hospitals and auditors. Hospitals would need to tailor their internal accounting systems to reflect a national definition of a cost center. It is not clear that the marginal improvement in precision created here is worth the additional administrative burden. The current hospital practice of matching costs to the generally intended meaning of a cost center ensures that most services in the cost center will be comparable across providers, even if the precise composition of a cost center among hospitals differs. Further, every hospital provides a different mix of services. Even if CMS specified the components of each cost center, costs and charges on the cost report would continue to reflect each hospital's mix of services. At the same time, internal consistency is very important to the IPPS. Costs are estimated on claims by matching CCRs for a given hospital to their own claims data through a cost center-to-revenue code crosswalk.

Despite the concerns raised in the comments, we believe that costs and charges are reported through the cost report with sufficient specificity to support CMS' use of cost report data to develop cost-based weights. The information we obtained from the cost report on the differing level of charge markups occurring between routine and

ancillary hospital departments supports MedPAC's conclusions that the most profitable DRGs that are leading to the development of specialty hospitals are those that require a lot of ancillary services with high markups and low CCRs. To the extent that charge markups vary significantly between the various routine and ancillary hospital departments, we believe that there is a need to adjust charges to cost prior to setting the relative weights. We will continue to rely on the cost report to establish the CCRs that we are finalizing to use to adjust the DRG charges to costs.

However, we continue to be interested in receiving suggestions on ways that hospitals can uniformly and consistently report charges and costs related to all cost centers that also acknowledge the ubiquitous tradeoff between greater precision in developing CCRs and administrative burden coupled with reduced flexibility in hospital accounting practices. Another issue to consider is the potential changes to the relative weights from undertaking efforts of this magnitude that will be costly for both CMS, its fiscal intermediaries and costly and burdensome to hospitals. Although we are not modifying the cost report or our cost report instructions at this time, we would be open to making improvements in the future.

Comment: Several commenters applauded CMS' efforts to find "an administratively feasible approach to improving the accuracy of the DRG weights." However, they expressed serious concerns about whether the proposed approach achieves that goal. Many commenters asserted that CMS proposes to move to a new cost-based methodology without offering any evidence that the proposed method actually improves payment accuracy.

A few commenters submitted analyses that suggest that the impact of the proposed HSRVcc methodology is substantially different than the MedPAC recommendations, and may even decrease payment accuracy relative to the charge-based weights. A few commenters specifically noted that cardiac procedures are more adversely impacted by the HSRVcc methodology. The proposed methodology reduces relative weights for the three major implantable cardioverter defibrillator (ICD) DRGs (515, 535, and 536) by 25 percent or more. While these proposed reductions imply that the weights based on the existing charge-based methodology overstate the costs of ICD procedures and therefore overpay them, the commenters presented analyses suggesting that these cases are actually underpaid. One such analysis by MedPAC, in its report on physician-owned specialty hospitals, found ICD procedures to have "lower marginal" profitability or "possibly a loss" for hospitals, based on calculation of payment-to-cost ratios and surveys of specialty hospitals. They also indicated that CMS, in approving cardiac resynchronization therapy defibrillators (CRT-D) for new technology add-on payments, found the device to be inadequately paid and granted the add-on payments to defray the costs of the therapy. Given that payment rates under the charge-based weights appear to be inadequate in many of the cardiovascular DRGs, the commenters believed the severe reductions resulting from the proposed HSRVcc methodology appear to be unjustified and provide ample reason to believe that the proposed methodology does not accomplish the goal of improving payment accuracy.

These commenters emphasized that while measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given the methodological

changes alone indicates the need for further analysis and study. The commenters believed CMS should publish reliable indicators that demonstrate how the goal of payment accuracy is achieved. One commenter requested that CMS produce and publish estimates of payment-to-cost ratios and the relative profitability by DRG to determine the effectiveness of different weight-setting and patient classification methodologies in improving overall payment accuracy. The commenter emphasized that such estimates must be adjusted to account for the cost of providing services that include high-technology devices that are understated in the cost reports. Another commenter recommended that CMS construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the results, including: a comparison of the CMS weights to MedPAC's HSRV cost approach; a comparison of CMS weights to an approach using standardized costs (as opposed to HSRV); comparison of CMS weights to weights calculated by estimating costs at the claim level using the 10 cost center approach; evaluation of other alternative methodologies for estimating costs; and an evaluation of the stability of weights over time.

Response: We appreciate the commenters concerns regarding the HSRVcc relative weight setting methodology we proposed and the large change in the relative weights that result from the application of this methodology. As we stated in the FY 2006 IPPS final rule, given the potential for significant redistribution in payments, the MedPAC recommendations should be studied extensively before any broad fundamental changes are made to the current system. In the proposed rule, we provided the results of such an extensive analysis and concluded that changes can be made to the relative weight

methodology and the DRG system to improve payment accuracy. Although we agree that adopting a methodology that results in large changes in payment should not be adopted without careful study, we do not believe that the mere presence of such significant impacts invalidates the methodology. On the contrary, we believe large payment impacts may suggest there is a significant degree of distortion present in the current payment system. In our view, we believe that the changes to the IPPS should be evaluated based on whether they represent an improvement to the current system. MedPAC has studied the IPPS extensively and found that improvement can be found in payment accuracy from adopting its recommendations that are similar to those we proposed.[2]

While we acknowledge the need for further study and evaluation of the HSRVcc methodology, we continue to believe that the differential markups among departmental CCRs have introduced distortion into the charge-based relative weights. We note that MedPAC found that "the current payment system encourages community hospitals to allocate capital to profitable services such as cardiology and stimulates the formation of specialty hospitals that often focus on providing profitable services and tend to care for low-severity patients."[3] The information we obtained from the cost reports on the differing level of charge markups occurring between routine and ancillary hospital departments supports MedPAC's conclusions that the most profitable DRGs that are leading to the development of cardiac specialty hospitals are those that require a lot of ancillary services with high markups and low CCRs. We note that the proposed rule

---

[2] Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 37-38.
[3] Hackbarth, Glenn, MedPAC Comments on the IPPS Rule, June 12, 2006, page 2.

showed that these hospitals are almost exclusively affected by changes to the relative weight methodology providing further evidence of bias and distortion in the relative weights by setting them using hospital charges. To the extent that charge markups vary significantly between the various routine and ancillary hospital departments, we believe that there is a need to adjust charges to cost prior to setting the relative weights. Although it suggested refinements to CMS' proposal (all of which we have adopted in this final rule), we note that MedPAC found that the CMS proposals made great strides toward achieving the goal of improvements in payment accuracy.[4] Therefore, as discussed in section II. C., we are using the national average CCRs to adjust the cost center charges for each DRG to cost prior to setting the relative weights. While we acknowledge that no payment methodology can be perfect because DRG-specific costs cannot be determined, we believe the cost-based methodology we are finalizing in this rule represents a significant improvement over the current charge-based methodology for all of the reasons we specified above. Under the cost-based methodology in this final rule, we will increase payment for relatively underpaid cases and reduce payment for relatively overpaid cases. We believe this reform is badly needed to reduce the bias in the weights and make more appropriate payments for both medical and surgical DRGs.

In order to mitigate the impact of the changes in the relative weights, we are implementing the new cost-based weight methodology in a 3 year transition, where the weights in the first year will be set based on 33 percent of the cost-based weight and 67 percent of the charge based weight. We will continue to study the HSRVcc

[4] Hackbarth, Glenn, MedPAC Comments on the IPPS Rule, June 12, 2006, page 2.

methodology, the potential effects of charge compression and ways in which we can better account for severity of illness within the DRG system in the coming year.

With respect to the changes new patient classification system, the proposed rule noted that we modeled the CS DRGs and observed a 12-percent increase in the explanatory power (or R-square statistic) of the DRG system to explain hospital charges. That is, we found more uniformity among hospital total charges within the CS DRGs than we did with Medicare's current DRG system (71 FR 24027). Thus, we believe that there is clear evidence that improvements can be made to the current DRG system that will reduce heterogeneity among patients within a given DRG. While this statistic indicates that the current CMS DRG system can be refined to improve payment accuracy, we agree that it does not necessarily mean we should adopt the system we proposed. For a variety of reasons explained further below, we believe that a number of factors must be considered in deciding how to revise the DRG system to better recognize severity of illness.

Comment: One commenter asserted that CMS published incorrect and deficient information about the HSRVcc methodology, its impact on hospitals, and the underlying data utilized in developing the proposed rule. Specifically, the commenter believed the HSRVcc methodology was flawed and therefore stated that the published impacts were inaccurate. The commenter believed that we failed to comply with the Federal Data Quality Act, and OMB, HHS, and CMS Guidelines which address the quality of the data used for policy development, in particular, meeting standards of utility, objectivity, integrity, and transparency and reproducibility. Because the commenter believed that we

have violated these data quality standards, the public was deprived of the opportunity to submit meaningful comments, as required by the Administrative Procedure Act (APA). The commenter urged CMS to take the appropriate steps that would result in the withdrawal of the FY 2007 IPPS proposed rule and the publication of a new proposed rule.

Response: We disagree with the commenter's claims that the data utilized in the development of the FY 2007 IPPS proposed rule were materially flawed, did not comply with the Federal Data Quality Act, and did not meet established OMB, Department and CMS guidelines for data quality. The data sources used in estimating the payment impacts from policy changes proposed in the FY 2007 IPPS proposed rule were the HCRIS files that contain Medicare cost report data, the MedPAR files that contain Medicare claims data, the OSCAR database, and the PSF (which is maintained by the fiscal intermediaries and used in paying Medicare claims). These are the best and most reliable data sources available to CMS for modeling the impacts of policy changes. We note that these same databases are used in modeling payment impacts under the LTCH PPS, the OPPS, the IRF PPS, and the IPF PPS, as well as other payment systems. We also note that the comment period to the FY 2007 IPPS proposed rule provided commenters with an opportunity to bring to our attention specific examples of incorrect or inaccurate data. In addition to our posting the impact files from the FY 2007 IPPS proposed rule on the CMS Web site, as always, commenters had access to the same CMS data files that we utilized through communication with our Office of Information Services (OIS).

The fact that the data we used in the development of the FY 2007 IPPS proposed rule were available and transparent to the public was attested by the detailed data analyses included with a significant number of the public comments we received on the FY 2007 IPPS proposed rule. Therefore, for the reasons stated above, we disagree with the commenter's assertion that the data used by CMS in the FY 2007 IPPS proposed rule does not meet the transparency and reproducibility standards. As is the case with any change in policy, we do not base policy decisions on mere assumptions, but rather we analyze the relevant data and any comments submitted in response to a proposed rule.

Comment: One commenter stated that it was unclear whether the weights published for CS DRGs included using the transfer-adjusted charges prior to calculating weights.

Response: We used the hospital's charge on the claim in the HSRVcc methodology. We presume the commenter is asking whether we adjusted the number of cases in setting the relative weights to reflect early transfer to either a post-acute or other acute care setting. We did use transfer-adjusted case counts when we applied the HSRVcc methodology for the relative weights that were shown in Table 5 of the IPPS proposed rule (71 FR 24272) and the "Consolidated severity adjusted DRG HSRVcc relative weights" provided on the CMS web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage. The case mix index that we use to iterate the proposed FY 2007 HSRVcc weights did not reflect a transfer-adjusted case count. That is, we used the sum of all the case weights divided by

the total number of cases unadjusted for transfers to post-acute or other acute care settings.

Comment: Many commenters stated that once a cost-based system is implemented, CMS should provide at least a three-year transition. They stated that a three-year transition is consistent with MedPAC's recommendation to implement the changes to the weights and DRG system over a transitional period. Commenters recommended that payments be made based on a blend of charge and cost-based weights culminating with full cost-based weights at the completion of the transition period.

Response: We have in the past provided for transition periods when adopting changes that have significant payment implications. Given the significant payment impacts upon some hospitals because of these changes to the DRG weighting methodology, we considered options to transition to cost-based weights. We believe the potential payment effects from the changes to the DRG relative weights can be mitigated by adopting a 3-year transition of the relative weights. During the first year of the transition, the relative weights will be based on a blend of 33 percent of the cost-based weights and 67 percent of the charge weights. In the second year of the transition, the relative weights will be based on a blend of 33 percent of the charge weights and 67 percent of the cost-based weights. In the third year of the transition, the relative weights will be based on 100 percent of the cost-based weights.

Comment: One commenter asserted that the proposed changes to improve payment accuracy and to provide payment equity between specialty and general hospitals do not address many of the differences between specialty and full-service hospitals. The

commenter stated that hospitals should be reimbursed for the additional services that are required to operate a full-service hospital which are often unnecessary in a specialty hospital setting. The commenter acknowledged that CMS already provides some support to hospitals that serve a high percentage of Medicaid patients through disproportionate share payments. However, the commenter suggested that CMS also make add-on payments to the base DRG payment for expenses such as: operation of a full-service, 24-hour emergency department; operation of a trauma service, a burn unit, or other high cost medically necessary services; sponsoring ground and helicopter ambulance services; operation of 24-hour diagnostic services; provision of round the clock nursing services; and provision of other support services such as clinical pharmacists, nutritionists, case managers, and medical social workers. The commenter believed these add-on payments will encourage hospitals to maintain these services rather than promote specialty hospitals that may be able to operate at a lesser cost without some or all of these services.

Response: Medicare does pay for all of these services through either the IPPS or OPPS payment. We disagree that add-on payments are necessary for services that are commonly provided at many hospitals. The costs of these services will be incorporated in the IPPS or OPPS relative weights. Rather, we continue to believe that Medicare's IPPS payment system needs to be changed to make more equitable payment across all hospitals and decrease the incentive to profit from patient and DRG selection.

Comment: A few commenters stated that although the DRG payment changes proposed by CMS seek to address the proliferation of physician-owned, limited service hospitals in response to recommendations by MedPAC, they do not believe that these

payment changes alone will remove the inappropriate incentives created by physician self-referral to limited-service hospitals. They stated that physicians will still have the ability and incentive to refer financially attractive patients to facilities they own, avoid serving low-income patients, and encourage utilization of profitable services. The commenters urged CMS to examine the investment structures of physician-owned, limited service hospitals and to continue the moratorium on issuing new provider numbers to physician-owned, limited service hospitals until the agency's strategic plan has been developed and the Congress has had the opportunity to consider the agency's final report on the topic.

Response: We are in the process of completing the Final Report to Congress and the Strategic and Implementing Plan on Specialty Hospitals, as required by section 5006 of the DRA. Section 5006 of the DRA requires us to consider, among other things, issues of bona fide investment and proportionality of investment with respect to physician investment in specialty (that is, cardiac, orthopedic or surgical) hospitals. Section 5006 of the DRA also provides that the suspension on enrollment of new specialty hospitals that we administratively instituted on June 9, 2005, shall expire upon the date we issue the final report, or, if the report is issued after August 8, 2006, it shall expire on October 8, 2006. We note that Congress has provided for a date certain for the end of the suspension on enrollment of new specialty hospitals. Furthermore, we have not identified a need at this time to continue the suspension beyond that date.

Comment: Many commenters stated that CMS's proposed HSRVcc methodology presented in the FY 2007 IPPS proposed rule failed to address issues of "charge

compression." The commenters explained that "charge compression" describes the common billing practice of hospitals applying higher percentage markups on lower cost items and lower percentage markups on higher cost items. The commenters noted that MedPAC explained that hospitals may reduce the mark-ups for higher-cost items to avoid "sticker shock."[5] As discussed below, many commenters believed that, to the extent "charge compression" exists, the proposed HSRVcc methodology would lead to systematic differences between estimates of costs and Medicare's payments. Therefore, the commenters believed that the proposal failed to accomplish CMS's stated goal of setting the DRG weights based on accurate cost determinations. If the proposed methodology is implemented, several commenters believed hospitals that perform a large volume of procedures requiring relatively costly supplies/procedures would be severely and unfairly penalized through inappropriately reduced Medicare DRG payments. The treatments they provide would be less likely to be provided, and consequently, Medicare beneficiaries' access to care may be diminished. Therefore, the commenters stated that if CMS adopts a cost-based DRG weighting methodology, a more accurate measure of determining hospitals' actual costs must be developed.

Many commenters believed that "charge compression" is a concern because the proposed HSRVcc methodology uses a single CCR for a variety of items and services in a department. Specifically, under the proposed HSRVcc methodology, we proposed to aggregate hospital-level departmental charges into 10 cost centers for each DRG, and then apply national average cost-center level CCRs to determine estimated costs. The

---

[5] Medicare Payment Advisory Commission, "Meeting Brief: Study of Hospital Charge-Setting Practices," September 9-10, 2004

commenters asserted that because most hospitals do not apply the same uniform percentage mark-up when setting the charges of each item in the department, the proposed HSRVcc methodology underestimates the cost of relatively more expensive items (particularly devices and implants) and overestimates the cost of relatively less expensive items. The commenters believed that the use of a single CCR for a variety of different items results in a systematic distortion of the estimated costs, and consequently the DRG relative weights that are used in determining the IPPS payment rates. Specifically, many commenters stated that the HSRVcc methodology has a disproportionate adverse impact on DRGs that include implantable technologies and devices, and in some case would result in Medicare reimbursement that is less than the actual cost of the device.

Some commenters discussed cost data research that has been performed since the implementation of the OPPS to determine the causes and effects of "charge compression." The commenters asserted that OPPS payment rates are also affected by charge compression. Specifically, one commenter recently commissioned research to investigate whether Medicare claims data provided statistical evidence of "charge compression." (This research was summarized in an executive summary by Christopher Hogan of Direct Research, LLC. entitled "A Proposed Solution for Charge Compression.") Many other commenters cited this recent research in their own comments, and recommended that the results of this research be used to develop an adjustment under the proposed HSRVcc methodology to account for "charge compression." This analysis utilized the detailed coding of charges for supplies by

revenue center on the Medicare claims data in the Standard Analytical Files (SAF) to divide the single cost-center CCR for "supplies and equipment" used under the proposed HSRVcc methodology into separate cost-center CCRs for 5 supplies subcategories (general supplies; implantables; sterile supplies; pacemakers and defibrillators; and all other supplies) based on a "strong statistical association between mix of charges for supplies (by revenue center) in a hospital and the [overall] supplies CCR in a hospital." Using these data from all hospitals, a regression analysis yielded a single "set of CCR adjustments reflecting national average CCRs for [each of] the [five supplies] sub-categories." This national-average set of adjustments is applied to each hospital (and combined with each hospital's actual supplies CCR) to determine an adjusted estimate of cost on each hospital's claim in the MedPAR file. The results of this research showed that this variation in CCRs across the supplies subcategories would result in weights for some DRGs being significantly different than under the HSRVcc methodology. In particular, the methodology advocated by Hogan would increase the relative weights "for DRGs with substantial charges in the implantable devices and pacemaker/defibrillator revenue centers."

The commenters pointed out that the results of this research are consistent with previous analyses demonstrating "charge compression" in hospitals' billing patterns. The commenters also noted that this research was conducted exclusively on Medicare claims data, without supplementation with any external data. The commenters believed that this research demonstrates that an adjustment for "charge compression" is possible. They further asserted that the research provides a solid analytical basis for a specific

adjustment. The commenters advocated that we use the coefficients from this regression analysis to develop a "data-driven" adjustment to the CCRs for the supplies and equipment to address the distortion caused by "charge compression."

Another commenter supported the idea of a "charge compression" adjustment but suggested that CMS should ensure appropriate stakeholder involvement before applying such a policy. Other commenters also advocated for the use of data from the SAF to analyze the relationship between costs and charges for non-implantable supplies and equipment to determine whether an adjustment to the medical-surgical supplies cost center on the MedPAR files to account for "charge compression" is also warranted.

As a result of the concerns discussed above, many commenters stated that any change toward a cost-based DRG weighting methodology under the IPPS must address the distortion caused by "charge compression" and must ensure that the methodology utilizes accurate cost determinations. Consequently, some commenters requested a delay in the implementation of the cost-based DRG weighting methodology until an adjustment for "charge compression" can be incorporated. In addition, some commenters stated that such an adjustment should also be used to address "charge compression" under the OPPS. Several commenters recommended that, in addition to including an adjustment for "charge compression," the methodology for determining the cost-based DRG relative weights be developed without employing the HSRV methodology. However, a few other commenters endorsed the proposed HSRVcc methodology, stating that the "HSRVcc methodology more closely represents the cost of providing services than the current charge-based system."

Several commenters referenced various research studies on this issue undertaken over the past 5 to 6 years. These commenters asserted that the research supports the existence of "charge compression" and its systemic distortion in payment rates. The commenters also stated that "although evidence of the effect of charge compression is not new," research that could support an adjustment to offset charge compression was not available. However, according to the commenters, "research just completed now presents a solution."

Response: We appreciate the commenters' concerns regarding charge compression and its impact on the relative weight calculations under the proposed HSRVcc methodology. We are interested in further studying the analytic technique suggested in the comments of using a regression analysis to identify adjustments that could be made to the CCRs to account for charge compression. We note that the Hogan study's regression model was only applied to expensive medical supplies and devices and was not applied uniformly to develop potential adjustments that could be made to costs and charges across all revenue and cost centers that could potentially be subject to charge compression. If such a model were to be applied, we believe further analysis would have to be undertaken to determine whether it should apply to all costs and revenue centers. At this time, we intend to research whether a rigorous model should allow an adjustment for "charge compression" to the extent it exists. Accordingly, we have engaged a contractor to undertake a study on charge compression and review the statistical models provided to us by the commenters. To the extent that we find "charge compression" exists, we will further study potential models that could adjust for it so we can develop

more accurate systems of cost-based weights to better reflect the relative costs of the different types of services provided under the IPPS. As suggested in the comments, we plan to fully involve appropriate stakeholders in future analysis of this issue to the extent feasible. Before implementing such an adjustment, we would fully describe our analysis and a potential proposed adjustment as part of the IPPS proposed rule for FY 2008.

Further, we intend to use the charge compression study that we will conduct over the next year as an opportunity to better understand the costs of medical devices. The United States faces a dilemna in health care. Although the rate-of-increase in health care spending slowed last year, costs are still growing at an unsustainable rate. One reason health care costs are rising so quickly is that most consumers of health care are frequently not aware of the actual cost of their care due to lack of transparency. We believe that cost, quality, and patient satisfaction information should be available across the spectrum of care.

Transparency of device pricing is a key aspect of consumer understanding of the cost of health care. We believe that the enhanced understanding of device pricing that will be brought about as part of our charge compression study will help accelerate the public release, in a consumer friendly fashion, of pricing information of medical devices. The public release of device pricing will help augment our overall efforts to empower consumers with better information on the health care they require.

In addition, we note that in order to mitigate the impact of adopting a revised methodology for calculating DRG weights, we are standardizing charges for MedPAR claims using the same methodology we have used in past years, rather than using the

HSRV methodology. However, as discussed in detail in section II.E. of this preamble to the final rule, we are adopting our proposal to adjust charges to account for costs prior to establishing DRG weights. However, we anticipate undertaking further analysis of the hospital-specific methodology over the next year in conjunction with the research we are doing on charge compression. If our analysis suggests that an adjustment for charge compression should be applied and/or that the hospital-specific methodology will result in relative weights that more closely approximate the relative costs of care, we will propose further changes for FY 2008. In the interim, we are further mitigating the potential payment effects from the changes to the DRG relative weights by adopting a 3-year transition of the relative weights. During the first year of the transition, the relative weights will be based on a blend of 33 percent of the cost-based weights and 67 percent of the charge weights. In the second year of the transition, the relative weights will be based on a blend of 33 percent of the charge weights and 67 percent of the cost-based weights. In the third year of the transition, the relative weights will be based on 100 percent of the cost-based weights.

3. Refinement of DRGs Based on Severity of Illness

For purposes of the following discussions, the term "CMS DRGs" means the DRG system we currently use under the IPPS; the term "APR DRGs" means the severity DRG system designed by 3M Health Information Systems that currently is used by the State of Maryland; and the term "consolidated severity-adjusted DRGs (CS DRGs)" means the DRG system based on a consolidated version of the APR DRGs (as described in detail below). We discussed the CS DRGs in the FY 2007 IPPS proposed rule and

solicited public comments on whether there are alternative DRG systems that could result in better recognition of severity than the CS DRGs we were proposing. As we made clear in the proposed rule, there are still further changes that are important to make to the CS DRG system before it is ready for adoption. In the remainder of this final rule, "CS DRGs" refers to the DRG system we analyzed and proposed for adoption in FY 2008. However, as we indicate below, we received a number of public comments about the proposed CS DRGs, potential alternatives, and a number of other issues related to our proposal. Below we summarize those comments, respond to the comments, and present our plans for adopting a severity-adjusted DRG system for FY 2008.

In the FY 2006 IPPS final rule (70 FR 47474), we stated that we would consider making changes to the CMS DRGs to better reflect severity of illness among patients. We indicated that we would conduct a comprehensive review of the CC list as well as consider the possibility of using the APR DRGs for FY 2007. We did not adopt APR DRGs for FY 2006 because such an adoption would represent a significant undertaking that could have a substantial effect on all hospitals. There was insufficient time between the release of the MedPAC report in March 2005 and the publication of the FY 2006 IPPS final rule for us to analyze fully a change of this magnitude. Instead, we adopted a more limited policy by implementing severity-adjusted cardiac DRGs.

After publication of the FY 2006 IPPS final rule, CMS contracted with 3M Health Information Systems to further analyze the MedPAC recommendations in support of our consideration of possible changes to the IPPS for FY 2007. Under one task of this contract, 3M Health Information Systems analyzed the feasibility of using a revised DRG

system under the IPPS that is modeled on the APR DRGs Version 23 to better recognize severity of illness. The APR DRGs have been used successfully as the basis of Belgium's hospital prospective global budgeting system since 2002. The State of Maryland began using APR DRGs as the basis of its all-payer hospital payment system in July 2005. More than a third of the hospitals in the United States are already using APR DRG software to analyze comparative hospital performance. Many major health information system vendors have integrated this system into their products. Several State agencies utilize the APR DRGs for the public dissemination of comparative hospital performance reports. APR DRGs have been widely applied in policy and health services research. In addition to being used in research by MedPAC, the APR DRGs also contain a separate measure of risk of mortality that is used in the Quality Indicators of the Agency for Healthcare Research and Quality, the Premier Hospital Quality Incentive Demonstration discussed in section IV.B. of this preamble, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hospital accreditation survey process (Shared Visions-New Pathways).

Below we present a comparison of the CMS DRG system and the APR DRG system.

a. Comparison of the CMS DRG System and the APR DRG System

The CMS DRG and APR DRG systems have a similar basic structure. There are 25 MDCs in both systems. The DRG assignments for both systems are based on the reporting of ICD-9-CM diagnosis and procedure codes. Both DRG systems are composed of a base DRG that describes the reason for hospital admission and a

subdivision of the base DRG based on other patient attributes that affect the care of the patient. For surgical patients, the base DRG is defined based on the type of procedure performed. For medical patients, the base DRG is defined based on the principal diagnosis. In Version 23.0 of the CMS DRG system, there are 367 base DRGs and 526 total DRGs. In Version 23 of the APR DRG system, there are 314 base DRGs and 1,258 total APR DRGs. Some of the base DRGs in the two systems are virtually identical. For example, there is no significant difference between the base DRG under both systems for medical treatment of congestive heart failure. For other base DRGs, there are substantial differences. For example, in the CMS DRG system, there are two base DRGs for appendectomy (simple and complex); in the APR DRG system, there is only one base DRG for appendectomy (the relative complexity of the patient is addressed in the subsequent subdivision of the base DRG into severity of illness subclasses).

The focus of the CMS DRGs is on complexity. Complexity is defined as the relative volume and types of diagnostic, therapeutic, and bed services required for the treatment of a particular illness. Thus, the focus of payment in the CMS DRG system reflects the relative resource use needed by the patient in one DRG group compared to another. Resource use is generally correlated with severity of illness but intensive resource use does not necessarily indicate a high level of severity in every case. It is possible that some patients will be resource-intensive and require high-cost services even though they are less severely ill than other patients. The CMS DRG system subdivides the base DRGs using age and the presence of a secondary diagnosis that represents a CC. The age subdivisions primarily relate to pediatric patients (those who are less than

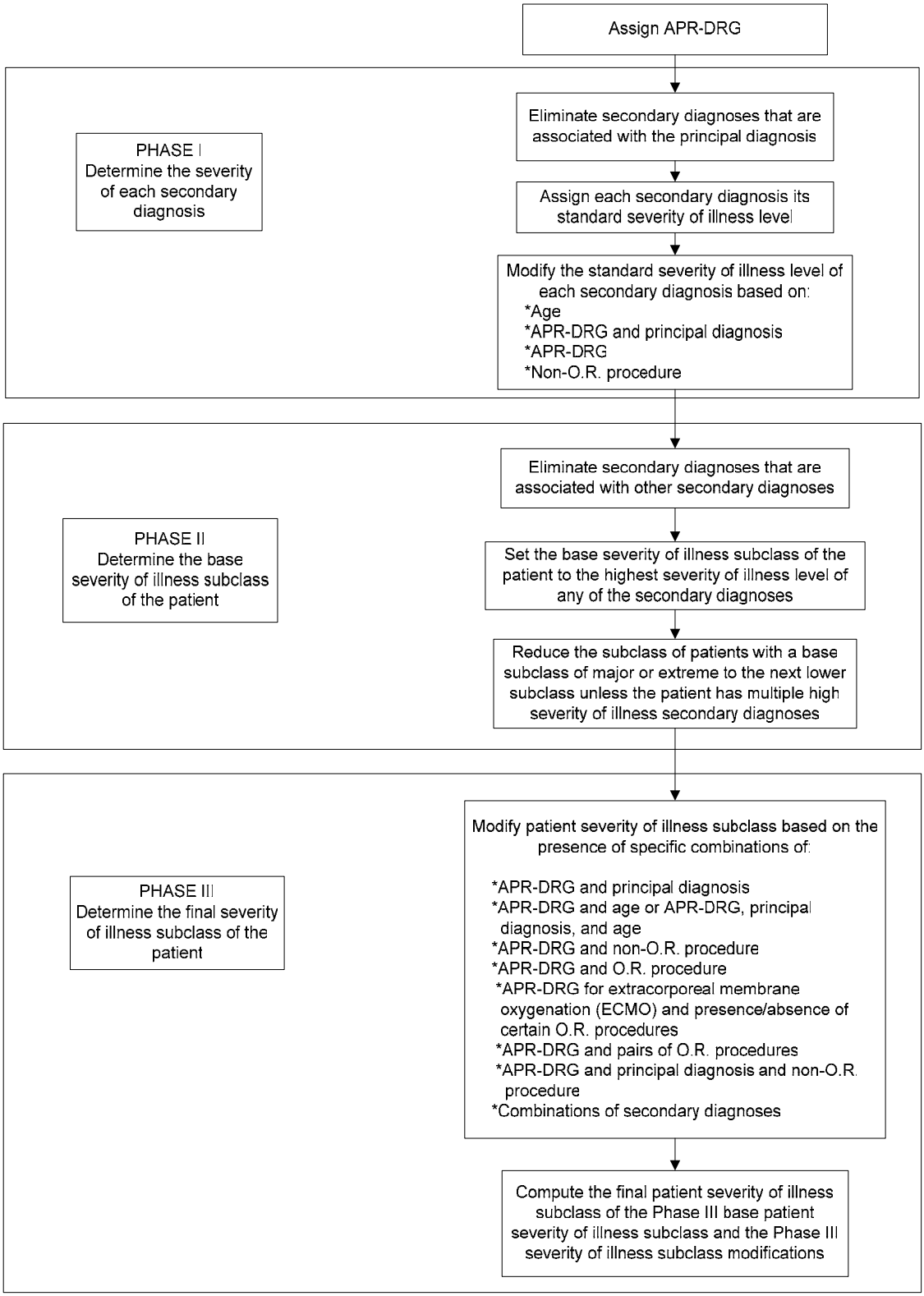
18 years of age). Patients are assigned to the CC subgroup if they have at least one secondary diagnosis that is considered a CC. The diagnoses that are designated as CCs are the same across all base DRGs. The subdivisions of the base CMS DRGs are not uniform: some base DRGs have no subdivision; some base DRGs have a two-way subdivision based on the presence of a CC; and other base DRGs have a three-way subdivision based on a pediatric subdivision followed by a CC subdivision of the adult patients. In addition, some base DRGs in MDC 5 (Diseases and Disorders of the Circulatory System) have a subdivision based on the presence of a major cardiovascular condition or complex diagnosis.

The APR DRG system subdivides the base DRGs by adding four severity of illness subclasses to each DRG. Under the APR DRG system, severity of illness is defined as the extent of physiologic decompensation or organ system loss of function. The underlying clinical principle of APR DRGs is that the severity of illness of a patient is highly dependent on the patient's underlying problem and that patients with high severity of illness are usually characterized by multiple serious diseases or illnesses. The assessment of the severity of illness of a patient is specific to the base APR DRG to which a patient is assigned. In other words, the determination of the severity of illness is disease-specific. High severity of illness is primarily determined by the interaction of multiple diseases. Patients with multiple comorbid conditions involving multiple organ systems are assigned to the higher severity of illness subclasses. The four severity of illness subclasses under the APR DRG system are numbered sequentially from 1 to 4, indicating minor (1), moderate (2), major (3), and extreme (4) severity of illness.

The APR DRG system does not subdivide base DRGs based on the age of the patient. Instead, patient age is used in the determination of the severity of illness subclass. In the CMS DRG system, the CC list is generally the same across all base DRGs. However, there are CC list exclusions for secondary diagnoses that are related to the principal diagnosis. In the APR DRG system, the significance of a secondary diagnosis is dependent on the base DRG. For example, an infection is considered more significant for an immune-suppressed patient than for a patient with a broken arm. The logic of the CC subdivision in the CMS DRG system is a simple binary split for the presence or absence of a CC. In the APR DRG system, the determination of the severity subclass is based on an 18-step process that takes into account secondary diagnoses, principal diagnosis, age, and procedures. The 18 steps are divided into three phases. There are six steps in Phase I, three steps in Phase II, and nine steps in Phase III.

The diagram below illustrates the three-phase process for determining patient severity of illness subclass.

Diagram--Three Phase Process for Determining Patient Severity of Illness



Under the CMS DRG system, a patient is assigned to the DRG with CC if there is at least one secondary diagnosis present that is a CC. There is no recognition of the impact of multiple CCs. Under the APR DRG system, high severity of illness is primarily determined by the interaction of multiple diseases. Under the CMS DRG system, patients are assigned to an MDC based on their principal diagnosis. While the principal diagnosis is generally used to assign the patient to an MDC in the APR DRG system, there is a rerouting step that assigns some patients to another MDC. For example, lower leg amputations can be performed for circulatory, endocrine, or musculoskeletal principal diagnoses. Instead of having three separate amputation base DRGs in different MDCs as is done in the CMS DRG system, the APR DRG system reroutes all of these amputation patients into a single base APR DRG in the musculoskeletal MDC. The CMS DRG system uses death as a variable in the DRG definitions but the APR DRG system does not. Both DRG systems are based on the information contained in the Medicare Uniform Bill. The APR DRG system requires the same information used by the current CMS DRG system. No changes to the claims form or the data reported would be necessary if CMS were to adopt APR DRGs or a variant of them.

The CMS DRG structure makes some DRG modifications difficult to accommodate. For example, high severity diseases that occur in low volume are difficult to accommodate because the only choice is to form a separate base DRG with relatively few patients. Such an approach could lead to a proliferation of low-volume DRGs. Alternatively, these cases may be included in DRGs with other patients that are dissimilar

clinically or in costs. Requests for new base DRGs formed on the use of a specific technology may also be difficult to accommodate. Base DRGs formed based on the use of a specific technology would result in the payment weight for the DRG being dominated by the price set by the manufacturer for the technology.

The structure of the APR DRGs provides a means of addressing high severity cases that occur in low volume through assignment of the case to a severity of illness subclass. However, the APR DRG structure does not currently accommodate distinctions based on complexity. Technologies that represent increased complexity, but not necessarily greater severity of illness, are not explicitly recognized in the APR DRG system. For example, in the CMS DRGs, there are separate DRGs for coronary angioplasty with or without insertion of stents. The APR DRGs do not make such a differentiation. The insertion of the stent makes the patient's case more complex but does not mean the patient is more severely ill. However, the inability to insert a stent may be indicative of a patient's more advanced coronary artery disease. Although such conflicts are relatively few in number, they do represent an underlying difference between the two systems. If Medicare were to adopt a severity DRG system based on the APR DRG logic but assign cases based on complexity as well as severity as we do under the current Medicare DRG system, such a distinction would represent a departure from the exclusive focus on severity of illness that currently forms the basis of assigning cases in the APR DRG system.

Section 1886(d)(4) of the Act specifies that the Secretary must adjust the classifications and weighting factors at least annually to reflect changes in treatment

patterns, technology, and other factors that may change the relative use of hospital resources. Therefore, we believe a method of recognizing technologies that represent increased complexity, but not necessarily greater severity of illness, should be included in the system. We plan to develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with the existing statutory provisions for new technology add-on payments. In the FY 2007 IPPS proposed rule, we invited public comments on this particular issue.

Another difference between the CMS DRG system and the APR DRG system is the assignment of diagnosis codes in category 996 (Complications peculiar to certain specified procedures). The CMS DRG system treats virtually all of these codes as CCs. With the exceptions of complications of organ transplant and limb reattachments, these complication codes do not contribute to the severity of illness subclass in the APR DRG system. While these codes could be added to the severity logic, the appropriateness of recognizing codes such as code 998.4 (Foreign body accidentally left during a procedure) as a factor in payment calculation could create the appearance of incentives for less than optimal quality. Although there is no direct recognition of the codes under the 996 category, the precise complication, in general, can be coded separately and could contribute to the severity of illness subclass assignment.

Comment: Some commenters strongly supported including the complication codes (996.00-999.9) when assigning a patient to a severity-adjusted DRG because the codes represent pre-existing or predictably higher risks upon admission for difficult patients who are typically referred to regional centers. The commenters stated that failure

to do so will create new incentives for adverse admission selection and underpay hospitals that treat difficult patients. The commenters stated that the 996 codes include some complications that should never be paid (for example, wrong site surgery and instruments left in the patient). However, the commenters indicated that these kinds of complications likely constitute less than one-half of one percent of all complications and revising the DRG system so that all 996 codes are not paid will provide incentives to hospitals to avoid admitting patients that are at high risk because of a pre-existing condition or other circumstance. Another commenter stated that all infections should be removed as complicating conditions under the DRG system.

Response: The discussion in this section of the proposed rule noted that 996 codes are used in assigning a patient to a CMS DRG but not to an APR DRG. Although the discussion in this section of the proposed rule did indicate that using these codes to assign a patient to a DRG may raise questions about incentives for less than optimal quality, the discussion was only intended to note the differences that currently exist between the CMS and the APR DRGs. The commenters raised issues that require further study. We will consider quality of care issues and payment incentives as we consider how to implement section 5001(c) of Pub. L. 109-171 with respect to hospital acquired conditions, including infections. There is a more detailed discussion of this provision of the law in a later section of this final rule.

Table B below summarizes the differences between the two DRG systems:

Table B.--Comparison of the CMS DRG System and the APR DRG System

Element	CMS DRG System	APR DRG System
Number of base DRGs	367	314

Element	CMS DRG System	APR DRG System
Total number of DRGs	526	1,258
Number of CC (severity) subclasses	2	4
Multiple CCs recognized	No	Yes
CC assignment specific to base DRG	No	Yes
Logic of CC subdivision	Presence or absence	18-step process
Logic of MDC assignment	Principal diagnosis	Principal diagnosis with rerouting
Death used in DRG definitions	Yes	No
Data requirements	Hospital claims	Hospital claims

To illustrate the differences between the two DRG systems, we compare in Table C below four cases that have been assigned to CMS DRGs and APR DRGs. In all four cases, the patient is a 67-year-old who is admitted for diverticulitis of the colon and who has a multiple segmental resection of the large intestine performed. ICD-9-CM diagnosis code 562.11 (Diverticulitis of colon (without mention of hemorrhage)) and ICD-9-CM procedure code 45.71 (Multiple segmental resection of large intestine) would be reported to capture this case. In both DRG systems, the patient would be assigned to the base DRG for major small and large bowel procedures. These four cases would fall into two different CMS DRGs and four different APR DRGs. We include Medicare average charges in the table to illustrate the differences in hospital resource use.

Case 1: The patient receives only a secondary diagnosis of an ulcer of anus and rectum (ICD-9-CM diagnosis code 569.41). Under the CMS DRG system, the patient is assigned to base DRG 149 (Major Small and Large Bowel Procedures Without CC). Under the APR DRG system, the patient is assigned to base DRG 221 (Major Small and Large Bowel Procedures) with a severity of illness subclass of 1 (minor).

Case 2: The patient receives a secondary diagnosis of an ulcer of anus and rectum and an additional secondary diagnosis of unspecified intestinal obstruction (ICD-9-CM

diagnosis code 560.9). Under the CMS DRG system, the patient is assigned to DRG 148 (Major Small and Large Bowel Procedures With CC). Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 2 (moderate).

Case 3: The patient receives multiple secondary diagnoses of an ulcer of anus and rectum, unspecified intestinal obstruction, acute myocarditis (ICD-9-CM diagnosis code 422.99), and atrioventricular block, complete (ICD-9-CM diagnosis code 426.0). Under the CMS DRG system, the patient is assigned to DRG 148. Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 3 (major).

Case 4: The patient receives multiple secondary diagnoses of an ulcer of anus and rectum, unspecified intestinal obstruction, acute myocarditis, atrioventricular block, complete, and the additional diagnosis of acute renal failure, unspecified (ICD-9-CM diagnosis code 584.9). Under the CMS DRG system, the patient is assigned to DRG 148. Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 4 (extreme).

Table C.--Example of Sample Cases Assigned under the CMS DRG System and under the APR DRG System

Principal Diagnosis Code: 562.11 Procedure Code: 45.71	CMS DRG System		APR DRG System	
	DRG Assigned	Average Charge	DRG Assigned	Average Charge
Case 1— Secondary Diagnosis: 569.41	149 without CC	$25,147	221 with severity of illness subclass 1	$25,988
Case 2— Secondary Diagnoses: 569.41 560.9	148 with CC	$59,519	221 with severity of illness subclass 2	$38,209
Case 3— Secondary Diagnoses: 569.41 560.9 422.99 426.0	148 with CC	$59,519	221 with severity of illness subclass 3	$66,597
Case 4— Secondary Diagnoses: 569.41 560.9 422.99 426.0 584.9	148 with CC	$59,519	221 with severity of illness subclass 4	$130,750

The largest significant difference in average charges is seen in case 4 where the average charge under the APR DRG assigned to the patient ($130,750) is more than double the average charge under the CMS DRG assigned to the patient ($59,519).

b. CS DRGs for Use in the IPPS

APR DRGs were developed to encompass all-payer patient populations. As a result, we found that, for the Medicare population, some of the APR DRGs have very low volume. MedPAC noted that the larger number of DRGs under a severity-weighted system might mean that CMS would be faced with establishing weights in many categories that have few cases and, thus, potentially creating unstable estimates. While

volume is an important consideration in evaluating any potential consolidation of APR DRGs for use under the IPPS, we believe that hospital resource use and clinical interpretability also need to be taken into consideration. For example, any consolidation of severity of illness subclasses within a base DRG should be restricted to contiguous severity of illness subclasses. Thus, it would not be reasonable clinically to combine severity of illness subclasses 1 and 4 solely because both consist of low-volume cases. We analyzed consolidating APR DRGs by either combining the base DRGs or the severity of illness subclasses within a base DRG. For consolidation across base APR DRGs, we considered patient volume, similarity of hospital charges across all four severity of illness subclasses and clinical similarity of the base APR DRGs. For consolidations of severity of illness subclasses within a base DRG, we considered patient volume and the similarity of hospital charges between severity of illness subclasses. In considering how to consolidate severity of illness subclasses, we believed it was important to use uniform criteria across all DRGs to avoid creating confusing and difficult to interpret results. That is, we were concerned about inconsistencies in the number of severity levels across different DRGs.

The objective to simultaneously take into consideration patient volume and average charges often produced conflict. Table D below contains the overall patient volume and average charge by APR DRG severity of illness subclass. While severity of illness subclass 4 (extreme) has the lowest patient volume of 5.80 percent, we found that the dramatically different average charges between severity of illness subclass 3 (major) and subclass 4 (extreme) patients of approximately $32,426 and $81,952, respectively,

would make it difficult to consolidate severity of illness subclass 3 and 4 patients. Conversely, we found that, while the average charge difference between severity of illness subclass 1 (minor) and 2 (moderate) patients was much smaller, of approximately $17,649 and $20,021, respectively, the majority of patient volume (68.08 percent) is in these two subclasses. Thus, low patient volume and small average charge differences rarely coincided.

Table D.--Overall Average Charges and Patient Volume by APR DRG Severity of Illness Subclass

	All Cases	APR DRG Severity of Illness Subclass 1	APR DRG Severity of Illness Subclass 2	APR DRG Severity of Illness Subclass 3	APR DRG Severity of Illness Subclass 4
Number of Cases	11,142,651	21.47%	46.61%	26.12%	5.80%
Average Charges	$26,342	$17,649	$20,021	$32,426	$81,952

There were also few opportunities to consolidate base DRGs. For base DRGs in which there was a clinical basis for considering a consolidation, there were usually significant differences in average charges for one or more of the severity of illness subclasses. APR DRGs already represented a considerable consolidation of base DRGs (314) compared to CMS DRGs (367). Thus, we expected that further base DRG consolidation would be difficult.

We reviewed the patient volume and average charges across APR DRGs and found that medical cases assigned severity of illness subclass 4 within an MDC have similar average charges. We observed the same pattern in average charges across severity of illness subclass 4 surgical patients within an MDC. The data suggest that, in cases with a severity of illness of subclass 4, the severity of the cases had more impact on

hospital resource use than the reason for admission (that is, the base APR DRG within an MDC). Thus, we believe that, within each MDC, the severity of illness subclass 4 medical and surgical patients, respectively, could be consolidated into a single group.

In some MDCs, it was not possible to consolidate into a single medical and a single surgical severity of illness subclass 4 group. In these MDCs, more than one group was necessary. For instance, Table E below contains the patient volume and average charges for severity of illness subclass 4 cases in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). Taking into consideration volume and average charges, except for APR DRG 440 (Kidney Transplant), surgical cases assigned severity of illness subclass 4 in MDC 11 could be consolidated into a single group having 5,492 patients and an average charge of $107,258. However, we decided not to include kidney transplant patients in this severity of illness subclass 4 due to their very high average charges (approximately $203,732 or more than $100,000 greater than other patients in MDC 11 having a severity of illness subclass 4). Average charges within the consolidated severity of illness subclass 4 surgical DRG in MDC 11 show some variation but are much higher than the corresponding average charges for the severity of illness subgroup 3 patients of $48,863. Thus, our analysis suggests that the data support maintaining three severity of illness levels for each base DRG in MDC 11; a separate severity of illness subclass 4 for all patients other than those having kidney transplant; and a separate DRG for kidney transplants.

Table E.--Summary Statistics for Surgical Cases with Severity of Illness Subclass 4 in MDC 11

APR DRG	Number of Cases	Average Length of Stay	Average Total Charges
440 (Kidney Transplant)	378	18.0	$203,732
441 (Major Bladder Procedures)	528	21.5	$128,729
442 (Kidney & Urinary Tract Procedure for Malignancy)	833	16.6	$101,501
443 (Kidney & Urinary Tract Procedure for Non-Malignancy)	966	18.4	$103,905
444 (Renal Dialysis Access Device Procedure Only - Severity of Illness Subclass 4)	935	18.3	$104,249
445 (Other Bladder Procedures)	186	15.2	$80,197
446 (Urethral & Transurethral Procedure - Severity of Illness Subclass 4)	492	13.4	$73,110
447 (Other Kidney, Urinary Tract & Related Procedures)	1,552	19.3	$121,011

The consolidation of severity of illness subclass 4 APR DRG into fewer groups was done for all MDCs except MDC 15 (Newborn and Other Neonates With Conditions Originating in the Perinatal Period), MDC 19 (Mental Diseases and Disorders), and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders). In the 22 MDCs in which the severity of illness subclass 4 consolidation was applied, the number of separate severity of illness subclass 4 groups was reduced from 262 to 69.

For MDC 14 (Pregnancy, Childbirth, and Puerperium), the base APR DRGs were consolidated from 12 to 6. Severity of illness subclass 1 through 3 were retained, and severity of illness subclass 4 was consolidated into a single APR DRG, except for cesarean section and vaginal deliveries, which were maintained as separate APR DRGs. This consolidation reduced the total number of obstetric APR DRGs from 48 to 22.

The Medicare patient volume in MDC 15 was very low, allowing for a more aggressive consolidation. For MDC 15, we consolidated 28 base APR DRGs into 7 base CS DRGs. For each of the 7 consolidated base MDC 15 DRGs, we combined severity of illness subclasses 1 and 2 into one DRG and severity of illness subclass 3 and 4 into

another DRG. This consolidation reduced the total number of MDC 15 DRGs from 112 in the APR DRG system to 14 CS DRGs.

In MDC 19, we consolidated 12 base DRGs into 4 base DRGs. We retained the 4 severity of illness subclasses in MDC 19 for each of the 4 base DRGs. In MDC 20, the base APR DRG for patients who left against medical advice has severity of illness subclass 1 and 2 consolidated and severity of illness subclass 3 and 4 consolidated. The remaining 4 base DRGs were consolidated into 1 base DRG with 4 severity of illness subclasses.

We did not consolidate any of the pre-MDC subclass 4 APR DRGs such as Heart Transplant. As explained earlier, pre-MDC DRGs are DRGs to which cases are directly assigned on the basis of ICD-9-CM procedure codes. These DRGs are for liver and/or intestinal transplants, heart and/or lung transplants, bone marrow transplants, pancreas transplants, and tracheotomies. For the pre-MDC DRGs, except for Bone Marrow Transplant, we consolidated severity of illness subclasses 1 and 2 into one DRG. In addition, the three base APR DRGs for Human Immunodeficiency Virus (HIV) with multiple or major HIV-related conditions had severity of illness subclasses 1 and 2 consolidated.

In total, we reduced 1,258 APR DRGs to 861 CS DRGs. In Appendix C of this proposed rule, we present the 861 unique combinations of CS DRGs.

Table F below includes a description of the consolidations that we did within each individual MDC and includes information about the total number of DRGs that were eliminated from the APR DRGs to develop the CS DRGs.

Table F.--Logic for Consolidating APR DRGs to CS DRGs

Number of Base APR DRGs		Reduction in DRG/SOI Groups			
Medical	Surgical	Medical	Surgical	Total	Consolidation Logic by MDC
	6		5	5	MDC 0: combine SOI 1&2 within a DRG except APR DRG 3 bone marrow transplant
19	6	17	5	22	MDC 1: combine med SOI 4; combine 049-4 and 050-4, combine all other surgical SOI 4
2	2	1	1	2	MDC 2: combine med SOI 4; combine surgical SOI 4
5	8	4	7	11	MDC 3: combine med SOI 4; combine surgical SOI 4
15	2	16	1	17	MDC 4: combine med SOI 4; combine surgical SOI 4 except for DRG 130; Combine DRG 132 & 142
16	16	15	16	31	MDC 5: combine med SOI 4; combine surgical 160-167 SOI 4, 169 & 173 SOI 4, and 170 & 171 & 174-180 SOI 4 , combine DRG 160&167
14	10	13	8	21	MDC 6: combine med SOI 4; combine surgical (1) 220-223 SOI 4, (2) 224-229 SOI 4
6	5	5	3	8	MDC 7: combine med SOI 4; combine APR DRG 260-261 SOI 4; combine APR DRG 262-264 SOI 4
9	16	8	12	20	MDC 8: combine med SOI 4; combine 303-304 and 321 SOI 4, combine surgical SOI 4 except DRG 312
6	4	5	3	8	MDC 9: combine med SOI 4; combine surgical SOI 4
6	4	5	3	8	MDC 10: combine med SOI 4; combine surgical SOI 4
7	8	6	6	12	MDC 11: combine med SOI 4; keep DRG 440 – 4, combine all other surgical SOI 4
2	5	1	4	5	MDC 12: combine med SOI 4; combine surgical SOI 4
3	8	2	7	9	MDC 13: combine med SOI 4; combine surgical SOI 4
6	6	13	13	26	MDC 14: APR DRG combine SOI 4 for DRG 541-548, combine SOI 4 for DRG 561-566; combine DRG 541-542; combine DRG 544-546; combine DRG 561&564; combine DRG 563, 565 & 566
23	5	81	17	98	MDC 15: APR DRG 580-581, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 583, 588-593, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 602,607,609, 611, 613, 621-623, combine SOI 1 & 2/combine SOI 3 & 4 APR DRG 603,608,614,625, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 630, 631, 633, 634, 636, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 639, combine SOI 1 & 2 / combine SOI 3 & 4 APR DRG 626, 640, combine SOI 1 & 2 / combine SOI 3 & 4
4	2	3	1	4	MDC 16: combine med SOI 4; combine surgical SOI 4
5	2	3	1	4	MDC 17: combine med SOI 4 for 690-693, leave 694 alone; combine surgical SOI 4
5	2	4	1	5	MDC 18: combine med SOI 4; combine surgical SOI 4
11	1	32	0	32	MDC 19: combine DRGs 750 & 751 & 753; combine DRGs 752 & 753-756 & 758-760
6	0	18	0	18	MDC 20; combine DRGs 772-776 all levels; combine DRG 770 level 1 & 2; combine DRG 770 level 3 & 4
5	1	7	0	7	MDC 21: combine all medical SOI 4 Combine APR DRG 815 and 816 SOI 1-3
2	2	1	4	5	MDC 22: combine med SOI 4; combine surgical SOI 4
4	1	6	0	6	MDC 23: combine med SOI 4 for DRGs 860-863; combine 862 & 863
4	0	6	0	6	MDC 24: combine medical SOI 4; Combine SOI 1 & 2 for DRG 890, 892 and 893
1	6	1	6	7	MDC 25: combine surgical SOI 4 DRGs 910-912; combine SOI 4 for 951-952; combine SOI 1 & 2 for DRG 910-912 & 930
186	128			397	**Total reduction in DRG/SOI Groups**
				859	**Number of Consolidated APR DRG Groups**

Number of Base APR DRGs		Reduction in DRG/SOI Groups			
Medical	Surgical	Medical	Surgical	Total	Consolidation Logic by MDC
				861	**Total Number of Consolidated APR DRG Groups Including 2 Error DRGs**

Appendix D of the FY 2007 IPPS proposed rule (71 FR 24433) showed the crosswalk of each CS DRG to its respective APR DRG. We numbered the DRGs sequentially and incorporated the severity of illness subclass into the DRG description. However, within the range of sequential numbers used for an MDC, we retained some unused numbers to allow for future DRG expansion. By using a three-digit number for the CS DRGs, we also avoid the need for reprogramming of computer systems that would be necessary to accommodate a change from the current three-digit DRG number to separate fields for the base CS DRG number and the severity of illness subclass.

Severity DRGs represent a significant change from our current DRG system. In addition to changing the way claims are grouped, severity DRGs introduce other issues requiring additional analysis, including possible increases in reported case-mix and changes to the outlier threshold. Our analysis of these issues is outlined further in the next section.

Comment: A number of commenters suggested further refinements that need to be made to the CS DRGs to account for complexity as well as severity. Commenters recommended that CMS create a "task force" to analyze situations in which the complexity of the patients is not always appropriately recognized by the proposed CS DRGs. One commenter stated that the severity system is flawed because it does not capture resource utilization or the utility of technologies that would be more appropriate for beneficiaries.

The commenters also provided examples of base DRG assignments under the current CMS DRGs that are different than those under the CS DRG. For instance, one commenter indicated that high dose interleukin-2 (HD IL2) is used to treat otherwise terminal cancer patients with metastatic renal cell cancer and melanoma. HD IL2 can evoke an immune response that eradicates the tumor and provides a potential opportunity for recovery. In the FY 2004 IPPS final rule, CMS created a new procedure code for HD IL2 therapy and assigned these patients to DRG 492. The commenter reported improved access to HD IL2 therapy as a result of these changes. However, the commenter was concerned that these patients could potentially be assigned to a number of different DRGs under the CS DRGs with a weighted average reduction in the relative weight of 58 percent. The commenter suggested revising the CS DRG to take into account the complexity associated with providing HD IL2 therapy. Other commenters noted:

- Some patients in need of ventricular assist devices (VAD) are currently paid in the same group as heart transplant patients using the CMS DRGs. Other heart assist devices are assigned to DRG 525 (Other Heart Assist Implant). These patients will be paid in the same group as implantable cardiac defibrillator patients under the CS DRGs. The commenters noted that it is possible that payment for these kinds of cases could decline by more than 70 percent under the proposed rule. The commenter believed that the assignment under the CS DRGs will not recognize higher resources associated with treating VAD patients relative to those in need of implantable cardiac defibrillators.

- Bare metal and drug-eluting coronary stents would be assigned to the same CS DRG eliminating the distinction currently made for these two different kinds of stents in the CMS DRGs. The commenters noted that CMS created separate DRGs for drug eluting and bare metal stents to recognize the higher costs of drug eluting stents.

- Defibrillator device replacement cases are currently assigned to DRG 551 (Permanent Cardiac Pacemaker Implant With Major Cardiovascular Diagnoses or AICD Lead or Generator). The commenters were concerned that these cases would be assigned to the DRGs for Permanent Cardiac Pacemaker Implant With & W/O AMI, Heart Failure or Shock and the cases would revert back to classification based on presence or absence of heart failure, AMI, or shock, rather than an MCV.

- Patients receiving tPA thrombolytic therapy for stroke are currently assigned to DRG 559 (Acute Ischemic Stroke With Use of a Thrombolytic Agent). CMS revised the DRGs in FY 2006 to provide a separate DRG for stroke patients being treated with a reperfusion agent. According to the commenter, these patients will be paid in the same group with all stroke cases under CS DRGs undoing the change that CMS made in FY 2006 according to the commenter.

- In FY 2006, CMS created separate DRGs for the revision of hip or knee replacement (DRG 545, Revision of Hip or Knee Replacement) to distinguish the higher resources associated with revisions from original replacements. Under CS DRGs, these cases would be assigned to the same group as the original replacement (bilateral or single) of the specific joint. The commenters were concerned that CMS' proposal to adopt cCS DRGs will undo a proposal that it adopted just 1 year ago.

● Combined anterior/posterior spinal fusion cases are currently assigned to DRG 496 (Combined Anterior/Posterior Spinal Fusion). This procedure requires two separate incisions and turning the patient over during surgery. The commenter expressed concern that under the CS DRG system, these cases would be paid in the same group as all spinal fusions and the new DRGs would not recognize higher costs associated with treating these patients.

● The APR DRG and CS DRG systems do not have DRGs for lung transplants alone or combined kidney/pancreas transplants. The commenter suggested that there should be separate DRGs for these transplants in addition to liver/intestinal transplants. The commenter indicated that lung transplants alone have lower costs and should not be in the same DRG as combined transplants.

Response: In the vast majority of clinical situations, severity of illness and treatment complexity are directly related and are therefore addressed in the CS DRGs. As discussed in the proposed rule, there are a number of clinical situations, primarily related to the use of specific technologies, in which low severity patients receive care with high treatment complexity and cost. We acknowledge that further refinements are needed to the proposed CS DRG system before it will be ready for adoption. In the FY 2007 IPPS proposed rule, we noted a number of concerns we had with adopting the CS DRGs in FY 2007 (71 FR 24027). Among them was our concern that we might need additional time to refine the CS DRGs to better account for complexity as well as severity. The commenters have brought some important issues to our attention that we believe should be carefully considered before we adopt the CS DRGs. We will consider

these issues if we were to make further modifications to the CS DRGs and propose adopting them for FY 2008. However, as we indicate elsewhere in this final rule, we have engaged a contractor to assist us with completing an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs and meet other criteria that would make them suitable to adopt for purposes of payment under the IPPS. We expect to complete this evaluation of alternative DRG systems quickly this fall as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS rulemaking for FY 2008. It is possible that some of the alternatives that we evaluate for better recognizing severity in the DRGs will be based on the current CMS DRGs. If we were to develop a clinical severity concept that uses the current CMS DRGs as the starting point, it is possible that the issues raised by the commenters will no longer be a concern. If, however, we were to propose adopting the CS DRGs for FY 2008, we would consider the issues raised by the commenters as we make further refinements to this DRG system so it accounts for complexity as well as severity as a proxy for relative resource use.

Comment: One commenter suggested a way of accounting for therapeutic complexity when assigning a patient under the CS DRGs. The commenter indicated that the patient should be assigned to a severity of illness subclass based on whether they received a separately identifiable technology that provides a clinical benefit and results in significantly higher case costs independent of severity level relative to the base DRG. The commenter also recommended that complexity levels be superimposed on the proposed severity of illness levels, such that either severity or complexity, or a

combination of the two, would increase the classification of a case. The classifications would be defined as severity of illness or complexity (1-4).

Response: We will further consider how to incorporate complexity into the assignment of a patient to a severity of illness subclass under either the CS DRGs if we propose to adopt them in FY 2008 or the alternative DRG system that we will consider once we complete our evaluation of potential DRG systems. It may be possible to assign a case to a severity of illness subclass under either the CS DRGs, the alternative system we plan to evaluate or even under refined CMS DRGs by using the procedures or services that are provided to the patient as a measure of resource use (that is, complexity). We agree that the use of a separately identifiable procedure or technology may be useful in determining the assignment of a patient to a specific subclass of a base DRG much like what occurs today under the CMS DRGs when assigning patients with placement of a bare metal or drug-eluting stent to separate DRGs.

Comment: Some commenters were concerned that CMS did not propose to adopt the already widely used APR DRGs endorsed by MedPAC, but rather proposed to adopt a CMS-developed CS DRGs. Some commenters stated that the CMS analysis that resulted in the CS DRGS is skewed because Medicare uses a truncated list of diagnosis and procedure codes. The commenter noted that CMS does not use comparable data to what 3M uses for the complete APR DRGs. Another commenter stated that the APR DRGs are the most advanced DRG classification system available yielding the most clinically homogenous groupings and the greatest predictive power. This commenter believed that it provides a sound basis for developing CS DRGs.

Response: MedPAC did not endorse using the APR DRGs.[6] However, MedPAC's analysis that led to their recommendation to refine the current DRGs to more fully account for difference in severity of illness among patients was based on the APR DRGs. Even though MedPAC's analysis was based on the APR DRGs, it recognized that CMS would have to consider a number of different factors when making decisions in the design of a DRG system. For instance, MedPAC noted that the large number of DRGs might mean that CMS would be faced with establishing weights in many categories that have few cases and thus potentially creating unstable estimates. To avoid creating refined DRGs with unstable relative weights, MedPAC recommended that the Secretary should be selective in adopting fine clinical distinctions similar to those reflected in the APR DRGs. Refining the DRGs will require carefully weighing the benefits of more accurate and economic distinctions against the potential for instability in relative weights based on a small number of cases.[7] We do not believe that MedPAC expected that we would adopt the APR DRGs without any changes.

Comment: Some commenters stated concerns with merging of dissimilar patient groups in the CS DRG system. Combining clinically dissimilar groups across the severity dimension has the potential to render the groups far less clinically meaningful. It is anticipated that such groups would have to be restructured frequently as treatment patterns change for primarily very ill patients. Some commenters stated that it seems that more categories may have been consolidated than necessary, giving up clinical and statistical homogeneity unnecessarily. It was noted that this is especially important if the

---

[6] Medicare Payment Advisory Commission. March, 2005. Report to the Congress, Physician-Owned Specialty Hospitals, page 76.
[7] Ibid, page 41.

CS DRGs are envisioned as part of the basis for evolving efforts towards value-based purchasing where such measures as post-admission complications and readmissions need to be evaluated on a risk-adjusted basis. An alternative approach was suggested to keep the patient groups separate from a classification perspective, but merge from a payment analysis perspective.

Response: As discussed above, the CS DRGs are based on the APR DRG system. The APR DRG system is comprised of 314 base DRGs, which are divided into four severity of illness subclasses. We believe that the APR DRG greatly improve recognition of resource use and clinical similarity of patients. However, in our analysis of the APR DRG system, we observed that cases assigned severity of illness subclass 4 within an MDC have similar average charges. Furthermore, our clinical consultants frequently considered the severity of illness subclass 4 patients across DRGs within an MDC to have a closer clinical resemblance than to lower severity patients in their respective DRGs because, in severely ill patients, comorbidities have a greater impact on severity than the reason for admisssion. Treatment patterns will evolve for these multiple comorbidities leading to severity level 4 (sepsis, shock, acute renal failure, among others). However, to the extent that these multiple comorbidities will change (for example, better treatment of septic shock so that this occurs less frequently) they should do so equally across all patients within an MDC. With respect to the comment about maintaining more DRG groups for purposes other than payment under the IPPS, we proposed to adopt the CS DRGs only for Medicare inpatient hospital payment. We chose to consolidate the APR DRGs to increase administrative simplicity, minimize the impact on existing claim

processing systems, and avoid having multiple DRGs with low case volumes and similar weights. The commenter's suggestion would essentially result in many more DRGs having exactly the same weight. Therefore, we do not see a need to adopt the commenter's suggestion. However, a hospital or any other entity can use an alternative patient classification system for the other purposes suggested in the comment.

Comment: Some commenters stated that the CS DRGs are problematic because they were not designed to accommodate non-Medicare populations. The commenters indicated that many hospitals use DRGs for quality and other outcome measurements and that the proposed CS DRGs may not be clinically appropriate for these purposes.

In addition, another commenter stated that private health insurance company contracts use the CMS DRG relative weights as the payment basis for inpatient services delivered to members under private health insurance plans. The commenter stated that because these contracts are typically negotiated based on a fairly static assumption of CMS DRGs (including classification and weights), the proposed redistribution will disrupt virtually every contract because of the varying services consumed by members covered under private health insurance. The commenter urged CMS to provide a greater lead time in implementing changes to the DRG system and relative weight methodology to allow health insurers more time to model the impact of the methodological changes to their hospital contracts.

Response: We acknowledge that Medicare DRGs are sometimes used by non-Medicare payers for their own purposes. However, CMS' primary focus of updates to the Medicare DRG classification system is on changes relating to payment for services

furnished to Medicare beneficiaries, not the obstetric, pediatric, or neonatal population. Cases involving these patients are found far less frequently among Medicare beneficiaries than in the general population. In fact, we applied consolidations to the APR DRGs to develop the CS DRGs to recognize that the APR DRGs were developed to accommodate all patient populations and there would be many DRGs with few Medicare cases or insufficient differences in the relative weights to warrant us maintaining a separate DRG. We encourage other payers that use Medicare's DRG system for payment to make appropriate modifications for patient populations that are found infrequently among Medicare beneficiaries such as neonates and children. Again, as we stated above, a hospital or any other entity can use an alternative patient classification system for purposes other than Medicare payment.

In response to the commenter's concern with regard to the impact on private health insurance plans, we are improving our relative weight methodology to make Medicare payments more accurate. We utilize Medicare specific data to calculate the relative weights designed to pay Medicare costs. We have a fiduciary responsibility to administer the trust fund in order to provide quality care for our beneficiaries and that, not private payer contracts, is our foremost concern. However, as we noted earlier in this section, we are postponing the implementation of the HSRV methodology while we study its impact on charge compression. Instead, we are using a more similar approach to calculating the IPPS relative weights that is used in the OPPS. That is, rather than using a hospital-specific relative weighting methodology, we are standardizing charges to

remove relevant payment factor adjustments and then adjusting those charges to costs using national cost center CCRs.

In addition, we are adopting a 3-year transition of the relative weights. We believe this transition may also mitigate any potential impacts to private payer contracts from the changes to the DRG relative weights. During the first year of the transition, the relative weights will be based on a blend of 33 percent of the cost-based weights and 67 percent of the charge weights. In the second year of the transition, the relative weights will be based on a blend of 33 percent of the charge weights and 67 percent of the cost-based weights. In the third year of the transition, the relative weights will be based on 100 percent of the cost-based weights.

Comment: One commenter suggested that CMS seek further refinements to the DRGs for mental services. The commenter suggested that these DRGs have been underpaid for many years.

Response: We will consider whether the psychiatric DRGs need further refinements as we proceed to refine the DRG system to better recognize severity for FY 2008. We note that the application of cost-based weights will increase Medicare's payments for the psychiatric DRGs in FY 2007.

Comment: Some commenters inquired how other prospective payment systems such as the IPF PPS and LTCH PPS that rely upon the IPPS DRG classifications would be affected by the changes to adopt CS DRGs.

Response: We did not propose any changes to the DRG classifications systems used under the IPF PPS or the LTCH PPS in the IPPS proposed rule. However, we

acknowledge that these PPSs use the IPPS DRG classifications to make payment determinations. Furthermore, we note that the refinements we are adopting to the current CMS DRG system to better recognize severity (which are discussed in detail in section II.C.7. of this final rule) will be applicable under the IPF PPS and LTCH PPS, just as past annual updates to the IPPS DRG classifications). We will need to consider whether corresponding changes need to be made to these other payment systems once final decisions are made about how DRG classification will occur under the IPPS in the future. Payment rate and policy changes to the IPF PPS and LTCH PPS went into effect for RY 2007 on July 1, 2006. These PPSs are using the Version 23 IPPS GROUPER for the first 3 months of RY 2007 (July 2006 through September 2006). Consistent with the IPPS, the IPF PPS will use Version 24 of the IPPS GROUPER, effective October 1, 2006. No further changes will be made to the IPF PPS until next July. Under the LTCH PPS, changes to the LTC-DRGs were proposed for FY 2007, based on the proposed Version 24 IPPS GROUPER (71 FR 24049 through 24068), and changes to the LTC-DRGs that will be effective October 1, 2006, based on the finalized Version 24 IPPS GROUPER (presented in this final rule) are discussed in section II.F. of the preamble of this final rule. Any changes to the DRG classification systems for these prospective payment systems would be undertaken through notice and comment rulemaking in their respective proposed rules.

Comment: One commenter stated that it was not clear how the judgment was made for the MDC 11 severity subclass 4 example shown that these average charge values were sufficiently similar to consolidate. The commenter suggested that CMS

provide further information about the criteria and considerations it used to judge categories as low volume and potentially unstable and to judge the mean charges (or costs) as sufficiently similar to warrant consolidation. One commenter expressed concern about the consolidations related to obstetrics and psychiatric care services.

Response: As discussed above, the CS DRGs are based on APR DRGs that are divided into severity subclasses 2 through 4 subclasses which greatly increase the resource and clinical similarity of the patients. Furthermore, as discussed above, our clinical consultants frequently considered the level 4 severity patients across DRGs within an MDC to have a closer clinical resemblance than to lower severity patients in their respective DRGs. In consolidating the severity level 4 patients in an MDC, volume was a primary consideration along with the extent of clinical difference. For example, in MDC 11 severity level 4, kidney transplants, were kept in a separate group and not consolidated with the other MDC 11 surgical DRGs because of the clinical distinctiveness of patients having a major organ transplant.

Comment: One commenter expressed concern that patients may need to suffer adverse consequences in order for the case to be assigned to a higher severity level. The commenter believed that the severity grouping should reflect complexity and patient benefit as well and should allow for an increased severity/complexity level even without adverse patient consequences.

Response: The current DRG system assigns a CC status to most patients with a complication or adverse event that occurs after admission. Although in the CS DRGs post admission complications can result in an increase in a patient's severity level,

patients are primarily assigned to the higher severity levels (levels 3 and 4) based on the presence of multiple serious comorbidities in multiple organ systems rather than a single adverse event. Thus, unlike the current DRGs in which a single post admission complication can place the patient in a higher paying DRG, the CS DRGs in general require multiple significant problems to be present in order for a higher severity level to be assigned. In general, these patients will be more costly to treat. The system does not reward "adverse" consequences as suggested by the commenter but instead recognizes severity of illness will also be associated, at least in part, with resource use.

Patients are increasingly admitted to the hospital at high severity of illness. Adverse consequences can and do occur within the hospital. However, some of those consequences are unavoidable (particularly for patients who are admitted at a high severity of illness). Section 5001(c) of Pub. L. 109-171 requires that, beginning in FY 2009, we select diagnosis codes associated with at least two conditions that result in assignment of a higher weighted DRG and that reasonably could be prevented through the application of evidence-based guidelines. Beginning with discharges in FY 2009, section 5001(c) requires that we not assign cases to higher weighted DRGs based on the presence of these preventable conditions. Section 5001(c) also mandates that, for discharges on or after October 1, 2007, we require a hospital to include the secondary diagnosis of a patient at admission as part of the information required to be reported by a hospital for payment purposes. We believe that the concerns of the commenter will be addressed when we implement section 5001(c) of Pub. L. 109-171.

Comment: A number of comments supported CMS' goal of improving payment accuracy. However, the commenters stated that the need for and best approach to changing the patient classification system has not been objectively demonstrated. One commenter provided a sophisticated statistical analysis that it asserted confirms MedPAC's conclusion that changes are needed to improve payment accuracy. However, this commenter suggested the greatest improvement in cost-margin consistency resulted from switching the basis for the DRG weights from charges to cost and neither the HSRVcc methodology nor the CS DRGs improved payment accuracy. Other commenters indicated that more careful analysis is needed, along with greater access to the details of the CS DRG methodology. The commenters identified the following concerns:

- Validation. The commenters indicated that it is unclear whether there is a need for a new patient classification system. The commenters stated that the implication of moving from a resource-based system to a severity-based payment system must be more fully explored and understood. They indicated that CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR DRGs.

- Budget neutrality adjustment. The commenter indicated that the proposed rule did not address an adjustment for improved documentation and coding or even a methodology for determining one. The commenter suggested that CMS not apply an adjustment for more comprehensive documentation and coding that increases perceived but not real case mix until there is evidence that one is needed. The commenter requested

that CMS monitor actual changes in coding and documentation practices associated with implementation of inpatient payment reforms to determine if any base payment adjustments are needed rather than adjust payments in anticipation of such changes.

- Availability of the GROUPER. Many commenters stated that the proprietary nature and lack of transparency of the proposed CS DRG GROUPER are concerns. The current DRG GROUPER logic has been in the public domain since the inception of IPPS. Without the new GROUPER logic, the commenters believed that it is virtually impossible for anyone to thoroughly analyze the system and comment. The commenters urged that CMS make any new classification system widely available to the public on the same terms as the current DRG system. Some commenters stated that CMS should provide the GROUPER for the CS DRGs and open a new public comment period. Several commenters were concerned about the cost of the GROUPER if the CS DRGs were implemented.

- Too few diagnoses and procedures considered. The commenters are concerned that the current CMS GROUPER does not use all diagnosis and procedures that affect a patient's severity of illness and/or the resources utilized. The commenters believed that the number of secondary diagnoses may be an important factor in determining differences in patient characteristics.

Response: With respect to the comment about the need for a new patient classification system, the proposed rule noted that we modeled the CS DRGs and observed a 12-percent increase in the explanatory power (or R-square statistic) of the DRG system to explain hospital charges. That is, we found more uniformity among

hospital total charges within the CS DRGs than we did with Medicare's current DRG system (71 FR 24027). Thus, we believe that there is clear evidence that improvements can be made to the current DRG system that will reduce heterogeneity among patients within a given DRG. While this statistic indicates that the current CMS DRG system can be refined to improve payment accuracy, we agree that it does not necessarily mean we should adopt the system we proposed. As suggested by the commenters, there are a number of other evaluation criteria that we need to consider before deciding whether to adopt the CS DRGs or a potential alternative. We describe these criteria in more detail below. With respect to the comments about a budget neutrality adjustment to account for potential improvements in documentation and coding, we discuss the comments and our responses on this issue more fully in the next section of this final rule. The comment about the availability of the GROUPER is related to a number of detailed comments we received about the potential for Medicare to adopt a proprietary DRG system. We have provided a more detailed description of these comments and our responses below. With respect to the comment about fully utilizing all of the diagnosis and procedure codes submitted on the claim, we note that CMS does not process codes submitted electronically on the 837i electronic format beyond the first 9 diagnosis codes and the first 6 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 many diagnosis and procedure codes. As suggested by the commenters, there may be 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 will consider this issue while we contemplate refinements to our DRG system to better recognize patient severity. 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 move forward with this recommendation without carefully evaluating implementation issues. One issue that we expect to consider in deciding whether to adopt such a major systems change is how frequently information beyond the ninth diagnosis code and sixth procedure code affects DRG assignment. Given the cost of an infrastructure change to accommodate this request, we want to be certain that there are sufficient benefits to justify the costs. Again, we will continue to carefully evaluate this request to expand the process capacity of our systems.

Comment: Some commenters stated that the CS DRG grouping methodology based on average charges is inconsistent with the proposed changes to adopt cost relative weights. The commenters recommended using the HSRVcc methodology to determine cost-based weights for consolidating the APR DRGs into CS DRGs.

Response: As explained above, we are not adopting the HSRVcc methodology for FY 2007 because of our concerns about the interaction of charge compression with the hospital-specific portion of the cost weight methodology. Instead, we are setting relative weights based on the estimated cost of the DRGs where cost is determined by applying the national average CCRs to the standardized charges for each DRG in each of the 13 cost centers. In general, when we consider whether to further distinguish types of cases within a DRG in order to create a new DRG or to reassign these cases to a different

DRG, we are comparing cases that are clinically similar. Therefore, it is possible or even likely that these cases will be using the same mix of routine and ancillary services and the results of the analysis will be similar whether the cases are compared based on average costs or charges. That is, the cases will be using services that have comparable charge markups over costs and the analysis will produce the same conclusion whether the comparison between cases is based on costs or charges. The major differences between cost and charge weights will occur when comparing across clinically dissimilar services that use a different mix of routine and ancillary services with variable markups. For this reason, we believe that we can continue to do our initial evaluation of potential DRG changes using average charges. Given the complexity associated with developing cost-based weights, we believe our preliminary analysis for evaluating whether to make a DRG change should use charges as a proxy for costs. However, we will consider the commenters' suggestion and, to the extent feasible, consider whether it is possible to evaluate potential DRG changes using costs as well as charges.

Comment: **N**umerous comments expressed concerns about the use of a proprietary DRG classification system. The commenters indicated that the current DRG GROUPER logic has been in the public domain since the inception of the IPPS. Many commenters noted that the source code, logic and documentation for the current DRG system can be purchased through the National Technical Information Service. The commenters stressed the importance of maintaining transparency within the DRG system (that is, any new DRG system should be available to the public on the same terms as the current one). The commenters stated that any methodology used for the Medicare

GROUPER must not be based on a proprietary system. One commenter questioned how future DRG refinements would be made if the underlying system is owned by 3M.

A number of commenters were concerned that it was not possible to thoroughly analyze the proposed CS DRGs and provide comments without the GROUPER logic. Other commenters stated that limited information on the proposed CS DRGs hampered their ability to conduct modeling of the new system. Some commenters raised serious concerns allowing CMS to assign the CS DRG without hospitals having the ability to group the case themselves. According to the commenters, without the CS DRG information, revenue and patient receivables cannot be recorded accurately. The commenters stated that hospitals must have the ability to accurately estimate payments in evaluating strategic initiatives, business plans, budgets, marketing, staffing, and other critical decisions. Commenters noted that CMS provided a link to a web tool on the 3M Web site that allowed hospitals to conduct their own analyses of the impact of moving to CS DRGs. However, these commenters stated that the reality was that if a hospital does not have its own APR DRG GROUPER software, it can only obtain CS DRG information one case at a time by entering specific diagnostic and procedure codes.

Several commenters stated that if CS DRGs are adopted and the GROUPER remains proprietary, they would be limited in their ability to educate and assist hospitals in use of the new system. One commenter indicated that the current 3M product is proprietary and not available in the public domain for hospitals or their software vendors who develop and support their patient account billing and case management software. The commenter also stated that it does not have any access to the underlying codes,

conditions and edits utilized by 3M with its product and as a result could not accurately comment on the interaction between severity and complexity associated with individual claims in contrast to resource consumption. The commenter stated that, although hospitals are not required to have a GROUPER, hospitals that hold compliance as a top priority rely on a grouper/encoder to ensure that claims meet all edits prior to submission.

Several commenters stated that a single company's monopoly over the DRG system would be costly to hospitals. The commenters indicated that it would be more difficult to obtain the system to integrate it into hospitals' existing systems. The commenters reported that Maryland hospitals report a GROUPER price of $20,000 per hospital with the ultimate price varying based on criteria such as whether it is used on a mainframe or personal computer. Another commenter expressed concerns that only 3M would be providing access to the GROUPER. The commenter stated that with over 4,000 hospitals requiring a new severity-adjusted DRG GROUPER, it is not feasible or reasonable to expect that one vendor could service all the hospitals nationally in the few months between the posting of the final IPPS rule and an October 1, 2006 implementation. The commenter stated that having 3M maintain control of the GROUPER software limits access by other software vendors to begin reprogramming of the many computer systems that would need to be loaded with the CS DRGs that is currently incompatible with the CMS DRGs. The commenter stated that there will need to be sufficient time between making the GROUPER available and implementation so that hospitals can test their systems, and study the impact on their facilities.

Another commenter stated that it offered software that hospitals and health plans utilize in managing the billing, coding, and payment for inpatient hospital services under the DRGs. The development of software related to Medicare's DRG system by private companies is possible only because the current DRG methodology is available in the public domain. The commenter also noted that the public can obtain full access to the details underlying the CMS DRG system by purchasing information and software from the National Technical Information Service for a nominal charge in a timely manner well in advance of the implementation of changes. The commenter noted the information was available to all of the public simultaneously and no company currently has a competitive advantage in producing DRG products. The commenter added that CMS currently engages in an open and comprehensive discussion about the structure of the DRG methodology through a variety of mechanisms including notices published in the **Federal Register**. CMS releases sufficient detail about its methodology in electronic formats to enable providers, health plans, and vendors to develop and validate their own computer programs. The commenter expressed concern that unfettered access to the underpinnings of the DRG system would not continue to be available under the CMS proposal to adopt CS DRGs. The commenter suggested the following criteria that a new DRG system should meet in order to be adopted by Medicare:

- Software distribution comparable to what is currently made available, which includes:
- GROUPER source code which produces all pertinent return information;
- All underlying tables that drive the GROUPER with documentation;

- A complete set of test cases to validate the functioning of the software;
- Complete system and user documentation;
- Contact people who can and will respond to questions in a timely fashion;
- The right to redistribute the methodology to business partners and consultants;
- The right to translate source code to other technology environments and to integrate it into other systems;
- Pre-releases of software and documentation well in advance of planned implementations; and
- An open inclusive process for considering future enhancements.

The commenter indicated that the agency must also ensure that whatever refinement methodology is adopted is open to public discussion and scrutiny, now and on an ongoing basis. The commenter stated that transparency is critical to advancing affordability in our health care system.

Response: With respect to making information available for the public to analyze the proposed DRGs, we were cognizant of this issue and attempted to provide as much information as possible that would allow the public an opportunity to comment meaningfully on the proposed CS DRGs. We provided the following data files on the CMS web site at no cost to the public to assist with understanding our proposed rule:

- Provider Specific File
- Impact file for IPPS FY 2007 Proposed Rule
- CCRs and Weighting Factors
- DRG Relative Weights

- CS DRG HSRVcc relative weights
- CAH List for FY 2007 Proposed Rule

In addition to this information, we made available for purchase both the FY 2004 and FY 2005 MedPAR data that were used in simulating the policies in the IPPS proposed rule. We also discussed the proposed rule in at least two national teleconferences that were open to the public. One of these calls was a Special Hospital Open Door call that was scheduled for 1 and ½ hours and was completely devoted to explaining the IPPS proposed rule and answering questions from the public. There were over 1,100 calls into this national teleconference. Finally, we were able to provide access to a Web tool on 3M's Web site that would allow an end user to build case examples using the proposed CS DRGs. While the commenters are correct that these case examples could only be analyzed one at a time, the tool did provide a detailed explanation of how the severity of illness was assigned and the demographic and diagnostic information that went into that determination. Further, other information about the CS DRGs and APR DRGs were available at that Web site, including access to the APR DRG definitions manual.

We acknowledge the many comments suggesting that the logic of Medicare's DRG system should continue to remain in the public domain as it has since the inception of PPS. We also acknowledge the commenters' concern about the impact of moving to a proprietary system and the potential for limiting public access to the underlying GROUPER logic relative to the current CMS DRGs. We note that the issues associated with using a proprietary DRG system were well illustrated in a public comment that we

received from the Maryland Health Services Cost Review Commission (HSCRC). Maryland adopted the APR DRGs in June 2004. The commenter noted that "despite the advance notice, a number of hospitals had not acquired the APR DRG GROUPER until near the time for full implementation to begin. In addition to acquiring the GROUPER, hospitals had to deal with issues of integrating the GROUPER with other hospital systems, which was at times difficult with proprietary systems." The commenter further noted that Maryland has 47 acute care hospitals and "moving the nation's entire hospital industry to a new system in a short period is likely to be much more difficult." The commenter indicated that "CMS has the opportunity to avoid some of the transition issues the HSCRC faced by placing the CS DRG logic in the public domain or by requiring open licensing of the GROUPER at reasonable rates." The commenter noted that consultants and vendors to hospitals have struggled to obtain access to the GROUPER as they advised their clients.

The public comments and Maryland's experience with APR DRGs have led to many commenters recommending that Medicare should adopt a new DRG system that is in the public domain. As we evaluate alternative severity classification systems, we will use public access to the system as an important element in evaluating whether each system can be adopted by Medicare. We will continue to strive to promote transparency in our decision making as well as in future payment and classification systems, as we have done in the past.

Comment: A number of commenters suggested that a more straightforward approach to achieving the same or similar objective would be for CMS to refine the

current DRG classification system by retaining the current base DRGs (eliminating the current paired DRGs with and without CC) and adding 3-4 levels of severity, rather than using APR DRGs. This option would preserve the many policy decisions that CMS has made over the last 20 years that are already incorporated into the DRG system and yet adjust hospital payments to reflect the cost of care based on patient needs and conditions. Other commenters suggested designating certain DRGs as device-dependent to ensure that device costs are appropriately reflected in the claims file data. Some commenters suggested that CMS retain the current DRG system but revise the CC list as an alternative approach to better recognizing severity of illness in the DRG system.

Several commenters stated that CMS did not conduct an objective study of the CS DRGs although alternatives for the APR DRG system are readily available. These commenters asked whether CMS considered adopting an alternative DRG system that could also better recognize severity.

Two commenters proposed alternative severity of illness systems to the APR DRG system. One commenter suggested that we use the Refined DRG (RDRG) severity of illness system which is supported by Health Systems Consultants, Inc, that contains 1,274 groups with 350 base DRGs. The commenter explained that each of the medical base DRGs is divided into three severity classes and each of the surgical base DRGs is divided into four severity classes. In addition, there are neonate groups based on birth weight, seven DRGs that do not have severity classes and an early death group in each MDC created to remove low outliers according to the commenter. The commenter noted that the research for the RDRG system was undertaken between 1986 and 1989

under a Health Care Financing Administration (now CMS) cooperative agreement. The commenter indicated that the RDRG system has been updated annually using the current CMS complications and comorbidities list since 1989. Solucient, LLC has also used the previous HCFA DRG severity work to develop a risk adjusted DRG system which they refer to as Refined Diagnosis Related Group (R-DRG). Solucient also reports that thay have updated their system annually with ICD-9-CM code changes. Another commenter noted that HSS/Ingenix has developed an all-payer severity-adjusted DRG system (APS-DRGs) which contains 1,130 case-mix cells with 376 consolidated DRGs plus 2 error categories. The commenter indicated that, outside of MDC 15, all consolidated DRGs are divided uniformly into three severity levels. The commenter also indicated that the number of severity levels within MDC 15 depends upon the consolidated DRG in the APS-DRG system.

One commenter stated that based on their analysis none of the off-the-shelf Version 23 DRG systems is the best alternative. Rather, it was recommended that a hybrid system be created which would combine the best features of each system. The commenter stated that the proposed CS DRG system or the current CMS DRG system would be the preferred systems to modify. One commenter stated that the use of objective, physiologic data on admission to enhance claims data significantly improves the accuracy of any severity stratification. The commenter suggested that CMS conduct one or more demonstration projects studying claims data enhanced with objective, time-stamped electronically captured laboratory results as an alternative approach for severity adjustment for payment and quality assessment purposes.

Response: The approach suggested in the comments to incorporating severity measures into the current CMS DRG system may be a viable option that we will evaluate in the coming year. With respect to the comment that we undertake demonstration projects to study alternative ways of better recognizing severity in the DRG system, we are concerned that such an endeavor could not be completed in time for FY 2008 implementation. We believe it is very important to make improvements to the DRG system to better recognize severity rapidly and there are a number of different ways that improvements in payment accuracy can be achieved without undertaking a lengthy demonstration project. As suggested by the commenters, much research has already been completed on alternative DRG systems. We believe it is likely that at least one of these systems (or potentially a system that we develop ourselves based on our own prior research) will be suitable to achieve our goal of improvements in payment accuracy by FY 2008. We are currently in the process of engaging a research contractor to evaluate the 3M Severity of Illness DRG products along with the other DRG severity systems that have come to our attention during the comment process.

As indicated above, we will use public access to the system as an important element in evaluating whether each system can be adopted by Medicare. With respect to the CS DRGs and potentially the other systems described in the public comments, there may be licensing issues. We proposed to use the CS DRGs beginning in FY 2008. While they were developed under a contract with the Federal government, the CS DRGs are essentially a variant of the APR DRGs that are copyrighted by 3M. The APS-DRGs are a proprietary product owned by HSS/Ingenix, a division of United Health Care.

However, HSS/Ingenix has indicated that, should we decide to adopt their product, it would make its DRG system available to the public under the same terms as the current CMS DRGs (that is, the source code, logic and documentation can be purchased through the National Technical Information Service). The RDRG system is supported by Health Systems Consultants.

There are other issues of note with respect to the DRG systems mentioned in the comments and Medicare's efforts to adopt a DRG system that better recognizes severity. In the late 1980's, CMS (then HCFA) funded a Yale University contract for the development of refined severity DRGs. The severity DRGs developed under this contract formed the basis for most of the severity DRG systems available today, including the Ingenix APS-DRGs, the 3M APR DRGs, the Health Systems Consultants RDRGs and the Australian government's AR-DRGs. In the mid-1990's, CMS (then HCFA) also adapted the Yale system and developed a potential severity DRG system, which was described in the Health Care Financing Review.[8] Although the APR DRGs have departed from the Yale approach to a greater extent than have the other systems, both the 3M product and the APS-DRGs were derived from the 1989 Yale severity system that is in the public domain. Given that the Yale system is in the public domain and CMS considered adopting a severity DRG system based on it in the mid 1990's, we will also consider updating our prior work part of our initiative to identify and implement a severity DRG system for use by Medicare in FY 2008. Consistent with the sentiment expressed in the public comments, this option would have the advantage of using the

[8] Edwards, Nancy et al., "Refinement of Medicare Diagnosis Related Groups to Incorporate a Measure of Severity," Health Care Financing Review, Winter 1994, pages 45-64.

current DRGs as a starting point and retaining the benefit of the many DRG decisions we have made in recent years. The DRG system we considered in the mid-1990's used a base DRG with 3 levels of severity depending upon whether the patient had no CC, a CC, or a major CC. During this past winter, CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Under this option, we could continue this review of the CC list, classifying them into one of the three categories described above in conjunction with updating the severity DRG system that we considered in mid-1990's.

c. Changes to CMI from a New DRG System

After the 1983 implementation of the IPPS DRG classification system, CMS observed unanticipated growth in inpatient hospital case-mix (the average relative weight of all inpatient hospital cases) that is used as proxy measurement for severity of illness.

There are three factors that determine changes in a hospital's CMI:

(1) Admitting and treating a more resource intensive patient-mix (due, for example, to technical changes that allow treatment of previously untreatable conditions and/or an aging population);

(2) Providing services (such as higher cost surgical treatments, medical devices, and imaging services) on an inpatient basis that previously were more commonly furnished in an outpatient setting; and

(3) Changes in documentation (more complete medical records) and coding practice (more accurate and complete coding of the information contained in the medical record).

Changes in CMI as a result of improved documentation and coding do not represent real increases in underlying resource demands. For the implementation of the IPPS in 1983, improved documentation and coding were found to be the primary cause in the underprojection of CMI increases, accounting for as much as 2 percent in the annual rate of CMI growth observed post-PPS.[9]

We believe that adoption of CS DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. MedPAC notes that "refinements in DRG definitions have sometimes led to substantial unwarranted increases in payments to hospitals, reflecting more complete reporting of patients' diagnoses and procedures." MedPAC further notes that "refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients'

[9] Carter, Grace M. and Ginsburg, Paul: The Medicare Case Mix Index Increase, Medical Practice Changes, Aging and DRG Creep, Rand, 1985.

comorbidities and complications." To address this issue, MedPAC recommended that the Secretary "project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the national average base payment amounts."[10]

The Secretary has broad discretion under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. While we modeled the changes to the DRG system and relative weights for the proposed rule to ensure budget neutrality, we are concerned that the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under a system that better recognizes severity. Thus, more accurate and complete documentation and coding may occur under a DRG system that better recognizes severity because it will result in higher payments than the current CMS DRGs. In the FY 2007 IPPS proposed rule, we solicited comments on this issue.

Comment: One commenter suggested that CMS should delay implementation of the proposed changes to the DRG system until it conducts nationwide coding and documentation education, particularly to physicians. The commenter also suggested that CMS should find a method to provide physicians who practice in hospitals with web-based documentation training and incentives document correctly.

---

[10]Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 42.

Response: The proposed CS DRG system is based on the reporting of current ICD-9-CM diagnosis and procedure codes. The proposed changes do not require any changes for hospitals or physicians in how they code or document information in the medical record. For this reason, we do not believe there is a need for any changes to education and training that occurs with respect to documentation and coding.

Comment: Several commenters expressed concern that the proposed rule did not provide any type of analysis to justify or support the need for an adjustment to the IPPS rates for anticipated changes in case mix from a new DRG system. These commenters noted that CMS did not provide a specific adjustment amount in the proposed rule. The commenters stated their view that it is the responsibility of CMS to provide adequate notice and the opportunity for meaningful public comments in response to such a specific proposal before any adjustment can be applied. One commenter recognized that CMS is authorized to make adjustments for changes in coding that are likely to occur. However, absent strong evidence, they urged CMS to avoid making negative adjustments to the standardized amount for anticipated increases in case mix. Another commenter provided two suggestions to CMS. The first suggestion was for CMS to share its thought process on how the standardized amount would be adjusted and allow the public an opportunity to provide comments on this basic set of criteria. The second suggestion was that CMS should make a commitment to adjust future base payment levels if it is determined that the initial adjustment projections are inaccurate. Another commenter stated that any adjustment to the standardized amount in an attempt to account for increased documentation and coding is unnecessary and unwarranted. The commenter asserted that

it is virtually impossible to objectively distinguish real changes in case mix from those that occur due to improved coding and documentation. This commenter stated claims are coded using the official coding guidelines that are the same regardless of the DRG system being used. Another commenter requested that CMS not overestimate the growth in CMI as a result of improved coding. This commenter asserted there are many needs for accurate data collection in a hospital setting and coders do not stop reviewing a medical record after locating the first CC that assigns the patient to a higher weighted DRG. The commenter maintained that several hospitals ask coders to assign codes to many of the non-invasive procedures that do not affect DRG assignment. This same commenter also stated they believe the increase in CMI will not be as significant as CMS anticipates.

One commenter representing the State of Maryland shared the state's experience with case mix index changes after adoption of the APR DRG system. The commenter stated correct coding resulting in maximum reimbursement under the CMS DRGs could understate a hospital's case mix under the APR DRGs. Facilities that have tried to improve their coding productivity by seeking to maximize reimbursement under Medicare may not obtain an accurate representation of its patient's severity of illness under APR DRGs. According to the commenter, hospitals have a financial incentive to improve their clinical documentation and to code more completely when APR DRGs (or CS DRGs which are based on APR DRGs) are used for reimbursement.

The commenter also indicated that case mix growth exceeded four percent for the State's hospitals on average, as they began to prepare for the full transition to APR DRGs. Case mix growth in this current fiscal year is about the same. As such, the State

has established a policy for FY 2006, limiting the amount of case mix growth experienced for each hospital until the coding patterns become stable. In addition, an appeals process for hospitals with services that generate rising case mix growth due to complexity has also been established.

Response: We appreciate the commenters' concerns and feedback regarding potential adjustments to the national standardized amount to account for improvements in documentation and coding that may cause the case-mix index to increase absent real case-mix growth. The commenters are correct that we did not propose a specific adjustment for improved documentation and coding. As stated in the proposed rule, we were soliciting comments on the possibility of changes in the case mix index as a result of the increase in the number of DRGs within the proposed CS DRGs. We will continue to analyze this issue as we evaluate alternative DRG systems that may better recognize severity of illness for implementation in FY 2008. We acknowledge the commenters' request to provide an opportunity for public comment before CMS adopts a specific adjustment to the standardized amounts for improved documentation and coding. As stated earlier, we intend to propose further changes to better recognize severity in the DRG system for FY 2008. If we decide to make an adjustment to the standardized amount to account for improvements in documentation and coding, we will provide the specific level adjustment and the data and analysis underlying it in a proposed rule that will allow for an opportunity for public comment.

We disagree with the commenters that suggested there is no need for an adjustment to the IPPS standardized amounts to account for improvements in

documentation that increase case mix and, therefore, payments. As presented above and in the proposed rule, Medicare's experience since the original inception of the IPPS and long-standing research provide substantiation that improvements in documentation and coding that increase case-mix and payment will occur when the opportunity arises through the expansion of the DRG system. Further, the comment representing the State of Maryland made clear that when CS DRGs "are used for reimbursement, hospitals have the financial incentive to improve their clinical documentation and to code administrative records more completely."[11] MedPAC also noted that "adopting our recommended refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients' comorbidities and complications." [12]

Comment: One commenter stated that, in its experience, a change to the severity of illness grouping logic will result in an increase to the rate of change in case-mix. Because any effect will not be revenue neutral, the commenter questioned if and how CMS intends to address the change in case-mix, for example, regulating the change or setting a cap for hospitals. The commenter indicated that case-mix could rapidly decline as well as rapidly increase at the hospital-specific level and asked if CMS had a mechanism to address that issue, as well. The commenter also recommended that hospitals with improved case mix due to improved coding accuracy and internal documentation should be entitled to the full CMI benefit.

Response: We appreciate the commenter's concern and agree that the severity of illness grouping logic will affect case-mix. Also, we have known since the development

[11] Redmon, Patrick, D., Comment Letter to CMS on the FY 2007 IPPS Proposed Rule, June 12, 2006.
[12] MedPAC, p. 42.

of a PPS for capital payments that changes in case-mix affect capital payments to certain hospitals as much, or more than, operating payments. However, we do not know, at this point, the extent and direction of the impact to case-mix that the severity of illness grouping logic would have, or how rapidly the changes to case-mix would occur. When a decision is made regarding implementing the severity logic, we will be carefully scrutinizing the data and a myriad of variables to ascertain its effect and whether or not adjustments or interventions are necessary.

4. Effect of CS DRGs on the Outlier Threshold

In its March 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that Congress amend the law to give the Secretary authority to adjust the DRG relative weights to account for the differences in the prevalence of high-cost outlier cases. MedPAC recommended DRG-specific outlier thresholds that would be financed by each DRG rather than through an across-the-board adjustment to the standardized amounts. Furthermore, in comments that MedPAC submitted during the comment period for the FY 2006 IPPS proposed rule, MedPAC stated its belief that the current policy makes DRGs with a high prevalence of outliers profitable for two reasons: (1) these DRGs receive more in outlier payments than the 5.1 percent that is removed from the national standardized amount; and (2) the relative weight calculation results in these DRGs being overvalued because of the high standardized charges of outlier cases. MedPAC also noted that, under its recommendations, outlier thresholds in each DRG would reduce the distortion in the relative weights that comes from including the outlier cases in the calculation of the weight and would correct the differences in profitability

that stem from using a uniform outlier offset for all cases. MedPAC added that its recommendation would help make relative profitability more uniform across all DRGs.

In the FY 2006 IPPS final rule (70 FR 47481), we responded to MedPAC's recommendation on outliers by noting that a change in policy to replace the 5.1 percent offset to the standardized amount would require a change in law. However, because the Secretary has broad discretion to consider all factors that change the relative use of hospital resources in the calculation of the DRG relative weights, we stated we would consider changes that would reduce or eliminate the effect of high-cost outliers on the DRG relative weights. At this time, we have not completed a detailed analysis of MedPAC's outlier recommendation because we do not have the authority to adopt such a change under current law. Instead, we have focused our resources on analyzing MedPAC's recommendations with respect to adopting severity DRGs and calculating cost-based HSRV weights that can be adopted without a change in law. While we intend to study MedPAC's recommendation in more detail at a future date, we note that changes to the DRG system that better recognize severity would have important implications for the outlier threshold. In the proposed rule, we analyzed how the outlier threshold would be affected by adopting the CS DRGs.

Using FY 2004 Medicare charge data, 3M Health Information Systems simulated the effect of adopting CS DRGs in conjunction with HSRVcc weights (described) on the FY 2006 outlier threshold using the same estimation parameters used by CMS in the FY 2006 final rule (that is, the charge inflation factor of 14.94 percent) (70 FR 47494). Under these assumptions, 3M Health Information Systems estimated that the outlier

threshold would be reduced from $23,600 under the current system to $18,758 under the CS DRGs with HSRVcc weights. By increasing the number of DRGs to better recognize severity, the DRG system itself would provide better recognition for cases that are currently paid as outliers. That is, many cases that are high-cost outlier cases under the current DRG system would be paid using a severity of illness subclass 3 or 4 under the CS DRGs and could potentially be paid as nonoutlier cases.

Comment: Some commenters noted that there was only a limited discussion of the CS DRGs' effect on the outlier threshold and no information about application of the postacute care transfer payment policy. Some commenters inquired how policy areas such as outliers and new technology will be affected by the proposed DRG changes.

Response: We will consider further the application of the postacute care transfer payment policy as we make changes to the DRG system. With respect to outliers, we discussed this issue in the proposed rule. We noted that better recognition of severity in the DRG system will result in some cases that are currently paid as outliers becoming nonoutliers. Under current law, we are required to establish an estimated outlier threshold so that between 5 and 6 percent of estimated IPPS payments are made as outlier payments. Our longstanding policy has been to set the outlier threshold so that estimated outlier payments equal 5.1 percent of estimated IPPS payments. If we were to continue this longstanding policy, we would expect DRG refinements that better recognize severity to lead to a reduction in the outlier threshold. In the proposed rule, using the same data and assumptions used for the FY 2006 final rule, we estimated that adoption of the CS DRGs would reduce the outlier threshold from $23,600 to $18,758.

Comment: One commenter recommended that CMS continue to provide the additional payment for blood clotting factor administered to hemophiliac inpatients in the future even if severity-adjusted DRGs are implemented.

Response: Section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to inpatients with hemophilia from the definition of "operating costs of inpatient hospital services." Therefore, under the statute, payment for blood clotting factor provided to hemophiliac inpatients is not included in Medicare's IPPS payment and is paid separately. For this reason, we will continue to apply Medicare's policy of paying separately for blood clotting factor provided to hemophiliac inpatients.

5. Impact of Refinement of DRG System on Payments

In the FY 2007 IPPS proposed rule (71 FR 24020), using the FY 2004 MedPAR claims data, we simulated the payment impacts of moving to the CS DRG GROUPER and the alternative HSRVcc method for developing HSRV weights. These payment simulations did not make any adjustments for changes in coding or case-mix. For purposes of this analysis, estimated payments were held budget neutral to estimated FY 2006 payments because we have a statutory requirement to make any changes to the weights or GROUPER budget neutral. Based on the results of this impact analysis, in the FY 2007 IPPS proposed rule, we proposed to adopt both the HSRVcc weighting methodology for FY 2007 and the CS DRGs for FY 2008. Later in the proposed rule (71 FR 24028) and in the Appendix A—Regulatory Impact Analysis (71 FR 24404), we modeled the effect of only adopting HSRVcc relative weights using the FY 2005 MedPAR claims data applying the traditional statutory budget neutrality requirements.

For reasons described in more detail above, we are adopting cost-based weights in this final rule. However, we are not adopting our proposal to standardize charges on MedPAR claims using HSRVs until we further research issues related to charge compression. Further, as described in more detail above, we are modifying our proposed plan to adopt the CS DRG system for FY 2008. Rather, we will evaluate the CS DRGs along with the other DRG severity systems that have come to our attention during the comment process and consider updating the work we did to develop a severity DRG system in the mid-1990's before adopting a system that better recognizes severity for FY 2008.

In the proposed rule, we presented the impact of the proposed changes on specific high volume DRGs. For comparison purposes, in the following table we are showing the percent changes in weight for these DRGs presented in the proposed rule and the percent changes in weights for these DRGs under the policies we are finalizing in this rule:

DRG	Title	Proposed Rule	Final Rule (w/o Transition)	Final Rule (with Transition)
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	3.8%	1.8%	0.6%
75	MAJOR CHEST PROCEDURES	1.4%	0.0%	0.0%
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	-3.4%	-1.7%	-0.6%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	7.6%	2.0%	0.7%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	10.9%	0.0%	0.0%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	8.3%	1.8%	0.6%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	9.7%	2.1%	0.7%
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	-11.0%	-3.1%	-1.0%
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	-7.2%	-2.3%	-0.8%
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	-5.4%	-3.3%	-1.1%

DRG	Title	Proposed Rule	Final Rule (w/o Transition)	Final Rule (with Transition)
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	5.0%	3.4%	1.1%
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	4.7%	0.7%	0.2%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	-19.7%	-9.3%	-3.1%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	-28.9%	-14.6%	-4.9%
127	HEART FAILURE & SHOCK	2.8%	3.7%	1.2%
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	2.7%	2.5%	0.8%
143	CHEST PAIN	-10.5%	-6.2%	-2.1%
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	4.2%	2.2%	0.7%
174	G.I. HEMORRHAGE W CC	11.2%	2.9%	1.0%
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	5.6%	-1.1%	-0.4%
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	5.7%	1.0%	0.3%
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	3.8%	2.2%	0.7%
277	CELLULITIS AGE >17 W CC	15.2%	9.1%	3.0%
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	10.6%	5.3%	1.8%
316	RENAL FAILURE	8.3%	3.7%	1.2%
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	10.9%	5.3%	1.8%
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	-4.0%	-4.6%	-1.5%
497	SPINAL FUSION EXCEPT CERVICAL W CC	-13.4%	0.5%	0.2%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	-20.6%	0.3%	0.1%
541	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	3.6%	-2.9%	-1.0%
542	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	8.4%	-0.8%	-0.3%
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	-3.7%	2.6%	0.9%
545	REVISION OF HIP OR KNEE REPLACEMENT	-5.8%	1.8%	0.6%
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	-8.9%	-5.5%	-1.8%
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	-11.9%	-6.2%	-2.1%
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	-5.8%	-3.8%	-1.3%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	-13.0%	1.3%	0.4%

DRG	Title	Proposed Rule	Final Rule (w/o Transition)	Final Rule (with Transition)
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	-15.0%	1.0%	0.3%
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	-5.8%	-0.5%	-0.2%
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	-6.5%	-1.4%	-0.5%
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	-34.9%	-16.2%	-5.4%
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	-25.5%	-10.4%	-3.5%
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	-34.5%	-13.8%	-4.6%

We received a number of comments, which we discuss below, expressing concern over the magnitude of the changes we proposed to the relative weight methodology and the effects on the DRG weights. As shown in this table above, the impact of the transitional cost based weights computed without using the HSRVcc method of standardization is significantly less than the impacts projected in the proposed rule. As a further demonstration of the manner in which our final policy mitigates the impacts of the proposed rule, we are presenting the following two tables showing the number of DRGs experiencing percent gains and losses in their relative weights in the proposed and final rules. We also are showing the number of providers experiencing percent gains and losses in case mix due to the proposed and final changes. As shown in the tables, the more extreme percent changes are greatly reduced with our final policies.

Comparison of the Number of DRGs Experiencing Percent Gains/Losses in Relative Weights in the Proposed Rule Relative to the Final Rule Transition

Percent Change in DRG Weight	Proposed Rule	Final Rule (with Transition)
More than -10%	32	0

Percent Change in DRG Weight	Proposed Rule	Final Rule (with Transition)
Between -5 and -10 %	42	1
Between -1 and -5 %	49	78
Between -1 and +1 %	42	308
Between 1% and 5%	111	130
Between 5% and 10%	97	12
More than +10%	153	7

Comparison of the Number of Hospitals Experiencing Percent Gains/Losses in Case-Mix Index in the Proposed Rule Relative to the Final Rule Transition

Percent Change in Case-Mix Index	Proposed Rule	Final Rule (with Transition)
More than -10%	40	0
Between -5 and -10 %	103	0
Between -1 and -5 %	597	30
Between -1 and +1 %	416	2,067
Between 1% and 5%	1493	1,450
Between 5% and 10%	794	28
More than +10%	79	20

For additional comparision purposes between the proposed and final rule relative weights and DRG changes, the following table shows the estimated payment impacts on case mix change by hospital group that we projected for the proposed rule and also shows the estimated payment impacts that we are finalizing in this rule.

	Proposed Rule Column 1	Severity Changes in DRGs	Severity DRG Changes & Cost Weights (with Transition)
All hospitals	0.0	0.0	0.0
By Geographic Location:			
Urban hospitals	-0.3	0.0	0.0
Large urban areas (populations over 1 million)	0.1	0.0	0.1
Other urban areas (populations of 1 million or fewer)	-0.9	0.0	-0.2

	Proposed Rule Column 1	Severity Changes in DRGs	Severity DRG Changes & Cost Weights (with Transition)
Rural hospitals	2.7	-0.1	0.2
Bed Size (Urban):			
0-99 beds	0.5	0.3	0.1
100-199 beds	1.8	0.0	0.3
200-299 beds	0.0	-0.1	0.1
300-499 beds	-1.1	0.0	-0.1
500 or more beds	-1.5	0.0	-0.2
Bed Size (Rural):			
0-49 beds	5.5	-0.1	0.3
50-99 beds	4.3	-0.2	0.3
100-149 beds	2.8	-0.2	0.2
150-199 beds	1.0	0.1	0.1
200 or more beds	-0.2	-0.2	-0.2
Urban by Region:			
New England	0.3	0.3	0.1
Middle Atlantic	0.1	0.0	0.2
South Atlantic	-0.7	-0.1	-0.2
East North Central	-0.4	0.0	0.0
East South Central	-0.8	-0.2	-0.3
West North Central	-1.4	0.1	-0.2
West South Central	-0.7	0.0	-0.1
Mountain	-1.4	0.2	-0.1
Pacific	0.6	-0.1	0.2
Puerto Rico	3.3	-0.4	0.1
Rural by Region:			
New England	1.8	0.1	0.5
Middle Atlantic	2.8	0.0	0.4
South Atlantic	3.4	-0.3	0.2
East North Central	1.9	-0.1	0.1
East South Central	2.9	0.0	0.0
West North Central	1.7	-0.1	0.1
West South Central	3.5	-0.2	0.1
Mountain	2.4	-0.1	0.2
Pacific	3.5	-0.4	0.3
By Payment Classification:			
Urban hospitals	-0.3	0.0	0.0
Large urban areas (populations over 1 million)	0.1	0.0	0.1
Other urban areas (populations of 1 million or fewer)	-0.9	0.0	-0.2
Rural areas	2.6	-0.1	0.2
Teaching Status:			
Non-teaching	1.1	0.0	0.2
Fewer than 100 Residents	-0.8	-0.1	-0.1
100 or more Residents	-0.8	0.0	-0.2

	Proposed Rule Column 1	Severity Changes in DRGs	Severity DRG Changes & Cost Weights (with Transition)
Urban DSH:			
Non-DSH	-1.1	0.1	0.0
100 or more beds	-0.2	-0.1	0.0
Less than 100 beds	3.5	0.1	0.4
Rural DSH:			
SCH	4.2	-0.2	0.2
RRC	1.3	-0.1	0.0
Other Rural:			
100 or more beds	4.2	0.1	0.3
Less than 100 beds	5.5	-0.1	0.2
Urban teaching and DSH:			
Both teaching and DSH	-0.6	0.0	-0.1
Teaching and no DSH	-1.7	0.1	-0.1
No teaching and DSH	1.1	0.0	0.2
No teaching and no DSH	-1.0	0.1	0.0
Rural Hospital Types:			
RRC	4.8	0.1	0.3
SCH	0.9	0.0	0.0
MDH	3.9	-0.3	0.2
SCH and RRC	5.1	-0.1	0.4
MDH and RRC	1.0	-0.3	0.0
Type of Ownership:			
Voluntary	-0.3	0.0	0.0
Proprietary	0.2	0.0	0.1
Government	1.3	0.0	0.0
Medicare Utilization as a Percent of Inpatient Days:			
0-25	2.7	0.2	0.3
25-50	-0.5	0.0	0.0
50-65	0.3	-0.1	0.0
Over 65	0.3	0.0	-0.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:			
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications:	-0.5	0.1	0.0
Urban Nonreclassified, First Half FY 2007:	-0.3	0.0	0.0
All Urban Hospitals Reclassified Second Half FY 2007:	-0.3	0.0	0.0
Urban Nonreclassified Hospitals Second Half FY 2007:	-0.3	0.0	0.0
All Rural Hospitals Reclassified Second Half FY 2007:	1.6	-0.1	0.1

	Proposed Rule Column 1	Severity Changes in DRGs	Severity DRG Changes & Cost Weights (with Transition)
Rural Nonreclassified Hospitals Second Half FY 2007:	4.5	-0.1	0.3
All Section 401 Reclassified Hospitals:	2.9	-0.1	0.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	4.6	-0.2	0.4
Section 508 Hospitals.....	-0.5	-0.1	0.0
Cardic Specialty Hospitals……..	-11.2	0.0	-2.3

We are discussing specific comments and responses relevant to our impact analysis below. The changes that we are adopting in this final rule are illustrated in our regulatory impact analysis.

Comment: Some commenters expressed concern that the proposed rule discusses the impact of moving to CS DRGs using FY 2004 inpatient claims rather than FY 2005 claims to estimate impact. Some commenters stated that using 2 separate years of claims data to show the impact of major changes made it impossible to assess the overall impact of the changes with any reasonable level of confidence.

Response: Because of the long lead time to develop the methodology and our proposed rule, we used the FY 2004 MedPAR data to calculate HSRVcc weights and model the CS DRGs for purposes of the analysis shown on pages 24007-24011, 24020-24026 of the FY 2007 IPPS proposed rule (71 FR 24007-24011, 24020-24026). At the time we were developing provisions of the proposed rule, FY 2005 MedPAR data were unavailable to us. Given the public interest in prompt publication of the rule, we decided not to replicate all of the analysis that we provided in section II.C. of the proposed rule based on the FY 2004 data once the new FY 2005 data became available to

us. We believed delaying publication of the proposed rule to revise our analysis so all of the payment impacts were shown based on FY 2005 data was not in the public interest. Once we developed the methodology and the analysis for the proposed rule, we calculated the relative weights using the HSRVcc methodology that we were proposing to adopt for FY 2007 using the FY 2005 MedPAR. We modeled the HSRVcc relative weights using the FY 2005 MedPAR because we would be using these data to calculate actual relative weights that would be used to determine FY 2007 hospital payments. We believed it was important to model our FY 2007 proposal as closely to how payments would be determined to provide the most meaningful opportunity for public comment. For purposes of providing the payment impacts shown on pages 24028-24030 and the Appendix A - Regulatory Impact Analysis (71 FR 24404) and the methodological description shown on pages 24044-24049 of the proposed rule, we used FY 2005 MedPAR data. We disagree with the commenters that providing separate analyses using 2 years of data makes it more difficult to understand and assess the payment impacts. Rather, we believe that providing these analyses makes it easier to understand how relative weights will change solely as a result of updating the data.

Comment: MedPAC was pleased that CMS proposed three of MedPAC's four recommended changes to the IPPS system. However, the MedPAC expressed concern the proposal not to implement the severity changes until FY 2008. They stated that it is important to correct for differences in patients' severity concurrently with the corrections for charging distortions. MedPAC believed that all of the proposed policy changes to the IPPS should happen concurrently. MedPAC stated that failure to adopt all of the changes

would leave some payment distortions in place, thereby continuing to favor some kinds of patients over others. According to MedPAC, adopting all of the policies would create the most accurate payments and prevent hospitals from facing unjustified shifts in their payments that may occur under partial adoption of the payment reforms. MedPAC stated that concerns about giving hospitals time to adapt to the changes may be better managed by implementing all changes in FY 2007 and then giving hospitals a transition period. Another commenter asked that CMS implement both of these proposed changes in FY 2007 for the following reasons:

- MedPAC's analysis revealed significant inaccuracy in the current payment system and recommended implementation of both the new severity-refined DRGs and a revised method for the weights at the same time.

- It is inequitable to remove the subsidy provided by the overpayments for cardiac and orthopedic surgery prior to correcting the underpayments for the most severely ill patients.

- It is not reasonable to ask that some hospitals experience financial losses from implementing the new weights this year if implementing severity would offset some or all of these losses. To stagger implementation will cause providers to experience unnecessary payment fluctuation between FY 2007 and FY 2008.

The commenter further added that a delay is not beneficial to taxpayers as hospitals will have more time to up-code and increase their Medicare payments. Many commenters agreed with MedPAC that the cost weights and severity-adjusted DRGs should be implemented simultaneously. However, these commenters suggested

implementation no sooner than FY 2008 to limit sharp fluctuations in payments to hospitals from year to year. Many commenters opposed a two-step implementation, whereby CMS would implement cost-based weights in one year and a new DRG system to better account for patient severity in a subsequent year. They noted that each of these two major reforms significantly redistributes payments, often in off-setting directions. They stated that large swings in payments between the two reforms would create unnecessary volatility and have a profound impact on hospitals' ability to plan effectively, especially for necessary major medical equipment purchases and other capital expenditures. Therefore, they recommended that CMS implement both cost-based weights and severity-adjusted DRGs concurrently. While some commenters urged CMS to implement both payment reforms concurrently in FY 2007, other commenters advised delaying until at least FY 2008 to allow enough time to improve the proposed methodologies and underlying cost data to ensure accuracy of payments. Some commenters stated that the cost-based weights methodology should be implemented after the severity adjusted DRG methodology.

Response: Although we are not adopting the CS DRGs this year, we agree that it is important to smooth the transition for our current DRG system to a more accurate payment system. As indicated above, we have decided to adopt traditional cost-based weights for FY 2007 without the HSRV part of the methodology and we are making refinements that will create 20 new CMS DRGs, modify 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. We believe it is appropriate to take steps

toward transitioning the IPPS to a severity based DRG system for FY 2007 by applying some of the severity logic from our proposal to the CMS DRGs where appropriate. By revising the CMS DRGs, we are offering hospitals an interim step toward severity DRGs. Hospitals would be able to take advantage of the improved recognition of severity within the context of the more familiar CMS DRGs. This interim step affords us the opportunity to adopt some of the more basic components of a severity DRG system, such as specific splits in DRGs that lead to groups with greater resource utilization.

Comment: Some commenters were concerned that CMS has not taken into account all of MedPAC's recommendations for reforming the IPPS.

Response: We believe the commenters were expressing concern that we did not analyze MedPAC's recommendation to adjust the relative weights to account for differences in the prevalence of outlier cases. As explained above, we placed most of our attention and resources on the recommendations related to refinement of the current DRGs to more fully account for differences in severity of illness among patients as we do not have the statutory authority to make the specific changes to our outlier policy that MedPAC recommended. While we have not made MedPAC's recommendation regarding outliers a central focus of our analysis, we do intend to examine this issue in more detail over the next year.

Comment: One commenter stated that the annual impact of the changes to the proposed CS DRG system will reduce payments for its institution by an additional $2.7 million per year. The commenter suggested that community, not for profit hospitals be exempt from these proposed changes as this is not the group of hospitals that were the

intended target of these changes. One commenter stated that the efforts to address issues identified in the MedPAC report should begin and end with the specialty hospital subset and should not occur in conjunction with payment systems at large for all other hospital facilities.

A few commenters urged CMS to further analyze and evaluate the impact of the proposed HSRVcc methodology on access to Centers of Excellence. They noted that the proposed changes are particularly significant for large volume hospitals and may have a negative impact on the Centers of Excellence. Any negative impact to these Centers could impede beneficiary access to high quality services. Several commenters stated that although CMS' intent may have been to eliminate reimbursement incentives for specialty hospitals to select the most profitable cases, the proposed methodology appears to negatively affect all hospitals serving the most prevalent diagnoses (cardiology, orthopedic joint replacement, and neurosurgery) within the Medicare population. The commenters stated that efforts to address issues identified in the MedPAC report should be limited to specialty hospitals. The payment systems at large that affect all other hospital facilities should not be changed. These commenters suggested that CMS address the reimbursement incentives of specialty hospitals by implementing a separate payment system for specialty hospitals, rather than implement a proposed policy that could negatively impact all hospitals. Several commenters suggested implementing the proposal only for specialty hospitals while deferring the proposed payment reforms for full-service hospitals to afford more time to study the implications of the HSRVcc as a method of general applicability. Another commenter stated that care for Medicare

beneficiaries in rural areas will be adversely affected by the proposed adoption of HSRVcc weights because of the dramatic impact on specialized services provided by rural referral centers that are not available at other smaller hospitals in rural communities. The commenter suggested that the future viability of these specialized services may be at risk. Therefore, the commenter recommended that CMS recognize the unique impact of the proposed changes on rural referral centers by excluding these hospitals from the change.

Response: Payments under a prospective payment system are predicated on averages. Therefore, we do not believe it would be appropriate to exclude certain hospital groups from implementation of the changes we are adopting to use cost-based weights or better recognize severity in the DRG system. While these changes are expected to reduce incentives for hospitals to "cherry pick" or treat only the most profitable patients, the objective of these proposed revisions is to improve the accuracy of payments, leading to better incentives for hospital quality and efficiency and ensure that payment rates relate more closely to patient resource needs. Even though few hospitals will have a large increase or decrease in overall Medicare payments, there may be a significant increase or decrease in payment for individual cases within a hospital. Under certain circumstances, the current DRG system benefits hospitals that focus on treating less severely ill patients. Adjusting payment for the severity of the patient will remove the incentives to systematically choose one patient over another. Currently, the DRGs overpay for some types of cases and underpay for others because the relative weight system is based on charges and the DRG system does not sufficiently distinguish more or

less resource intensive patients based on severity of illness. The changes we are making to account for costs in the DRG relative weights and improve recognition of severity within the DRG system will significantly increase payment accuracy at both the patient and hospital level.

For these reasons, we believe these changes should apply to all hospitals paid using the IPPS, regardless of whether a hospital is a specialty hospital or a rural referral center. We have made significant changes to our proposal and the impacts shown in this final rule may be very different for an individual hospital than those we showed in the proposed rule. The impact on any specific hospital will depend on the types of cases it treats.

Comment: Several commenters stated that in order to analyze and comment, a crosswalk between the current DRGs and the severity DRGs should be made available.

Response: As indicated earlier, we provided a number of resources during the comment period to assist commenters in analyzing our proposal. We provided a number of data files listed earlier on the CMS Web site at no cost to the public. In addition to this information, we made available for purchase both the FY 2004 and FY 2005 MedPAR data that were used in simulating the policies in the FY 2007 IPPS proposed rule. We also provided access to a Web tool on 3M's Web site that would allow an end user to build case examples using the proposed CS DRGs.

Comment: One commenter stated that the best estimates on a hospital–specific basis, of the incremental effects on payment of CMS' changes to the DRG system should

be published in the FY 2007 IPPS final rule. The commenter also suggested that CMS release impact files by hospitals far in advance of any implementation.

Response: Information to determine hospital-specific impacts is available on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage. Click on: "Acute Inpatient - Files for Download http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp." For the proposed rule impact file, click on "Impact file for IPPS FY 2007 Proposed Rule http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2>&sortOrder=ascending&itemID=CMS061736." Similar information for the final rule will also be available on the CMS Web site shortly after the publication of this final rule. We note that some level of familiarity with data concepts and Medicare payment variables will be necessary for hospitals to use these files and simulate a payment analysis for their own facility. Using the latest data available at the time this final rule was prepared, we estimated impacts by category of hospital, and the tables displaying these impacts are published in the impact section of this final rule. Space limitations preclude us from being able to provide hospital-level impacts. In addition, to the extent that adjustments for providers such as the IME adjustment, DSH adjustment, and/or operating and capital CCRs may be updated for FY 2007 subsequent to the publication of this final rule, the actual impacts on individual providers may differ slightly from those we estimated. We believe that by providing the payment variables and other information electronically on the CMS Web site, hospitals have the flexibility

to simulate and develop their own impact analyses that may be better suited to their needs than any analysis CMS would do at the hospital level.

Comment: Some commenters stated that CMS needs to extend the comment period to allow hospitals additional time to evaluate the effects of these proposed changes.

Response: One of the reasons that we proposed adopting the CS DRGs for FY 2008 was to give hospitals more than the 60-day public comment period and the additional 60-day delay between the publication of the final rule and implementation on October 1, 2006, to fully understand and plan for the change to the CS DRG system. As indicated earlier, we are not adopting CS DRGs for FY 2007. Therefore, we do not see a need to extend the 60-day public comment period. Although we are not extending the 60-day public comment period, we will involve hospitals and other stakeholders in our plans for moving to a severity DRG system for FY 2008. We are interested in public input on the types of criteria that we should consider and how to evaluate improved payment accuracy as we consider changes to the DRG system to better recognize severity of illness.

Comment: Some commenters encouraged CMS to review the cost/benefit of implementing the cost-based weight methodology and a severity-adjusted DRG system in conjunction with changes to the CMS UB04 claim form and the adoption of ICD-10-CM. The commenters suggested that implementing these changes simultaneously could help alleviate the additional cost of multiple system upgrades both for the hospital and the fiscal intermediaries. Some commenters stated that CMS should conduct a single

independent study to determine the impact that implementation of this methodology will have on coding and billing productivity or hospital cash flow. Some commenters stated that implementing the significant DRG changes proposed by CMS is only a temporary solution until a more refined DRG system can be adopted with more specific clinical classification systems such as ICD-10-CM and ICD-10-PCS that will be capable of fully recognizing a patient's severity of illness and the services provided to treat that condition.

Response: We believe that it is important to improve the payment accuracy in the hospital IPPS by implementing these changes when appropriate. The IPPS payment reforms that we have proposed do not require information system changes for hospitals similar to those that will be required for adoption of ICD-10 or a new HIPAA compliant transaction system. The relative weights are merely one component in a payment formula for calculating Medicare's IPPS payment rate. Although there will be increases and decreases in the relative weights that are used in the payment formula for different DRGs, this payment change does not require hospitals to make any computer system changes. Similarly, the changes to adopt a severity DRG system will also not necessarily require hospitals to make any upgrades to their computer systems. The proposed DRG system or any alternative that we consider would use the same ICD-9-CM diagnosis and procedures codes as the current CMS DRGs. Although it seems likely that hospitals will want to acquire the DRG system that Medicare will use, we do not expect that substituting one DRG GROUPER for another should be burdensome and require upgrades to hospital information systems. With regard to the comment that a more refined DRG system can only be adopted with more specific classification systems such

as ICD-10-CM and ICD-10-PCS, the Secretary is evaluating whether we should adopt ICD-10.

Comment: One commenter supported the decision to use the CS DRGs noting that use of a 3-digit DRG number would avoid the undue health programming costs that move limited financial resources away from initiatives focused on improving quality care and access to health care. However, the commenter also indicated that the number of digits in the DRG number should not be a factor in choosing the best severity classification system.

Response: We appreciate the commenter's support for our proposal as well as the comment that the DRG classification system used by Medicare should not be dependent upon the number of digits in the DRG number. We will consider any information system infrastructure issues as we evaluate alternative DRG systems.

Comment: Several commenters stated that the reasons CMS gave in the proposed rule for not implementing CS DRGs for FY 2007 are valid. The commenters stated that they are all the more valid because hospitals now would have less time to prepare if CMS were to implement its proposed severity adjusted DRGs this October 1.

Response: We agree. The proposed change to adopt CS DRGs represents a major change to how hospitals are paid for Medicare inpatient services. We will not be implementing the CS DRGs for FY 2007. However, we do plan to evaluate potential alternative DRG systems that better recognize severity than the current CMS DRGs for FY 2008.

Comment: One commenter suggested that the CS DRG system's reliance on 3M's proprietary APR DRG grouping logic and software may not be in compliance with Pub. L. 104-113, the National Technology Transfer and Advancement Act of 1995. The commenter recommended that we participate in the formation of expert committees with a proven consensus standards body to develop a standardized DRG classification and severity adjustment system for the IPPS.

Response: We appreciate the commenter's support for the use of a consensus standards body to develop a severity-adjusted DRG system. The National Technology Transfer and Advancement Act of 1995 directs Federal agencies to use voluntary consensus standards in lieu of government-unique standards, except where inconsistent with law or otherwise impractical. As we move toward implementing a severity-adjusted DRG system, we will carefully consider whether it would be appropriate to involve a voluntary consensus standards body in the process.

Comment: Some commenters stated a transition (blended) period with stop loss protections should be provided over a period of one to three years. Other commenters suggested a longer transition period given the magnitude of payment distribution across DRGs and hospitals. The commenters believe that the transition approach would be consistent with many other major changes that have been implemented gradually over the years, including the capital prospective payment system. The commenters suggested that a minimum of 1 year should be allowed for the development of software systems to handle these changes.

Response: We agree that these changes should be implemented over a transitional period. As we indicated earlier, we are revising the current DRG system to better recognize severity (which is discussed in detail in section II.C.7. of the preamble of this final rule) and are also adopting cost-based weights for FY 2007. We are providing for a transition period of 3 years with the relative weights becoming an increasing blend of costs weights as the transition proceeds. We also believe that the 20 new DRGs we are adopting for 2007 will improve the transition from our current system to a more sophisticated severity DRG system in FY 2008.

Comment: One commenter noted that MedPAC recommended excluding statistical and high cost outliers from the computation of the DRG weights in order that the weights reflect the average cost of the inlier case only. MedPAC further recommended shifting the financing of the outlier pool from all cases to cases in the DRGs with the highest prevalence of outliers. The commenter noted that outlier cases occur most frequently in high-weighted DRGs. Therefore, MedPAC's proposal of accounting for the high prevalence of outliers in the DRGs would compound the weight compression caused by the HSRV methodology. The commenter believed that each proposal by MedPAC (to exclude statistical and high cost outliers from the computation of the DRGs) would exacerbate payment inaccuracies and the two proposals combined would be deleterious. The commenter stated that it would further analyze MedPAC's proposal to test their theory empirically.

Another commenter was also concerned about MedPAC's recommendation to adjust the DRGs to account for the prevalence of high-cost cases. The commenter

explained that reducing the relative weights to finance the outlier pool will adversely affect payment for hospitals specializing in the most complex patients. Hospitals may be discouraged from developing the capacity to treat high cost outliers and responding to the needs of their community according to the commenter. Meanwhile, the commenter suggested that hospitals that have the capacity to treat the highest cost and most complex cases may abandon such an infrastructure because it will be too costly to maintain.

One commenter supported MedPAC's proposal and believed that implementing MedPAC's proposal would support the goal of achieving payment accuracy. The commenter explained that the current system provides double reward for DRGs with a high prevalence of outliers. The commenter recommended that CMS seek legislative authority to implement MedPAC's proposal of DRG specific outlier thresholds.

Another commenter was supportive of MedPAC's recommendation and noted that MedPAC stated in a letter to CMS that "failure to adopt any of (MedPAC's) recommendations would leave some payment distortions in place, thereby continuing to favor some patients over others." Therefore, the commenter recommended that CMS implement all of MedPAC's recommendations simultaneously when Congress has granted CMS authority to adopt MedPAC's outlier recommendation.

One commenter was concerned that CMS provided only "minimal" analysis of the effect of the DRG refinements on the outlier threshold. Noting that the 5.1 percent set aside for outlier payments could be significantly reduced with the adoption of severity DRG refinements, the commenter believed that implementation of severity DRGs is

premature until the Secretary determines whether statutory changes are needed to determine the percentage of total IPPS payments that should be made as outliers.

One commenter recommended that, even though CMS does not have the authority to change the outlier policy, it should review creating DRG-specific or day outliers under a severity DRG system. Another commenter recommended that CMS reduce payments for outliers and eventually eliminate them upon implementing severity DRGs.

Response: We thank the commenters for taking the time to comment on MedPAC's recommendation. As noted above, we do not have the statutory authority to implement MedPAC's recommendation, and, therefore, we placed most of our attention and resources on the recommendations related to refinement of the current DRGs to more fully capture differences in severity of illness among patients. However, we intend to examine MedPAC's recommendation regarding outliers in more detail in the future and will consider the comments we received on the FY 2007 IPPS proposed rule.

6. Conclusions

As we describe in more detail below, we believe that adopting cost-based weights and making improvements to the DRG system to better recognize severity has the potential to result in significant improvements to Medicare's IPPS payments. This final rule implements a cost weight methodology effective for FY 2007. Further, we are creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. Further, as suggested by MedPAC and others, we are

adopting these changes over a transition period while we plan further improvements to the IPPS for FY 2008.

In developing our proposed and final policies, we considered a range of alternatives outlined below, and we solicited comments on both the proposal and the alternatives. We asked commenters to consider both the CS DRGs and alternative severity adjustment methods for accounting for severity more comprehensively in the DRG payment system. For example, under one alternative in the proposed rule, we would implement the CS DRGs in FY 2007 along with the HSRVcc weighting methodology. In this event, as discussed above, to maintain budget neutrality, we would also implement in FY 2007 an adjustment to the standardized amounts to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. Although we did receive comments in support of this idea, many commenters requested that we not adopt the CS DRGs and the HSRVcc weights for FY 2007. Many of these commenters suggested delaying implementation of both proposals until at least FY 2008. Under another alternative, we would have adopted and implemented CS DRGs in FY 2008. Although we did receive comments in support of this idea, we also received many comments raising important concerns about licensing and proprietary issues potentially associated with use of the CS DRGs. The commenters asked us not to adopt the CS DRGs unless we could make them available on the same terms as the current CMS DRGs. Yet other commenters objected to our proposed implementation of the CS DRGs unless we evaluated alternatives and better justified why there is a need to adopt a revised DRG system. Under yet another alternative, we would

consider partially implementing the CS DRGs in FY 2007 and complete implementation in FY 2008. However, we noted that there were practical difficulties associated with partial implementation of CS DRGs because cases in a single DRG under the current CMS DRG system may group to multiple DRGs and MDCs under the CS DRG system. Conversely, cases that group to multiple MDCs and DRGs under the current system may group to a single MDC and DRG under the current CS DRG system. We did not receive any comments supporting the idea of partial adoption of the CS DRGs.

In the FY 2007 IPPS proposed rule, we discussed in some detail an alternative to partially adopting CS DRGs that would apply a clinical severity concept to an expanded set of DRGs in FY 2007. For example, we have received correspondence that raised the concern that hospitals may have incentives under the current DRG system to avoid severely ill, resource-intensive back and spine surgical cases (as discussed in section II.D.3.b. of the proposed rule; the correspondence specifically requested that we apply a clinical severity concept to DRG 546). In the proposed rule, we noted that other surgical DRGs may not accurately recognize case severity. Because of the frequency of DRG use and the potential for risk selection, we pointed out that certain DRGs may be particularly important in creating a financial incentive for hospitals to select a less severely ill patient whose case would be assigned to the same DRG as a more severely ill patient.

Therefore, while we proposed to adopt the CS DRGs in FY 2008, we were considering whether to make more limited changes to the current DRG system to better recognize severity of illness in FY 2007. In the FY 2006 IPPS final rule (70 FR 47474 through 47478), we took steps to better recognize severity of illness among

cardiovascular patients. For all DRGs except cardiac DRGs, we currently distinguish between more and less complex cases based on the presence or absence of a CC. However, the diagnoses that we designate as CCs are the same across all base DRGs. Because the CC list is not dependent on the patient's underlying condition, CCs may not accurately recognize severity in a given case. The changes we made in FY 2006 to the cardiac DRGs significantly improved recognition of severity between patients by distinguishing between more and less severe cases based on the presence or absence of a MCV. In the proposed rule, we indicated that we were considering whether a similar approach applied to other DRGs would improve payment.

Much like the approach we took last year to identify MCV conditions that represented higher severity in cardiovascular patients, in the proposed rule, we indicated that we planned to examine which conditions identified more severely ill cases in selected MDCs and DRGs. We solicited comments as to whether it would be appropriate to adopt these types of limited changes in FY 2007 as an intermediate step to adopting CS DRGs in FY 2008. There were a number of comments that suggested we should make improvements to our current DRG system rather than adopting the CS DRGs. A number of comments expressed support for using the current DRG system as the starting point for revising the DRG system to better recognize severity to avoid losing the many positive changes that have been made over the years to the CMS DRGs. We also encouraged commenters to send us suggestions regarding potential changes that could be made to the current DRG system to better recognize severity of illness. As indicated

below, some commenters did provide us with specific suggestions for how we could revise the current DRGs.

In the FY 2007 IPPS proposed rule, we also discussed an additional alternative under which we would implement the CS DRGs in FY 2007 and the HSRVcc methodology in FY 2008. We did receive one comment supporting this idea. However, as we have discussed elsewhere, we believe that we should not adopt CS DRGs in FY 2007, but rather evaluate severity DRG systems for adoption in FY 2008.

With respect to the relative weight calculations, we believe that adopting HSRVcc weights has the potential to significantly improve payment equity between DRGs. As MedPAC notes, a "survey of hospitals' charging practices suggests that hospitals use diverse strategies for setting service charges and raising them over time." MedPAC found that data from the Medicare cost reports indicate that hospital markups for ancillary services (for example, operating room, radiology, and laboratory) are generally higher than for routine services (for example, intensive care unit and room and board).[13] Thus, MedPAC has concluded that the relative weights for DRGs that use more ancillary services may be too high compared to other DRGs where the routine costs account for a higher proportion of hospital costs. Although we agree with MedPAC's conclusion, the public comments raised important issues about the effect of charge compression on the relative weights using the HSRVcc methodology. These commenters argued that the HSRV calculation exacerbates the effect of charge compression or the practice of hospitals applying higher percentage markups on lower cost items and lower percentage markups on higher cost items. As we indicated above, we have engaged a contractor to

[13] Ibid, p. 26.

assist us with studying whether charge compression is an actual phenomenon and how it affects the HSRV methodology. As part of this analysis, we will study an adjustment for charge compression suggested in the public comments and will consider adopting HSRV weights in the future. Nevertheless, in the interim, we believe it is important to adopt a methodology for calculation of DRG relative weights that takes costs into account. We have revised the CCRs that we used to develop cost-based weights based on the public comments. Although they do not show the same differentials indicated in the proposed rule, they continue to support MedPAC's conclusion that a system based on charges pays too much for some types of cases and pays too little for others. As indicated above, we summarized hospital-level cost and charge information to 2 routine and 11 ancillary departmental cost centers and found that national average routine cost center CCRs ranged from 50 percent (intensive care unit days) to 56 percent (routine days), while ancillary cost center CCRs ranged from 16 percent (anesthesiology) to 46 percent (labor and delivery room).

MedPAC also found that relative profitability ratios were higher among cardiovascular surgical DRGs than the medical DRGs.[14] We believe the relative profitability of the surgical cardiovascular DRGs has been an important factor in the development of specialty heart hospitals. Our payment impact analysis indicates that this issue will be addressed by adopting cost-based weights. Moving from the current system of charge-based weights to cost-based weights increases payment in the medical DRGs relative to the surgical DRGs. We expected this result, given that routine costs will generally account for a higher proportion of total costs in the medical DRGs than in the

[14] Ibid, p. 29.

surgical DRGs. In the proposed rule, we estimated that all of our combined changes would, on average, increase the medical DRG weights by approximately 7.3 percent while reducing the surgical DRG weights by approximately 6.9 percent. Implementing the cost-based weights without utilizing the HSRV standardization method under the 3-year transition period where the weights for FY 2007 will be based on 33 percent of the cost-based weight and 67 percent of the charge weight will lessen the effects of redistribution between medical and surgical DRGs. In this final rule, we estimate that the increase in the average medical DRG weight will be 0.9 percent and that the decrease in the average surgical DRG weight will be 1.2 percent. The pattern of increasing medical weights and decreasing surgical weights still holds true. However, by adopting the cost based weights in a transition period, we are mitigating the larger swings in payments that our proposed policies adopted in full would have caused.

Although adopting HSRVcc weights would result in the most significant improvement in hospital payment-to-cost ratios among the changes to the IPPS recommended by MedPAC,[15] we have concerns about implementing this methodology until we can further study whether the relative weights might be affected by charge compression. For this reason, we are adopting cost-based weights without HSRV for FY 2007. However, we will consider applying the HSRV methodology in subsequent years if our analysis of charge compression suggests the issue is not a concern or, if appropriate, we can apply an adjustment that would account for its effects.

Based on our analysis, we concur with MedPAC that the CS DRGs would account more completely for differences in severity of illness and associated costs among

[15] Ibid, p. 37.

hospitals. MedPAC observed some modest improvements in hospitals' payment-to-cost ratios from adopting APR DRGs.[16] We modeled the CS DRGs discussed above and observed a 12-percent increase in the explanatory power (or R-square statistic) of the DRG system to explain total hospital charges. That is, we found more uniformity among hospital total charges within the CS DRG system than we did with Medicare's current DRG system. While we believe the CS DRG system that we described above has the potential to improve the IPPS, we have the following concerns about adopting it for FY 2007:

- Further adjustments are needed to the proposed DRG system. In the proposed rule, we indicated that further adjustments need to be made to the proposed CS DRGs to account for situations where less severely ill patients may be more resource-intensive because they need expensive medical technology. The CS DRGs assign a patient to a DRG based on severity of illness but do not recognize increased complexity due to the types of services/technology provided. In addition, the CS DRGs do not incorporate many of the changes to the base DRG assignments that have been made over the years to the CMS DRGs. There was significant interest in the public comments in either revising the CS DRGs to reflect these changes or use the CMS DRGs at the starting point to better recognize severity. The public comments provided a number of examples where we need to consider whether further changes are needed to the CS DRGs before they are ready for implementation.

- Use of a proprietary DRG system. The commenters raised valid points about adopting a proprietary DRG system, including concerns about the availability, price and

[16] Ibid, p. 37.

transparency of logic of the APR DRGs that are currently in use in Maryland. The CS DRGs are a variant of the APR DRG system. As we evaluate alternative severity classification systems, we will use public access to the system as an important element in evaluating whether each system can be adopted for Medicare. We will continue to strive to promote transparency in our decisionmaking as well as in future payment and classification systems as we have done in the past.

- No alternatives have been evaluated. We have not evaluated alternative DRG systems that could also better recognize severity. We have received comments suggesting that alternative DRG systems can better recognize severity than the CS DRGs. It appears that all of the DRG systems that were raised in the public comments as potential alternatives to the CS DRGs are proprietary systems. However, it is possible that we could use one of these systems if it were made available in the public domain on the same terms as the current CMS DRGs. Further, as discussed above, CMS (then HCFA) did work on developing a severity DRG system in the mid-1990's. It is possible that we could update this work and adopt a system that better recognizes severity based on the current CMS DRGs for FY 2008 that does not raise the licensing issues that are involved with using prioprietary ystems.

Therefore, for the reasons indicated above, we are not adopting the CS DRGs for FY 2007. However, we are creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. Furthermore, as discussed earlier, we have engaged a contractor to assist us with evaluating alternative DRG

systems that were raised as potential alternatives to the 3M Severity of Illness DRG products in the public comments. Finally, we will consider the review that we have undertaken of the 13,000 codes on the CC list 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-1990's to adopt severity DRGs. Again, we expect to complete this work in time for proposing changes to the DRG system to better recognize severity of illness by FY 2008.

7. Severity Refinements to CMS DRGs

In response to the FY 2007 IPPS proposed rule, we received a number of public comments that supported the refinement of the current CMS DRGs so that they better capture severity. Several commenters supported the expanded use of a clinical severity concept similar to the approach used in FY 2006 to refine the cardiac DRGs. One commenter urged CMS to expand the set of DRGs to which this clinical severity concept would apply, including the DRGs that capture the implanting of defibrillators. Another commenter expressed support for additional modifications to the current DRGs to better capture severity and complexity of patients. Another commenter recommended that CMS start with the current DRG system and provide overlays for severity, complexity and patient benefit. One commenter suggested that CMS develop severity levels within all of the existing DRGs (or pairs of DRGs, in the cases where CC or MCV splits now exist), or identify specific DRGs that may be most appropriate for severity adjustments. Several commenters recommended specific adjustments to better capture severity for

septicemia, headache, and mechanical ventilation patients. (The DRG recommendations are discussed below under the specific DRG topic.)

We recognize the importance of having a classification system that recognizes cases that utilize greater resources and have higher levels of severity of illness. While we discussed moving to a new DRG system such as the CS DRGs for FY 2007, we stated that we were also interested in improving the current DRGs so that they better capture patients with greater severity of illness as early as FY 2007. We solicited comments in the proposed rule on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV.

We believe it is appropriate to move in a direction toward a DRG system that better recognizes severity. Our strategy involves following recommendations received as part of public comments and implementing some of the severity logic in the proposed CS DRGs in the CMS DRGs where appropriate. By doing so, we would be taking an interim step toward better recognizing severity in the DRG system. Hospitals would be able to take advantage of a portion of improved severity logic in the proposed CS DRGs within the context of the more familiar CMS DRGs. This interim step would also afford hospitals a more detailed understanding of some of the basic types of DRG logic used in the proposed CS DRG system. Obviously, we were not able to adopt some of the more sophisticated logic involved in the 18 steps included in the proposed CS DRG system. However, we were able to adopt some of the more basic components such as specific splits in DRGs that lead to groups with greater resource utilization.

We began our process of adopting some of the severity logic within the proposed CS DRGs by first comparing the current CMS DRGs to the base DRGs in the proposed CS DRGs to identify areas where improvements could be made to better account for severity of illness and resource utilization. We used two general approaches to evaluate potential DRG changes. First, we analyzed where the assignment of a case to a DRG differed under the CMS DRGs and the proposed base CS DRGs. Second, we analyzed whether there was a list of "major conditions" that could be used to revise any DRGs to better recognize severity, similar to the changes to the cardiovascular DRGs involving MCVs we established in last year's final rule. We used the diagnoses listed as "major" or "extreme" under the proposed CS DRGs for this review. The changes described below will result in better recognition of severity in the current DRG system and, like the changes we made last year to reform the cardiovascular DRGs based on MCVs, represent an excellent next step in refining the Medicare inpatient hospital payment system so our payments are better targeted to specific patients based on their costs of care.

We began our review by focusing on the cardiac and orthopedic DRGs because of our concerns that cardiac, orthopedic, and surgical hospitals have taken advantage of opportunities in the DRG system to specialize in the least complex and most profitable inpatient cases. However, with respect to orthopedic and surgical specialty hospitals, we considered that they have very small inpatient volume and the issues that are leading to their creation are generally unrelated to profit opportunities in the IPPS. Although we did review the orthopedic DRGs, we generally did not find opportunities within the current DRG system to make further refinements for severity of illness. We were also unable to

find a strong basis to subdivide further most of the cardiovascular DRGs. In last year's IPPS rule, we already made significant changes to the DRG system to better account for severity of illness in the DRGs frequently performed by cardiac hospitals. As mentioned earlier, this DRG change involved splitting some cardiac DRGs based on the presence or absence of an MCV. We then conducted a comparison of the base DRGs in the CMS DRG system and proposed CS DRGs. We analyzed data to identify specific CMS DRGs with wide ranges in charges that had been subdivided or in other ways modified under the proposed CS DRGs. As stated earlier, this process did not allow CMS to use the more sophisticated logic involved in the proposed CS DRGs to differentiate groups with greater severity. However, we were able to identify a group of DRGs that could be created to better align our payments based on severity of illness. We used our own analysis along with specific recommendations received during the comment period to develop further severity refinements to the current DRGs.

We identified 20 new CMS DRGs involving 13 different clinical areas that would improve the CMS DRG system's recognition of severity of illness. Twelve of the new DRGs are medical and 8 are surgical. The 20 new DRGs are constructed through a combination of approaches used in the proposed CS DRGs to refine the base DRGs such as:

- Subdividing existing DRGs through the use of diagnosis codes.
- Subdividing DRGs based on specific surgical procedures.
- Selecting cases with specific diagnosis and/or procedure codes and assigning them to a new DRG which better accounts for their resource use and severity.

We also modified 32 DRGs to better capture differences in severity. The new and revised DRGs were selected from 40 current DRGs which contain 1,666,476 cases and represent a number of body systems. In creating these 20 new DRGs, we are deleting 8 existing DRGs and modifying 32 existing DRGs. The specific DRG changes are described below:

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

(1) Nervous System Infection Except Viral Meningitis

Under our current DRG system, all nervous system infections except viral meningitis are assigned to CMS DRG 20 (Nervous System Infection Except Viral Meningitis). By combining all nervous system infections except viral meningitis into one DRG, we are grouping together patients with wide ranges of severity. Under our proposed CS DRGs, there are separate DRGs that distinguish bacterial infection and tuberculosis from other infections of the nervous system. The CS DRGs divided these cases in order to better recognize severity. The codes which describe bacterial infection and tuberculosis are listed below.

We then divided the cases within CMS DRG 20 based on the presence or absence of bacterial infections and tuberculosis of the nervous system. Our medical advisors support dividing these cases in this manner to better recognize severity of illness. The data indicated that these are two distinctly different groups with significant differences in severity. The bacterial and tuberculosis infection group had average charges of $47,034 compared to the $36,507 average charges for cases with other types of infection of the nervous system. Clearly these charge data support the fact that the bacterial and

tuberculous infection group has a significantly greater degree of severity. The chart below illustrates these data:

DRG	Number of Cases	Average Length of Stay	Average Charges
CMS DRG 20	6,130	9.88	$42,191.76
DRG 20 with Bacterial & TB Infections of Nervous System	3,310	10.1	$47,034.42
DRG 20 w/o Bacterial &TB Infections of Nervous System	2,820	9.54	$36,507.64

The data support the creation of two separate DRGs for these two groups of patients. Therefore, we are deleting DRG 20 and creating the following two new DRGs:

- DRG 560 (Bacterial & Tuberculosis Infections of Nervous System)
- DRG 561 (Non-Bacterial Infections of Nervous System Except Viral Meningitis)

The ICD-9-CM diagnosis codes assigned to each new DRG are as follows.

The new DRG 560 will have principal diagnosis codes listed in the following table.

Diagnosis Code	DRG 560 Diagnosis Code Titles
003.21	Salmonella meningitis
013.00	Tuberculous meningitis, unspecified examination
013.01	Tuberculous meningitis, bacteriological or histological examination not done
013.02	Tuberculous meningitis, bacteriological or histological examination results unknown (at present)
013.03	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy
013.04	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.05	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.06	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.10	Tuberculoma of meninges, unspecified examination
013.11	Tuberculoma of meninges, bacteriological or histological examination not done
013.12	Tuberculoma of meninges, bacteriological or histological examination results unknown (at present)
013.13	Tuberculoma of meninges, tubercle bacilli found (in sputum) by microscopy
013.14	Tuberculoma of meninges, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.15	Tuberculoma of meninges, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically

Diagnosis Code	DRG 560 Diagnosis Code Titles
013.16	Tuberculoma of meninges, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.20	Tuberculoma of brain, unspecified examination
013.21	Tuberculoma of brain, bacteriological or histological examination not done
013.22	Tuberculoma of brain, bacteriological or histological examination results unknown (at present)
013.23	Tuberculoma of brain, tubercle bacilli found (in sputum) by microscopy
013.24	Tuberculoma of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.25	Tuberculoma of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.26	Tuberculoma of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.30	Tuberculous abscess of brain, unspecified examination
013.31	Tuberculous abscess of brain, bacteriological or histological examination not done
013.32	Tuberculous abscess of brain, bacteriological or histological examination results unknown (at present)
013.33	Tuberculous abscess of brain, tubercle bacilli found (in sputum) by microscopy
013.34	Tuberculous abscess of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.35	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.36	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.40	Tuberculoma of spinal cord, unspecified examination
013.41	Tuberculoma of spinal cord, bacteriological or histological examination not done
013.42	Tuberculoma of spinal cord, bacteriological or histological examination results unknown (at present)
013.43	Tuberculoma of spinal cord, tubercle bacilli found (in sputum) by microscopy
013.44	Tuberculoma of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.45	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.46	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.50	Tuberculous abscess of spinal cord, unspecified examination
013.51	Tuberculous abscess of spinal cord, bacteriological or histological examination not done
013.52	Tuberculous abscess of spinal cord, bacteriological or histological examination results unknown (at present)
013.53	Tuberculous abscess of spinal cord, tubercle bacilli found (in sputum) by microscopy
013.54	Tuberculous abscess of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.55	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically

Diagnosis Code	DRG 560 Diagnosis Code Titles
013.56	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.60	Tuberculous encephalitis or myelitis, unspecified examination
013.61	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done
013.62	Tuberculous encephalitis or myelitis, bacteriological or histological examination results unknown (at present)
013.63	Tuberculous encephalitis or myelitis, tubercle bacilli found (in sputum) by microscopy
013.64	Tuberculous encephalitis or myelitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.65	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.66	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.80	Other specified tuberculosis of central nervous system, unspecified examination
013.81	Other specified tuberculosis of central nervous system, bacteriological or histological examination not done
013.82	Other specified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present)
013.83	Other specified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy
013.84	Other specified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.85	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.86	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
013.90	Unspecified tuberculosis of central nervous system, unspecified examination
013.91	Unspecified tuberculosis of central nervous system, bacteriological or histological examination not done
013.92	Unspecified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present)
013.93	Unspecified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy
013.94	Unspecified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
013.95	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
013.96	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
036.0	Meningococcal meningitis
036.1	Meningococcal encephalitis
098.82	Gonococcal meningitis
320.0	Hemophilus meningitis
320.1	Pneumococcal meningitis
320.2	Streptococcal meningitis

Diagnosis Code	DRG 560 Diagnosis Code Titles
320.3	Staphylococcal meningitis
320.7	Meningitis in other bacterial diseases classified elsewhere
320.81	Anaerobic meningitis
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified
320.89	Meningitis due to other specified bacteria
320.9	Meningitis due to unspecified bacterium
324.0	Intracranial abscess
324.1	Intraspinal abscess
324.9	Intracranial and intraspinal abscess of unspecified site
357.0	Acute infective polyneuritis

The new DRG 561 will have principal diagnosis codes listed in the following table.

Diagnosis Code	DRG 561 Diagnosis Code Titles
006.5	Amebic brain abscess
045.00	Acute paralytic poliomyelitis specified as bulbar, unspecified type of poliovirus
045.01	Acute paralytic poliomyelitis specified as bulbar, poliovirus type i
045.02	Acute paralytic poliomyelitis specified as bulbar, poliovirus type ii
045.03	Acute paralytic poliomyelitis specified as bulbar, poliovirus type iii
045.10	Acute poliomyelitis with other paralysis, unspecified type of poliovirus
045.11	Acute poliomyelitis with other paralysis, poliovirus type i
045.12	Acute poliomyelitis with other paralysis, poliovirus type ii
045.13	Acute poliomyelitis with other paralysis, poliovirus type iii
045.90	Unspecified acute poliomyelitis, unspecified type poliovirus
045.91	Unspecified acute poliomyelitis, poliovirus type i
045.92	Unspecified acute poliomyelitis, poliovirus type ii
045.93	Unspecified acute poliomyelitis, poliovirus type iii
049.8	Other specified non-arthropod-borne viral diseases of central nervous system
049.9	Unspecified non-arthropod-borne viral diseases of central nervous system
052.0	Postvaricella encephalitis
052.2	Postvaricella myelitis
053.14	Herpes zoster myelitis
054.3	Herpetic meningoencephalitis
054.74	Herpes simplex myelitis
055.0	Postmeasles encephalitis
056.01	Encephalomyelitis due to rubella
056.09	Rubella with other neurological complications
062.0	Japanese encephalitis
062.1	Western equine encephalitis
062.2	Eastern equine encephalitis
062.3	St. louis encephalitis
062.4	Australian encephalitis
062.5	California virus encephalitis
062.8	Other specified mosquito-borne viral encephalitis

Diagnosis Code	DRG 561 Diagnosis Code Titles
062.9	Mosquito-borne viral encephalitis, unspecified
063.0	Russian spring-summer (taiga) encephalitis
063.1	Louping ill
063.2	Central european encephalitis
063.8	Other specified tick-borne viral encephalitis
063.9	Tick-borne viral encephalitis, unspecified
064	Viral encephalitis transmitted by other and unspecified arthropods
066.2	Venezuelan equine fever
071	Rabies
072.2	Mumps encephalitis
090.40	Juvenile neurosyphilis, unspecified
090.41	Congenital syphilitic encephalitis
090.42	Congenital syphilitic meningitis
090.49	Other juvenile neurosyphilis
091.81	Acute syphilitic meningitis (secondary)
094.2	Syphilitic meningitis
094.3	Asymptomatic neurosyphilis
094.81	Syphilitic encephalitis
100.81	Leptospiral meningitis (aseptic)
100.89	Other specified leptospiral infections
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115.01	Histoplasma capsulatum meningitis
115.11	Histoplasma duboisii meningitis
115.91	Histoplasmosis meningitis, unspecified
130.0	Meningoencephalitis due to toxoplasmosis
321.0	Cryptococcal meningitis
321.1	Meningitis in other fungal diseases
321.2	Meningitis due to viruses not elsewhere classified
321.3	Meningitis due to trypanosomiasis
321.4	Meningitis in sarcoidosis
321.8	Meningitis due to other nonbacterial organisms classified elsewhere
322.0	Nonpyogenic meningitis
322.1	Eosinophilic meningitis
322.2	Chronic meningitis
322.9	Meningitis, unspecified
323.01	Encephalitis and encephalomyelitis in viral diseases classified elsewhere
323.02	Myelitis in viral diseases classified elsewhere
323.1	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere
323.2	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere
323.41	Other encephalitis and encephalomyelitis due to infection classified elsewhere
323.42	Other myelitis due to infection classified elsewhere
323.51	Encephalitis and encephalomyelitis following immunization procedures
323.52	Myelitis following immunization procedures
323.61	Infectious acute disseminated encephalomyelitis (ADEM)
323.62	Other postinfectious encephalitis and encephalomyelitis
323.63	Postinfectious myelitis
323.81	Other causes of encephalitis and encephalomyelitis

Diagnosis Code	DRG 561 Diagnosis Code Titles
323.82	Other causes of myelitis
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis
341.20	Acute (transverse) myelitis NOS
341.21	Acute (transverse) myelitis in conditions classified elsewhere
341.22	Idiopathic transverse myelitis

(2) Seizure and Headache

Comment: One commenter stated that the current DRGs do not adequately capture the severity of patients with more severe types of headaches. The commenter further noted that seizures and headaches represent distinctly different levels of severity, yet they are grouped together in the CMS DRGs:

- CMS DRG 24 (Seizure & Headache Age >17 with CC)
- CMS DRG 25 (Seizure & Headache Age >17 without CC)
- CMS DRG 26 (Seizure & Headache Age 0-17)

The commenter stated that more severely ill patients, such as those with intense migraine headaches should be differentiated from other patients in the DRG. The commenter suggested splitting these DRGs into two or more new DRGs to better capture severity. Alternatively, the commenter suggested that CMS examine how the APR DRG system handles these types of cases.

Response: Under both the APR DRGs and our proposed CS DRGs, seizure and headache cases are assigned to separate DRGs while these cases are grouped together in the CMS DRGs. Both severity DRG systems recognize different levels of severity for these two groups of patients. Our medical advisors found that seizure and headache patients are clinically different. with seizure patients having a higher level of severity.

We also analyzed data for patients with seizures versus those who are admitted with headaches and found that seizure cases have higher average charges than headaches. We did not have enough cases to analyze potential DRG changes for DRG 26. As the chart below shows, seizure patients age greater than 17 have average charges of $17,125 with CC and $10,540 without CC. Headaches patients greater than 17 years of age have average charges of $11,618. The data did not support creating a split for headache patients greater than 17 years with and without CC. The difference in average charges for these groups was only $2,596 ($12,591 with CC as compared to $9,995 for those without a CC).

DRGs 24, 25, and 26

DRG	Number of Cases	Average Length of Stay	Average Charges
24	60,186	4.67	$16,403.55
25	25,816	3.13	$10,419.00
26	21	4.05	$17,396.43

Seizures Age > 17 With and Without CC

DRG	Number of Cases	Averge Length of Stay	Average Charges
With CC	50,605	4.8	$17,125.19
Without CC	20,065	3.1	$10,540.27

Headaches > 17

Number of Cases	Average Length of Stay	Average Charges
15,332	3.4	$11,618.15

Headaches > 17 With and Without CC

DRG	Number of Cases	Average Length of Stay	Average Charges
With CC	9,581	3.7	$12,591.92
Without CC	5,751	2.9	$9,995.85

The data also support creating separate DRGs for seizure and headache patients greater than 17 years of age. The data further support an additional split for seizure patients based on the presence of a complication or comorbidity (CC). Seizure cases with a CC have $6,585 greater average charges compared to cases without a CC. The data are less compelling for creating a split based on the presence of a CC for headache cases since the difference in average charges is only $2,596.

The clinical data and our medical advisors support the creation of separate DRGs for these two groups of patients. Therefore, we are deleting the following DRGs:

- DRG 24 (Seizure & Headache Age >17 with CC)
- DRG 25 (Seizure & Headache Age >17 without CC)

We are creating the following three new DRGs:

- DRG 562 (Seizure Age > 17 with CC)
- DRG 563 (Seizure Age > 17 without CC)
- DRG 564 (Headaches Age >17)

The ICD-9-CM codes and DRG logic for cases assigned to these new DRGs will be as follows.

New DRG 562 will have the following principal diagnosis codes and age greater than 17 years with a CC.

Diagnosis Code	Diagnosis Code Title
345.00	Generalized nonconvulsive epilepsy, without mention of intractable epilepsy
345.01	Generalized nonconvulsive epilepsy, with intractable epilepsy
345.10	Generalized convulsive epilepsy, without mention of intractable epilepsy
345.11	Generalized convulsive epilepsy, with intractable epilepsy
345.2	Petit mal status, epileptic
345.3	Grand mal status, epileptic
345.40	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy
345.41	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
345.50	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
345.51	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
345.60	Infantile spasms, without mention of intractable epilepsy
345.61	Infantile spasms, with intractable epilepsy
345.70	Epilepsia partialis continua, without mention of intractable epilepsy
345.71	Epilepsia partialis continua, with intractable epilepsy
345.80	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
345.81	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
345.90	Epilepsy, unspecified, without mention of intractable epilepsy
345.91	Epilepsy, unspecified, with intractable epilepsy
780.31	Febrile convulsions (simple), unspecified
780.32	Complex febrile convulsions
780.39	Other convulsions

New DRG 563 will have the principal diagnosis codes listed above for DRG 562, age greater than 17 years, but no complication/comorbidity.

New DRG 564 will have the principal diagnosis codes listed as follows and an age greater than 17 years.

Diagnosis Code	Diagnosis Code Title
307.81	Tension headache
310.2	Postconcussion syndrome
346.00	Classical migraine without mention of intractable migraine
346.01	Classical migraine with intractable migraine, so stated
346.10	Common migraine without mention of intractable migraine
346.11	Common migraine with intractable migraine, so stated
346.20	Variants of migraine without mention of intractable migraine
346.21	Variants of migraine with intractable migraine, so stated
346.80	Other forms of migraine without mention of intractable migraine
346.81	Other forms of migraine with intractable migraine, so stated
346.90	Migraine, unspecified without mention of intractable migraine
346.91	Migraine, unspecified with intractable migraine, so stated
348.2	Benign intracranial hypertension
349.0	Reaction to spinal or lumbar puncture
437.4	Cerebral arteritis
784.0	Headache

b. MDC 4 (Diseases and Disorders of the Respiratory System): Respiratory System Diagnosis with Ventilator Support

Medical patients who are treated with mechanical ventilation for respiratory failure are currently assigned to DRG 475 (Respiratory System Diagnosis with Ventilator Support). This DRG includes patients who are on a mechanical ventilator for only a few hours as well as patients who are on mechanical ventilation for several days. The proposed CS DRGs divide these patients into two groups, those on ventilator support for 96 or more hours and those on ventilator support for less than 96 hours. The CS DRGs recognize the difference in severity between these two groups of patients. Our medical advisors agree that medical patients who are treated with mechanical ventilation for respiratory failure for 96 or more hours in most cases are more severely ill than patients who are treated with mechanical ventilation for fewer than 96 hours. A review of these

cases illustrates a significant difference in average charges for patients on ventilator support for 96 or more hours which supports the greater severity of these patients. The chart below shows that patients on ventilator support for 96 or more hours have average charges of $83,058 compared to $38,300 for patients on ventilator support for less than 96 hours, a difference of $44,758 in charges. The following chart summarizes these data.

DRG 475 Respiratory System Diagnosis with Ventilator Support

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 475	114,199	10.64	$55,873.15
DRG 475 with Ventilator Support 96+ Hours	44,836	15.30	$83,058.24
DRG 475 with Ventilator Support < 96 Hours	69,363	7.64	$38,300.81

The proposed CS DRGs do a much better job of identifying patients on ventilator support who have higher levels of severity and utilize significantly more resources. Therefore, we will adopt the approach used under the CS DRG system and split these patients based on whether or not the patients are on mechanical ventilation for 96 hours. We are deleting DRG 475 and creating the following two new DRGs:

- DRG 565 (Respiratory System Diagnosis with Ventilator Support 96+ Hours)
- DRG 566 (Respiratory System Diagnosis with Ventilator Support < 96 Hours)

The DRG logic for these two new DRGs is as follows.

New DRG 565 will have a respiratory system diagnosis and procedure code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more).

New DRG 566 will have a respiratory system diagnosis and the following procedure codes:

96.70 (Continuous mechanical ventilation of unspecified duration)

96.71 (Continuous mechanical ventilation for less than 96 consecutive hours)

c. MDC 6 (Diseases and Disorders of the Digestive System)

(1) Major Esophageal Disorders and Major Gastrointestinal and Peritoneal Infections

The proposed CS DRGs assign major esophageal disorders to a single DRG because these disorders have been shown to have a higher level of severity than do other types of esophageal disorders. Under the current CMS DRGs these disorders are dispersed throughout 8 separate DRGs. The conditions included in the list of major esophageal disorders are described in the table below. The proposed CS DRGs also assign specific gastrointestinal and peritoneal infections that represent a high level of severity into a single DRG. These conditions are assigned to the same group of eight CMS DRGs mentioned above within CMS' current DRGS. The conditions considered gastrointestinal and peritoneal infections are described in the table below.

Our data show that the two groups of cases assigned to major esophageal disorders and to the gastrointestinal and peritoneal infections represent significantly greater severity levels and have higher average charges than do other cases in the eight CMS DRGs. The eight current CMS DRGs to which these two groups of higher severity cases as assigned are as follows:

- CMS DRG 174 (G.I. Hemorrhage with CC)
- CMS DRG 175 (G.I. Hemorrhage without CC)
- CMS DRG 182 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 with CC)

- CMS DRG 183 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 without CC)
- CMS DRG 184 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age 0 – 17)
- CMS DRG 188 (Digestive System Diagnoses Age >17 with CC)
- CMS DRG 189 (Digestive System Diagnoses Age >17 without CC)
- CMS DRG 190 (Digestive System Diagnoses Age 0-17)

DRGs 174, 175, 182, 183, 184, 188, 189, and 190

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 174	249,359	4.69	$16,987.26
DRG 174 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	241,508	4.69	$16,934.86
DRG 175	28,485	2.86	$9,573.73
DRG 175 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	27,816	2.87	$9,934.86
DRG 182	282,619	4.48	$14,269.01
DRG 182 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	243,563	4.07	$13,124.03
DRG 183	77,582	2.89	$9,933.62
DRG 183 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	74,899	2.84	$9,845.81
DRG 184	66	4.38	$12,116.67
DRG 184 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	60	3.88	$10,053.38
DRG 188	88,970	5.45	$18,278.19
DRG 189 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	87,210	5.43	$18,194.27
DRG 189	12,454	3.06	$9,963.90
DRG 190 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	12,123	3.02	$9,855.31
DRG 190	58	5.02	$14,156.52
DRG 190 w/o Major Esophageal Disorders or Gastrointestinal and Peritoneal Infections	45	5.13	$14,829.47

Major Esophageal Disorders

Number of Cases	Average Length of Stay	Average Charges
10,633	4.7	$18,410.30

Major Gastrointestinal and Peritoneal Infections

Number of Cases	Average Length of Stay	Average Charges
41,736	6.9	$20,861.06

As can be seen from the tables above, cases assigned to these eight DRGs without a major esophageal disorder or a major gastrointestinal disorder and peritoneal infection have average charges ranging from $9,845 to $18,194. The average charges for major esophageal disorders are $18,410, while average charges for major gastrointestinal disorders and peritoneal infections are $20,861. Removing these higher severity cases from the eight DRGs does not have a significant impact on the DRG weights for the remaining cases. Most of the higher severity cases are being removed from DRG 182. There were 282,619 cases in this DRG. By removing the two new groups of cases, the DRG has 243,563 cases remaining. The average charge for DRG 182 with the remaining cases decreases from $14,269 to $13,124. Therefore, the impact on the remaining cases is not that significant. However, reassigning cases with major esophageal and gastrointestinal disorders and peritoneal infections to two new DRGs has the effect of creating two groups which have higher levels of severity and use significantly greater resources. Our medical advisors agree that these two groups represent higher levels of severity and that it is appropriate to move these two groups of cases out of their existing assignments and into the following two new DRGs:

- DRG 571 (Major Esophageal Disorders)
- DRG 572 (Major Gastrointestinal Disorders and Peritoneal Infections)

We are creating new DRG 571 with the following ICD-9-CM diagnosis codes (removing them from DRGs 174, 175, 182, 183, 184, 188, 189, and 190):

Diagnosis Code	Major Esophageal Disorders Diagnosis Code Titles
017.80	Tuberculosis of esophagus, unspecified examination
017.81	Tuberculosis of esophagus, bacteriological or histological examination not done
017.82	Tuberculosis of esophagus, bacteriological or histological examination results unknown (at present)
017.83	Tuberculosis of esophagus, tubercle bacilli found (in sputum) by microscopy
017.84	Tuberculosis of esophagus, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
017.85	Tuberculosis of esophagus, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
017.86	Tuberculosis of esophagus, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
112.84	Candidal esophagitis
456.0	Esophageal varices with bleeding
456.1	Esophageal varices without mention of bleeding
456.20	Esophageal varices in diseases classified elsewhere, with bleeding
530.4	Perforation of esophagus
530.7	Gastroesophageal laceration-hemorrhage syndrome
530.82	Esophageal hemorrhage
530.84	Tracheoesophageal fistula
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis
750.4	Other specified congenital anomalies of esophagus
862.22	Injury to esophagus without mention of open wound into cavity
947.2	Burn of esophagus

We are creating new DRG 572 with the following ICD-9-CM diagnosis codes (removing them from DRGs 182, 183, 184, 188, 189, and 190):

Diagnosis Code	Major Gastrointestinal Disorders and Peritoneal Infections Diagnosis Code Titles
001.0	Cholera due to vibrio cholerae
001.1	Cholera due to vibrio cholerae el tor
001.9	Cholera, unspecified
003.0	Salmonella gastroenteritis
004.0	Shigella dysenteriae
004.1	Shigella flexneri
004.2	Shigella boydii
004.3	Shigella sonnei
004.8	Other specified shigella infections
004.9	Shigellosis, unspecified
005.0	Staphylococcal food poisoning

Diagnosis Code	Major Gastrointestinal Disorders and Peritoneal Infections Diagnosis Code Titles
005.2	Food poisoning due to clostridium perfringens (c. welchii)
005.3	Food poisoning due to other clostridia
005.4	Food poisoning due to vibrio parahaemolyticus
005.81	Food poisoning due to vibrio vulnificus
005.89	Other bacterial food poisoning
006.0	Acute amebic dysentery without mention of abscess
006.1	Chronic intestinal amebiasis without mention of abscess
006.2	Amebic nondysenteric colitis
007.0	Balantidiasis
007.1	Giardiasis
007.2	Coccidiosis
007.3	Intestinal trichomoniasis
007.4	Cryptosporidiosis
007.5	Cyclosporiasis
007.8	Other specified protozoal intestinal diseases
007.9	Unspecified protozoal intestinal disease
008.00	Intestinal infection due to e. coli, unspecified
008.01	Intestinal infection due to enteropathogenic e. coli
008.02	Intestinal infection due to enterotoxigenic e. coli
008.03	Intestinal infection due to enteroinvasive e. coli
008.04	Intestinal infection due to enterohemorrhagic e. coli
008.09	Intestinal infection due to other intestinal e. coli infections
008.1	Intestinal infection due to arizona group of paracolon bacilli
008.2	Intestinal infection due to aerobacter aerogenes
008.3	Intestinal infection due to proteus (mirabilis) (morganii)
008.41	Intestinal infection due to staphylococcus
008.42	Intestinal infection due to pseudomonas
008.43	Intestinal infection due to campylobacter
008.44	Intestinal infection due to yersinia enterocolitica
008.45	Intestinal infection due to clostridium difficile
008.46	Intestinal infection due to other anaerobes
008.47	Intestinal infection due to other gram-negative bacteria
008.49	Intestinal infection due to other organisms
008.5	Bacterial enteritis, unspecified
014.00	Tuberculous peritonitis, unspecified examination
014.01	Tuberculous peritonitis, bacteriological or histological examination not done
014.02	Tuberculous peritonitis, bacteriological or histological examination results unknown (at present)
014.03	Tuberculous peritonitis, tubercle bacilli found (in sputum) by microscopy
014.04	Tuberculous peritonitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
014.05	Tuberculous peritonitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
014.06	Tuberculous peritonitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
014.80	Other tuberculosis of intestines and mesenteric glands, unspecified

Diagnosis Code	Major Gastrointestinal Disorders and Peritoneal Infections Diagnosis Code Titles
	examination
014.81	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination not done
014.82	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination results unknown (at present)
014.83	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli found (in sputum) by microscopy
014.84	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
014.85	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
014.86	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
021.1	Enteric tularemia
022.2	Gastrointestinal anthrax
032.83	Diphtheritic peritonitis
039.2	Abdominal actinomycotic infection
095.2	Syphilitic peritonitis
098.86	Gonococcal peritonitis
123.1	Cysticercosis
123.5	Sparganosis (larval diphyllobothriasis)
123.6	Hymenolepiasis
123.8	Other specified cestode infection
123.9	Cestode infection, unspecified
126.0	Ancylostomiasis due to ancylostoma duodenale
126.1	Necatoriasis due to necator americanus
126.2	Ancylostomiasis due to ancylostoma braziliense
126.3	Ancylostomiasis due to ancylostoma ceylanicum
126.8	Other specified ancylostoma
126.9	Ancylostomiasis and necatoriasis, unspecified
540.0	Acute appendicitis with generalized peritonitis
540.1	Acute appendicitis with peritoneal abscess
567.0	Peritonitis in infectious diseases classified elsewhere
567.1	Pneumococcal peritonitis
567.21	Peritonitis (acute) generalized
567.22	Peritoneal abscess
567.23	Spontaneous bacterial peritonitis
567.29	Other suppurative peritonitis
567.31	Psoas muscle abscess
567.38	Other retroperitoneal abscess
567.39	Other retroperitoneal infections
567.89	Other specified peritonitis
567.9	Unspecified peritonitis
569.5	Abscess of intestine

(2) Principal or Secondary Diagnosis of Major Gastrointestinal Diagnosis

We examined the diagnosis codes assigned to MDC 6 for severity using the proposed CS DRGs and created a list of diagnosis codes that are identified as major or extreme in the APR DRGs or the consolidated severity DRGs. We refer to this set of higher severity diagnosis codes as Major Gastrointestinal Diagnoses. The list of higher severity diagnosis codes considered to be a Major Gastrointestinal Diagnosis is provided in the table below showing new DRG 569.

We then examined DRGs 148 and 149 (Major Small & Large Bowel Procedures with and without CC, respectively) and DRGs 154 through 156 (Stomach, Esophageal & Duodenal Procedures Age >17 with and without CC and Age 0-17, respectively) when these Major Gastrointestinal Diagnoses were present as either a principal or secondary diagnosis. In general, these Major Gastrointestinal Diagnoses represent or are associated with the reason for performing the surgical procedure in DRGs 148 and 149 and DRGs 154 through 156 and are the most serious diagnoses that necessitate surgery. As the following tables illustrate, the presence of these Major Gastrointestinal Diagnoses identifies patients with a higher level of severity. The presence of these Major Gastrointestinal Diagnoses leads to significantly higher average charges for these two groups of surgical patients, particularly for cases currently assigned to DRGs 148 and 154 which are the surgical procedures that include the presence of a CC. The surgical patients with Major Gastrointestinal Diagnoses would not only be considered to have a greater level of severity and be more expensive, they would also be assigned to the surgical DRG that includes a CC. The tables below show that patients in DRG 148 with

a Major Gastrointestinal Diagnosis have average charges of $70,001.16 compared to average charges of $43,809.03 when a Major Gastrointestinal Diagnosis is not present. The difference in charges for cases in DRG 149 was not as great. The difference in average charges was $29,103.84 for DRG 149 when a Major Gastrointestinal Diagnosis was present and $23,077.84 when it was not. The number of cases with a Major Gastrointestinal Diagnosis was significantly larger for DRG 148 (58,153 cases compared to only 1,822 in DRG 149). Similar findings occur for DRGs 154, 155, and 156. Cases with a Major Gastrointestinal Diagnosis occur with significantly greater numbers in DRG 154 (9,924 compared to only 357 in DRG 155 and none in DRG 156). The average charges for cases with a Major Gastrointestinal Diagnosis were $84,270.92 for DRG 154, and only $29,193.81 for DRG 155.

DRGs 148, 149, 154, 155, and 156

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 148	126,156	11.92	55,882.59
DRG 148 with PDX/SDX of Major GI Diagnoses	58,153	14.24	$70,001.16
DRG 148 w/o PDX/SDX Major GI Diagnoses	68,003	9.94	$43,809.03
DRG 149	18,471	5.66	23,672.25
DRG 149 with PDX/SDX of Major GI Diagnoses	1,822	7.66	$29,103.84
DRG 149 w/o PDX/SDX Major GI Diagnoses	16,649	5.44	$23,077.84
DRG 154	25,617	12.95	$66,257.17
DRG 154 with PDX/SDX of Major GI Diagnoses	9,924	15.59	$84,270.92
DRG 154 w/o PDX/SDX Major GI Diagnoses	15,693	11.28	$54,865.56
DRG 155	5,679	3.96	$21,543.88
DRG 155 with PDX/SDX of Major GI Diagnoses	357	7.10	$29,193.81
DRG 155 w/o PDX/SDX Major GI Diagnoses	5,322	3.75	$21,030.50
DRG 156	4	9.25	$48,015.50
DRG 156 with PDX/SDX of Major GI Diagnoses	0	0	0
DRG 156 w/o PDX/SDX Major GI Diagnoses	4	9.25	$48,015.50

Our medical advisors agree that these gastrointestinal surgical patients with a Major Gastrointestinal Diagnosis are more severely ill and represent patients with a higher level of severity. They support subdividing cases in DRG 148 and 154 based on the presence of a Major Gastrointestinal Diagnosis to better capture patients with higher level of severity. A summary of these changes is provided below.

We are deleting DRG 148 and creating the following two new DRGs:

- DRG 569 (Major Small & Large Bowel Procedures with CC with Major Gastrointestinal Diagnosis)
- DRG 570 (Major Small & Large Bowel Procedures with CC without Major Gastrointestinal Diagnosis)

The DRG logic for new DRGs 569 and 570 is as follows.

New DRG 569 will have a principal diagnosis from MDC 6 and one of the following codes as either the principal or secondary diagnosis. This DRG will also have an operating room procedure from current DRG 148 and a Complication/Comorbidity (as defined in CMS DRG GROUPER Version 24.0).

Diagnosis Code	Principal or Secondary Diagnosis –Major Gastrointestinal Diagnosis Diagnosis Code Title
008.41	Intestinal infection due to staphylococcus
008.42	Intestinal infection due to pseudomonas
008.43	Intestinal infection due to campylobacter
008.45	Intestinal infection due to clostridium difficile
008.46	Intestinal infection due to other anaerobes
008.49	Intestinal infection due to other organisms
014.04	Tuberculous peritonitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
098.86	Gonococcal peritonitis
456.0	Esophageal varices with bleeding
456.20	Esophageal varices in diseases classified elsewhere, with bleeding
530.21	Ulcer of esophagus with bleeding
530.4	Perforation of esophagus
530.7	Gastroesophageal laceration-hemorrhage syndrome

Diagnosis Code	Principal or Secondary Diagnosis –Major Gastrointestinal Diagnosis Diagnosis Code Title
530.84	Tracheoesophageal fistula
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction
532.10	Acute duodenal ulcer with perforation, without mention of obstruction
532.11	Acute duodenal ulcer with perforation, with obstruction
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction

Diagnosis Code	Principal or Secondary Diagnosis –Major Gastrointestinal Diagnosis Diagnosis Code Title
534.51	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
535.01	Acute gastritis with hemorrhage
535.11	Atrophic gastritis with hemorrhage
535.21	Gastric mucosal hypertrophy with hemorrhage
535.31	Alcoholic gastritis with hemorrhage
535.41	Other specified gastritis with hemorrhage
535.51	Unspecified gastritis and gastroduodenitis with hemorrhage
535.61	Duodenitis with hemorrhage
537.3	Other obstruction of duodenum
537.83	Angiodysplasia of stomach and duodenum with hemorrhage
540.0	Acute appendicitis with generalized peritonitis
540.1	Acute appendicitis with peritoneal abscess
550.00	Unilateral or unspecified inguinal hernia, with gangrene
550.01	Recurrent unilateral or unspecified inguinal hernia, with gangrene
550.02	Bilateral inguinal hernia, with gangrene
551.00	Unilateral or unspecified femoral hernia with gangrene
551.1	Umbilical hernia with gangrene
551.20	Unspecified ventral hernia with gangrene
551.21	Incisional ventral hernia, with gangrene
551.29	Other ventral hernia with gangrene
551.3	Diaphragmatic hernia with gangrene
551.8	Hernia of other specified sites, with gangrene
551.9	Hernia of unspecified site, with gangrene
557.0	Acute vascular insufficiency of intestine
557.1	Chronic vascular insufficiency of intestine
557.9	Unspecified vascular insufficiency of intestine
560.0	Intussusception
560.2	Volvulus
560.31	Gallstone ileus
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)
560.89	Other specified intestinal obstruction
560.9	Unspecified intestinal obstruction
562.02	Diverticulosis of small intestine with hemorrhage
562.03	Diverticulitis of small intestine with hemorrhage
562.12	Diverticulosis of colon with hemorrhage
562.13	Diverticulitis of colon with hemorrhage
564.7	Megacolon, other than hirschsprung's
567.0	Peritonitis in infectious diseases classified elsewhere
567.1	Pneumococcal peritonitis
567.21	Peritonitis (acute) generalized
567.22	Peritoneal abscess
567.23	Spontaneous bacterial peritonitis
567.29	Other suppurative peritonitis
567.31	Psoas muscle abscess
567.38	Other retroperitoneal abscess

Diagnosis Code	Principal or Secondary Diagnosis –Major Gastrointestinal Diagnosis Diagnosis Code Title
567.39	Other retroperitoneal infections
567.81	Choleperitonitis
567.9	Unspecified peritonitis
568.81	Hemoperitoneum (nontraumatic)
569.5	Abscess of intestine
569.83	Perforation of intestine
569.85	Angiodysplasia of intestine with hemorrhage
578.0	Hematemesis
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis
863.30	Injury to small intestine, unspecified site, with open wound into cavity
863.31	Injury to duodenum with open wound into cavity
863.39	Other injury to small intestine with open wound into cavity
863.50	Injury to colon, unspecified site, with open wound into cavity
863.51	Injury to ascending (right) colon with open wound into cavity
863.52	Injury to transverse colon with open wound into cavity
863.53	Injury to descending (left) colon with open wound into cavity
863.54	Injury to sigmoid colon with open wound into cavity
863.55	Injury to rectum with open wound into cavity
863.59	Other injury to colon and rectum with open wound into cavity
863.90	Injury to gastrointestinal tract, unspecified site, with open wound into cavity
863.95	Injury to appendix with open wound into cavity
863.99	Injury to other and unspecified gastrointestinal sites with open wound into cavity
868.13	Injury to peritoneum with open wound into cavity
947.3	Burn of gastrointestinal tract

New DRG 570 will have an operating room procedure code from current CMS DRG 148 and a principal diagnosis from MDC 6, except for a principal or secondary diagnosis listed above in the Major Gastrointestinal Diagnosis list and will have a Complication/Comorbidity.

We also are deleting DRG 154 and creating two new DRGs as follows:

- DRG 567 (Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity with Major Gastrointestinal Diagnosis)
- DRG 568 (Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity without Major Gastrointestinal Diagnosis)

New DRG 567 will have a principal diagnosis from MDC 6 with either a principal or secondary diagnosis of a Major Gastrointestinal Diagnosis (see list of Major Gastrointestinal Diagnoses listed above). New DRG 567 will also have an operating room procedure from current CMS DRG 154 and a CC. New DRG 568 will have a principal diagnosis from MDC 6, except it will not have a principal or secondary diagnosis from the list of Major Gastrointestinal Diagnoses. It will also have an operating room procedure from current CMS DRG 154 and a CC.

d. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Major Bladder Procedures

Under our proposed CS DRGs, cases with a major bladder procedure were found to have a higher level of severity than were cases with other types of bladder procedures. Therfore, cases with a major bladder procedure are assigned to a single DRG in the CS DRGs. The procedures classified as a major bladder procedure are as follows:

Major Bladder Procedures

Procedure Code	Description
57.6	Partial cystectomy
57.71	Radical cystectomy
57.79	Other total cystectomy
57.83	Repair of fistula involving bladder and intestine
57.84	Repair of other fistula of bladder
57.85	Cystourethroplasty and plastic repair of bladder neck
57.86	Repair of bladder exstrophy
57.87	Reconstruction of urinary bladder
57.88	Other anastomosis of bladder
57.89	Other repair of bladder

The CMS DRGs assign these cases to one of the five following DRGs:

- DRG 303 (Kidney, Ureter & Major Bladder Procedures for Neoplasm)

- DRG 304 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm with CC)
- DRG 305 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm without CC)
- DRG 308 (Minor Bladder Procedures with CC)
- DRG 309 (Minor Bladder Procedures without CC)

Our medical advisors support creating a new DRG for major bladder procedures because they represent cases with higher levels of severity, are clinically different, and use greater resources. We examined data on cases containing a major bladder procedure and determined they represent cases with a higher level of severity and utilize significantly more resources than other cases within the DRGs where they are currently assigned. Cases with a major bladder procedure had average charges of $53,434 compared to $14,976 to $38, 119 for other cases within the five DRGs where the patient did not have a major bladder procedure. The tables below illustrate these data.

DRGs	Number Of Cases	Average Length of Stay	Average Charges
DRG 303	23,328	7.28	$37,510.79
DRG 303 Without Major Bladder Procedures	18,909	6.33	$32,867.55
DRG 304	13,257	8.35	$38,800.38
DRG 304 Without Major Bladder Procedures	12,835	8.19	$38,119.74
DRG 305	2,827	3.10	$19,528.35
DRG 305 without Major Bladder Procedures	2,776	3.02	$19,295.59
DRG 308	6,358	6.15	$27,982.54
DRG 308 Without Major Bladder Procedures	5,180	5.30	$24,017.30
DRG 309	3,104	1.98	$15,446.61
DRG 309 Without Major Bladder Procedures	2,820	1.72	$14,976.79

Major Bladder Procedures

Number of Cases	Average Length of Stay	Average Charges
6,354	10.8	$53,434.93

Therefore, we are moving these procedures out of their current DRGs (DRG 303, 304, 305, 308, and 309) and into new DRG 573 (Major Bladder Procedures). A summary of these changes is as follows:

We are renaming the following three DRGs:

- DRG 303 – " Kidney and Ureter Procedures for Neoplasm"
- DRG 304 – " Kidney and Ureter Procedures for Non-Neoplasm With CC"
- DRG 305 – " Kidney and Ureter Procedures for Non-Neoplasm Without CC"

We are removing the following procedure codes from DRG 303-305, 308, and 309 and assigning them to new DRG 573. New DRG 573 will contain the following procedure codes.

Major Bladder Procedures

Procedure Code	Description
57.6	Partial cystectomy
57.71	Radical cystectomy
57.79	Other total cystectomy
57.83	Repair of fistula involving bladder and intestine
57.84	Repair of other fistula of bladder
57.85	Cystourethroplasty and plastic repair of bladder neck
57.86	Repair of bladder exstrophy
57.87	Reconstruction of urinary bladder
57.88	Other anastomosis of bladder
57.89	Other repair of bladder

e. MDC 16 (Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders): Major Hematological and Immunological Diagnoses

Under our proposed CS DRGs, major hematological and immunological diagnoses were found to identify cases with a higher level of severity. They are assigned

to a single DRG under the CS DRGs. The diagnoses considered to be major hematological and immunological diagnoses include the following conditions:

Diagnosis Code	Major Hematological and Immunological Code Titles
279.11	Digeorge's syndrome
279.12	Wiskott-aldrich syndrome
279.13	Nezelof's syndrome
279.19	Other deficiency of cell-mediated immunity
279.2	Combined immunity deficiency
283.0	Autoimmune hemolytic anemias
283.10	Non-autoimmune hemolytic anemia, unspecified
283.19	Other non-autoimmune hemolytic anemias
283.2	Hemoglobinuria due to hemolysis from external causes
283.9	Acquired hemolytic anemia, unspecified
284.8	Other specified aplastic anemias
284.9	Aplastic anemia, unspecified
288.1	Functional disorders of polymorphonuclear neutrophils
288.2	Genetic anomalies of leukocytes
996.85	Complications of transplanted bone marrow

These conditions are currently assigned to the following four CMS DRGs:

- DRG 395 (Red Blood Cell Disorders Age >17)
- DRG 396 (Red Blood Cell Disorders Age 0 – 17)
- DRG 398 (Reticuloendothelial & Immunity Disorders with CC)
- DRG 399 (Reticuloendothelial & Immunity Disorders without CC)

Our medical advisors agree that major hematological and immunological disorders are found in patients with significantly greater levels of severity and are different from other conditions in the four DRGs where they are assigned. Our data analysis shows that major hematological and immunological diseases identify patients with significantly greater levels of severity. They are more resource intensive than other conditions assigned to these four DRGs. Cases with major hematological and

immunological conditions had average charges of $21,276 compared to $11,066 to $18,791 for the other conditions where these cases are currently assigned. Most of the nonhematological and immunological cases (96,557) are assigned to DRG 395 and have an average charge of $12,977.

DRGs 395, 396, 398, and 399

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 395	109,874	4.28	14,078.78
DRG 395 Without Major Hematological Diagnosis excluding Sickle Cell Crisis & Coagulation Disorders	96,557	4.10	$12,977.20
DRG 396	19	2.95	10,406.05
DRG 396 Without Major Hematological Diagnosis excluding Sickle Cell Crisis & Coagulation Disorders	17	3.06	$11,066.94
DRG 398	17,608	5.71	19,902.21
DRG 398 Without Major Hematological Diagnosis excluding Sickle Cell Crisis & Coagulation Disorders	6,381	3.28	$18,791.32
DRG 399	1,552	3.38	11,277.35
DRG 399 Without Major Hematological Diagnosis excluding Sickle Cell Crisis & Coagulation Disorders	1,011	3.28	$11,207.22

Major Hematological Diagnosis excluding Sickle Cell Crisis & Coagulation Disorders

Number of Cases	Average Length of Stay	Average Charges
25,087	5.6	$21,276.25

We are creating a new CMS DRG 574 (Major Hematologic/Immunologic Diagnoses Except Sickle Cell Crisis and Coagulation Disorders). We are removing the codes mentioned in the table above from DRGs 395, 396, 398, and 399 and assigning them to new DRG 574. We also are assigning the new diagnosis codes indicated by an asterisk (*) to new DRG 574. These new codes also capture major hematological and immunological conditions and were created to provide more detail than the current codes in this section of ICD-9-CM. The DRG assignments for these new codes are also shown in Table 6A of the Addendum to this final rule.

Diagnosis Code	Major Hematological and Immunological Code Titles
279.11	Digeorge's syndrome
279.12	Wiskott-aldrich syndrome
279.13	Nezelof's syndrome
279.19	Other deficiency of cell-mediated immunity
279.2	Combined immunity deficiency
283.0	Autoimmune hemolytic anemias
283.10	Non-autoimmune hemolytic anemia, unspecified
283.19	Other non-autoimmune hemolytic anemias
283.2	Hemoglobinuria due to hemolysis from external causes
283.9	Acquired hemolytic anemia, unspecified
284.01*	Constitutional red blood cell aplasia
284.09*	Other constitutional aplastic anemia
284.8	Other specified aplastic anemias
284.9	Aplastic anemia, unspecified
288.00*	Neutropenia, unspecified
288.01*	Congenital neutropenia
288.02*	Cyclic neutropenia
288.03*	Drug induced neutropenia
288.04*	Neutropenia due to infection
288.09*	Other neutropenia
288.1	Functional disorders of polymorphonuclear neutrophils
288.2	Genetic anomalies of leukocytes
996.85	Complications of transplanted bone marrow

f. MDC 18 (Infections and Parasitic Diseases (Systemic or Unspecified Sites)): O.R. Procedure for Patients with Infectious and Parasitic Diseases

Under the APR DRG system, cases in DRG 415 (O.R. Procedure for Infectious and Parasitic Diseases) are subdivided based on the presence or absence of one of the following principal diagnosis codes, which we are referring to as Postoperative or Post-Traumatic Infection:

- 958.3, Posttraumatic wound infection, not elsewhere classified
- 998.51, Infected postoperative seroma
- 998.59, Other postoperative infection
- 999.3, Infection complicating medical care, not elsewhere classified

The APR DRG system found cases with one of the above infection codes to represent a higher level of severity. Our medical advisors examined cases in the current CMS DRG system in DRG 415 and found that the presence of one of these infection codes as a principal diagnosis led to significantly higher levels of severity. Charge data also support this conclusion. The following table illustrates our findings.

DRG	Redefinition of DRG 415	Number of Cases	Average Length of Stay	Average Charges
415	O.R. Procedure for Infectious & Parasitic Diseases	52,458	14.03	$63,211.99
A	O.R. Procedure with Principal Diagnosis Except Postoperative or Post-Traumatic Infection	33,077	15.90	$74,964.28
B	O.R. Procedure with Principal Diagnosis of Postoperative or Post-Traumatic Infection	19,381	10.8	$43,154.68

As can be seen from the above table, cases in DRG 415 with a principal diagnosis except for postoperative or post-traumatic infection have average charges of $74,964.28. Cases with a principal diagnosis of postoperative or post-traumatic infection have average charges of $43,154.68, or $31,809.60 less. Therefore, cases without one of the four infection codes, 958.3, 998.51, 998.59, and 999.3, have significantly higher severity levels than do cases that contain one of the four infection codes.

Accordingly, we are deleting DRG 415 and divide the cases into two new DRGs as follows:

- DRG 578, Infectious and Parasitic Diseases with O.R. Procedure
- DRG 579, Postoperative or Post-traumatic Infection with O.R. Procedure

Cases will be assigned to new DRG 578 if they were previously in DRG 415, but do not contain one of the following principal diagnosis codes:

- 958.3, Posttraumatic wound infection, not elsewhere classified
- 998.51, Infected postoperative seroma
- 998.59, Other postoperative infection
- 999.3, Infection complicating medical care, not elsewhere classified

Cases will be assigned to DRG 579 if they were previously assigned to DRG 415 and contain one of the four principal diagnosis codes listed above.

g. Severe Sepsis

Comment: As an alternative to the proposed CS DRGs, commenters recommended a new DRG to identify patients with severe sepsis associated with respiratory failure requiring mechanical ventilation. One commenter suggested using an approach to better recognize severity of illness that is similar to the change CMS implemented in the FY 2006 final rule for major cardiovascular conditions (MCVs). This approach involved examining the MCVs which could be present as either a principal or secondary diagnosis leading to greater severity of illness and resource consumption. Another option suggested by two commenters involved modifying DRG 416 (Septicemia Age >17) so that it would be split based on mechanical ventilation greater than 96 hours (code 96.72). The commenter stated that patients on mechanical ventilation for greater than 96 hours have a greater severity of illness than do those who are not on mechanical ventilation for 96 or more hours. Another commenter recommended considering mechanical ventilation as a pre-MDC DRG on the basis of the mechanical ventilation

greater than 96 hours procedure code (96.72) to better recognize patients with a greater severity level. This commenter also provided an option to add systemic infections (038.x) as an acceptable principal diagnosis for DRG 475 when reported in conjunction with mechanical ventilation or tracheostomy. One commenter maintained that the clinical reason to address a new DRG for severe sepsis is related to proper recognition and treatment for this group of patients with a greater degree of severity. This commenter stated clinicians are getting better at understanding the importance of early recognition and treatment. As sepsis presents with organ dysfunction, treatments must be prompt or mortality rapidly increases according to the commenter.

Response: We analyzed data for patients in DRG 416 and 417 who are on mechanical ventilation for 96 or more hours. The following table shows our findings.

DRGs	Number of Cases	Average Length of Stay	Average Charges
DRG 416	272,603	7.45	$28,344.81
DRG 416 With Mechanical Ventilation 96 Hours (96.72)	10.369	15.55	$94,994.49
DRG 416 Without Mechanical Ventilation 96 + Hours	262,234	7.13	$25,709.42
DRG 417	31	6.35	$27,131.58
DRG 417 With Mechanical Ventilation 96 + Hours	0	0	0
DRG 417 Without Mechanical Ventilation 96 + Hours	31	6.35	$27,131.58

The data clearly show that DRG 416 septicemia patients who are on mechanical ventilation for 96 or more hours have a significantly greater severity of illness level and use greater resources than do other patients in DRG 416. Those patients on mechanical ventilation for 96 or more hours had average charges of $94,994 compared to $25,709 for other patients in DRG 416. We found no cases in DRG 417 with patients who reported mechanical ventilation for 96 or more hours. Therefore, we agree with the commenters

that patients in DRG 416 who are on long term mechanical ventilation of 96 or more hours have greater severity of illness and use significantly greater resources. These patients should be assigned to a separate DRG to better reflect their higher severity level. Because we have no data on patients in DRG 417, we are not modifying that DRG at this time. Because the data on DRG 416 are compelling, we are deleting DRG 416 and splitting these cases into two new DRGs based on whether or not the patient is on mechanical ventilation for 96 or more hours. These two new DRGs are as follows:

- DRG 575 (Septicemia with Mechanical Ventilation 96 + Hours Age >17)
- DRG 576 (Septicemia without Mechanical Ventilation 96 + Hours Age >17)

Cases will be assigned to DRG 575 when they have a principal diagnosis from current DRG 416 and code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more). Cases will be assigned to DRG 576 when they have a principal diagnosis from current DRG 416 and do not have code 96.72.

We note that this DRG split is similar to the change we are making in MDC 4, for DRG 475 which was discussed earlier. The creation of these two new DRGs is distinct from the request to create a separate DRG for severe sepsis, which is discussed in section II.D.7. of this final rule.

D. Changes to Specific DRG Classifications

1. Pre-MDCs

a. Heart Transplant or Implant of Heart Assist System: Addition of Procedure to DRG 103

Based on public comments, we are assigning an additional procedure code to DRG 103 (Heart Transplant or Implant of Heart Assist System) under the pre-MDCs. In the FY 2006 IPPS final rule (70 FR 47297), we addressed suggestions concerning the placement of codes for external heart assist systems in DRG 103. Although we found that charges associated with code 37.65 (Implant of external heart assist system) were more than $100,000 lower than the average charges for all cases in DRG 103, we found that there was a subgroup of patients who were comparable in resource use and length of stay to other cases included in DRG 103. Those patients received both the external heart assist device (code 37.65) and later had the device removed (code 37.64, Removal of heart assist system) after a lengthy period of rest and recovery of their native hearts. We note that commenters provided external data indicating that survival rates are improving for patients receiving more advanced versions of these devices. In addition, commenters provided information indicating that longer periods of support with the external heart assist device are improving patients' survival chances and opportunity to be discharged with their native heart. These data show a 50-percent survival rate with an average total length of stay of 43 days for all AMI heart recovery patients. On average, a surviving patient will receive 31 days of average support time followed by an additional 38 days in the hospital after the device is removed. Based on information considered from a later year than our MedPAR data, it is clear that patients weaned from the external heart assist system have longer lengths of stay and are very different from the average patients having this procedure that were in our FY 2004 data.

Given the newness of this procedure and the latest generation of this device, the Medicare charge data included a limited number of patients having the device implanted and removed. However, the Medicare charge data did support that patients receiving both an implant and removal of an external heart assist system in a single hospital stay had an average length of stay exceeding 50 days and average charges of $378,000 that are more comparable to patients in DRG 103 than DRG 525 (Other Heart Assist System Implant). Accordingly, in FY 2006, we revised DRG 103 so that both implantation and removal of an external heart assist device in the same hospitalization would group to DRG 103.

However, we did not consider those cases where an external heart assist system is switched during a hospitalization, and replaced with another external heart assist system, that is subsequently removed. The ICD-9-CM coding structure specifies that the replacement of the system be coded to 37.63 (Repair of heart assist system), and not to 37.65. These cases are assigned to DRG 525 not DRG 103 even though the cases are comparable in resources expended, length of stay, etc., to other patients where the device is implanted and explanted during the same hospital stay.

Based on public comments, we believe that DRG 103 should be revised to take this situation into account. Therefore, we are reconfiguring DRG 103 in the following manner: Those patients who have both the replacement of an external heart assist system (code 37.63) and the explantation of that system (code 37.64) prior to the hospital discharge will be assigned to DRG 103.

By making this change, Medicare will be making higher payments for patients who receive both a replacement and an explant of an external heart assist system during a single hospital stay. Our intent in making this change is to recognize the higher costs of patients who have a longer length of stay and are discharged alive with their native heart. Cases in which a heart transplant also occurs during the same hospitalization episode will continue to be assigned to DRG 103.

b. Pancreas Transplants

On July 1, 1999, we issued coverage policy that specified that pancreas transplants were only covered when performed simultaneously with or after a Medicare covered kidney transplant. A noncoverage policy for pancreas transplant remained in effect for patients who had not experienced end stage renal failure secondary to diabetes. On July 29, 2005, we opened a national coverage determination (NCD) to determine whether pancreas transplant alone, that is, without a kidney transplant, is a reasonable and necessary service for Medicare beneficiaries. On April 26, 2006, we published the NCD for pancreas transplants on our Web site at: http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=260.3&ncd_version=3&basket=ncd%3A260%2E3%3A3%3APancreas+Transplants. The NCD specifies the limited circumstances where the evidence is adequate to conclude that pancreas transplant alone is reasonable and necessary for Medicare beneficiaries.

Medicare coverage of pancreas transplants alone is limited to transplants in those facilities that are Medicare-approved for kidney transplantation. A listing of approved transplant centers can be found at:

http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage. The CMS NCD includes several criteria for the coverage of pancreas transplants alone, including having a diagnosis of Type I diabetes. (We refer readers to section 260.3 of the Medicare National Coverage Manual for the entire language of the NCD.)

Because we had issued a proposed NCD and a final NCD was not expected to be completed until late April 2006 (after completion of the proposed rule), we used the FY 2007 IPPS proposed rule to indicate the coding changes that we would make to DRG 513 (Pancreas Transplant) in FY 2007 if Medicare's final decision memorandum would have continued the program's national noncoverage of pancreas transplants (71 FR 24030). In addition, we also indicated the conforming changes that we would make to the MCE "NonCovered Procedure" edit if Medicare coverage was established for pancreas transplants alone. That discussion was included in section II.D.6. of the preamble of the proposed rule (71 FR 24039), which described proposed changes to the MCE.

Because the April 2006 Medicare final decision memorandum stated that the performance of pancreas transplants alone is reasonable and necessary for Medicare beneficiaries in limited circumstances, the logic for the determination of patient case assignment to DRG 513 in the FY 2006 GROUPER program needs to be modified to remove the requirement that patients also have kidney disease. Therefore, because the NCD was finalized, we are modifying DRG 513 to consist of the following logic: List A (the diabetes codes) of the required principal or secondary diagnosis codes remains the same, as does the required operating room procedures (codes 52.80 (Pancreatic transplant

NOS), and 52.82, (Homotransplant of pancreas)). List B is removed from the logic; the following codes will no longer be required as a principal or secondary diagnosis:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease
- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease
- 585.1, Chronic kidney disease, Stage I
- 585.2, Chronic kidney disease, Stage II (mild)
- 585.3, Chronic kidney disease, Stage III (moderate)
- 585.4, Chronic kidney disease, Stage IV (severe)
- 585.5, Chronic kidney disease, Stage V

- 585.6, End stage renal disease
- 585.9, Chronic kidney disease, unspecified
- V42.0, Organ or tissue replaced by transplant, kidney
- V43.89, Organ or tissue replaced by other means, other organ or tissue, other

We note that DRG 513 remains in the pre-MDC hierarchy.

Comment: Five commenters supported the proposed coding changes to DRG 513 and the MCE.

Response: We appreciate the support of the commenters. Accordingly, as the NCD for pancreas transplants alone was approved, in this final rule, we are adopting the changes as described above to DRG 513 and the MCE logic.

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

a. Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (DBS)

Deep-brain stimulation (DBS) is designed to deliver electrical stimulation to the subthalamic nucleus or internal globus pallidus to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's disease and essential tremor. DBS implants for essential tremor are unilateral, with neurostimulation leads on one side of the brain. DBS implants for Parkinson's disease are bilateral, requiring implantation of neurostimulation leads in both the left and right sides of the brain.

The implantation of a full DBS system requires two types of procedures. First, surgeons implant leads containing electrodes into the targeted sections of the brain where

neurostimulation therapy is to be delivered. Second, a neurostimulator pulse generator is implanted in the pectoral region and extensions from the neurostimulator pulse generator are then tunneled under the skin along the neck and connected with the proximal ends of the leads implanted in the brain. Hospitals stage the two procedures required for a full-system DBS implant.

In FY 2005, to better account for these two types of procedures, we revised procedure code 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)) for the lead placement and created three new procedures codes for the pulse generator: 86.94 (Insertion or replacement of single array neurostimulator pulse generator); 86.95 (Insertion or replacement of dual array neurostimulator pulse generator); and 86.96 (Insertion or replacement of other neurostimulator pulse generator). We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2005 IPPS final rule (69 FR 49627 and 49641).

In FY 2006, we made further refinements to the pulse generator codes to identify rechargeable pulse generators. We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2006 IPPS final rule (70 FR 47637 and 47639). The current list of pulse generators codes are:

- 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable);
- 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable);

- 86.96 (Insertion or replacement of other neurostimulator pulse generator);
- 86.97 (Insertion or replacement of single array neurostimulator rechargeable generator); and
- 86.98 (Insertion or replacement of dual array neurostimulator rechargeable generator).

Kinetra® is an implantable dual array neurostimulator pulse generator that is approved for a new technology add-on payment through FY 2006. For more information about the new technology add-on payment, please refer to section II.G.3.a. of this preamble.

Medtronic, the manufacturer of Kinetra®, argues that the new technology add-on payment provision is designed to recognize the higher costs of new medical innovations for the initial period the technology is available on the market, and until the associated costs and charges related to the technology are available in the MedPAR database and can be used to recalibrate the DRG weights. Medtronic also argues that, once a technology is no longer eligible for new technology add-on payments, the new technology add-on payment provision is designed to support the reclassification of the technology to other clinically coherent DRGs with comparable resource costs.

With the conclusion of the new technology add-on payment, Medtronic is concerned that Kinetra ® will be inadequately paid in DRG 1 (Craniotomy Age >17 With CC) or DRG 2 (Craniotomy Age >17 Without CC) under MDC 1. Medtronic recommended that CMS reassign the full-system Kinetra® implants to DRG 543 (Craniotomy with Implant of Chemo Agent or Acute Complex CNS Principal Diagnosis)

under MDC 1. To accommodate this recommendation, procedure codes 02.93 and 86.95 would have to be reassigned to DRG 543 and the title for DRG 543 would have to be revised to "Craniotomy with Implantation of Major Device or Acute Complex CNS Principal Diagnosis." Medtronic argued that DRG 543 would be a "clinically-consistent DRG that more appropriately reflects the resource utilization associated with full-system [deep brain stimulation] procedures." Medtronic also emphasized that its proposal would only apply to full-system Kinetra® implants when both the leads and generators are implanted during a single inpatient stay and procedure codes 02.93 and 86.95 both appear on the claim. Medtronic believes the current DRG assignment is appropriate for partial system implants.

Medtronic provided an analysis of FY 2004 MedPAR data. Procedure code 86.95 was not created until FY 2005 so Medtronic used procedure codes 02.93 and 86.09 (Other incision of skin and subcutaneous tissue) to identify the full system. It identified 193 cases assigned to DRG 1 with average charges of approximately $69,155, and 532 cases assigned to DRG 2 with average charges of approximately $56,113.

In the FY 2007 IPPS proposed rule we indicated that we have reviewed the latest data for the full-system DBS implants assigned to DRG 1 or DRG 2 in the FY 2005 MedPAR file. We identified cases with procedure codes 02.93 and 86.95 for full-system dual array cases. We also identified cases with reported codes 02.93 and 86.96 for those full-system cases where the type of pulse generator was not specified. The following table displays our results:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 1 - All Cases	23,037	9.61	$55,494

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 1 - Cases with 02.93 and 86.95 (Kinetra®)	51	5.18	$73,020
DRG 1 - Cases with 02.93 and 86.96 (Unspecified)	101	4.86	$53,356
DRG 2 - All Cases	9,707	4.41	$32,791
DRG 2 - Cases with 02.93 and 86.95 (Kinetra®)	146	2.40	$59,414
DRG 2 - Cases with 02.93 and 86.96 (Unspecified)	249	2.12	$47,047
DRG 543 - All cases	5,192	11.71	$71,138

These data showed that approximately one-quarter of the full-system dual array neurostimulator pulse generator cases are assigned to DRG 1 and approximately three-quarters of these cases are assigned to DRG 2. In both DRGs, the average length of stay was shorter for the full-system array neurostimulator pulse generator cases than for all other cases. However, the average charges for the full-system dual array neurostimulator pulse generator cases are approximately $18,000 and $27,000 higher than the average charges for DRGs 1 and 2, respectively. The average charges for these cases in DRG 1 are comparable to those for DRG 543. However, the more commonly occurring cases in DRG 2 have average charges that are less than those in DRG 543 by nearly $12,000. We reviewed all of the procedures that will result in a case being assigned to DRGs 1 and 2. Unlike the full-system DBS implants, we believe for most of the cases assigned to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for cases involving full-system dual array neurostimulator pulse generators are likely accounted for by the cost of the device. While it is possible that the cost of the device itself will make the full-system DBS implants more expensive than other cases in the DRG, the hospital's charge markup may also explain the higher charges but lower average length of stay. As indicated in section II.G.3.a. of this final rule, the national average CCR for medical

equipment and supplies is approximately 34 percent. Thus, the actual cost to the hospital of the case including the full-system dual array neurostimulator pulse generator may be much lower than the charges would suggest.

With respect to whether the cost of the technology itself, absent a charge markup, makes the case more expensive, in the FY 2007 IPPS proposed rule, we stated that we intended to address this issue as we make further refinements to the DRG system to address severity of illness as discussed in section II.C. of this preamble.

Comment: Several commenters opposed CMS' proposed decision to retain the current assignment of implantable dual array neurostimulator pulse generator cases in DRGs 1 and 2. Several commenters stated that CMS should recognize the higher resources associated with this technology and reassign implantable dual array neurostimulator pulse generator cases to DRG 543. Two commenters disagreed with CMS' statements that markups associated with Kinetra® may overstate the total charges of the implant procedure. Medtronic submitted information on charge compression in which the company contends that it conclusively finds the hospital charge markups for implantable devices are in fact significantly lower than for other, lower cost supplies and equipment. Medtronic and one other commenter argued that the total charges found in the FY 2005 MedPAR data associated with implantable dual array neurostimulator pulse generator procedures may be understated relative to other procedures in DRG 1, DRG 2 and DRG 543 and that reassignment of this technology to DRG 543 is fully warranted. The commenters stated that the implementation of the CS DRGs should be deferred to at

least FY 2008 and not be a factor in CMS' decision to make DRG reassignments this year.

Response: With regard to the issue of charge compression, we are studying this issue in our effort to improve payment accuracy in the IPPS. The average charges for the 51 cases in DRG 1 where the patient received a dual array neurostimulator are $17,426 or 31 percent higher than the rest of the cases in DRG 1. The average charges are comparable to those for DRG 543 ($73,020 for dual array neurostimulator cases and $71,138 for DRG 543).

The average charges for the 146 cases in DRG 2 are $26,623 or 81 percent higher than the rest of the cases in DRG 2 and only $12,000 less than the average charges for DRG 543. Based on these data, we believe that the dual array neurostimulator cases will be more accurately paid in DRG 543 than DRGs 1 and 2. We will be implementing this change to the DRG assignment for the full-system dual array neurostimulator cases for FY 2007. Implantable dual array neurostimulator pulse generator procedure cases reported with ICD-9-CM procedure codes 02.93 and 86.95 will be reassigned to DRG 543. We are changing the DRG title for DRG 543 to "Craniotomy With Major Device Implant or Acute Complex CNS Principal Diagnosis."

b. Carotid Artery Stents

Background: Stroke is the third leading cause of death in the United States and the leading cause of serious, long-term disability. Approximately 70 percent of all strokes occur in people age 65 and older. The carotid artery, located in the neck, is the principal artery supplying the head and neck with blood. Accumulation of plaque in the

carotid artery can lead to stroke either by decreasing the blood flow to the brain or by the plaque breaking free and lodging in the brain or other arteries leading to the head. The percutaneous transluminal angioplasty (PTA) procedure involves inflating a balloon-like device in the narrowed section of the carotid artery to reopen the vessel. A carotid stent is then deployed in the artery to prevent the vessel from closing or restenosing. A distal filter device (embolic protection device) may also be present, which is intended to prevent pieces of plaque from entering the bloodstream.

Effective July 1, 2001, Medicare covered PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, was considered to be a reasonable and necessary service only when provided in the context of such clinical trials and, therefore, was considered a covered service for the purposes of those trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remained noncovered until the release of the October 12, 2004 NCD for PTA of the carotid artery in post-approval studies. This decision extended coverage of PTA in the carotid artery concurrent with placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with the FDA-approved protocols governing post-approval studies. On March 17, 2005, CMS released an NCD that extended coverage to patients at high risk for carotid endarterectomy (CEA) who also have symptomatic carotid artery stenosis ≥70

percent. Procedures must be performed in CMS-approved facilities and with FDA-approved carotid artery stent(s) with distal embolic protection. (Section 20.7 of the NCD manual which discusses this decision may be viewed at the Web site: http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf.)

Placement of a carotid artery stent in patients who have had a disabling stroke (modified Rankin scale ≥3) is excluded from coverage.

We established codes for carotid artery stent procedures for use with discharges occurring on or after October 1, 2004, for inpatients who were enrolled in an FDA-approved clinical trial and who were using on-label FDA-approved stents and embolic protection devices. These codes are as follows:

- 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)); and
- 00.63 (Percutaneous insertion of carotid artery stent(s)).

We assigned procedure code 00.61 to four MDCs and seven DRGs. The most likely clinical scenario is that in which cases are assigned to MDC 1 (Diseases and Disorders of the Nervous System) in DRGs 533 (Extracranial Procedures with CC) and 534 (Extracranial Procedures without CC). Other DRG assignments can be found in Table 6B of the Addendum to the FY 2005 IPPS final rule (69 FR 49624). Code 00.63 is not considered a procedure code itself and should be used in combination with code 00.61.

Based on the results of evaluation of PTA and carotid stents for our FY 2006 final rule (70 FR 47300, August 12, 2005), we did not find sufficient evidence to warrant a DRG change at that time.

We again reviewed the PTA and insertion of a carotid stent(s) for the FY 2007 proposed rule, as manufacturer representatives suggested that we assign all carotid stenting cases to DRG 533 only, bypassing DRG 534. As we indicated in the FY 2007 IPPS proposed rule (71 FR 24032), we reviewed the FY 2005 MedPAR data on all cases in DRGs 533 and 534 and on those cases containing code 00.61 in combination with 00.63. The following table displays those results:

DRG	Number of Cases	Average Length of Stay (Days)	Average Charges
DRG 533 - All cases	44,031	3.65	$26,376
DRG 533 with codes 00.61 and 00.63 reported	2,400	2.94	$33,344
DRG 533 with code 00.61 and without 00.63	99	5.95	$46,591
DRG 534 - All cases	40,381	1.72	$17,196
DRG 534 with codes 00.61 and 00.63 reported	2,056	1.52	$25,000
DRG 534 with code 00.61 and without 00.63	55	2.31	$27,895

We found that 5.5 and 5.1 percent of the cases in DRGs 533 and 534, respectively, involved placement of a carotid artery stent. In DRG 533, the average length of stay was 19.4 percent shorter for the carotid stenting cases than for all other cases. In DRG 534, the average length of stay was 11.6 percent shorter for the carotid stenting cases than for all other cases. However, the average charges for the carotid stent cases were higher by $6,968 in DRG 533 and $7,804 in DRG 534. We reviewed all of the procedures that would result in a case being assigned to DRGs 533 and 534. Unlike the carotid artery stent placements, we believe that, for most of the other cases assigned

to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for the cases involving carotid artery stents could be accounted for by the cost of the device. We discussed the possibility that the cost of the device itself makes the stent cases more expensive than other cases in the DRG, and that the hospital's charge markup may also explain the higher charges but lower average length of stay. We also suggested that we intended to address this issue as we make further refinements to the CS DRG system previously described. The use of a carotid stent or stents may increase complexity and resource use even though the patient is not necessarily more severely ill. We indicated that we believed that the CS DRG system we proposed would need to be further refined to assign cases based on complexity as well as severity to account for technologies such as carotid stents that increase costs. For this reason, we did not propose a change to the current DRG assignment for these cases.

Comment: More than a dozen commenters addressed this topic. State hospital associations, in particular, were unanimous in their recommendation that all carotid stenting cases should immediately be assigned only to DRG 533, bypassing DRG 534 entirely. The commenters suggested this solution to increase payments to hospitals in order that the higher costs associated with carotid stents are recognized within the existing DRG system.

Response: We are opposed to this suggestion. The DRGs comprise a native structure of the types of patients within each DRG category. Further, this structure is based on an organizing principle. For example, cases in DRGs 533 and 534 are

organized on the principle of surgical approach (extracranial procedures) as well as the presence or absence of CCs. To ignore the structure of the DRG solely for the purpose of increasing payment would set an unwelcome precedent for defining all of the other DRGs in the system.

Comment: Several commenters mentioned that, while CMS suggested that the higher average charges and lower lengths of stay for cases involving carotid artery stents are likely accounted for by the cost of the device, CMS provided no evidence to support this assertion.

Response: The average length of stay for patients in DRGs 533 and 534 with the placement of carotid stent(s) are 19.4 and 11.6 percent shorter than the other patients assigned to DRGs 533 and 534, respectively. Therefore, a long length of stay is not the reason for the higher average charges. We based our assertion on the contribution of the cost of the device to the total cost of the patients in these DRGs compared to other cases in the DRG with longer lengths of stay. We note that the next comment suggests that our analysis is correct that the higher charges for the carotid artery stent cases relative to other cases in the DRG are, in part, associated with higher supply costs.

Comment: One commenter suggested that CMS create a new pair of DRGs with and without MCVs until the adequacy of payment under the severity adjustment methodology is fully assessed. This commenter noted that, while length of stay and operating room costs are lower for carotid stenting, supply and radiology charges associated with the stent and the angiography are higher, resulting in higher overall costs for carotid stenting.

Response: While we recognize the creativity of this approach, we note that the MCVs are applicable to cases in MDC 5 (Diseases and Disorders of the Circulatory System), while DRGs 533 and 534 are in MDC 1 (Diseases and Disorders of the Nervous System). Such an approach for MDC 1 might have merit, but we would want to evaluate the entire MDC thoroughly before creating such a list of complicating diagnoses. We will further consider this concept as we evaluate severity DRG systems for adoption in FY 2008.

Comment: One commenter, while urging CMS to reconsider our decision not to assign all carotid cases to DRG 533, noted that the current National Coverage Determination on CAS [Carotid Artery Stenting] very clearly states that only those patients who are at high risk for [open] surgery due to the presence of a detailed list of complications or comorbidities are eligible for carotid artery stenting. Therefore, by CMS' own characterization, all patients undergoing carotid artery stenting have complications and comorbidities and should be assigned to DRG 533.

Response: This assumption is theoretically correct. However, the detailed list of comorbidities or anatomical risk factors that are required to support the surgeon's decision to perform carotid stenting instead of a carotid endarterectomy is not the same as the CMS list of CCs. For example, amaurosis fugax, code 362.34 (Transient arterial occlusion) is recognized as a risk factor which would justify carotid stenting, but is not recognized by the CMS GROUPER as a diagnosis defined as a CC.

Comment: Several commenters suggested that CMS create two new DRGs for the carotid stent cases.

Response: We note that the number of procedures has increased from the data reported in the FY 2006 IPPS final rule (70 FR 47300), thus indicating acceptance of this procedure by the medical community as a main-stream surgical alternative. In FY 2006, as the specific codes for carotid stenting had only been in use since October 1, 2004, we used the existing codes 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)) and 39.90 (Insertion of non-drug-eluting peripheral vessel stent(s)), in combination with principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) as a proxy for the number of cases involved in clinical trials. In DRG 533, we had 1,586 cases with the proxy codes reported, and in DRG 534, there were 1,397 cases. In FY 2005, the patients represented 3.5 percent and 3.3 percent of all cases in DRGs 533 and 534, respectively. That figure has now climbed to 2,400 cases and 2,056 cases, and 5.5 percent and 5.1 percent, respectively.

In addition, the difference in the average charges are 26 percent higher for carotid artery stent cases in DRG 533 than for the average charges in all cases in that DRG, and 45 percent higher using the same parameters for DRG 534. We believe these data are compelling enough to warrant creation of a new DRG.

Accordingly, we are creating DRG 583 (Carotid Artery Stent Procedure). This DRG will be located in MDC 1, and will be hierarchically ordered above DRGs 533 and 534. DRG 583 will contain two procedure codes. Code 00.61 will determine the DRG, and will be combined with code 00.63. Both codes must be reported in order for cases to be assigned to this DRG.

We are not splitting this DRG based on the presence or absence of a CC as suggested by the commenters. One criterion for splitting a DRG based on the presence or the absence of a CC is that it must have an impact of at least $40 million. In this situation, the overall average of the charges for all cases in DRGs 533 and 534 is $30,193. We then subtracted the actual average charges for only the carotid stent cases in both DRGs 533 and 534, and multiplied that figure by the actual number of cases. For DRG 533 and DRG 534, we estimate an impact of approximately $10 million each. Added together, the total impact would be $20 million, falling short of our threshold of a $40 million impact to create a CC/non-CC split. Therefore, we are not creating a CC/non-CC split in the DRG for carotid artery stenting at this time.

We reiterate that coverage of the carotid artery stent procedure is limited to patients at risk of developing a stroke due to narrowing or stenosis of the carotid artery. Diagnosis code 433.10 (Occlusion and stenosis of carotid artery without mention of cerebral infarction) should be used to identify the site of the procedure in the carotid artery. If it is necessary to identify bilateral occlusion or stenosis, diagnosis code 433.30 (Occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction) may also be used. These codes should be used together, as code 433.30 contains arterial sites that are not currently covered for Medicare patients. Reporting of code 433.30 alone will cause the case to fail the editing system at the fiscal intermediary, and the case could be denied.

Inclusion of the fifth digit of “1” (with cerebral infarction) with either 433.1x or 433.3x will cause the claim to be rejected.

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

a. Insertion of Epicardial Leads for Defibrillator Devices

As we indicated in the FY 2007 IPPS proposed rule (71 FR 24033), we received a comment indicating that a change in coding advice for the insertion of epicardial leads for CRT-D defibrillator devices affects DRG assignment. The commenter noted that the Third Quarter 2005 issue of the American Hospital Association's publication Coding Clinic for ICD-9-CM instructs coders to assign code 37.74 (Insertion or replacement of epicardial lead [electrode] into atrium) for pacemaker or defibrillator leads inserted through use of a thoracotomy into the epicardium. While the use of code 37.74 is standard coding practice for pacemakers, the advice is new for defibrillators. This coding advice was discussed at the ICD-9-CM Coordination and Maintenance Committee meeting held on September 29 and 30, 2005. Participants at the Committee meeting proposed modifications for the code category 37.7 (insertion, revision, replacement, and removal of pacemaker leads; insertion of temporary pacemaker system; and revision of cardiac device pocket). These modifications involved expanding the category so that the codes for leads would no longer be restricted to pacemakers. This change would guide coders to use code 37.74 for the insertion of epicardial leads for both defibrillators and pacemakers for the ICD-9-CM and will become effective on October 1, 2006.

The commenter indicated that this coding advice would restrict some defibrillator cases from being assigned to the defibrillator DRGs. Specifically, the commenter expressed concerns about the DRG logic for the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter)

- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock)
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock)

Cases are assigned to one of these three DRGs when a total defibrillator system, including both the device and one or more leads, is implanted. The implant could be represented by the ICD-9-CM codes for the total system, that is, code 00.51 (Implantation of cardiac resynchronization defibrillator, total system [CRT-D]) or code 37.94 (Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]). Cases can also be assigned to DRGs 515, 535, and 536 when a combination of a device and a lead code is reported. The following combinations of defibrillator device and lead codes are present in the current DRG logic:

- 00.52 (Implantation or replacement of transvenous lead [electrode] into left ventricular coronary venous system) and 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) and 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) and 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only)

- 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only) and 00.54 (Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT-D])
- 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only) and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only)

A DRG logic issue has arisen concerning the instruction to use code 37.74 for epicardial leads inserted with CRT-D defibrillators. The new combination of a defibrillator device with an epicardial lead (code 37.74) is not included in DRGs 515, 535, and 536. The commenter recommended that the following combinations be added to DRGs 515, 535, and 536 so that all types of defibrillator device and lead combinations would be included: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.

We agree that these three combinations should be added to the list of combination codes included in DRGs 515, 535, and 536. This change would result in all combinations of defibrillator devices and leads being assigned to one of the defibrillator DRGs. Therefore, in the FY 2007 IPPS proposed rule, we proposed to add these three combinations to the list of procedure combinations under DRGs 515, 535, and 536.

Comment: A number of commenters supported adding the new combinations of defibrillator devices with the epicardial leads to DRGs 515, 535, and 536. One commenter stated that this change would bring the DRGs into alignment with the change in coding advice to assign code 37.74 in conjunction with implantation of CRT-D defibrillators.

Response: We appreciate the support of commenters and agree that this change would bring the DRGs into alignment with the change in coding advice.

In this final rule, we are adding the following combinations of device and lead codes to DRGs 515, 535, and 536: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.

b. Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs

In the FY 2006 IPPS final rule (70 FR 47289 and 47474 through 47479), we addressed a comment we had received in response to the FY 2006 proposed rule which noted that section 507(c) of Pub. L. 108-173 required MedPAC to conduct a study to determine how the DRG system should be updated to better reflect the cost of delivering care in a hospital setting. The commenter noted that MedPAC reported that the "cardiac surgery DRGs have high relative profitability ratios." While the commenter acknowledged that it may take time to conduct and complete a thorough evaluation of the MedPAC payment recommendations for all DRGs, the commenter strongly encouraged CMS to revise the cardiac DRGs through patient severity refinement as part of the IPPS final rule effective for FY 2006.

In response to this comment, we performed an extensive review of the cardiovascular DRGs in MDC 5, particularly those DRGs that were commonly billed by specialty hospitals. We observed that there was some overlap between the lists of cardiovascular complications and complex diagnoses and that these lists were already used to segregate patients into DRGs that used greater resources. Because the hospital industry already was familiar with the major complication and complex diagnosis lists

used within the cardiovascular DRGs, we began our analysis with these two overlapping lists.

The two lists were originally developed for the current DRG system because they contained conditions that could have an impact on the resources needed to treat a patient with cardiovascular complications. Many of the conditions were cardiovascular diagnoses and, therefore, would be classified to MDC 5. However, we determined that some of the diagnoses were not cardiovascular, but would still have an impact on a patient with cardiovascular complications. The conditions that were not cardiovascular diagnoses were not assigned to MDC 5 if they were the principal diagnosis.

We reviewed the conditions on the two overlapping lists and identified conditions that we believed would lead to a more complicated patient stay requiring greater resource use. We referred to these conditions as "major cardiovascular conditions (MCVs)." The MCVs could be present as either a principal diagnosis or a secondary diagnosis and lead to greater resource consumption. The complete list of MCVs was published in the FY 2006 IPPS final rule (70 FR 47477 and 47478).

In the FY 2006 IPPS final rule, we also adopted new DRGs 547 through 558, effective October 1, 2005 (70 FR 47475 and 47476). However, we emphasized that the refinements to the DRGs were being taken as an interim step to better recognize severity in the DRG system for FY 2006 until we could complete a more comprehensive analysis of the APR DRG system and the CC list as part of a complete analysis of the MedPAC recommendations that we planned to perform for FY 2007 (and which was addressed in section II.C. of the preamble of the FY 2007 proposed rule).

Since publication of the FY 2006 IPPS final rule, we have received a question from a commenter as to why we did not apply the MCV list to the following defibrillator DRGs: 515, 535, and 536. The commenter noted that the pacemaker DRGs were revised using the MCV list, but the defibrillator DRGs were not.

As noted above, for FY 2006, we created new DRGs 546 through 558 to identify cases with more costly and severely ill patients as an interim step to evaluating severity DRGs. We analyzed for the first time last year data on cases within MDC 5 and presented data that showed significant difference for patients in certain DRGs based on the presence or absence of an MCV. This split did not work for the defibrillator DRGs, as we could not identify groups with significantly different resource use. For instance, splitting DRG 515 based on the presence of an MCV would lead to two groups with differences in charges of only $3,430 ($89,341 for those with an MCV and $85,911 for those without an MCV). In the data we displayed in the FY 2006 IPPS final rule, the differences for DRGs selected for an MCV split ranged from $10,319 to $21,035. Splitting DRG 515 based on an MCV would produce a difference in charges of only 10.1 percent as compared to differences of 28.7 to 47.7 percent for DRGs 547 through 558. Therefore, the data did not support including DRG 515 among those split based on the presence or absence of an MCV. Similar results were found when DRG 536 was split by an MCV. There was only an 8.1 percent difference in charges between the two groups. We also identified other problems with splitting DRG 535 based on the presence or absence of an MCV. Some of the codes a claim must include for the case to be grouped to DRG 535 under our current system are also codes on the MCV list.

Therefore, applying the MCV list to DRG 535 would result in all cases being assigned to the DRG with an MCV and none to the DRG without an MCV. For these reasons, we did not subdivide DRGs 515, 535, and 536 based on the presence or absence of an MCV.

In the FY 2007 IPPS proposed rule, we indicated that we had decided not to propose additional refinements of the DRGs based on MCVs for FY 2007 because of our efforts to propose a broader refinement of the DRG system, as discussed in detail in section II.C. of the proposed rule. However, as discussed further in section II.C. of the preamble of the proposed rule, we solicited comments on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV.

Comment: Commenters agreed with the recommendation that we not subdivide DRGs 515, 535, and 536 based on MCV. However, one commenter expressed concerns about how the current DRGs were achieving their goal of identifying patients with greater severity of illness. Other commenters opposed the proposal to delay refining defibrillator DRGs based on MCVs. These commenters believed it was appropriate for CMS to apply a clinical severity concept similar to the approach used in FY 2006 to refine cardiac DRGs to an expanded set of DRGS (for example, defibrillator DRGs) based on the presence or absence of an MCV.

Response: We agree with the commenters who suggested that our goal should be to reform the Medicare DRG system to develop a better means of capturing severity of illness and complexity. As discussed in section II.C. of the preamble of the proposed

rule, we solicited comments on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV. As discussed in section II.C.7., we are implementing revisions to the current DRGs to better recognize severity of illness. However, the analysis we have performed to this point does not support splitting defibrillator DRGs based on the presence or absence of an MCV. As stated earlier, simply applying the MCVs to the defibrillator DRGs in DRGs 515, 535, and 536 would not lead to significant improvements for DRG 515. Applying the MCV list to DRG 535 would result in all cases being assigned to the DRG with an MCV and none to the DRG without an MCV. For these reasons, we did not subdivide DRGs 515, 535, and 536 based on the presence or absence of an MCV.

While we did not find additional severity improvements for defibrillator cases, we will continue to study this area and look for further improvements.

4. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Hip and Knee Replacements

In the FY 2006 final rule (70 FR 47303), we deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement) to help resolve payment issues for hospitals that perform revisions of joint replacements because we found revisions of joint replacements to be significantly

more resource intensive than original hip and knee replacements. DRG 544 includes the following 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

DRG 545 includes 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

In the FY 2006 IPPS final rule (70 FR 47305), we indicated that the American Association of Orthopaedic Surgeons had requested that, once we receive claims data using the two DRG procedure code assignments, we closely examine data from the use of the codes under the two DRGs to determine if future additional DRG modifications are needed.

After publication of the FY 2006 IPPS final rule, a number of hospitals and coding personnel advised us that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity), which utilizes the new and revised hip and knee procedure codes under DRGs 544 and 545, also includes codes that describe procedures that are not bilateral or that do not involve multiple major joints. DRG 471 was developed to include cases where major joint procedures such as revisions or replacements were performed either bilaterally or on two joints of one lower extremity. We changed the logic for DRG 471 last year for the first time when we added the new and revised codes. The commenters indicated that, by adding the more detailed codes that do not include total revisions or replacements to the list of major joint procedures to DRG 471, we are assigning cases to DRG 471 that do not have bilateral or multiple joint procedures. For example, when a hospital reports a code for revision of the tibial component (code 00.81) and patellar component of the right knee (code 00.83), the current DRG logic assigns the case to DRG 471. The commenters indicated that this code assignment is incorrect because only one joint has undergone surgery, but two components were used. One commenter indicated that ICD-9-CM does not identify left/right laterality. Therefore, it is difficult to use the current coding structure to

determine if procedures are performed on the same leg or on both legs. The commenters raised a concern about whether CMS intended to pay hospitals using DRG 471 for procedures performed on one joint. The commenters indicated that the DRG assignments for these codes would also make future data analysis misleading. The commenters recommended removing codes from DRG 471 that do not specifically identify bilateral or multiple joint procedures.

We agree that the new and revised joint procedure codes should not be assigned to DRG 471 unless they include bilateral and multiple joints. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24035), we proposed to remove the following codes from DRG 471:

- 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
- 00.81, 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 total knee replacement, tibial insert (liner)
- 81.53, Revision of hip replacement, not otherwise specified
- 81.55, Revision of knee replacement, not otherwise specified

The proposed revised DRG 471 would then contain only the following codes:

- 00.70, Revision of hip replacement, both acetabular and femoral components
- 00.80, Revision of knee replacement, total (all components)

- 81.51, Total hip replacement
- 81.52, Partial hip replacement
- 81.54, Total knee replacement
- 81.56, Total ankle replacement

We proposed to assign the codes removed from DRG 471 (codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55) to DRG 545 when used either alone or in combination. This list of codes removed from DRG 471 and added to DRG 545 includes partial revisions of the knee and hip as well as unspecified joint procedures such as code 81.55 where it is not clear if the revision is total or partial.

Comment: Several comments supported our proposals to remove codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55 from the combinations assigned to DRG 471 and assign cases with these codes to DRG 545. The commenters agreed that these codes should be removed from DRG 471 because they do not represent bilateral and multiple joint revisions or replacements.

Response: We appreciate the commenters support to remove codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55 from the combinations assigned to DRG 471. These cases will be assigned to DRG 545.

We are finalizing the changes to DRG 471 and DRG 545 that we proposed. Further, as we indicated in the proposed rule, we plan to perform extensive data analysis on the new and revised joint procedure codes as we receive billing data to determine if future refinements of these DRGs are needed. In addition, as indicated in section II.C. of the preamble of the proposed rule, we are planning in the future to adopt a revised DRG

system for the IPPS that addresses severity of illness. We encouraged commenters to evaluate how the new and revised joint procedures should be addressed in such a revised system. We received comments indicating that the CS DRGs that we proposed do not distinguish between patients receiving an original joint replacement from a revision. As we indicate elsewhere in this final rule, we will evaluate these issues as we develop our plans for adopting a revised DRG system that addresses severity of illness.

b. Spinal Fusion

In the FY 2006 IPPS final rule (70 FR 47307), we created new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). DRG 546 is composed of all noncervical spinal fusions previously assigned to DRGs 497 (Spinal Fusion Except Cervical with CC) and 498 (Spinal Fusion Except Cervical without CC) that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy. The principal diagnosis codes that lead to DRG 546 assignment are the following:

- 170.2, Malignant neoplasm of vertebral column, excluding sacrum and coccyx
- 198.5, Secondary malignant neoplasm of bone and bone marrow
- 213.2, Benign neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx
- 238.0, Neoplasm of uncertain behavior of other and unspecified sites and tissues; Bone and articular cartilage
- 239.2, Neoplasms of unspecified nature; bone, soft tissue, and skin
- 732.0, Juvenile osteochondrosis of spine

- 733.13, Pathologic fracture of vertebrae
- 737.0, Adolescent postural kyphosis
- 737.10, Kyphosis (acquired) (postural)
- 737.11, Kyphosis due to radiation
- 737.12, Kyphosis, postlaminectomy
- 737.19, Kyphosis (acquired), other
- 737.20, Lordosis (acquired) (postural)
- 737.21, Lordosis, postlaminectomy
- 737.22, Other postsurgical lordosis
- 737.29, Lordosis (acquired), other
- 737.30, Scoliosis [and kyphoscoliosis], idiopathic
- 737.31, Resolving infantile idiopathic scoliosis
- 737.32, Progressive infantile idiopathic scoliosis
- 737.33, Scoliosis due to radiation
- 737.34, Thoracogenic scoliosis
- 737.39, Other kyphoscoliosis and scoliosis
- 737.8, Other curvatures of spine
- 737.9, Unspecified curvature of spine
- 754.2, Congenital scoliosis
- 756.51, Osteogenesis imperfecta

The secondary diagnoses that will lead to DRG 546 assignment are:

- 737.40, Curvature of spine, unspecified

- 737.41, Curvature of spine associated with other conditions, kyphosis
- 737.42, Curvature of spine associated with other conditions, lordosis
- 737.43, Curvature of spine associated with other conditions, scoliosis

After publication of the FY 2006 IPPS final rule, we received a comment stating that creating new DRG 546 was insufficient to address clinical severity and resource differences among spinal fusion cases that involve fusing multiple levels of the spine. Specifically, the commenter suggested that the spinal fusion DRGs be further modified to incorporate Bone Morphogenic Protein (BMP), code 84.52 (Insertion of recombinant bone morphogenetic protein). The commenter also suggested that CMS apply a clinical severity concept to all back and spine surgical cases similar to the approach that we used for the MCVs to refine the cardiac DRGs in the final rule for FY 2006. The commenter recommended recognizing additional conditions that reflect higher resource needs, regardless of whether they are principal or secondary diagnoses. The commenter also suggested that the spine DRGs be further subdivided based on the use of specific spinal devices such as artificial discs. These changes would entail the creation of 10 new spine DRGs in addition to other changes requested.

Response: We agree that it is important to recognize severity when classifying patients into specific DRGs. In response to recommendations made by MedPAC last year that are discussed in section II.C. of this final rule, we are conducting a comprehensive analysis of the entire DRG system to determine whether to undertake significant reform to better recognize severity of illness. At this time, we believe it is premature to develop a severity adjustment for spine surgeries while we are considering a

more systematic approach to capturing severity of illness across all DRGs. We also believe it would be premature to make revisions to DRG 546 because this DRG was created on October 1, 2005, and we do not yet have data to analyze its impact. Given the number of innovations occurring in spinal surgery over the last several years (for example, artificial spinal disc prostheses, kyphoplasty, and vertebroplasty), we agree that additional analysis of the spine DRGs would be warranted if we were to continue with the current DRG system and not adopt CS DRGs. However, as discussed above, in the FY 2007 IPPS proposed rule, we proposed to develop a severity-adjusted DRG system. For this reason, we are not further researching this issue for FY 2007. However, in the proposed rule, we encouraged commenters to examine the proposed CS DRG system described in section II.C. of the preamble of the proposed rule to determine whether there is a better recognition of severity of illness and resource use in that system.

Comment: One commenter stated that it was premature to consider splitting the spinal fusion DRGs into potentially up to 10 new DRGs at this time. The commenter stated there is a need for additional data analysis prior to recommending new DRGs.

Response: We agree with the commenter that it is premature to consider splitting the spinal fusion DRGs into as many as 10 new DRGs. We will continue to study this area. In the meantime, we will not modify the spinal fusion DRGs for October 1, 2006.

c. CHARITE™ Spinal Disc Replacement Device

CHARITE™ is a prosthetic intervertebral disc. On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease between L4 and S1. On October 1, 2004,

we created new procedure codes for the insertion of spinal disc prostheses (codes 84.60 through 84.69). We provided the DRG assignments for these new codes in Table 6B of the FY 2005 IPPS proposed rule (69 FR 28673). We received comments on the FY 2005 proposed rule recommending that we change the assignments for these codes from DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC) to the DRGs for spinal fusion, DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC) for procedures on the lumbar spine and to DRGs 519 and 520 for procedures on the cervical spine. In the FY 2005 IPPS final rule (69 FR 48938, August 11, 2004), we indicated that DRGs 497 and 498 are limited to spinal fusion procedures. Because the surgery involving the CHARITE™ Artificial Disc is not a spinal fusion, we decided not to include this procedure in these DRGs. However, we stated that we would continue to analyze this issue and solicited further public comments on the DRG assignment for spinal disc prostheses.

In the FY 2006 final rule (70 FR 47353, August 12, 2005), we noted that, if a product meets all of the criteria for Medicare to pay for the product as a new technology under section 1886(d)(5)(K) of the Act, there is a clear preference expressed in the statute for us to assign the technology to a DRG based on similar clinical or anatomical characteristics or costs. However, for FY 2006, we did not find that the CHARITE™ Artificial Disc met the substantial clinical improvement criterion and, thus, did not qualify as a new technology. Consequently, we did not address the DRG classification request made under the authority of this provision of the Act.

However, we did evaluate whether to reassign the CHARITE™ Artificial Disc to different DRGs using the Secretary's authority under section 1886(d)(4) of the Act (70 FR 47308, August 12, 2005). We indicated that we did not have Medicare charge information to evaluate DRG changes for cases involving an implant of a prosthetic intervertebral disc like the CHARITE™ and did not make a change in its DRG assignments. We stated that we would consider whether changes to the DRG assignments for the CHARITE™ Artificial Disc were warranted for FY 2007, once we had information from Medicare's data system that would assist us in evaluating the costs of these patients.

As we discussed in the FY 2007 IPPS proposed rule (71 FR 24036), we received correspondence regarding the DRG assignments for the CHARITE™ Artificial Disc, code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral). The commenter had previously submitted an application for the CHARITE™ Artificial Disc for new technology add-on payments for FY 2006 and had requested a reassignment of cases involving CHARITE™ implantation to DRGs 497 and 498. The commenter asked that we examine claims data for FY 2005 and reassign procedure code 84.65 from DRGs 499 and 500 into DRGs 497 and 498. The commenter again stated the view that cases with the CHARITE™ Artificial Disc reflect comparable resource use and similar clinical indications as do those in DRGs 497 and 498. If CMS were to reject reassignment of the CHARITE™ Artificial Disc to DRGs 497 and 498, the commenter suggested creating two separate DRGs for lumbar disc replacements.

On February 15, 2006, we posted a proposed national coverage determination (NCD) on the CMS Web site seeking public comment on our proposed finding that the evidence is not adequate to conclude that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is reasonable and necessary. The proposed NCD stated that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is generally not indicated in patients over 60 years old. Further, it stated that there is insufficient evidence among either the aged or disabled Medicare population to make a reasonable and necessary determination for coverage. With an NCD pending to make spinal arthroplasty with the CHARITE™ Artificial Disc noncovered, we indicated in the FY 2007 IPPS proposed rule that we did not believe it was appropriate at that time to reassign procedure code 84.65 from DRGs 499 and 500 to DRGs 497 and 498.

. After considering the public comments and additional evidence received, we made a final NCD on May 16, 2006, that Medicare would not cover the CHARITE™ Artificial Disc for the Medicare population over 60 years of age. For Medicare beneficiaries 60 years of age and under, local Medicare contractors have the discretion to determine coverage for lumbar artificial disc replacement procedures involving the CHARITE™ Artificial Disc. The final NCD can be found at: http://www.cms.hhs.gov/mcd/viewncd.asp:ncd_id-150.10&ncd_version1&basket=ncd%3A150%2E10%3A1%3ALumbar+Artificial+Disc+Replacement%280ADR%29.

Comment: Some commenters agreed with our proposed decision not to reassign CHARITE™ Artificial Disc at this time to the spinal fusion DRGs. Other commenters disagreed with our proposal not to move code 84.65 (CHARITE™) from DRGs 499 and

500 to DRGs 497 and 498. One commenter noted that the national noncoverage determination for the CHARITE™ Artificial Disc only applies to patients over 60 years of age. The commenter further noted that local Medicare carriers have the discretion to make coverage decisions for Medicare beneficiaries who are under 60 years of age. The commenter stated that patients who receive the CHARITE™ Artificial Disc are candidates for a fusion procedure involving an anterior surgical approach. The commenter goes on to state that the CHARITE™ Artificial Disc is an alternative therapy to spinal fusion for patients with similar diagnoses. The commenter supplied data from FY 2005 MedPAR file in support of its request for a DRG change. These data included 54 cases that were assigned to DRGs 499 and 500. The 23 cases in DRG 499 had mean charges of $61,750, while the 31 cases assigned to DRG 500 had mean charges of $53,802. These data compare to mean charges of $26,974 for all cases in DRG 499 and $17,731 for all cases in DRG 500. The commenter reported mean charges of $71,581 for DRG 497 and $55,489 for DRG 498. The commenter stated that the 54 CHARITE™ cases are more similar in average charges to all cases in DRGs 497 and 498 than to DRGs 499 and 500.

Response: We agree with the commenter that it is not appropriate to consider a DRG revision at this time for the CHARITE™ Artificial Disc, given the recent decision to limit coverage for surgical procedures involving this device. Although we have reviewed the Medicare charge data, we are concerned that there are a very small number of cases for patients under 60 years of age who have received the CHARITE™ Artificial Disc. We believe it appropriate to base the decision on a DRG change on charge data

only on the population for which the procedure is covered. We have an extremely small number of cases for patients under 60 on which to base such a decision. For this reason, we do not believe it is appropriate to modify the DRGs at this time for CHARITE™ cases.

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

In FYs 2005 and 2006, we considered requests for the creation of a separate DRG for the diagnosis of severe sepsis. Severe sepsis is described by ICD-9-CM code 995.92 (Systemic inflammatory response syndrome due to infection with organ dysfunction). Patients admitted with sepsis as a principal diagnosis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417 (Septicemia Age 0-17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The commenter requested that all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere), be included in this new DRG. In both FY 2005 and FY 2006 (69 FR 48975 and 70 FR 47309), we did not believe the current clinical definition of severe sepsis was specific enough to identify a meaningful cohort of patients in terms of clinical coherence and resource utilization to warrant a separate DRG. Sepsis is found across hundreds of medical and surgical DRGs, and the term "organ dysfunction" implicates numerous currently existing diagnosis codes. While we recognize that Medicare beneficiaries with severe sepsis are quite ill and require extensive hospital resources, in the past we have not found that they can be identified adequately to justify removing them from all of the other DRGs in which they

appear. For this reason, we did not create a new DRG for severe sepsis for FY 2005 or FY 2006. We indicated that we would continue to work with National Center for Health Statistics (NCHS) to improve the codes so that our data on these patients improve. We also indicated that we would continue to examine data on these patients as we consider future modifications.

For the FY 2007 IPPS proposed rule, we again received a request to consider creating a separate DRG for patients diagnosed with severe sepsis (71 FR 24037). The information and data available to us from hospital bills with respect to identifying patients with severe sepsis have not changed since last year. However, the NCHS discussed modifications to the current ICD-9-CM diagnosis codes for systemic inflammatory response syndrome (SIRS), codes 995.91 through 995.94 (which include severe sepsis) at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting. During the meeting, it became clear that there is still confusion surrounding the use of these codes. As a result of the meeting and the comments received, the Committee made modifications to the set of SIRS codes. These modifications are reflected in Table 6E, Revised Diagnosis Code Titles, of the Addendum to this final rule.

We believe that implementation of the modified SIRS diagnosis codes and the updated coding guidelines over the next year could begin the process of improving data for this group of patients. The desired outcome is to be able to better evaluate Medicare beneficiaries with severe sepsis with regard to their clinical coherence, resource

utilization, and charges. Therefore, in the FY 2007 IPPS proposed rule, we did not propose to create a new DRG for severe sepsis for FY 2007.

Comment: Numerous commenters asked for changes to the current sepsis classification. The commenters agreed that coding of systemic inflammatory response syndrome (SIRS), sepsis, septicemia, severe sepsis, and septic shock has been confusing to the provider community in the last few years. Specifically, one commenter stated coding guidelines have been revised based on clinical definitions, which in turn has affected the DRG classification for sepsis. Another commenter referenced the ICD-9-CM Code Book tabular section and the American Hospital Association's (AHA) fourth quarter (4Q) 2003 Coding Clinic, "for patients with severe sepsis, the code for the systemic infection (038.x) or trauma should be sequenced first, followed by either code 995.92 (Systemic Inflammatory Response Syndrome due to infectious process with organ dysfunction) or code 995.94 (Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction). Codes for the specific organ dysfunction should also be assigned." The commenter stated that as a result of this coding guideline, respiratory failure cannot be sequenced as the principal diagnosis because it is considered an organ dysfunction of the patient's sepsis. However, reverting sequencing instructions would be confusing and again disrupt the data according to some of the commenters. As a result, many commenters stated that a new DRG for severe sepsis is not appropriate due to the inconsistent data.

Response: We agree that there has been a great deal of confusion in the coding and sequencing of cases with severe sepsis and SIRS. The commenters are correct that

the coding directives lead cases with severe sepsis that are on mechanical ventilation for respiratory failure to be assigned to DRG 416 (Septicemia Age >17) and DRG 417 (Septicemia Age 0-17) instead of DRG 475 (Respiratory System Diagnosis with Ventilator Support). As stated in the proposed rule, we have continued to work with NCHS to improve the codes so that our data on these patients improve. We believe that implementation of the modified SIRS diagnosis codes and the updated coding guidelines over the next year will further improve the coding of this subset of patients.

Comment: One commenter presented its analysis of the MedPAR data and again requested the creation of two new DRGS for severe sepsis, one medical and one surgical. The other option suggested by the commenter was to split DRGs 415 and 416 into DRGs with and without severe sepsis cases. The commenter expressed concern that, while there has been some confusion over the use of the SIRS family of codes (995.90 – 995.94) over the past three years, the confusion has been mainly associated with the other codes and not the severe sepsis code (995.92). The commenter provided information concerning the definition of severe sepsis and its adoption following a 1992 consensus panel of the American College of Chest Physicians and the Society of Critical Care Medicine. According to the commenter, the panel defined severe sepsis as a systemic inflammatory response to infection that leads to acute organ dysfunction. The commenter noted this definition has been used successfully to identify thousands of patients with severe sepsis and in more than 30 large-scale clinical trials. The commenter also stated severe sepsis cases are clinically coherent with a common underlying problem (SIRS) leading to complications (acute organ dysfunction) and are managed similarly, receiving advanced

life support in intensive care units. The commenter also provided examples to demonstrate how clinical coherence leads to resource use coherence.

Response: We appreciate the commenter's analysis of the data. As stated above, there has been significant confusion over the use of the sepsis codes. While the definition may be well understood among the individuals involved with the clinical trials, there has been uncertainty in the application of the codes as evidenced by repeated discussions at the ICD-9-CM Coordination and Maintenance Committee meetings and comments received in response to the proposed rule. We note that the National Center for Health Statistics has revised the sepsis and systemic inflammatory response syndrome codes in response to suggestions made at the Committee meetings. These revisions are shown in Table 6E of the Addendum to this final rule and will go into effect on October 1, 2006 (codes 995.91 through 995.94). We did not propose a new DRG for severe sepsis for FY 2007 in the proposed rule due to the data inconsistencies and difficulty expressed with properly assigning the sepsis codes, among other reasons cited previously.

In the FY 2007 IPPS proposed rule, we also solicited comments on the proposal we were considering to adopt a CS DRG system. We noted it is possible that the proposed system would better recognize the extensive resources that hospitals use to treat patients with severe sepsis. We encouraged commenters to examine the proposed system and provide comments. The comments and responses on this proposal are discussed in section II.C of this final rule.

Therefore, in this FY 2007 final rule we are not creating new DRGs for medical or surgical severe sepsis cases as requested by the commenter.

6. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of this preamble, 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), discharge status, and demographic information go 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 2007, we proposed to make several changes to the MCE edits (71 FR 24038 and 24039). We received one comment on this topic. As a result of new and modified codes approved after the annual spring ICD-9-CM Coordination and Maintenance meeting, we make changes to the MCE. In the past, in both the IPPS proposed and final rules, we only provided the list of changes to the MCE in the IPPS that were brought to our attention after the prior year's final rule. We historically have not listed the changes we have made to the MCE as a result of the new and modified codes approved after the annual spring ICD-9-CM Coordination and Maintenance meeting. These changes are approved too late in the rulemaking schedule for inclusion in the proposed rule. Furthermore, although our MCE policies have been described in our proposed and final rules, we have not provided the detail of each new or modified diagnosis and procedure code edit in the final rule. However, in response to a public comment and in the interest of making the IPPS more transparent, we are including in this final rule a comprehensive list of all the changes to the MCE edits for the next fiscal year as a result of coding changes.

a. Edit: Newborn Diagnoses

We proposed to add code 780.92 (Excessive crying of infant (baby)) to the "Newborn Diagnoses" edit in the MCE. This edit is structured for patients with an age of "0". In the Tabular portion of the ICD-9-CM diagnosis codes, the "excludes" note at code 780.92 states that this code "excludes excessive crying of child, adolescent or adult" and sends the coder to code 780.95 (Other excessive crying. (The new title of this code, shown on Table 6E of the Addendum to this final rule is "Excessive crying of child, adolescent, or adult".) To make a conforming change, we also proposed that code 780.92 be removed from the "Pediatric Diagnoses--Age 0 Through 17" edit.

We did not receive any public comments on the proposed edit and, therefore, are adopting it as final.

In addition, there were diagnosis codes discussed at the March 2006 ICD-9-CM Coordination and Maintenance meeting that were approved too late in the rulemaking schedule for inclusion in the proposed rule. Therefore, the following ICD-9-CM diagnosis codes are added to the Newborn Diagnosis" MCE edit for FY 2007:

- 768.7, Hypoxic-ischemic encephalopathy (HIE)
- 770.87, Respiratory arrest of newborn
- 770.88, Hypoxemia of newborn
- 775.81, Other acidosis of newborn
- 775.89, Other neonatal endocrine and metabolic disturbances
- 779.85, Cardiac arrest of newborn

Because diagnosis code 775.8 (Other transitory neonatal endocrine and metabolic disturbances) was expanded to the fifth-digit level, this code is being deleted from the Newborn Diagnosis edit.

b. Edit: Diagnoses for Pediatric – Age 0-17 Years Old

We are adding the following new diagnosis codes to the edit for diagnosis for pediatrics--age 0-17 years old:

- V85.51, Body Mass Index, pediatric, less than 5th percentile for age
- V85.52, Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age
- V85.53, Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
- V85.54, Body Mass Index, pediatric, greater than or equal to 95th percentile for age

c. Edit: Maternity Diagnoses – Age 12 through 55

We are adding the following new codes to the edit for maternity diagnoses - age 12 through 55:

- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.01, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.02, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication

- 649.03, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.04, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.11, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.12, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.13, Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.14, Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.21, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.22, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.23, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

- 649.24, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.31, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.32, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.33, Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.34, Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.41, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.42, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.43, Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.44, Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication

- 649.50, Spotting complicating pregnancy unspecified as to episode of care or not applicable
- 649.51, Spotting complicating pregnancy delivered, with or without mention of antepartum condition
- 649.53, Spotting complicating pregnancy antepartum condition or complication
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 649.61, Uterine size date discrepancy, delivered, with or without mention of antepartum condition
- 649.62, Uterine size date discrepancy, delivered, with mention of postpartum complication
- 649.63, Uterine size date discrepancy, antepartum condition or complication
- 649.64, Uterine size date discrepancy, postpartum condition or complication

d. Edit: Diagnoses Allowed for Females Only

The following codes are now invalid codes, as shown in Table 6C of the Addendum to the FY 2007 IPPS proposed rule and this final rule. In the FY 2007 IPPS proposed rule, we proposed to remove them from the "Diagnosis Allowed for Females Only" edit in the MCE.

- 616.8, Other specified inflammatory diseases of cervix, vagina, and vulva
- 629.8, Other specified disorders of female genital organs

Codes 616.8 and 629.8 have been expanded to the fifth-digit level. Therefore, we proposed to place the following expanded codes in the "Diagnoses Allowed for Females Only" edit.

- 616.81, Mucositis (ulcerative) of cervix, vagina, and vulva
- 616.89, Other inflammatory disease of cervix, vagina, and vulva
- 629.81, Habitual aborter without current pregnancy
- 629.89, Other specified disorders of female genital organs

The following two codes have revised descriptions (as shown in Table 6E of the Addendum to this final rule) which specify gender. Therefore, we proposed to add them to "Diagnoses Allowed for Females Only" edit.

- V26.31, Testing of female for genetic disease carrier status
- V26.32, Other genetic testing of female

We did not receive any public comments on the proposed changes to this edit. Therefore, we are adopting the changes as final.

In addition, we are adding the following new ICD-9-CM codes to this edit:

- 618.84, Cervical stump prolapse
- 629.29, Other female genital mutilation status
- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.01, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition

- 649.02, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.03, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.04, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.11, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.12, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.13, Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.14, Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.21, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.22, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication

- 649.23, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.24, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.31, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.32, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.33, Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.34, Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.41, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.42, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.43, Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication

- 649.44, Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.50, Spotting complicating pregnancy unspecified as to episode of care or not applicable
- 649.51, Spotting complicating pregnancy delivered, with or without mention of antepartum condition
- 649.53, Spotting complicating pregnancy antepartum condition or complication
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 649.61, Uterine size date discrepancy, delivered, with or without mention of antepartum condition
- 649.62, Uterine size date discrepancy, delivered, with mention of postpartum complication
- 649.63, Uterine size date discrepancy, antepartum condition or complication
- 649.64, Uterine size date discrepancy, postpartum condition or complication
- 795.06, Papanicolaou smear of cervix with cytologic evidence of malignancy
- 795.82, Elevated cancer antigen 125 [CA 125]

e. Edit: Diagnoses Allowed for Males Only

Code 608.2 (Torsion of testis) is now an invalid code (as shown in Table 6C of the Addendum to the proposed rule and this final rule). Therefore, we proposed to remove it from the "Diagnoses Allowed for Males Only" edit. This code has been

expanded to the fifth-digit level. We proposed to place the following expanded codes in the "Diagnoses Allowed for Males Only" edit:

- 608.20, Torsion of testis, unspecified
- 608.21, Extravaginal torsion of spermatic cord
- 608.22 Intravaginal torsion of spermatic cord
- 608.23, Torsion of appendix testis
- 608.24, Torsion of appendix epididymis

The following codes have been created effective for FY 2007 and are gender specific. Therefore, we proposed to add them to the "Diagnosis Allowed for Males Only" edit.

- V26.34, Testing of male for genetic disease carrier status
- V26.35, Encounter for testing of male partner of habitual aborter
- V26.39, Other genetic testing of male

We did not receive any public comments on our proposed changes to this edit. Therefore, we are adopting the changes as final.

f. Edit: Procedures Allowed for Females Only

The following new codes are added to the list of female procedures:

- 68.41, Laparoscopic total abdominal hysterectomy
- 68.49, Other and unspecified total abdominal hysterectomy
- 68.61, Laparoscopic radical abdominal hysterectomy
- 68.69, Other and unspecified radical abdominal hysterectomy
- 68.71, Laparoscopic radical vaginal hysterectomy [LRVH]

- 68.79, Other and unspecified radical vaginal hysterectomy

In addition, the following codes were expanded to the fourth digit and, therefore, are removed from this edit:

- 68.4, Total abdominal hysterectomy
- 68.6, Radical abdominal hysterectomy
- 68.7, Radical vaginal hysterectomy

g. Edit: Manifestations Not Allowed as Principal Diagnosis

We proposed to add the following codes to the "Manifestations Not Allowed as Principal Diagnosis" edit in the MCE:

- 362.03, Nonproliferative diabetic retinopathy, NOS
- 362.04, Mild nonproliferative diabetic retinopathy
- 362.05, Moderate nonproliferative diabetic retinopathy
- 362.06, Severe nonproliferative diabetic retinopathy
- 362.07, Diabetic macular edema.

We did not receive any public comments concerning this proposed change. Therefore, we are adopting the above proposed changes as final.

In addition, we are adding the following new codes to this edit:

- 284.2, Myelophthisis
- 289.83, Myelofibrosis
- 323.01, Encephalitis and encephalomyelitis in viral diseases classified elsewhere
- 323.02, Myelitis in viral diseases classified elsewhere

- 323.41, Other encephalitis and encephalomyelitis due to infection classified elsewhere
- 323.42, Other myelitis due to infection classified elsewhere
- 323.61, Infectious acute disseminated encephalomyelitis (ADEM)
- 323.62, Other postinfectious encephalitis and encephalomyelitis
- 323.63, Postinfectious myelitis
- 323.71, Toxic encephalitis and encephalomyelitis
- 323.72, Toxic myelitis
- 341.21, Acute (transverse) myelitis in conditions classified elsewhere

The following codes have been expanded to the fifth-digit level of specificity, which results in making the four-digit code invalid. Therefore, these codes are removed from the manifestation edit:

- 323.0, Encephalitis in viral diseases classified elsewhere
- 323.4, Other encephalitis due to infection classified elsewhere
- 323.6, Postinfectious encephalitis
- 323.7, Toxic encephalitis

In the proposed rule, we had suggested we would remove code 525.10 (Acquired absence of teeth, unspecified) from this edit in the MCE. However, all codes in subcategory 525.1 (Loss of teeth due to trauma, extraction, or periodontal disease) are considered manifestation codes. Therefore, we are retracting this proposal, and are leaving code 525.10 in this edit.

h. Edit: Nonspecific Principal Diagnosis

We proposed to add the following codes to the "Nonspecific Principal Diagnosis" edit in the MCE:

- 255.10, Hyperaldosteronism, unspecified
- 323.9, Unspecified causes of encephalitis, myelitis, and encephalomyelitis
- 770.10, Fetal and newborn aspiration, unspecified.
- 780.31, Febrile convulsions (simple), unspecified

Codes 255.10, 323.9, and 780.31 appear on Table 6E, Revised Diagnosis Codes, and are being included in this edit because of their revised descriptions. Code 770.10 was inadvertently left off this list for FY 2006 when the code was created.

We did not receive any public comments on the proposed changes to this edit. Therefore, we are adopting the proposed changes as final. In addition, we are adding the following codes to this edit:

- 238.75, Myelodysplastic syndrome, unspecified
- 276.50, Volume depletion NOS
- 277.30, Amyloidosis, unspecified
- 288.00, Neutropenia, unspecified
- 288.50, Leukocytopenia, unspecified
- 288.60, Leukocytosis, unspecified
- 341.20, Acute (transverse) myelitis NOS
- 379.60, Inflammation (infection) of postprocedural bleb, unspecified
- 523.30, Aggressive periodontitis, unspecified
- 523.40, Chronic periodontitis, unspecified

- 525.60, Unspecified unsatisfactory restoration of tooth
- 528.00, Stomatitis and mucositis, unspecified
- 608.20, Torsion of testis, unspecified
- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.50, Spotting complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 958.90, Compartment syndrome, unspecified
- 995.20, Unspecified adverse effect of unspecified drug, medicinal and biological substance
- 995.22, Unspecified adverse effect of anesthesia
- 995.23, Unspecified adverse effect of insulin

- 995.29, Unspecified adverse effect of other drug, medicinal and biological substance

We are removing the following codes from this edit:

- 362.03, Nonproliferative diabetic retinopathy NOS
- 525.10, Acquired absence of teeth, unspecified
- 793.9, Other nonspecific abnormal findings on radiological and other examinations of body structure

Comment: Two commenters suggested that the expanded code (793.99, Other nonspecific abnormal findings on radiological and other examinations of body structure) be added back into this edit.

Response: We will not act on those suggestions at this time, as we believe that code 739.9 should not originally have been in the edit as it is more like an "other" code than a "nonspecific" code.

i. Edit: Unacceptable Principal Diagnosis

Most V-codes describe an individual's health status, but these codes are not usually a current illness or injury. Therefore, most V-codes are included in the "Unacceptable Principal Diagnosis" edit. The following codes became invalid (as shown in Table 6C of the Addendum to the proposed rule and this final rule) for FY 2007, and we proposed to remove them from this edit:

- V18.5, Family history, digestive disorders
- V58.3, Attention to surgical dressings and sutures
- V72.1, Examination of ears and hearing

The following V-codes represent either fifth-digit extensions of the above codes, or new codes that were created effective October 1, 2006 (Table 6A of the Addendum to the proposed rule and this final rule). Therefore, we proposed to add the following codes to the "Unacceptable Principal Diagnosis" edit:

- V18.51, Family history, colonic polyps
- V18.59, Family history, other digestive disorders
- V26.34, Testing of male for genetic disease carrier status
- V26.35, Encounter for testing of male partner of habitual aborter
- V26.39, Other genetic testing of male
- V45.86, Bariatric surgery status
- V58.30, Encounter for change or removal of nonsurgical wound dressing
- V58.31, Encounter for change or removal of surgical wound dressing
- V58.32, Encounter for removal of sutures
- V72.11, Encounter for hearing examination following failed hearing screening
- V72.19, Other examination of ears and hearing
- V82.71, Screening for genetic disease carrier status
- V82.79, Other genetic screening
- V85.51, Body mass index, pediatric, less than 5th percentile for age
- V85.52, Body mass index, pediatric, 5th percentile to less than 85th percentile for age
- V85.53, Body mass index, pediatric, 85th percentile to less than 95th percentile for age

- V85.54, Body mass index, pediatric, greater than or equal to 95th percentile for age
- V86.0, Estrogen receptor positive status [ER+]
- V86.1, Estrogen receptor negative status [ER-]

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

j. Edit: Nonspecific O.R. Procedures

We proposed to remove code 00.29 (Intravascular imaging unspecified vessel(s)) from the "Nonspecific O.R. Procedure" edit in the MCE. This code was erroneously placed in this edit; it is not considered an O.R. procedure.

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

In addition, we are removing code 68.39 (Other subtotal abdominal hysterectomy) from this edit. Code 68.39 is not a nonspecific code, it is considered other, and was originally included in this edit in error.

k. Edit: Noncovered Procedures

Under the proposed changes to DRG 513 (Pancreas Transplant) under the Pre-MDCs described in section II.D.1.of the preamble of the FY 2007 IPPS proposed rule, a patient must have a history of medically uncontrollable, insulin-dependent diabetes mellitus, that is, Type I diabetes mellitus. Therefore, to conform the "Noncovered Procedures" Edit in the MCE to these proposed changes, we proposed to revise Diagnosis List 1 in this edit to include only the following codes:

- 250.01, Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
- 250.03, Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled
- 250.11, Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled
- 250.13, Diabetes with ketoacidosis, type I [juvenile type], uncontrolled
- 250.21, Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled
- 250.23, Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled
- 250.31, Diabetes with other coma, type I [juvenile type], not stated as uncontrolled
- 250.33, Diabetes with other coma, type I [juvenile type], uncontrolled
- 250.41, Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled
- 250.43, Diabetes with renal manifestations, type I [juvenile type], uncontrolled
- 250.51, Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled
- 250.53, Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled
- 250.61, Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled

- 250.63, Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
- 250.71, Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled
- 250.73, Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled
- 250.81, Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled
- 250.83, Diabetes with other specified manifestations, type I [juvenile type], uncontrolled
- 250.91, Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled
- 250.93, Diabetes with unspecified complication, type I [juvenile type], uncontrolled

In addition, we proposed to remove Diagnosis List 2 from the "Noncovered Procedures" edit, which is comprised of the following codes:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease

- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease
- 585.1, Chronic kidney disease, Stage I
- 585.2, Chronic kidney disease, Stage II (mild)
- 585.3, Chronic kidney disease, Stage III (moderate)
- 585.4, Chronic kidney disease, Stage IV (severe)
- 585.5, Chronic kidney disease, Stage V
- 585.6, End stage renal disease
- 585.9, Chronic kidney disease, unspecified
- V42.0, Organ or tissue replaced by transplant, kidney
- V43.89, Organ or tissue replaced by other means, other organ or tissue, other

All of the comments we received regarding this proposal were favorable. Therefore, we are adopting the above changes as final.

Lumbar Artificial Disc: CMS has found that lumbar artificial disc replacement (LADR) with the Charite™ lumbar artificial disc is not reasonable and necessary for the Medicare population over 60 years of age. Therefore, we issued a national noncoverage determination for LADR with the Charite™ lumbar artificial disc for Medicare patients over 60 years of age. For Medicare beneficiaries 60 years of age and under, there is no national coverage determination, leaving such determinations to be made on a local basis. The coverage decision memo can be viewed on the CMS Web site at http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=170.

To conform to this decision, procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is put on the Non-Covered Procedure edit except when the patient is 60 years of age or less. The logic will be as follows:

84.65, Insertion of total spinal disc prosthesis, lumbosacral

AND

Age <=61

l. Edit: Bilateral Procedure

We proposed to remove the following codes from the Bilateral Procedure edit, as these are adjunct codes. They are not O.R. codes recognized by the GROUPER as procedures, and the edit was created in error last year.

- 00.74, Hip replacement bearing surface, metal-on-polyethylene
- 00.75, Hip replacement bearing surface, metal-on-metal
- 00.76, Hip replacement bearing surface, ceramic-on-ceramic

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

In addition, we are deleting the following joint revision codes from this edit, as they should not have been added last year.

- 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
- 00.81, 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 total knee replacement, tibial insert (liner)
- 81.53, Revision of hip replacement not otherwise specified
- 81.55, Revision of knee replacement not otherwise specified

7. 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 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 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 DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of 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 DRGs. For example, in MDC 11, the surgical class "kidney transplant" consists of a single DRG (DRG 302) and the class "kidney, ureter and major bladder procedures" consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of 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 DRG in the class by frequency (that is, by the number of cases in the 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 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 DRG or 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.

Based on the preliminary recalibration of the DRGs, in the FY 2007 IPPS proposed rule (71 FR 24039), we proposed to revise the surgical hierarchy for Pre-MDCs, MDC 1 (Diseases and Disorders of the Nervous System), MDC 2 (Diseases

and Disorders of the Eye), MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat), MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), and MDC 13 (Diseases and Disorders of the Female Reproductive System) as follows:

In Pre-MDCs, we proposed to reorder DRG 481 (Bone Marrow Transplant) above DRG 513 (Pancreas Transplant).

In MDC 1, we proposed to reorder DRGs 531-532 (Spinal Procedures, With CC and Without CC, respectively) above DRGs 529-530 (Ventricular Shunt Procedures, With CC and Without CC, respectively).

In MDC 2, we proposed to reorder DRG 42 (Intraocular Procedures Except Retina, Iris and Lens) above DRG 36 (Retinal Procedures).

In MDC 3, we proposed to reorder DRGs 168-169 (Mouth Procedures, With CC and Without CC, respectively) above DRG 57 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age > 17) and DRG 58 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age 0-17).

In MDC 8, we proposed to reorder DRG 213 (Amputation for Musculoskeletal System and Connective Tissue Disorders) above DRG 216 (Biopsies of Musculoskeletal System and Connective Tissue).

In MDC 10, we proposed to reorder DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Diseases and Disorders) above DRG 288 (O.R. Procedures for Obesity).

In MDC 13, we proposed to reorder DRG 363 (D&C, Conization and Radio-Implant, for Malignancy) and DRG 364 (D&C, Conization and Radio-Implant, Except for Malignancy) above DRG 360 (Vagina, Cervix, and Vulva Procedures).

We did not receive any public comments on the proposed changes to the surgical hierarchy described above. Based on a test of the proposed revisions using the March 2006 update of the FY 2005 MedPAR file and the revised GROUPER software, we found that the revisions are still supported by the data. Therefore, we are incorporating these proposed revisions to the surgical hierarchy as final for FY 2007. In addition, because, in this final rule, we are deleting 8 DRGs and creating 20 new DRGs as discussed under section II.D.7. of this preamble, we are reordering the following DRGs in MDC 1 (Diseases and disorders of the Nervous System), MDC 6 (Diseases and Disorders of the Digestive System), MDC 11 (Diseases and Disorders of the Kidney and urinary Tract), and MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)):

- In MDC 1, we are reordering DRG 577 (Carotid Artery Stent Procedure) above DRG 533 (Extracranial Procedures With CC).
- In MDC 6, we are reordering DRGs 567 and 568 (Stomach, Esophageal and Duodenal Procedures Age >17 With CC With and Without Major GI Diagnoses, respectively) above DRG 155 (Stomach, Esophageal and Duodenal Procedures Age >17 Without CC);

- In MDC 6, we are reordering DRGs 569-570 (Major Small and Large Bowel Procedures With CC With and Without Major GI Diagnoses, respectively) above DRG 149 (Major Small and Large Bowel Procedures Without CC).
- In MDC 11, we are reordering DRG 573 (Major Bladder Procedures) above DRG 303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm).
- In MDC 18, we are reordering DRG 578 (Infections and Parasite Diseases With O.R. Procedure) above DRG 579 (Postoperative or Post-Traumatic Infections With O.R. Procedure).

8. Refinement of Complications and Comorbidities (CC) List

a. Background

As indicated earlier in this preamble, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered complications or comorbidities (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.

b. Comprehensive Review of the CC List

In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list, but we have never conducted a comprehensive review of the list. Given the long period of time that had elapsed since the original CC list was developed, the incremental nature of changes to it, and changes in the way inpatient care is delivered, and in partial response to recommendations in MedPAC's March 2005 Report to Congress on Physician-Owned Specialty Hospitals, for the FY 2006 IPPS final rule, we reviewed the 121-paired DRGs that were split on the presence or absence of a CC among the 3,285 diagnosis codes on the CC list. We presented the results of that review and summarized public comments that we received in the FY 2006 proposed rule on the review results in the FY 2006 IPPS final rule (70 FR 47313 through 47315). Further analysis of the CC list and refinement to

recognize the effects of differences in severity of illness among patients is discussed in section II.C. of the preamble of the proposed rule as part of our efforts to develop a CS DRG system for use in the IPPS.

During this past winter, CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Although we did not complete this review because of the work we did to develop the CS DRGs, we are considering whether to continue our analysis of the CC list as part of an effort to develop and adopt a severity DRG system that is in the public domain for FY 2008. As we explained in more detail above, we may update the work we did to develop a severity DRG system in the mid-1990's that classified patients into a base DRG that was further subdivided based on three levels of severity depending upon whether the patient had no CC, a CC, or a major CC in conjunction with continuing our review of the CC list.

c. CC Exclusions List for FY 2007

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. We did not propose to delete any of the diagnosis codes on the CC list for FY 2007.

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.[17]

As we proposed, 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, 2006. (See section II.D.10. of this preamble 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.

Tables 6G and 6H in the Addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 2006. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G--Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H--Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented

[17] 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; and the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 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.

diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $152.50 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88-133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553-6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, and 2006) and those in Tables 6G and 6H of this final rule for FY 2007 must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2006. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD-9-CM codes for FY 2000.)

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 23.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 24.0 of this manual, which will include the final FY 2007 DRG changes, will be available in hard

copy for $250.00. Version 24.0 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.

9. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 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. DRG 476 is 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 DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[18]

For FY 2007, we did not propose to change the procedures assigned among these DRGs. We did not receive any comments on our proposal and, therefore, are adopting it as final.

a. Moving Procedure Codes from DRG 468 or DRG 477 to MDCs

We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to

[18]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.

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. Based on this year's review, as proposed, we are not removing any procedures from DRG 477 with assignment to one of the surgical DRGs. We did not receive any comments on our proposal, and, therefore, there will be no change to DRG 477.

However, we did receive a comment regarding DRG 468 after the publication of the proposed rule. The comment addressed advances in treatment technology for hypertension and noted that two procedure codes cause cases to be assigned to DRG 468 instead of more appropriately to DRGs in MDC 5. Therefore, we are moving the following two codes into MDC 5, DRG 479 (Other Vascular Procedures without CC), and paired DRGs 553 and 554 (Other Vascular Procedures with CC with and without Major CV Diagnosis, respectively):

- 04.92, Implantation or replacement of peripheral neurostimulator lead(s)
- 86.96, Insertion or replacement of other neurostimulator pulse generator

b. Reassignment of Procedures among DRGs 468, 476, and 477

We also annually review the list of ICD-9-CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476,

and 477, to ascertain if 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.

We did not propose to move any procedure codes from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476 for FY 2007. We did not receive any public comments on our proposal and; therefore, are adopting it as final.

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 2007. We did not receive any public comments on our proposal and, therefore, are adopting it as final.

10. Changes to the ICD-9-CM Coding System

As described in section II.B.1. of this preamble, 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 $25.00 by calling (202) 512-1800.) 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 2007 at a public meeting held on September 29-30, 2005, and finalized the coding changes after consideration of comments received at the meetings and in writing by December 2, 2005. Those coding changes were announced in the FY 2007 IPPS proposed rule and are listed in Tables 6A through 6F in the Addendum to this final rule. The Committee held its 2006 meeting on March 23-24, 2006. Proposed new codes for which there was a consensus of public support and for which complete tabular and indexing changes can be made by May 2006 will be included in the October 1, 2006 update to ICD-9-CM. Code revisions that were discussed at the March 23-24, 2006 Committee meeting could not be finalized in time to include them in the FY 2007 IPPS proposed rule. These additional codes 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 29-30, 2005 meeting can be obtained from the CMS Web site: http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. The minutes of the diagnosis codes discussions at the September 29-30, 2005 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, 2006. 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 proposed 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 2007 IPPS proposed rule, we only solicited comments on the proposed classification of these new codes.

Comment: One commenter expressed concern about the DRG assignment for codes 629.81 (Habitual aborter without current pregnancy) and 629.89 (Other specified disorders of female genital organs). The commenter indicated that CMS proposed to

assign both codes to DRG 368 (Infections, Female Reproductive System) within MDC 18. The commenter posited that CMS may have erred in listing the DRG assignment as DRG 368 and instead intended to assign the code to DRG 369 (Menstrual and Other Female Reproductive System Disorders) since these conditions are not infections.

Response: We agree with the commenter that codes 629.81 and 629.89 do not represent infections and should not be assigned to DRG 368 within MDC 18. They should instead be assigned to DRG 369 as the commenter suggested. Therefore, we are changing the DRG assignment for codes 629.81 and 629.89 from DRG 368 to DRG 369. This change is shown in Table 6A of the Addendum to this final rule.

Comment: One commenter asked whether the footnotes for codes 995.20 through 995.29 in Table 6A of the Addendum to the proposed rule was in error. The commenter stated that the predecessor code, 995.2 (Unspecified adverse effect of drug, medicinal and biological substance) is considered a secondary diagnosis of a "major problem" diagnosis that will assign a patient to DRGs 387 (Prematurity with Major Problems) and DRG 389 (Full-Term Neonate with Major Problems) when present only as a secondary diagnosis. However, the commenter added, the footnote on the expanded codes 995.20 through 995.29 lists them as principal or secondary diagnoses that will assign a patient to DRGs 387 and 389 for neonates with major problems. The specific codes are as follows:

- 995.20 (Unspecified adverse effect of unspecified drug, medicinal and biological substance)
- 995.21 (Arthus phenomenon)

- 995.22 (Unspecified adverse effect of anesthesia)
- 995.23 (Unspecified adverse effect of insulin)
- 995.27 (Other drug allergy)
- 995.29 (Unspecified adverse effect of other drug, medicinal and biological substance)

Response: The commenter is correct that we made an error in the footnote. The predecessor code 995.2 when present as a secondary diagnosis, will be a major problem that assigns the patient to DRGs 387 and 389. The footnote should have indicated codes 995.20 through 995.29 will only assign patients DRGs 387 and 389 when present as a secondary diagnosis. We have corrected the footnote in Table 6A of the Addendum to this final rule.

For codes that have been replaced by new or expanded codes, 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, 2006. 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, 2006. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2007.

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 April meeting as part of the code revisions effective the following October. As stated previously, ICD-9-CM codes discussed at the March 23-24, 2006 Committee meeting that received consensus and that were finalized by May 2006, are included in Tables 6A through 6F of the Addendum to this final rule.

Section 503(a) of Pub. L. 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 in 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 capture the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to capture 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 publicized on CMS and NCHS Web pages 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 Pub. L. 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 for an expedited April l, 2006 implementation of an ICD-9-CM code at the September 29-30, 2005 Committee meeting. Therefore, there were no new ICD-9-CM codes implemented on April 1, 2006.

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 capture 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 page at: 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 page at: 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. This mapping was specified by section 1886(d)(5)(K)(vii) of the Act as added by section 503(a) of Pub. L. 108-173. 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.

Comment: Many commenters recommended that the Secretary use the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously. Several commenters indicated that the April 2005 ICD-9-CM Coordination and Maintenance Committee meeting included discussions of limiting the creation of new procedure codes in order to allow the classification system to last at least 2 more years. ICD-9-CM procedure code categories 00 and 17 were created to identify a diverse group of procedures and interventions affecting all body systems. The commenters stressed that the establishment of these code categories represented a deviation from the normal structure of ICD-9-CM and was a stopgap measure to accommodate new technology when there are no other codes available in the corresponding body system chapters (for example, musculoskeletal system and circulatory system). The commenters indicated that category 00 is now full, and the ICD-9-CM Coordination and Maintenance

Committee is considering proposals for codes in category 17. The commenters stated that at the April Coordination and Maintenance meeting a proposal was presented that would in effect leave only 80 codes available in the new category 17. The commenters stated that in recent years, as many as 50 new procedure codes have been created in a single year. The commenters strongly recommended that the Secretary use the regulatory process to implement ICD-10-CM and ICD-10-PCS in place of ICD-9-CM expeditiously.

Several commenters indicated that limitations with ICD-9-CM make data collected with these codes less precise. The commenters stated that systems such as the CS DRGs could make use of the more detailed information in ICD-10-CM and ICD-10-PCS to group claims more accurately and better identify differences in severity and complexity. Similar comments were received from a number of other individuals.

Response: We agree that it is important to have an accurate and precise coding system. The Department will continue to study whether to adopt ICD-10-CM. In the interim, we continue to update both ICD-9-CM and ICD-10-PCS.

Comment: A number of commenters expressed concern that only nine diagnosis codes and six procedure codes are processed by Medicare. 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 procedures 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 to process codes beyond the first nine diagnosis

codes and six procedure codes. The commenters indicated that complex classification systems such as the proposed CS DRGs could make use of the information in these additional codes to better classify the patients.

One commenter stated that an incremental step in working towards a refined DRG system is to have CMS systems process 25 diagnosis and procedure codes.

Response: The commenters are correct that CMS does not process codes submitted electronically on the 837i electronic format beyond the first 9 diagnosis codes and first 6 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 many diagnosis and procedure codes.

As suggested by the commenters, 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 contemplated 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 move forward with this recommendation without carefully evaluating implementation issues. We will continue to carefully evaluate this request to expand the process capacity of our systems.

Comment: One commenter expressed concern about the process involved with updating the ICD-9-CM Coding Guidelines. The guidelines are updated by the cooperating parties of ICD-9-CM, including representatives from the Centers for Disease

and Prevention Control (CDC), CMS, the AHA, and the AHIMA. The commenter complimented CMS staff for becoming more "provider friendly" and using such tools as the open door forum to involve providers in policy discussions. The commenter requested that some of the coding guideline discussions be held in an open meeting so that providers could give input.

Response: We agree with the commenter that it is important to involve the provider community in activities involving the updating of ICD-9-CM codes and guidelines. The Department utilizes the ICD-9-CM Coordination and Maintenance Committee to discuss proposed changes to the coding system. At times, this Committee also addresses coding guidelines that affect code selection. The current process of approving new and revised coding guidelines involves approval by all four cooperating parties. It is our understanding that AHA and AHIMA actively seek input from their members on coding issues. AHA and AHIMA use this input when they are voting on coding issue to be published in the AHA's Coding Clinic for ICD-9-CM and on coding guidelines. We will refer these concerns to the cooperating parties so that they may discuss improvements which could be made in obtaining providers' input into coding guidelines. We will also welcome recommendations on specific coding guideline issues that providers wish to be included in future agendas of the ICD-9-CM Coordination and Maintenance Committee. The Committee recently discussed coding guidelines for septicemia. We will continue to work with the provider community to offer a public forum for discussion of ICD-9-CM code revisions and guidelines.

11. Other Issues

a. Chronic Kidney Disease

Comment: Two commenters expressed concern regarding the revised diagnosis codes for chronic kidney disease and their DRG assignments which appeared in Table 6E of the Addendum to the proposed rule. The following codes were identified as being classified to DRGs 331, 332, and 333 (Other kidney and urinary tract diagnoses with and without CC, and age 0-17, respectively) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract):

- 403.00 (Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified)
- 403.10 (Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified)
- 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified)

The commenters stated that revisions made to these three codes will go into effect October 1. These changes would add the concept of chronic kidney disease to the three codes. Therefore, these three codes should be assigned to the same DRGs as other codes for chronic kidney disease. The codes with chronic kidney disease are assigned to DRGs 315 (Other kidney and urinary tract procedures) and 316 (Renal failure) and not to DRGs 331 through 333 where they were proposed.

Response: The commenters are correct. The three codes listed above were modified to include the concept of chronic kidney disease. As such, they should be assigned to DRG 315 (Other Kidney and Urinary Tract Procedures) and DRG 316

(Renal Failure) (and not to DRGs 331 through 333. We have made these changes in Table 6E of the Addendum to this final rule. Therefore, we will assign codes 403.00, 403.10, and 403.90 to DRG 315-316.

b. Bronchial Valve

Comment: Two commenters that manufacture minimally invasive surgical therapies for patients with chronic obstructive pulmonary disease addressed the establishment of a new code for the insertion of a bronchial valve. This topic was discussed at the March 23-24, 2006 meeting of the ICD-9-CM Coordination and Maintenance Committee. (A complete summary report of the meeting including handouts can be found at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopofPage.) CMS created a new code for endoscopic insertion of a bronchial valve: code 33.71 (Endoscopic insertion or replacement of bronchial valve(s)). The new code is listed in Table 6B of the Addendum to this final rule. The predecessor codes that are currently used for this procedure are:

- 33.22, Fiber-optic bronchoscopy
- 96.05, Other intubation of respiratory tract

The commenters expressed support for the creation of the new code, but requested that the code not be assigned to the same DRG as its predecessor codes. The predecessor codes are assigned to a medical DRG if the patient is admitted with a respiratory diagnosis. If the patient is admitted with a history of malignancy, the patient would be assigned to DRG 412 (History of Malignancy with Endoscopy). The commenters

requested that code 33.71 be assigned to DRG 75 (Major Chest Procedure). Although the commenters acknowledged that CMS has no data on which to evaluate this request, they recommended that CMS use a combination of the diagnosis of air leaks and treatment with scarification as a proxy for cases that receive a bronchial valve. The commenters stated that these patients are clinically similar and can be expected to have similar resource intensity to patients that would receive an endobronchial insertion or replacement of bronchial valves.

The commenters undertook their own data analysis using the FY 2005 MedPAR file. They used the following diagnosis procedure codes to identify the proxy patients:

- 512.0, Spontaneous tension pneumothorax
- 512.8, Other spontaneous pneumothorax
- 34.6, Scarification of the pleura

Using these codes, the companies identified 490 patients which were assigned to DRG 75. These patients had average charges of $56,711 as compared to $49,698 for all patients in DRG 75. The commenters stated that, although the resource utilization for scarification (and by inference, valve implantation) appears to be higher than the average for DRG 75, they believed it would still be reasonable to initially assign code 33.71 to DRG 75 until actual cost data can be gathered using the new procedure code.

Response: We do not agree that the endoscopic insertion of a bronchial valve is clinically similar to scarification of the pleura. The commenters themselves indicate that insertion of the bronchial valve is a minimally invasive procedure. Scarification of the pleura is a significantly invasive procedure. Furthermore, the bronchial valves are

inserted into patients admitted with chronic obstructive pulmonary disease, not spontaneous pneumothorax. Therefore, we do not agree with using the pneumothorax diagnoses as a proxy for patients who will receive the bronchial valve.

The bronchial valve code 33.71 will go into effect on October 1, 2006. At this time, we have no information that suggests we should assign this new code to a DRG that is different than the predecessor codes. For this reason, we are classifying code 33.71, Endoscopic insertion or replacement of bronchial valve(s) as a nonoperating room procedure that will be assigned to DRG 412. This classification is listed in Table 6B of the Addendum to this final rule. Once we receive data using the new code, we will evaluate this issue further.

c. Female Reproductive System Reconstruction Procedures

Comment: One commenter recommended that CMS consider revising the current procedure code assignments for DRG 356 (Female Reproductive System Reconstructive Procedures) under MDC 13 (Diseases and Disorders of the Female Reproduction System) to better reflect the clinical coherence of those procedures that are specific to maintaining reproductive health. The proposal suggested by the commenter would distinguish procedures that are intended to ensure the reproductive function of a woman from urinary conditions that cause discomfort and emptying the bladder. The commenter suggested revising DRG 356 to limit it to procedures that are specific to maintaining reproductive health while creating four new DRGs that would be clinically similar for procedures performed to repair pelvic floor defects which cause urinary incontinence. The commenter stated these new DRGs would be timely with the procedure code proposal

they are planning to present at the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting.

Response: We appreciate the commenter's recommendation to create four new DRGs in order to recognize the clinical coherence of procedures specific to maintaining reproductive health. There are two aspects to the commenter's proposal. The first part of the proposal would limit DRG 356 to procedures that are intended to maintain reproductive health. The second part of the commenter's proposal would create four new DRGs for repairing pelvic floor defects that create urinary incontinence. These four new DRGs would consist of two new DRG pairs (each split based on whether or not the patient has a CC) that would separate patients based on whether or not they had a graft procedure.

The commenter provided no data to support its proposal. Further, two of the four new DRGs being requested by the commenter would be based on new and revised procedure codes that have not yet been proposed or created. Therefore, we are unable to evaluate the request at this time. We may consider this proposal further in the future if the ICD-9-CM Coordination and Maintenance Committee creates the new codes being requested by the commenter and further data are made available for review.

d. Devices That are Replaced Without Cost or Where Credit for a Replaced Device is Furnished to the Hospital

In recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators (ICDs) and pacemakers. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or

credit for the device being replaced if the patient required a more expensive device. In some circumstances, manufacturers have also offered, through a warranty package, to pay specified amounts for unreimbursed expenses to persons who had replacement devices implanted. In addition, we believe that incidental device failures that are covered by manufacturer warranties occur routinely. While we understand that some device malfunctions may be inevitable as medical technology grows increasingly sophisticated, we believe that early recognition of problems would reduce the number of people with the potential to be adversely affected by these device problems. The medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that it can take appropriate action to care for Medicare beneficiaries. Systematic efforts must be undertaken by all interested and involved parties, including manufacturers, insurers, and the medical community, to ensure that device problems are recognized and addressed as early as possible so that people's health is protected and high quality medical care is provided. We are taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harmful device-related effects on the health of Medicare patients and the public in general.

In recent years, CMS has recognized the importance of data collection as a condition of Medicare coverage for selected services. In 2005, CMS issued a National Coverage Determination (NCD) that expanded coverage of ICDs and also required registry participation when the devices were implanted for certain clinical indications. The NCD included this requirement in order to ensure that the care received by Medicare

beneficiaries was reasonable and necessary and, therefore, appropriately reimbursed. Presently, the American College of Cardiology – National Cardiovascular Data Registry (ACC-NCDR) collects these data and maintains the registry.

In addition to ensuring appropriate payment of claims, collection, and ongoing analysis of ICD implantation, data can facilitate public health response in the event of future device recalls. The systematic recording of device manufacturer and model number can enhance patient and provider notification. Analysis of registry data may uncover patterns in complication rates (for example, device malfunction, device related infection, or early battery depletion) associated with particular devices that signify the need for a more specific investigation. Patterns found in registry data may identify problems earlier than the currently available mechanisms, which do not systematically collect such detailed information surrounding procedures.

We encourage the medical community to work to develop additional registries for implantable devices, so that timely and comprehensive information is available regarding devices, recipients of those devices, and their health status and outcomes. While participation in an ICD registry is required as a condition of coverage for ICD implantation for certain clinical conditions, we believe that the potential benefits of registries extend well beyond their application in Medicare's specific NCDs. As medical technology continues to advance swiftly, data collection regarding the short and long term outcomes of new technologies, and especially concerning implanted devices that may remain in the bodies of patients for their lifetimes, will be essential to the timely recognition of any specific problems and patterns of complications. This information

will facilitate early interventions to mitigate harm and improve the quality and efficiency of health care services.

Moreover, data from registries may help further the development of high quality, evidence-based clinical practice guidelines for the care of patients who may receive device-intensive procedures. In turn, widespread use of evidence-based guidelines may reduce variation in medical practice, leading to improved personal and public health. Registry information may also contribute to the development of more comprehensive and refined quality metrics that may be used to systematically assess and then improve the safety and quality of health care. Such improvements in the quality of care that result in better personal health will require the sustained commitment of industry, payers, health care providers, and others towards that goal, along with excellent and open communication and rapid systemwide responses in a comprehensive effort to protect and enhance the health of the public. We look forward to further discussions with the public about new strategies to recognize device problems early and how to definitively address them, in order to minimize both the harmful health effects and increased health care costs that may result.

In addition, we believe that the routine identification of Medicare claims for certain device implantation procedures in situations where a payment adjustment is appropriate may enhance the medical community's recognition of device problems, potentially leading to more timely improvements in device technologies. This systematic approach, where hospitals identify and then appropriately report selected services when devices are replaced without cost to the hospital or with full credit to the hospital for the

cost of the replaced device, should provide comprehensive information regarding the hospital experiences of Medicare patients with certain devices that are being replaced. Because Medicare patients are common recipients of implanted devices, this claims information may be particularly helpful in identifying patterns of device problems early in their natural history so that appropriate strategies to reduce future problems may be developed.

In addition to our concern for the public health, we also have a fiduciary responsibility to the Medicare Trust Fund to ensure that Medicare pays only for covered services. Therefore, we believe that we need to consider whether it is appropriate to reduce the Medicare payment in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. Such a proposal could cover certain devices for which credit for the replaced device is given or which are replaced as a result of or pursuant to a warranty, field action, voluntary recall, involuntary recall, and certain devices which are provided free of charge. It could provide for a reduction in the IPPS payment when we determine that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device. We will need to develop a methodology to determine the amount of the reduction to the otherwise payable IPPS payment. We believe that this is appropriate because in these cases the full cost of the replaced device is not incurred and, therefore, we believe that an adjustment to the payment is necessary to remove the cost of the device.

E. Recalibration of DRG Weights

In the FY 2007 IPPS proposed rule, we proposed to change the DRG recalibration process methodology for FY 2007 to move to an HSRV weighting method as discussed in section II.C.2. of the preamble to the proposed rule (71 FR 24044). For FY 2006 and years prior, we have recalibrated the DRG weights based on charge data for Medicare discharges using the most current charge information available (for example, the FY 2005 MedPAR file would have been used for FY 2007). Our thorough analysis of the March 2005 MedPAC recommendations regarding refinement of the DRG system used for the IPPS (see discussion of the MedPAC recommendations in section II.C.2. of this preamble) has shown that using gross charges as a basis for setting the DRG weights has introduced bias into the weighting process. Specifically, hospitals that are systematically more expensive than others (that is, teaching hospitals and specialty hospitals) tend to treat certain cases more commonly than others, causing the weights for these cases to be artificially high. In addition, hospitals may mark up their charges for routine days, intensive care days, and various ancillary services by different percentages. This practice of differential markups among hospital cost centers may also introduce bias into the weights. For instance, we have observed that ancillary service cost centers generally have higher charge markups than routine services. Thus, the charge-based relative weight methodology may result in higher weights for DRGs that use more ancillary services relative to DRGs that use more routine services than would occur under a system where the weights are based on costs.

As discussed in section II.C.2. of the preamble of the proposed rule, based on our study of the MedPAC recommendations, we developed an alternative methodology for

recalibrating the DRG weights. This proposed method is discussed in detail beginning on 71 FR 24044. The proposed method involved applying the HSRV methodology at the cost center level (HSRVcc) to remove the bias introduced by hospital characteristics (that is, teaching, disproportionate share, location, and size, among others) and then scaling the weights to costs using national cost center CCRs derived from cost report data. However, in response to comments discussed in section II.C.2 of this final rule, we have postponed the implementation of the HSRV methodology in order to further study its effects and have subsequently revised the methodology for setting relative weights based on cost. Further, we are adopting the cost relative weights under a 3-year transition period such that in FY 2007, year one of the transition, the relative weights will be a blended of 33 percent of the relative cost weight and 67 percent of the relative charge weight. In year two, the relative weights will be based on 67 percent of the relative cost weight and 33 percent of the relative charge weight and in year three, the relative weights will be 100 percent cost based.

In developing the final 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 2005 MedPAR data used in this proposed rule include discharges occurring on October 1, 2004, through September 30, 2005, based on bills received by CMS through March 31, 2006, 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 2005 MedPAR file used in calculating the relative

weights includes data for approximately 12,238,146 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice 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 relative weight methodology are the FY 2004 Medicare cost report data files from HCRIS, which represents the most recent full set of cost report data available. We used the March 31, 2006 update of the HCRIS cost report files for FY 2004 in setting the final relative cost based weights.

Because we are implementing the relative weights on a transitional basis it is necessary to calculate both charge based and cost based relative weights. The charge-based methodology used to calculate the DRG relative weights from the MedPAR data is the same methodology that was in place for FY 2006 and was applied as follows:

- To the extent possible, all the claims were regrouped using the FY 2007 DRG classification revisions discussed in section II.D. of this preamble.

- The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 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 was necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

- Total charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

- The average standardized charge per DRG was calculated by summing the standardized total charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case was counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for non-transfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a non-transfer would be counted as 0.5 of a total case.

- 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 charges per case and the charges per day for each DRG.

- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight.

The new charge-based weights were then normalized by an adjustment factor of 1.49338 so that the average case weight after recalibration was equal to the average case

weight before recalibration. This 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. We note that due to the decision in Bellevue Hosp. Center v. Leavitt, in which the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final rule for more details of this Court decision), we are unable to finalize the FY 2007 wage index data at this time. Since we are relying on the wage index data as one of the standardizing factors that we use in calculating both the charge-based and the cost-based relative weights that are blended to set the FY 2007 transitional relative weights, we will recalculate the FY 2007 relative weights when the wage data becomes available and will publish these recalculated relative weights in a subsequent Federal Register notice prior to October 1, 2006.

The methodology we used to calculate the DRG cost-based weights from the FY 2005 MedPAR claims data and FY 2004 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the FY 2007 DRG classification revisions discussed in section II.D. of this preamble.

- The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 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 dropped. 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 and anesthesia charges were also dropped. At least 94 percent of the providers in the MedPAR file had charges for 10 of the 13 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 13 cost centers were dropped.

- 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 13 cost groups for each claim were standardized to remove the

effects of differences in area wage levels, indirect medical education and disproportionate share payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Charges were then summed by DRG for each of the 13 cost groups such that each DRG had 13 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2004 cost report data.

The 13 cost centers that we used in the DRG cost calculation are shown in the following table. In addition, the table shows the lines on the cost report that we used to create the national cost center CCRs that we used to adjust the DRG charges to cost:

Cost Center Group Name (13 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	

Cost Center Group Name (13 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
				Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28 C_1_C7_28	D4_HOS_C2_28
				Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29 C_1_C7_29	D4_HOS_C2_29
				Other Special Care Unit	C_1_C5_30	C_1_C6_30 C_1_C7_30	D4_HOS_C2_30
Drugs	Pharmacy Charges	025X, 026X and 063X		Intravenous Therapy	C_1_C5_48	C_1_C6_48 C_1_C7_48	D4_HOS_C2_48
				Drugs Charged To Patient	C_1_C5_56	C_1_C6_56 C_1_C7_56	D4_HOS_C2_56
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X		Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55 C_1_C7_55	D4_HOS_C2_55
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299		DME-Rented	C_1_C5_66	C_1_C6_66 C_1_C7_66	D4_HOS_C2_66

Cost Center Group Name (13 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
	Used Durable Medical Charges	0293		DME-Sold	C_1_C5_67	C_1_C6_67 C_1_C7_67	D4_HOS_C2_67
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 (13 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		Anesthesiology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X		Electrocardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
				Electro-encephalography	C_1_C5_54	C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
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

Cost Center Group Name (13 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
				PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45 C_1_C7_45	D4_HOS_C2_45
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X		Radiology - Diagnostic	C_1_C5_41	C_1_C6_41 C_1_C7_41	D4_HOS_C2_41
	MRI Charges	061X		Radiology - Theraputic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
Other Services	Lithotripsy Charge	079X		Radioisotope	C_1_C5_43	C_1_C6_43 C_1_C7_43	D4_HOS_C2_43
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X		Whole Blood & Packed Blood Cells	C_1_C5_46	C_1_C6_46 C_1_C7_46	D4_HOS_C2_46
	Blood Charges	038X		Blood Storing Processing & Transfusing	C_1_C5_47	C_1_C6_47 C_1_C7_47	D4_HOS_C2_47
	Blood Administratio n Charges	039X		ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58 C_1_C7_58	D4_HOS_C2_58
	Outpatient Service Charges	049X and 050X		Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59

Cost Center Group Name (13 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_59	
	Emergency Room Charges	045X		Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
						C_1_C7_60	
	Ambulance Charges	054X		Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
						C_1_C7_61	
	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	
				FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
						C_1_C7_6360	
				Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
						C_1_C7_64	
				Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65

Cost Center Group Name (13 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 Reimbursable	C_1_C5_68	C_1_C7_65 C_1_C6_68 C_1_C7_68	D4_HOS_C2_68

We developed the national average CCRs as follows:

Taking the FY 2004 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 .01. In response to a comment from MedPAC discussed in section II.C.1. of this preamble, 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 all 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. In the proposed rule we had used a trim of 1.96 times the standard deviation. However, in response to comments as discussed in section II C. of this preamble, we have subsequently revised our trim to 3 standard deviations as commenters stated that this less stringent trim appropriately retains more providers in the database.

Once the cost report data were trimmed, we calculated a Medicare specific CCR, again in response to a comment from MedPAC as discussed in section II.C. of this preamble. The Medicare specific CCR was determined by taking the Medicare charges for each line item from worksheet D Part 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 Part 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. In the proposed rule, we used hospital-specific CCRs, but in response to comments as discussed in section II C. of this preamble, we have revised our methodology to use charge-weighted CCRs in establishing the national average CCRs.

After we multiplied the total charges for each DRG in each of the 13 cost centers by the corresponding national average CCR, we summed the 13 '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 weights were then normalized by an adjustment factor of 1.49338 so that the average case weight after recalibration was equal to the average case weight before recalibration. This 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.

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 used that same case threshold in recalibrating the DRG weights for FY 2007. Using the FY 2005 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. In FY 2006, we computed weights for low volume DRGs by adjusting the FY 2005 weights of these low volume DRGs by the percentage change in the average weight of the cases in other DRGs. Because we believe that we do not have sufficient MedPAR data to set accurate and stable HSRVcc weights for these low-volume DRGs, we proposed to assign them the weights of similar DRGs for which we have more complete data and solicited comment on this proposal. The crosswalk table we proposed is shown in the FY 2007 IPPS proposed rule (71 FR 24048).

Comment: One commenter stated that we should not assign weights based on other DRGs but should instead supplement our current data with data from other sources so that we can set weights for these DRGs based on actual cases.

Response: Because we are implementing cost based weights in a transition phase and because we intend to study the DRGs and relative weight methodologies during the coming year we have reconsidered our proposal to assign low volume DRGs the weights of other DRGS for FY 2007 and are reverting to our previous method of updating the prior year's weight for these DRGs by the percentage change in the average weight of the

cases in the other DRGs. We may consider supplementing our MedPAR data with additional claims data in the future.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, 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, and as discussed in section II.A.4.a. of the Addendum to this final rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

F. LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2007

1. Background

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 currently used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the long-term care diagnosis-related group (LTC-DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the

DRGs used under the IPPS. In that same final rule, 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. Furthermore, we stated that we will publish the annual update of the LTC-DRGs in the proposed and final rules for the IPPS.

In the past, the annual update to the IPPS DRGs has been based on the annual revisions to the ICD-9-CM codes and was effective each October 1. As discussed in the FY 2006 IPPS final rule (70 FR 47323 through 47341) and in the Rate Year (RY) 2007 LTCH PPS final rule (71 FR 27803 through 27809), with the implementation of section 503(a) of Pub. L. 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 Pub. L. 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 at an earlier date. 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 added to existing DRGs in the middle of the Federal fiscal year on April 1. However, this policy change will have no effect on the LTC-DRG relative weights,

which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS. 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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191.

As we explained in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27809), in the health care industry, historically annual changes to the ICD-9-CM codes were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD-9-CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As noted above, the patient classification system used under the LTCH PPS (LTC-DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically had been updated annually and is effective for discharges occurring on or after October 1 through September 30 each year. As also mentioned above, the ICD-9-CM coding update process was revised as a result of implementing section 503(a) of Pub. L. 108-173, which includes a requirement for updating diagnosis and procedure codes as often as twice a year instead of the current process of annual updates on October 1 of each year (as discussed in greater detail in section II.D.10. of the preamble of this final rule). The agency uses the ICD-9-CM codes as its code set for diagnoses and procedures. Therefore, the ICD-9-CM codes currently used under both the IPPS and LTCH PPS may be updated as often as 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.

Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology ICD-9-CM codes, as discussed most recently in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27808), there will be no impact on either LTC-DRG assignments or payments under the LTCH PPS at that time. That is, changes to the LTC-DRGs (such as the creation or deletion of LTC-DRGs) and the relative weights will continue to be updated in the manner and timing (October 1) as they are now. As noted above and as described in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27809), updates to the GROUPER for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We also explained that because we do not publish a midyear IPPS rule, any April 1 code updates will not be published in a midyear IPPS rule. 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.D.10. of this preamble). Any coding updates will be available through the Web sites provided in section II.D.10. of this preamble 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 we must use current ICD-9-CM

codes. Therefore, for purposes of the LTCH PPS, because each ICD-9-CM code must be included in the GROUPER algorithm to classify each case into a LTC-DRG, 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 Pub. L. 108-173, there will only be an April 1 update if new technology codes are requested and approved. We note that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD-9-CM has been an open process through the ICD-9-CM Coordination and Maintenance Committee since 1995. Requestors will be given the opportunity to present the merits for a new code and 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.D.10. of this preamble).

However, as we discussed in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27809), at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2006 implementation of ICD-9-CM codes, and, therefore, the next update to the ICD-9-CM coding system would not occur until October 1, 2006 (FY 2007). Presently, as there were no coding changes suggested for an April 1, 2006 update, the ICD-9-CM coding set implemented on October 1, 2005, will continue through September 30, 2006 (FY 2006). The update to the ICD-9-CM coding system for FY 2007 is discussed above in section II.D.10. of this

preamble. Accordingly, in this final rule, as discussed in greater detail below, we are revising the LTC-DRG classifications and relative weights, to be effective October 1, 2006 through September 30, 2007 (FY 2007). Furthermore, we will notify LTCHs of any revisions to the GROUPER software used under the IPPS and the LTCH PPS that will be implemented April 1, 2007. The LTC-DRGs and relative weights for FY 2007 in this final rule are based on the IPPS DRGs (GROUPER Version 24.0) discussed in section II.B. of the preamble to this final rule.

Comment: Two commenters urged us to consolidate rulemaking for the LTCH PPS into one annual cycle rather than setting the payment rates and policy changes on a July 1 through June 30 rate year but making changes to the LTC-DRGs and relative weights based on the Federal fiscal year, October 1 through September 30. Both commenters noted that this situation has caused management and planning difficulty for some LTCHs. One of the commenters, whose LTCH has a June 1 through May 31 fiscal year, emphasizes the difficulties in "estimating the impact of changes in case weights as part of the final rule" associated with the hospital IPPS.

One commenter noted that other Medicare provider types only experience one routine annual adjustment to their respective PPSs and that it is not reasonable to expect the LTCH provider community to comment on the reasonableness of a proposed payment level in February when "that payment level is subject to change in a second rulemaking proposed in April or May of the same year." This commenter suggested that, commencing with FY 2008, all LTCH PPS rulemaking should occur on the same schedule as it does under the IPPS, which would maintain the established cycle for the

update of the LTC-DRGs and relative weights. The same commenter further suggested that, should CMS make this change in the rulemaking schedule, for the first year only, CMS should establish a 3-month (July through September) and 12- month (October through September) update factor to the Federal rate.

Response: In the LTCH RY 2004 final rule (68 FR 34122), we revised our regulations at §412.535, which established a LTCH PPS rate year with a July 1 effective date for the annual update of the Federal payment rate and associated payment policies while also maintaining an October 1 implementation date for the update of the LTC-DRG patient classification system and associated weighting factors. In changing the effective date of the annual LTCH PPS rate year update and the resulting publication dates of the proposed and final regulations for the LTCH PPS, we stated that this shift in the schedule would promote "administrative feasibility and efficiency" by avoiding concurrent rulemaking and publication with the IPPS final rule. We also noted, that although section 1886(e)(5)(A) of the Act required that, for the IPPS, the proposed rule be published in the **Federal Register** "not later than the April 1 before each fiscal year; and the final rule, not later than the August 1 before such fiscal year," no similar requirement is imposed on the LTCH PPS and that we believed that this schedule change was well within the considerable discretion that Congress afforded the Secretary in the implementation of the LTCH PPS (68 FR 34125 through 34128). We maintained at that time, and we continue to believe, that this change to the LTCH rate year annual rulemaking schedule was not unduly burdensome for the LTCH industry because we had not added any requirements that LTCHs maintain payment systems or coding software in order to be paid under the

LTCH PPS, although we understood that it was common for many hospitals, consultants, and industry associations to do so.

With regard to the commenter who described a LTCH with a fiscal year beginning on June 1, we would also reiterate what we stated in the FY 2004 final rule that "since the start of cost reporting periods for many LTCHs, as well as acute care hospitals, have not generally coincided with the October starting date of the Federal fiscal year, those hospitals that choose to have their own payment software are very familiar with the virtually seamless routine of inputting new numbers to their existing systems when a final rule is published" (68 FR 34127).

Therefore, we continue to believe that there is no significant administrative burden imposed on the LTCH industry by the establishment of the July 1 through June 30 rate year for the annual payment rate update under the LTCH PPS while still maintaining the October 1 through September 30 update of the LTC-DRGs and relative weights which are linked to the annual update of the diagnosis and procedure code set (ICD-9-CM) currently adopted by the DHHS and the IPPS DRGs and relative weights.

However, two commenters also stated that the separate rule-making cycles cause difficulty in "estimating the impact of changes in case weights," which will be published in April or May, when commenting on the payment rates published in the LTCH PPS proposed rule in the preceding January or February. From the volume of correspondence that we receive from LTCH associations and their consultants, some of which include detailed analyses of CMS data, we do not believe that our annual publication in the IPPS proposed rule of the proposed updates of the LTC-DRGs and corresponding relative

weights (which are derived solely from the best available LTCH MedPAR claims data) prohibits the public from assessing the impact such proposed changes would have if finalized. In fact, in their specific comments on the proposed FY 2007 LTC-DRG relative weights (discussed in greater detail below), several commenters presented analyses of the combined effect of the policy changes established in the RY 2007 LTCH PPS final rule, effective July 1, 2007 (for example, revisions to the short-stay outlier policy), and the proposed changes to the LTC-DRGs and relative weights for FY 2007. Furthermore, the comments received on the policies presented in the LTCH PPS RY 2007 proposed rule, a number of which contained detailed data evaluations, demonstrated the availability as well as the ability of the public to analyze the proposed policy changes using the most recent LTCH MedPAR claims data. Therefore, we do not believe that our present publication schedule deprives industry stakeholders of the opportunity to submit meaningful comments on proposed changes to payment levels when we are establishing the payment rates and associated policy under the LTCH PPS, even though changes to the LTC-DRG weights are proposed in a separate notice of proposed rulemaking.

Given the considerable discretion granted to the Secretary under the BBRA of 1999 and the BIPA of 2000 to develop the LTCH PPS, we may revisit the rulemaking schedule for the LTCH PPS in the future. If a revision to the schedule is proposed, the public will have the opportunity to submit comments on any proposed change to the schedule during the rulemaking process.

2. Changes in the LTC-DRG Classifications

a. Background

Section 123 of Pub. L. 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 Pub. L. 106-554 modified the requirements of section 123 of Pub. L. 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."

In accordance with section 307(b)(1) of Pub. L. 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. The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, in this final rule, we are using the IPPS GROUPER Version 24.0 for FY 2007 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2006, through September 30, 2007. The changes to the CMS-DRG classification system used under the IPPS for FY 2007 (GROUPER Version 24.0) are discussed in section II.D. of the preamble to this final rule.

We note that, as we discuss in section II.C.6. of the preamble to this final rule,

MedPAC, in its 2005 Report to Congress on Physician-Owned Specialty Hospitals, recommended that CMS, among other things, refine the current DRGs under the IPPS to more fully capture differences in severity of illness among patients. As we also discuss in that same section, in evaluating the MedPAC recommendation for the IPPS, we are evaluating the APR DRG GROUPER used by MedPAC in its analysis. Based on this analysis, we concur with MedPAC that the modified version of the APR DRGs would account more completely for differences in severity of illness and associated costs among hospitals. However, as we made clear in the proposed rule and reiterate in section II.C.6. of the preamble of this final rule, there are still further changes that are important to make to the CS DRG system before it is ready for adoption. At this time, we are not adopting a new severity-adjusted DRG system, such as the APR DRGs or a modified version of the APR DRGs, under the IPPS, as discussed in greater detail in section II.C.6. of the preamble of this final rule. However, we are refining the current CMS-DRG system by creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. We note that the LTCH PPS uses the same patient classification system (DRGs) as the IPPS. That is, the patient classification system used under the LTCH PPS (LTC DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically had been updated annually and is effective for discharges occurring on or after October 1 through September 30 each year. As such, the updates to the CMS DRG classification system used under the IPPS for FY 2007 (GROUPER Version 24.0), discussed in section II.D. of the preamble to this

final rule, will also be updates that apply under the LTCH PPS.

Under the LTCH PPS, we determine relative weights for each of the DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2006 IPPS final rule (70 FR 47324), we use low-volume quintiles in determining the LTC-DRG relative weights for LTC-DRGs with less than 25 LTCH cases, because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Specifically, we group those low-volume LTC-DRGs (that is, LTC-DRGs with fewer than 25 cases) into 5 quintiles based on average charge per discharge. (A listing of the composition of low-volume quintiles for the FY 2006 LTC-DRGs (based on FY 2004 MedPAR data) appears in section II.G.3. of the FY 2006 IPPS final rule (70 FR 47325 through 47332).) 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 cases (§412.529), as discussed below in section II.F.4. of this preamble.

b. Patient Classifications into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC-DRG to which a beneficiary's stay is assigned. Just as cases are classified into DRGs for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into 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 age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using the ICD-9-CM codes.

As discussed in section II.B. of this preamble, the CMS-DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve 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. Some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. (See section II.B. of this preamble for further discussion of surgical DRGs and medical DRGs.)

Because the assignment of a case to a particular LTC-DRG will determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD-9-CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980") and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. We point out again that the ICD-9-CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the Transactions and Code Sets Standards under HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by acute care hospitals to ensure accuracy and consistency in coding practices. There will be only one LTC-DRG assigned per long-term care hospitalization; it will be assigned at the time of discharge of the patient. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnosis codes for conditions that coexist at the time of admission, for conditions that are subsequently developed, or for conditions that affect the treatment received. Similarly, all procedures performed in a LTCH, or paid for under arrangements by a LTCH, during that stay are to be reported on each claim.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD-9-CM. Completed claim forms are to be submitted electronically to the LTCH's Medicare fiscal intermediary. Medicare fiscal intermediaries 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 LTC-DRG can be made.

After screening through the MCE, each LTCH claim will be classified into the appropriate LTC-DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is

specialized computer software and is the same GROUPER used under the IPPS. After the LTC-DRG is assigned, the Medicare fiscal intermediary determines the prospective payment by using the Medicare LTCH PPS PRICER program, which accounts for LTCH hospital-specific adjustments and payment rates. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC-DRG assignments made by the fiscal intermediary and to submit additional information, if necessary, within a specified timeframe (§412.513(c)).

The LTCH GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the 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 DRG classification changes and to recalibrate the DRG weights during our annual update (as discussed in section II.E. of this preamble). The LTC-DRG relative weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient-mix than patients in short-term acute care hospitals.

3. Development of the FY 2007 LTC-DRG Relative Weights

a. General Overview of Development of the 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 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 adjust the LTCH PPS standard Federal prospective payment system rate by the applicable LTC-DRG relative weight in determining payment to LTCHs for each case. Under the LTCH PPS, relative weights for each 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 LTC-DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. For example, cases in a LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC-DRG with a weight of 1.

b. Data

In the FY 2007 IPPS proposed rule (71 FR 24052), to calculate the proposed LTC-DRG relative weights for FY 2007, we obtained total Medicare allowable charges from FY 2005 Medicare LTCH bill data from the December 2005 update of the MedPAR file, which were the best available data at that time, and we used the proposed Version 24.0 of the CMS GROUPER used under the IPPS (as discussed in that same proposed rule) to classify cases. In that same proposed rule, we also proposed that if more recent data were available, we would use that data and the finalized Version 24.0 of the CMS GROUPER (used under the IPPS) to determine the final LTC-DRG relative weights for FY 2007. Accordingly, to calculate the final LTC-DRG relative weights for FY 2007 in this final rule, we obtained total Medicare allowable charges from FY 2005 Medicare

hospital bill data from the March 2006 update of the MedPAR file (which are the most recent available data), and used the final Version 24.0 of the CMS GROUPER used under the IPPS (as discussed in section II.B. of this preamble) to classify cases.

We also stated in the FY 2007 IPPS proposed rule (71 FR 24052), as we discussed in the FY 2006 IPPS final rule (70 FR 47325), 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 Pub. L. 90-248 as amended. Therefore, consistent with the proposed rule, in the development of the FY 2007 LTC-DRG relative weights in this final rule, we have excluded the data of the 19 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2005 MedPAR file.

c. Hospital-Specific Relative Value 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 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, we use a hospital-specific relative value (HSRV) method to calculate the LTC-DRG relative weights instead of the methodology used to determine the DRG relative weights under the IPPS described in section II.E. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average

charges. Specifically, we reduce the impact of the variation in charges across providers on any particular 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 method, 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 under §412.523, as implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under §412.529 as described in section II.F.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under §412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC-DRG. 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. Low-Volume LTC-DRGs

In order to account for LTC-DRGs with low-volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those "low-volume LTC-DRGs" (that is, 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. Consistent with the FY 2007 IPPS proposed rule (71 FR 24052 and 24053), we will

continue to employ this treatment of low-volume LTC-DRGs in determining the FY 2007 LTC-DRG relative weights using the best available LTCH data in this final rule. In that same proposed rule, using LTCH cases from the December 2005 update of the FY 2005 MedPAR file, we identified 173 LTC-DRGs that contained between 1 and 24 cases. As noted above, we also proposed that if more recent data were available, we would use that data and the finalized Version 24.0 of the CMS GROUPER (used under the IPPS) to determine the final LTC-DRG relative weights for FY 2007. Accordingly, for this final rule, using LTCH cases from the March 2006 update of the FY 2005 MedPAR file, we identified 180 LTC-DRGs that contained between 1 and 24 cases. This list of LTC-DRGs was then divided into one of the 5 low-volume quintiles, each containing 36 LTC-DRGs (180/5 = 36). In accordance with our established methodology, as we proposed, we then make an assignment to a specific low-volume quintile by sorting the low-volume LTC-DRGs in ascending order by average charge. For this final rule, this results in an assignment to a specific low-volume quintile of the sorted 180 low-volume LTC-DRGs by ascending order by average charge. For this final rule, based on LTCH claims data from the March 2006 update of the FY 2005 MedPAR file and the finalized Version 24.0 of the CMS GROUPER, the number of low-volume LTC-DRGs is evenly divisible by five (that is, the number of low-volume quintile used to determine the LTC-DRG relative weights). Consequently, for this final rule, it was not necessary to employ our established methodology to determine which low-volume quintile would receive the additional LTC-DRG(s) if the number of low-volume LTC-DRGs had not been evenly divisible by five. However, if the number of LTC-DRGs with less than

25 LTCH cases for this final rule had not evenly divisible by five, we would have employed our established methodology that compares the average charge of the low-volume LTC-DRGs, to determine which low-volume quintile would receive the additional LTC-DRG, as presented in greater detail in the FY 2007 IPPS proposed rule (71 FR 24053). Because, for this final rule, the number of LTC-DRGs with less than 25 LTCH cases was evenly divisible by five, to determine the composition of the low-volume quintiles, in accordance with our established methodology, as was proposed, we sorted the 180 low-volume LTC-DRGs in ascending order, and grouped the first fifth (1st through 36th) of low-volume LTC-DRGs(with the lowest average charge) into Quintile 1; the next fifth (37th through 72nd) of low-volume LTC-DRGs were into Quintile 2; and so on until the last fifth (145th through 180th) of low-volume LTC-DRGs (with the highest average charge) were grouped into Quintile 5.

In order to determine the relative weights for the LTC-DRGs with low volume for FY 2007, as was proposed, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), in this final rule, 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 LTC-DRG relative weights for FY 2007. As was proposed, for this final rule, we determined a relative weight and (geometric) average length of stay for each of the five low-volume quintiles using the formula that we apply to the regular LTC-DRGs (25 or more cases), as described below in section II.F.4. of this preamble. We assigned the same relative weight and average length of stay to each of the LTC-DRGs that make up that low-volume

quintile. We note that, as this system is dynamic, it is possible that the number and specific type of 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 LTC-DRGs and to calculate the relative weights based on our methodology.

Composition of Low-Volume Quintiles for FY 2007

LTC-DRG	DESCRIPTION
	Quintile 1
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC
31	CONCUSSION AGE >17 W CC
45	NEUROLOGICAL EYE DISORDERS
65	DYSEQUILIBRIUM
69	OTITIS MEDIA & URI AGE >17 W/O CC
83	MAJOR CHEST TRAUMA W CC
93	INTERSTITIAL LUNG DISEASE W/O CC
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG
129	CARDIAC ARREST, UNEXPLAINED
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC
140	ANGINA PECTORIS
143	CHEST PAIN
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC
181	G.I. OBSTRUCTION W/O CC
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC
208	DISORDERS OF THE BILIARY TRACT W/O CC
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH
241	CONNECTIVE TISSUE DISORDERS W/O CC
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC
273	MAJOR SKIN DISORDERS W/O CC
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY
324	URINARY STONES W/O CC
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC
335	MAJOR MALE PELVIC PROCEDURES W/O CC
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION

LTC-DRG	DESCRIPTION
432	OTHER MENTAL DISORDER DIAGNOSES
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC
	Quintile 2
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
11	NERVOUS SYSTEM NEOPLASMS W/O CC
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
46	OTHER DISORDERS OF THE EYE AGE >17 W CC
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE
128	DEEP VEIN THROMBOPHLEBITIS
133	ATHEROSCLEROSIS W/O CC
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC
173	DIGESTIVE MALIGNANCY W/O CC
175	G.I. HEMORRHAGE W/O CC
177	UNCOMPLICATED PEPTIC ULCER W CC
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC
246	NON-SPECIFIC ARTHROPATHIES
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION
276	NON-MALIGNANT BREAST DISORDERS
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC
284	MINOR SKIN DISORDERS W/O CC
295	DIABETES AGE 0-35
301	ENDOCRINE DISORDERS W/O CC
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC
348	BENIGN PROSTATIC HYPERTROPHY W CC
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC
427	NEUROSES EXCEPT DEPRESSIVE
431	CHILDHOOD MENTAL DISORDERS
441	HAND PROCEDURES FOR INJURIES
445	TRAUMATIC INJURY AGE >17 W/O CC
447	ALLERGIC REACTIONS AGE >17
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC
479	OTHER VASCULAR PROCEDURES W/O CC
492	CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC
524	TRANSIENT ISCHEMIA
563	SEIZURE AGE >17 W/O CC
	Quintile 3
21	VIRAL MENINGITIS

LTC-DRG	DESCRIPTION
22	HYPERTENSIVE ENCEPHALOPATHY
44	ACUTE MAJOR EYE INFECTIONS
67	EPIGLOTTITIS
72	NASAL TRAUMA & DEFORMITY
97*	BRONCHITIS & ASTHMA AGE >17 W/O CC
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
119	VEIN LIGATION & STRIPPING
142*	SYNCOPE & COLLAPSE W/O CC
157	ANAL & STOMAL PROCEDURES W CC
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY
206*	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC
227	SOFT TISSUE PROCEDURES W/O CC
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC
235	FRACTURES OF FEMUR
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC
299	INBORN ERRORS OF METABOLISM
312	URETHRAL PROCEDURES, AGE >17 W CC
338	TESTES PROCEDURES, FOR MALIGNANCY
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC
467	OTHER FACTORS INFLUENCING HEALTH STATUS
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC
532	SPINAL PROCEDURES W/O CC
555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX
	Quintile 4
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES
95*	PNEUMOTHORAX W/O CC
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC

LTC-DRG	DESCRIPTION
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
288	O.R. PROCEDURES FOR OBESITY
304	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC
306	PROSTATECTOMY W CC
308	MINOR BLADDER PROCEDURES W CC
310	TRANSURETHRAL PROCEDURES W CC
336	TRANSURETHRAL PROSTATECTOMY W CC
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
487	OTHER MULTIPLE SIGNIFICANT TRAUMA
488	HIV W EXTENSIVE O.R. PROCEDURE
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC
503	KNEE PROCEDURES W/O PDX OF INFECTION
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH
519	CERVICAL SPINAL FUSION W CC
533	EXTRACRANIAL PROCEDURES W CC
538	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC
539	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX
	Quintile 5
1	CRANIOTOMY AGE >17 W CC
146	RECTAL RESECTION W CC
150	PERITONEAL ADHESIOLYSIS W CC
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC
168	MOUTH PROCEDURES W CC
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC
195	CHOLECYSTECTOMY W C.D.E. W CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR
232	ARTHROSCOPY
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC

LTC-DRG	DESCRIPTION
293*	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC
341	PENIS PROCEDURES
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY
497	SPINAL FUSION EXCEPT CERVICAL W CC
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
504	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT
505	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT
529	VENTRICULAR SHUNT PROCEDURES W CC
531	SPINAL PROCEDURES W CC
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK
543	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY
545	REVISION OF HIP OR KNEE REPLACEMENT
567	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX
568	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX
569	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX
573	MAJOR BLADDER PROCEDURES

*One of the original 180 low-volume LTC-DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (see step 5 below).

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in these low-volume quintiles to ensure that our quintile assignment results in appropriate payment for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

4. Steps for Determining the FY 2007 LTC-DRG Relative Weights

As we noted previously, as was proposed, the FY 2007 LTC-DRG relative weights in this final rule are determined in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, LTCH cases must be grouped in the appropriate LTC-DRG, while taking into account the

low-volume LTC-DRGs as described above, before the FY 2007 LTC-DRG relative weights can be determined. After grouping the cases in the appropriate LTC-DRG, we calculated the relative weights for FY 2007 in this final rule 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 LTC-DRG for the effect of short-stay outlier cases under §412.529, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate "relative adjusted weights" in each LTC-DRG using the HSRV method described above.

Below we discuss in detail the steps for calculating the FY 2007 LTC-DRG relative weights in this final rule. These steps are the same as the ones we presented in the FY 2007 IPPS proposed rule for calculating the proposed FY 2007 LTC-DRG relative weights. We note that, as we stated above in section II.F.3.b. of this preamble, 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 2005 MedPAR file.

Step 1--Remove statistical outliers.

The first step in the calculation of the FY 2007 LTC-DRG relative weights, as was proposed, is to remove statistical outlier cases. We 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 LTC-DRG. These statistical outliers are removed prior to calculating the relative weights. As noted above, 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 LTC-DRGs.

Step 2--Remove cases with a length of stay of 7 days or less.

The FY 2007 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. As explained above, if we were to include stays of 7 days or less in the computation of the FY 2007 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, in order to include data from these very short-stays. Thus, as explained above, in determining the FY 2007 LTC-DRG relative weights in this final rule, as was proposed, we remove LTCH cases with a length of stay of 7 days or less.

Step 3--Adjust charges for the effects of short-stay outliers.

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. The next step in the calculation of the FY 2007 LTC-DRG relative weights is to adjust each LTCH's charges per discharge for those remaining cases for the effects of short-stay outliers as defined in

§412.529(a). (However, 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 a short-stay outlier if its length of stay was less than or equal to five-sixths of the average length of stay of the LTC-DRG, in accordance with §412.529.)

We make this adjustment by counting a short-stay outlier 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 LTC-DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the LTC-DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier 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 LTC-DRG.

As we explained in the FY 2007 IPPS proposed rule (71 FR 24059), counting short-stay outlier cases as full discharges with no adjustment in determining the LTC-DRG relative weights would lower the LTC-DRG relative weight for affected LTC-DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed LTC-DRG. This would result in an "underpayment" for nonshort-stay outlier cases and an "overpayment" for short-stay outlier cases. Therefore, in this final rule, as was proposed, we adjust for short-stay outlier cases under §412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4--Calculate the FY 2007 LTC-DRG relative weights on an iterative basis.

The process of calculating the LTC-DRG relative weights using the HSRV methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier 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 is 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 LTC-DRG, the FY 2007 LTC-DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the LTC-DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated LTC-DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's LTC-DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of LTC-DRG relative weights across all LTCHs. In this final rule, as was proposed, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5--Adjust the FY 2007 LTC-DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the FY 2007 CMS DRGs, on which the FY 2007 LTC-DRGs are based, contain "pairs" that are differentiated based on the presence or absence of CCs. The LTC-DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the FY 2006 IPPS final rule (70 FR 47336), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a LTC-DRG means that cases classified into a "without CC" LTC-DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across "with CC/without CC" pairs of LTC-DRGs.

For a case to be assigned to a LTC-DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a LTC-DRG "without CCs" (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more), but were not coded completely. Both types of cases are grouped to a LTC-DRG "without CCs" when only the principal diagnosis was coded. Since the LTCH PPS was only implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), and LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, coding by LTCHs for these cases may not have been as detailed as possible.

Thus, in developing the FY 2003 LTC-DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC-DRG "with CCs" of a "with CC/without CC" pair had a lower average charge than the corresponding LTC-DRG "without CCs." Similarly, as discussed in the FY 2006 IPPS final rule (70 FR 47336 through 47337), based on FY 2004 claims data, we also found on occasion that the data suggested that cases classified to the LTC-DRG "with CCs" of a "with CC/without CC" pair have a lower average charge than the corresponding LTC-DRG "without CCs" for the FY 2006 LTC-DRG relative weights.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a "without CC" LTC-DRG. It would not be appropriate to pay a lower amount for the "with CC" LTC-DRG because, in general, cases classified into a "with CC" LTC-DRG are expected to have higher resource use (and higher cost) as discussed above. Therefore, previously when we determined the LTC-DRG relative weights in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990) when we implanted the LTCH PPS, we grouped both the cases "with CCs" and "without CCs" together for the purpose of calculating the LTC-DRG relative weights. As we stated in that same final rule, we will continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC-DRG

pairs. We expect that, as was the case when we first implemented the IPPS, in most instances, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

There are three types of "with CC" and "without CC" pairs that could be nonmonotonic; that is, where the "without CC" LTC-DRG would have a higher average charge than the "with CC" LTC-DRG. For this final rule, using the LTCH cases in the March 2006 update of the FY 2005 MedPAR file (the most recent and complete data available at this time), we identified one of the three types of nonmonotonic LTC-DRG pairs. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we believe this anomaly may be due to coding inaccuracies and expect that, as was the case when we first implemented the acute care hospital IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

The first category of nonmonotonically increasing relative weights for LTC-DRG pairs "with and without CCs" contains one pair of LTC-DRGs in which both the LTC-DRG "with CCs" and the LTC-DRG "without CCs" had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic LTC-DRG pairs, based on our established methodology (67 FR 55983 through 55990), we combined the LTCH cases and computed a new relative weight based on the case-weighted average of the combined LTCH cases of the LTC-DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC-DRG. This new relative

weight is then assigned to both of the LTC-DRGs in the pair. In this final rule, for FY 2007, there were no LTC-DRGs that fell into this category.

The second category of nonmonotonically increasing relative weights for LTC-DRG pairs "with and without CCs" consists of one pair of LTC-DRGs that has fewer than 25 cases, and each LTC-DRG is grouped to different low-volume quintiles in which the "without CC" LTC-DRG is in a higher-weighted low-volume quintile than the "with CC" LTC-DRG. For those pairs, based on our established methodology, we combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC-DRG. Based on the case-weighted average LTCH charge, we determine within which low-volume quintile the "combined LTC-DRG" is grouped. Both LTC-DRGs in the pair are then grouped into the same low-volume quintile, thus having the same relative weight. In this final rule, for FY 2007, there were no LTC-DRGs that fell into this category.

The third category of nonmonotonically increasing relative weights for LTC-DRG pairs "with and without CCs" consists of one pair of LTC-DRGs where one of the LTC-DRGs has fewer than 25 LTCH cases and is grouped to a low-volume quintile and the other LTC-DRG has 25 or more LTCH cases and has its own LTC-DRG relative weight, and the LTC-DRG "without CCs" has the higher relative weight. Based on our established methodology, as proposed, we removed the low-volume LTC-DRG from the low-volume quintile and combined it with the other LTC-DRG for the computation of a new relative weight for each of these LTC-DRGs. This new relative weight is assigned

to both LTC-DRGs, so they each have the same relative weight. In this final rule, for FY 2007, 5 "pairs" of LTC-DRGs fall into this category: LTC-DRGs 94 and 95; LTC-DRGs 96 and 97; LTC-DRGs 141 and 142; LTC-DRGs 205 and 206; and LTC-DRGs 292 and 293.

Step 6--Determine a FY 2007 LTC-DRG relative weight for LTC-DRGs with no LTCH cases.

As we stated above, in this final rule, as we proposed we determine the relative weight for each LTC-DRG using total Medicare allowable charges reported in the March 2006 update of the FY 2005 MedPAR file. Of the 538 LTC-DRGs for FY 2007, we identified 183 LTC-DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2005 MedPAR file used in this final rule, no patients who would have been classified to those LTC-DRGs were treated in LTCHs during FY 2005 and, therefore, no charge data were reported for those LTC-DRGs. Thus, in the process of determining the LTC-DRG relative weights, we are unable to determine weights for these 183 LTC-DRGs using the methodology described in Steps 1 through 5 above. However, because patients with a number of the diagnoses under these LTC-DRGs may be treated at LTCHs beginning in FY 2007, as was proposed, for this final rule, we assigned relative weights to each of the 183 "no volume" LTC-DRGs based on clinical similarity and relative costliness to one of the remaining 355 (538 - 183 = 355) LTC-DRGs for which we are able to determine relative weights, based on FY 2005 LTCH claims data. As there are currently no LTCH cases in these "no volume" LTC-DRGs, as proposed, we determined relative weights for the 183 LTC-DRGs with no

LTCH cases in the FY 2005 MedPAR file used in this final rule by grouping them to the appropriate low-volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for the low-volume LTC-DRGs described above.

As was proposed, for this final rule, our methodology for determining the relative weights for the "no volume" LTC-DRGs is as follows: We crosswalk the no volume LTC-DRGs by matching them to other similar LTC-DRGs for which there were LTCH cases in the FY 2005 MedPAR file based on clinical similarity and intensity of use of resources as determined by 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 assigned the relative weight for the applicable low-volume quintile to the no volume LTC-DRG if the LTC-DRG to which it is crosswalked is grouped to one of the low-volume quintiles. If the LTC-DRG to which the no volume LTC-DRG is crosswalked is not one of the LTC-DRGs to be grouped to one of the low-volume quintiles, we compared the relative weight of the LTC-DRG to which the no volume LTC-DRG is crosswalked to the relative weights of each of the five quintiles and we assigned the no volume LTC-DRG the relative weight of the low-volume quintile with the closest weight. For this final rule, a list of the no volume FY 2007 LTC-DRGs and the FY 2007 LTC-DRG to which it is crosswalked in order to determine the appropriate low-volume quintile for the assignment of a relative weight for FY 2007 is shown in the chart below.

No Volume LTC-DRG Crosswalk and Quintile Assignment for FY 2007

LTC-DRG	Description	Cross-Walked LTC-DRG	Low-Volume Quintile Assignment
2	CRANIOTOMY AGE >17 W/O CC	1	Quintile 5
3	CRANIOTOMY AGE 0-17	1	Quintile 5
6	CARPAL TUNNEL RELEASE	237	Quintile 1
26	SEIZURE & HEADACHE AGE 0-17	563	Quintile 2
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	29	Quintile 1
32	CONCUSSION AGE >17 W/O CC	31	Quintile 1
33	CONCUSSION AGE 0-17	31	Quintile 1
36	RETINAL PROCEDURES	46	Quintile 2
37	ORBITAL PROCEDURES	46	Quintile 2
38	PRIMARY IRIS PROCEDURES	46	Quintile 2
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	46	Quintile 2
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	46	Quintile 2
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	46	Quintile 2
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	46	Quintile 2
43	HYPHEMA	45	Quintile 1
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	45	Quintile 1
48	OTHER DISORDERS OF THE EYE AGE 0-17	45	Quintile 1
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4
50	SIALOADENECTOMY	63	Quintile 4
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 4
52	CLEFT LIP & PALATE REPAIR	63	Quintile 4
53	SINUS & MASTOID PROCEDURES AGE >17	63	Quintile 4
54	SINUS & MASTOID PROCEDURES AGE 0-17	63	Quintile 4
56	RHINOPLASTY	63	Quintile 4
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
61	MYRINGOTOMY W TUBE INSERTION AGE >17	69	Quintile 1
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	69	Quintile 1
66	EPISTAXIS	69	Quintile 1
70	OTITIS MEDIA & URI AGE 0-17	69	Quintile 1
71	LARYNGOTRACHEITIS	97	Quintile 2
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	69	Quintile 1
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	69	Quintile 1
84	MAJOR CHEST TRAUMA W/O CC	93	Quintile 1
86	PLEURAL EFFUSION W/O CC	102	Quintile 1
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	90	Quintile 2
98	BRONCHITIS & ASTHMA AGE 0-17	97	Quintile 2
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 4
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 4
106	CORONARY BYPASS W PTCA	110	Quintile 4
108	OTHER CARDIOTHORACIC PROCEDURES	110	Quintile 4
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 4

LTC-DRG	Description	Cross-Walked LTC-DRG	Low-Volume Quintile Assignment
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	136	Quintile 1
147	RECTAL RESECTION W/O CC	171	Quintile 3
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	176	Quintile 3
151	PERITONEAL ADHESIOLYSIS W/O CC	160	Quintile 1
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 5
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	567	Quintile 5
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	567	Quintile 5
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 3
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	160	Quintile 1
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	160	Quintile 1
163	HERNIA PROCEDURES AGE 0-17	160	Quintile 1
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	171	Quintile 3
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	171	Quintile 3
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	171	Quintile 3
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	171	Quintile 3
169	MOUTH PROCEDURES W/O CC	185	Quintile 2
178	UNCOMPLICATED PEPTIC ULCER W/O CC	160	Quintile 1
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	183	Quintile 1
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	185	Quintile 2
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 2
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	189	Quintile 2
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	191	Quintile 5
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	193	Quintile 4
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 4
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 4
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	210	Quintile 5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	210	Quintile 5
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	210	Quintile 5
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	218	Quintile 5
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	237	Quintile 1
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	237	Quintile 1
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	237	Quintile 1
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	253	Quintile 2
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	253	Quintile 2
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
267	PERIANAL & PILONIDAL PROCEDURES	270	Quintile 3

LTC-DRG	Description	Cross-Walked LTC-DRG	Low-Volume Quintile Assignment
275	MALIGNANT BREAST DISORDERS W/O CC	274	Quintile 3
279	CELLULITIS AGE 0-17	273	Quintile 1
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	281	Quintile 2
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 4
289	PARATHYROID PROCEDURES	63	Quintile 4
290	THYROID PROCEDURES	63	Quintile 4
291	THYROGLOSSAL PROCEDURES	63	Quintile 4
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	297	Quintile 1
303	KIDNEY AND URETER PROCEDURES FOR NEOPLASM	318	Quintile 3
305	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC	318	Quintile 3
307	PROSTATECTOMY W/O CC	306	Quintile 4
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 4
311	TRANSURETHRAL PROCEDURES W/O CC	310	Quintile 4
313	URETHRAL PROCEDURES, AGE >17 W/O CC	312	Quintile 3
314	URETHRAL PROCEDURES, AGE 0-17	312	Quintile 3
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	318	Quintile 3
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	321	Quintile 1
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	321	Quintile 1
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	321	Quintile 1
328	URETHRAL STRICTURE AGE >17 W CC	325	Quintile 2
329	URETHRAL STRICTURE AGE >17 W/O CC	325	Quintile 2
330	URETHRAL STRICTURE AGE 0-17	325	Quintile 2
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	332	Quintile 1
334	MAJOR MALE PELVIC PROCEDURES W CC	335	Quintile 1
337	TRANSURETHRAL PROSTATECTOMY W/O CC	306	Quintile 4
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	339	Quintile 3
342	CIRCUMCISION AGE >17	339	Quintile 3
343	CIRCUMCISION AGE 0-17	339	Quintile 3
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	339	Quintile 3
351	STERILIZATION, MALE	339	Quintile 3
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	365	Quintile 4
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	365	Quintile 4
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	365	Quintile 4
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	365	Quintile 4
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	365	Quintile 4
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	365	Quintile 4
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	365	Quintile 4
360	VAGINA, CERVIX & VULVA PROCEDURES	365	Quintile 4
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	383	Quintile 1
362	ENDOSCOPIC TUBAL INTERRUPTION	383	Quintile 1
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	383	Quintile 1
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	383	Quintile 1

LTC-DRG	Description	Cross-Walked LTC-DRG	Low-Volume Quintile Assignment
370	CESAREAN SECTION W CC	383	Quintile 1
371	CESAREAN SECTION W/O CC	383	Quintile 1
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	383	Quintile 1
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	383	Quintile 1
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	383	Quintile 1
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	383	Quintile 1
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	383	Quintile 1
378	ECTOPIC PREGNANCY	383	Quintile 1
379	THREATENED ABORTION	383	Quintile 1
380	ABORTION W/O D&C	383	Quintile 1
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	383	Quintile 1
382	FALSE LABOR	383	Quintile 1
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	383	Quintile 1
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	383	Quintile 1
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	383	Quintile 1
387	PREMATURITY W MAJOR PROBLEMS	383	Quintile 1
388	PREMATURITY W/O MAJOR PROBLEMS	383	Quintile 1
389	FULL TERM NEONATE W MAJOR PROBLEMS	383	Quintile 1
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	383	Quintile 1
391	NORMAL NEWBORN	383	Quintile 1
392	SPLENECTOMY AGE >17	197	Quintile 4
393	SPLENECTOMY AGE 0-17	197	Quintile 4
396	RED BLOOD CELL DISORDERS AGE 0-17	399	Quintile 1
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	395	Quintile 2
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	404	Quintile 3
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	408	Quintile 4
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	173	Quintile 2
412	HISTORY OF MALIGNANCY W ENDOSCOPY	173	Quintile 2
417	SEPTICEMIA AGE 0-17	576	Quintile 3
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	426	Quintile 1
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	523	Quintile 1
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	445	Quintile 2
446	TRAUMATIC INJURY AGE 0-17	445	Quintile 2
448	ALLERGIC REACTIONS AGE 0-17	447	Quintile 2
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	449	Quintile 3
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	449	Quintile 3
481	BONE MARROW TRANSPLANT	394	Quintile 4
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5
485	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	487	Quintile 4
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 4
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	497	Quintile 5

LTC-DRG	Description	Cross-Walked LTC-DRG	Low-Volume Quintile Assignment
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	511	Quintile 1
518	PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	125	Quintile 1
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 5
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	521	Quintile 2
525	OTHER HEART ASSIST SYSTEM IMPLANT	468	Quintile 5
528	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE	1	Quintile 5
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 5
534	EXTRACRANIAL PROCEDURES W/O CC	500	Quintile 4
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	517	Quintile 4
540	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC	399	Quintile 1
546	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	499	Quintile 5
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	517	Quintile 4
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	517	Quintile 4
549	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	517	Quintile 4
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	517	Quintile 4
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	125	Quintile 1
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	125	Quintile 1
559	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	16	Quintile 3
577	CAROTID ARTERY STENT PROCEDURE	533	Quintile 4

To illustrate this methodology for determining the relative weights for the 183 LTC-DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume LTC-DRGs crosswalk information for FY 2007 provided in the chart above.

Example 1:

There were no cases in the FY 2005 MedPAR file used for this final rule for LTC-DRG 3 (Craniotomy Age 0-17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we

determined that LTC-DRG 1 (Craniotomy Age >17 with CC), which is assigned to low-volume Quintile 5 for the purpose of determining the FY 2007 relative weights, would display similar clinical and resource use. Therefore, we assigned the same relative weight of LTC-DRG 1 of 1.6835 (Quintile 5) for FY 2007 (Table 11 in the Addendum to this final rule) to LTC-DRG 3.

Example 2:

There were no LTCH cases in the FY 2005 MedPAR file used in this final rule for LTC-DRG 91 (Simple Pneumonia and Pleurisy Age 0-17). Since the severity of illness in patients with pneumonia and pleurisy is similar in patients regardless of age, we determined that LTC-DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to LTC-DRG 91. There were over 25 cases in LTC-DRG 90 in the FY 2005 MedPAR file data used determining the FY 2007 LTC-DRG relative weights in this final rule. Therefore, it would not be assigned to a low-volume quintile for the purpose of determining the LTC-DRG relative weights. However, under our established methodology, LTC-DRG 91, with no LTCH cases, would need to be grouped to a low-volume quintile. We determined that the low-volume quintile with the closest weight to LTC-DRG 90 (0.4958) (refer to Table 11 in the Addendum to this final rule) would be low-volume Quintile 2 (0.5594) (refer to Table 11 in the Addendum to this final rule). Therefore, we assigned LTC-DRG 91 a relative weight of 0.5694 for FY 2007. We note that we will continue to monitor the volume (that is, the number of LTCH cases) that have few or no LTCH cases to ensure that our no volume LTC-DRG crosswalking

and relative weight assignment results in appropriate payments for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

Furthermore, as was proposed, we are establishing LTC-DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC-DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2007 in this final rule 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 would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

However, 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 LTC-DRGs affected. At the present time, we would only include these six transplant LTC-DRGs in the GROUPER program for administrative purposes. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these LTC-DRGs would be administratively burdensome.

Again, we note that, as this system is dynamic, it is entirely possible that the number of LTC-DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume LTC-DRGs and to determine the relative weights in this final rule.

Table 11 in the Addendum to this final rule lists the LTC-DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under §412.529) for FY 2007.

We also wish to point out that in section VI.A.5. of the preamble of this rule, we discuss our revision to the regulations for grandfathered HwHs, grandfathered hospital satellite facilities, and grandfathered satellite units at §§412.22(f), 412.22(h), and 412.25(e), respectively. In addition, in section VI.A.6. of the preamble of this final rule, we discuss our revision and clarification to the existing policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS based on the proposal presented in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135).

5. Summary of Public Comments and Departmental Responses

Comment: Numerous commenters opposed the proposed changes in the LTC-DRG weights, which they noted would result in an approximately 1.4 percent decrease in estimate aggregate payments to LTCHs. Several of the commenters noted that LTCHs had been subject to a number of "significant Medicare payment reductions in recent years," including an estimated 4.2 percent reduction as a result of the reweighting

of the LTC-DRGs for FY 2006; a zero update (as opposed to a 3.4 percent market-basket increase) in the Federal rate for RY 2007; an estimated 3.7 percent decrease caused by the revised short-stay outlier payment policy for RY 2007; and, most recently, the estimated 1.4 percent reduction as a result of the proposed reclassification and reweighting of the LTC-DRGs for FY 2007. The commenters maintained that the cumulative effect of these established and proposed Medicare payment reductions is not sustainable for the LTCH industry and will cause much "volatility" for LTCH providers, and also restrict access to LTCHs for patients.

One commenter provided a chart that indicated that if CMS finalizes the proposed LTC-DRG relative weights, LTCH industry-wide margins would approximate 0 percent. Another commenter, an association that represents large LTCH chains, urged CMS to postpone implementation of the proposed FY 2007 reweighting of the LTC-DRGs until an analysis of the impact of this change on payment adequacy, as well as other payment changes established for RY 2007, is conducted.

Response: While we understand the commenters' concerns with the estimated decrease of 1.4 percent in LTCH PPS payments as a result of the proposed changes in the LTC-DRGs, and relative weights for FY 2007, we did not propose any changes in the methodology used to determine the proposed recalibration of the LTC-DRG relative weights for FY 2007. (We note that based on the final LTCH-DRG relative weights for FY 2007 the estimate is a 1.3 percent decrease.) The proposed update to the LTC-DRG relative weights for FY 2007 is based on the proposed Version 24.0 of the CMS GROUPER (including the proposed changes in the DRG classifications relative weights

and geometric mean length of stay) and FY 2005 LTCH claims data. For this final rule, we used updated data as described previously. In the FY 2003 final rule for the LTCH PPS, which first implemented the payment system, we described in great detail, the methodology for the development of the LTC-DRG relative weights, and we have reiterated these steps in every subsequent rulemaking cycle. (When we revised our regulations at §412.535, establishing the LTCH PPS rate year, while still publishing the LTC-DRG updates on the Federal fiscal year (October through September) cycle, we continued to include a brief write-up of our LTC-DRG update methodology in the annual LTCH PPS proposed and final rules and a comprehensive description of the policy in the annual IPPS proposed and final rules (67 FR 55984-55995; 68 FR 34131-334132; 69 FR 25681; 69 FR 48989-48999; 70 FR 24177-24178; 70 FR 37323-37341; and 71 FR 27808).) There has been no methodological change in the way in which the LTC-DRG relative weights are computed since the implementation of the LTCH PPS. The annual determination of the LTC-DRG relative weights is data-driven; that is, based on claims data in the most current MedPAR files which are derived from patient bills submitted by LTCHs.

We agree with the commenters who noted that the LTCH industry has indeed been impacted by significant changes since the start of the LTCH PPS for FY 2003. Since we first established the LTCH PPS, the unadjusted Federal payment rate, which began at $34,956.15, increased to $38,086.64 for RY 2006. (The zero percent update finalized in the RY 2007 LTCH PPS final rule (71 FR 27798) resulted in the stabilization of this amount for RY 2007.) From RY 2005 to RY 2006, there was a 5.7 percent

increase in estimated aggregate LTCH PPS payments (70 FR 24217). The average Medicare payment per case for FY 2003 was reported at $26,751, while, for RY 2006, it was estimated to be $33,208, which is an increase of over 24 percent. Significantly, there was a 13.8 percent increase in estimated Medicare payments to LTCHs in RY 2005 alone. The results of the first 2 years of this "volatility" were aggregate industry margins estimated at 7.8 percent for FY 2003, and for FY 2004, preliminary cost report data revealed an estimated average Medicare margin of 12.7 percent, as stated in the RY 2007 LTCH PPS final rule (71 FR 27819).

The commenters noted the Medicare payment reductions in recent years, including the estimated 4.2 percent reduction for FY 2006 due to the recalibration of the LTC-DRG weights and the estimated 1.4 percent decrease in aggregate LTCH PPS payments due to the proposed update to the LTC-DRG relative weights for FY 2007. As noted above, the decrease in average case-mix based on the proposed LTC-DRG relative weights for FY 2007 as compared to FY 2006, as well as the decrease in average case-mix from FY 2006 as compared to FY 2005, which were estimated to result in an aggregate estimated decrease in LTCH PPS payments, were data driven. For this final rule they remain data driven as well. In the FY 2006 IPPS proposed rule (70 FR 23667), we noted that we continued to observe a significant increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year. The addition of these lower charge cases resulted in a decrease in many of the LTC-DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC-DRG relative weights, in turn, resulted in an estimated decrease in LTCH PPS payments from

FY 2005 to FY 2006. As we explained in that same rule, contributing to this increased number of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year were improvements in coding practices, which are typically found when moving from a reasonable cost-based payment system to a PPS.

Our analyses of data from the March 2005 update of the FY 2004 MedPAR files, which were used to calculate the FY 2006 LTC-DRG relative weights, and the most recent update of the FY 2005 MedPAR files which were used to determine the proposed and final FY 2007 LTC-DRG relative weights continue to show an increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year. As we explained in the FY 2006 IPPS final rule (70 FR 47335) and the FY 2007 IPPS proposed rule (71 FR 24413), the impact of including cases with relatively lower charges into LTC-DRGs that had a relatively higher relative weight in the previous fiscal year's GROUPER is a decrease in the average relative weight for those LTC-DRGs, which, in turn, may result in an estimated aggregate decrease in LTCH PPS payments.

The commenters also mentioned the zero update to the RY 2007 standard Federal rate as one of the "significant Medicare payment reductions in recent years." In the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), we explained our rationale for establishing a zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year, which was based on the most recent estimate in the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket offset by an adjustment for changes in coding practices that are unrelated to case mix, rather than solely using the most recent estimate of the RPL market basket to update the RY 2006 Federal rate. This market basket offset

resulted from a number of factors that included our ongoing monitoring activities, which prompted us to examine the changes in LTCHs' patient case-mix index and margins since the inception of the LTCH PPS for FY 2003 (67 FR 56014).

First, we noted that there has been tremendous growth in the number of LTCHs reimbursed by Medicare. Specifically, the number of LTCHs almost doubled from approximately 200 LTCHs in FY 2003 to 378 LTCHs at the start of FY 2005. In addition, Medicare spending for LTCHs has also grown rapidly, as noted in MedPAC's June 2004 Report to Congress (page 122). Rapid increases in LTCH growth and Medicare spending under the LTCH PPS, in conjunction with the fact that over 98 percent of LTCHs are currently paid based fully on the Federal rate (rather than choosing to be paid under a blend of the reasonable cost-based (TEFRA) payment amount and the LTCH PPS Federal rate payment amount), prompted us to examine changes in LTCHs' patient case-mix index and margins under the LTCH PPS. We believed the zero percent update factor for RY 2007, which was based on the most recent estimate of the RPL market basket at that time, adjusted to account for coding changes, was supported by our findings regarding the case-mix index, Medicare margins, and patient census based on the most recent complete LTCH data.

As we explained in considerable detail in the RY 2007 final rule for the LTCH PPS (71 FR 27818 through 27824), a LTCH's case-mix index is defined as the case-weighted average LTC-DRG relative weight for all its discharges in a given period. Changes in the case-mix index consist of two components: "real" case-mix index changes and "apparent" case-mix index changes. Real case-mix index increase is defined as the

increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. Apparent case-mix index increase is defined as the increase in computed case-mix index that is due to changes in coding practices (including better documentation of the medical record by physicians and more complete coding of the medical record by coders). Observed case-mix index increase is defined as real case-mix index increase plus the apparent case-mix index increase.

If LTCH patients have more costly impairments, lower functional status, or increased comorbidities, and thus require more resources in the LTCH, we consider this a real change in case-mix. Conversely, if LTCH patients have the same impairments, functional status, and comorbidities but are coded differently resulting in higher payment, we consider this an apparent change in case-mix. We believe that changes in payment rates should accurately reflect changes in LTCHs' true cost of treating patients (real case-mix index increase), and should not be influenced by changes in coding practices (apparent case-mix index increase). Apparent case-mix index increase results in a case being grouped to a LTC-DRG with a higher weight than it would be without such changes in coding practices, which results in a higher payment to the LTCH that does not necessarily reflect the true cost of treating the patient. Therefore, in the RY 2007 LTCH PPS final rule (71 FR 27798) under the broad discretionary authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we revised the annual update to the LTCH PPS standard Federal rate set forth at §412.523(a)(2) for the 2007 LTCH PPS rate year to adjust the payment amount for

LTCH inpatient hospital services to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs' case-mix.

Our determination to specifically provide a zero update resulted from data analysis by 3M Health Information Systems (3M) regarding changes in case-mix and coding since the implementation of the LTCH PPS, based on the most recently available data, which compared FY 2003 LTCH claims data from the first year of implementation of the PPS with FY 2004 LTCH claims data, and also looked at FY 2001 claims data (generated prior to the implementation of the LTCH PPS). (The FY 2001 data was the same LTCH claims data used to develop the LTCH PPS.) The analysis indicated, among other things, that the average annual case-mix index increase from FY 2001 to FY 2003 was 2.75 percent. Since coding of diagnoses was not a factor in determining payments under the former reasonable cost-based (TEFRA) payment system, and since payments were not directly tied to diagnosis codes, there was no incentive for LTCHs to attempt to influence payments through changes in coding practices. Therefore, it was reasonable to assume that the observed 2.75 percent change in case-mix in the years prior to the implementation of the LTCH PPS represent the value for the real case-mix index increase (that is, we assumed that the 2.75 percent increase in case-mix is due to treatment of more resource intensive patients, rather than to improvements in documentation or more complete coding of the medical record during this period). Using the average annual 2.75 percent observed case-mix index increase as a baseline, we separated the computed case-mix index increase between FY 2003 and FY 2004 into the real case-mix index increase, which is based on the treatment of more resource intensive patients, and the

apparent case-mix index increase, due to improvements in documentation and coding practices.

As we stated in the RY 2007 LTCH PPS final rule (71 FR 27820), the calculated observed case-mix index increase between FY 2003 and FY 2004 was 6.75 percent. Assuming that the real case-mix index increase observed (on average) from FY 2001 to FY 2003 remained relatively constant into FY 2004, then the difference of 4.0 percent (6.75 percent minus 2.75 percent) represented the apparent case-mix index increase that was due to improvements in documentation and coding. This was considerably higher than the 0.34 percent behavioral offset originally estimated by the CMS Office of the Actuary, which was used in the development of the FY 2003 LTCH PPS standard Federal rate (67 FR 56033). Therefore, we believed that it was appropriate that the market basket be offset by an adjustment to account for changes in coding practices that do not reflect changes in real case mix. This adjustment was implemented to ensure that the LTCH PPS payment rates continue to reflect, as closely as possible, the true costs of treating LTCH patients. It was our intent that such an adjustment to the most recent estimate of the LTCH PPS market basket would eliminate the effect of coding or classification changes that did not reflect real changes in LTCHs' case-mix in prior years.

Regarding the impact of the revised short-stay outlier policy on Medicare payments to LTCHs, we continue to believe that the revisions we established to the short-stay outlier payment adjustments in the RY 2007 LTCH PPS final rule were highly appropriate and that they provide fair and reasonable payment for short-stay patients in LTCHs, which are required to meet the same certification criteria as short-term acute care

hospitals set forth in section 1861(e) of the Act and generally have an average length of stay of greater than 25 days. Therefore, our present policy under the short-stay outlier policy at §412.529, effective for discharges beginning on or after July 1, 2006, is to base Medicare payment on the least of 100 percent of the estimated costs of the discharge, 120 percent of the LTC-DRG per diem payment amount multiplied by the length of stay, the full LTC-DRG payment, or a LTCH PPS payment based on a blend of the IPPS-comparable per diem payment amount (capped at the full IPPS comparable payment amount) and a payment based on 120 percent of the LTC-DRG per diem amount.

We believe that this finalized policy clearly demonstrates our rationale, which is that as the length of a short-stay outlier case increases, the case begins to resemble a more "typical" LTCH stay as defined under section 1886(d)(1)(B)(IV)(I) of the Act and envisioned by the statutes authorizing the establishment of the LTCH PPS. Furthermore, the estimated 3.7 percent decrease in payments cited by the commenters will only have an impact on payments to those LTCHs that continue to admit a large number of very short-stay patients. We believe that the previous short-stay outlier policy, under which Medicare paid the least of 120 percent of the estimated cost of the case, 120 percent of the per diem LTC-DRG multiplied by the length of stay, or the full LTC-DRG, inadvertently provided an incentive for a LTCH to inappropriately admit patients who could otherwise have been treated in acute care hospitals and paid for under the IPPS. Therefore, we believe the provisions of the short-stay outlier policy that were finalized in the RY 2007 LTCH PPS final rule (71 FR 27845 through 27872) will result in fair and equitable payment for short-stay patients at LTCHs.

In response to the commenter who provided a chart that indicated industry-wide margins of approximately zero percent because of the proposed changes in the LTC-DRG relative weights that are anticipated to result from the 1.4 percent payment reduction, we continue to believe that our case-mix analysis (case-mix index) and Medicare margins analysis are sound. In the RY 2007 final rule for the LTCH PPS, we calculated "revenue-weighted" Medicare margins, which are the sum of hospital inpatient Medicare revenue (payments) minus the sum of hospital inpatient Medicare expenses (costs) divided by the sum of hospital inpatient Medicare revenue (payments). This margin analysis, which is also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs in general. In our analysis of the latest available LTCH data, we found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent, and preliminary data for FY 2004 based on the most recent HCRIS data revealed an even higher Medicare margin of 12.7 percent. Moreover, our analysis of LTCHs' payments and costs per discharge based on the latest available cost report data supports our adjustment to account for changes in coding practices that do not reflect changes in real case mix because it shows that, while payments (revenue) increased approximately 15 percent from FY 2002 to FY 2003, costs (expenses) per discharge increased by only 8 percent for the same period.

Thus, payments to LTCHs from FY 2002 to FY 2003 increased almost twice as much as the increase of costs for the same period. We also noted that even though we a established a zero update to the Federal payment rate for RY 2007, we continue to believe that, based on the sizeable Medicare margins among LTCHs, the standard rate for

the RY 2007 LTCH PPS will not affect beneficiary access to LTCH services because LTCHs will continue to be paid adequately to reflect the cost of resources needed to treat Medicare beneficiaries. We also note that MedPAC's March 2006 Report to Congress on Medicare Payment Policy included similar data on margins and, based on its indepth evaluation of payment adequacy for LTCHs for 2006, MedPAC recommended that there be no update to the LTCH PPS Federal rate for RY 2007.

In addition, we do not believe that it would be appropriate to "postpone implementation" of the proposed reweighting of the LTC-DRGs pending an analysis of the impact on LTCH payment adequacy of this change, as well as other payment changes established for LTCHs for RY 2007. The annual recalibration of the LTC-DRG relative weights, which is based on patient data, is one of the cornerstones of all prospective payment systems. To reiterate, we believe that the policies finalized for RY 2007, including the zero percent update to the standard Federal rate and the payment adjustment for short-stay outlier cases, do not provide any impediment to the ability of LTCHs to continue to maintain the quality or the availability of appropriately delivered LTCH services to Medicare beneficiaries.

Comment: Several comments questioned the methodology that we used that distinguishes between payment "reductions" resulting from the zero update to the standard Federal rate finalized in the RY 2007 LTCH PPS final rule and payment reductions resulting from the proposed reweighting of the LTC-DRGs for FY 2007. One commenter asserted that CMS has utilized the same rationale as a basis to propose to reduce the FY 2007 LTC-DRG relative weights that were used to apply a zero percent

update in the RY 2007 LTCH PPS final rule. The commenters believed CMS has double-counted the same phenomenon.

Another commenter stated that, because the LTC-DRG relative weights are not updated in a budget-neutral manner, through the annual recalibration of the weights, the LTC-DRG system will "self-correct over time" without the need for any lowering of the Federal payment rate. The commenter believed that this non-budget neutral weight recalibration will continue to correct for the case-mix creep until coding improvement reaches a plateau, at which point annual case-mix variation will reflect actual variations in case-mix intensity. Citing our justification of "apparent" as opposed to real case-mix increase based on FY 2004 LTCH data for the zero percent update to the Federal rate for RY 2007, the commenter believed that CMS has overpenalized LTCHs by a net 4.2 percent. The commenter recommended that CMS work with the industry to establish an update system that eliminates the possibility of "over reduction" due to case-mix creep by one of the following options: implementing a budget neutral recalibration system and address case-mix creep through the update; or alternatively, maintaining the current non-budget neutral weight recalibration system but foregoing any future Federal rate update reduction for case-mix creep.

Response: The commenters have expressed concern that, if we finalize the proposed change in the FY 2007 LTC-DRG relative weights, the change would result in an estimated 1.4 percent decrease in payments. Because we have already finalized the zero update to the RY 2007 standard Federal rate, the commenters believe we will have reduced payments to LTCHs twice for the same phenomenon. We would like to remind

the commenters that the "zero percent" update to the Federal rate for RY 2007 did not reduce LTCH PPS payments from their previous level. Instead, the Federal rate remained at $38,086.04 from RY 2006 to RY 2007. Furthermore, we disagree and do not believe that LTCHs are being penalized twice, once through adjustment of the standard Federal rate and again due to the proposed and finalized recalibration of the LTC-DRG relative weights for FY 2007.

In the LTCH PPS RY 2007 final rule, we addressed a similar allegation by commenters that we were "unfairly penalizing" LTCHs twice in proposing the zero percent update to the standard Federal rate as a remedy for inappropriate Medicare payments to LTCHs resulting from "case-mix creep" (that is, the "apparent" case-mix index increase) between FYs 2003 and 2004. At that time, several commenters stated that CMS had already corrected any coding issues from FY 2004 by the annual recalibration of the LTC-DRGs for FY 2006 based on case-mix changes from FYs 2003 and 2004, which resulted in an estimated decrease of 4.2 percent in payments to LTCHs.

In the RY 2007 LTCH PPS final rule (71 FR 27882), we presented the explanation of the distinction between the annual reweighting of the LTC-DRGs, which we expect to result in appropriate payments for the forthcoming fiscal year's LTCH discharges, and determinations regarding the appropriate application of adjustments to the market basket increase applied to the standard Federal rate which was established to account for payments made in a prior year that were based on improved coding rather than increased patient severity (71 FR 27821). At that time, we reviewed the discussion in the FY 2006 IPPS final rule (70 FR 47701- 47702) in which we estimated that a

payment reduction of -4.2 percent would result from the FY 2006 recalibration of the LTC-DRG relative weights, which were based on LTCH claims data from the FY 2004 MedPAR file. We stated "…[t]hus FY 2004 LTCH claims data, which reflected improved coding, were used to determine the LTC-DRG relative weights used to pay LTCH PPS discharges occurring during FY 2006. While it is true that the reweighting of the LTC-DRGs using FY 2004 LTCH claims served to update the relative weights based on actual claims data in each LTC-DRG, which also reflects coding improvements that occurred in FY 2004, the recalibration of LTC-DRG weights only corrects for any coding improvement for the purpose of making accurate LTCH PPS payments in FY 2006." (71 FR 27822)

However, annual recalibration does not serve to account for payments that were made based on improved coding (rather than patient severity) in prior years. The case-mix adjustment to the market basket in determining the RY 2007 Federal rate is meant to reduce current payments to account for the increase payments that occurred in FY 2004 that resulted from the CMI increase that is attributable to 'case-mix' creep in that year 71 FR 27822).

We also explained the rationale and computations underlying our update for RY 2007 in that same final rule: "In the RY 2007 LTCH PPS proposed rule, we proposed to offset the market basket by an amount equal to the increase in case mix that was due solely to improved documentation and coding rather than changes in real case mix. At the time of the proposed rule, that increase was within rounding error of the market basket, and therefore resulted in a proposed Federal rate for RY 2007 that was

equal to the RY 2006 Federal rate, and not a reduction to the RY 2006 Federal rate." (71 FR 27821). Therefore, this policy determination regarding the market basket increase of zero percent for RY 2007 was based on changes in the LTCHs' case-mix indices in conjunction with a broader analysis of trends in the LTCH industry (noted most recently by MedPAC in the Commission's March 2006 Report to the Congress (page 211)) and in particular, driven by a detailed analysis of LTCH margins since the implementation of the LTCH PPS. As we stated in that same final rule, we believe that, in determining the Federal rate update for RY 2007, it is appropriate to apply an adjustment to the most recent estimate of the LTCH PPS market basket to eliminate the effects of coding and classification changes that do not reflect changes in real case-mix. This adjustment is necessary to account for prior year payments that were made based on improved coding practices (rather than increased patient severity) (71 FR 27821). Furthermore, we note that FY 2004 LTCH claims data were used to determine the adjustment to the market basket to account for changes in coding practices in establishing the zero percent update to the Federal rate for RY 2007, while FY 2005 LTCH claims data were used to determine the proposed and final FY 2007 LTC-DRG relative weights. Because LTCH claims data from different years were used to determine the two adjustments noted by the commenters, we further disagree that we "double counted the same phenomenon."

Regarding our margins analysis, based on data from the LTCHs' cost reports received as of December 31, 2005, updated LTCH margins analysis for the LTCH PPS RY 2007 final rule continued to show high Medicare margins among LTCHs since the implementation of the LTCH PPS in FY 2003. As noted in the RY 2007 LTCH PPS final

rule, “[w]e calculated "revenue-weighted" Medicare margins, which are the sum of hospital inpatient Medicare revenue (payments) minus the sum of hospital inpatient Medicare expenses (costs) divided by the sum of hospital inpatient Medicare revenue (payments). This margin calculation, also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs in general. In an analysis of the latest available LTCH cost reports, we found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent and preliminary cost report data for FY 2004 based on the most recent update to the cost report data in HCRIS reveal an even higher Medicare margin of 12.7 percent. For periods prior to the implementation of the LTCH PPS (that is, FY 1999 through FY 2002), we found that aggregate Medicare margins ranged between a minimum of -2.3 percent in FY 2000, and a maximum of 1.5 percent in FY 2002.” (71 FR 27823).

We wish to emphasize that, as we specified in the RY 2007 LTCH PPS proposed rule, the large observed increase in LTCH case-mix was not accompanied by a corresponding increase in Medicare costs. This was consistent with our belief expressed earlier that a significant part of this observed increase in case-mix was "apparent" and not "real." In conjunction with an increase in real case-mix (that is, patient severity), we would have expected to see a significant increase in costs per discharge, even taking into account LTCH operating efficiencies, to pay for the resources needed to treat sicker patients. Consistent with MedPAC's most recent research discussed in its March 2006 Report to Congress (section 4C), our margins analysis indicated that, in spite of the estimated real increase in case-mix (severity of patients), payments to LTCHs under the

LTCH PPS are generally more than adequate to cover the Medicare costs of the inpatient hospital services provided to LTCH patients.

Therefore, for the reasons discussed above, we disagree with the commenters who believe that we "double counted the same phenomenon." To summarize, the purpose of the adjustment to the market basket which was to account for changes in coding practices that resulted in a zero percent update to the Federal rate for RY 2007 and the changes in payments that will result from the proposed and final reweighting of the LTC-DRGs are different. Specifically, the objective of our adjustment to the standard Federal rate update for RY 2007 was to adjust payments to account for prior year payments made by the Medicare program that were due to changes in coding practices, that did not reflect actual costs of beneficiary care. However, the annual recalibration of the relative weights for LTC-DRGs reflects the variation in coding practices and charges from the previous year and it helps ensure that the LTC-DRG relative weights in the upcoming fiscal year will result in appropriate payments to LTCHs for the resources they expend to treat patients. This was the case for FY 2006, when LTC-DRG relative weight recalibrations were estimated to result in a payment decrease of 4.2 percent and it was also the case for the estimated 1.4 percent decrease based on the proposed LTC-DRG relative weights for FY 2007. It is also the case for the estimated 1.3 percent decrease in this final rule due to the recalibration of the LTC-DRG relative weights.

Therefore, in response to the commenter who presented an "either/or" scenario suggesting that we should adjust payments based on case-mix variation through the present (that is, not budget neutral) recalibration of the LTC-DRG relative weights but

forego any future Federal rate update for case-mix creep, or we should address "case-mix creep" through the annual update in the Federal rate but implement a budget neutral recalibration system, we do not believe that this approach is appropriate, given that, as discussed in greater detail above, the purposes of the case-mix adjustments in each context are distinct. It is possible that if coding practices stabilize and reach "a plateau," as one of the commenters suggested, and case-mix variation only reflects real variations in case-mix intensity, the "self-correcting" mechanism of the annual recalibrations of LTC-DRG relative weights may be a reliable indication of actual costs at LTCHs by DRG. However, we emphasize that there is a distinct difference between the payment adjustments that could result from data-driven determinations that we consider, as described earlier, when we promulgate our policy regarding the annual application of the market basket update to the standard Federal rate and the data-driven effects of the recalibration of the LTC-DRG relative weights. Moreover, we do not believe that the zero update to the standard Federal rate implemented for RY 2007, which was intended to adjust for payments that were reflective of payments that were made based on improved coding rather than patient severity in 2004, and the reweighting of the relative weights for the LTC-DRGs, which would only address making appropriate payments for FY 2007, have resulted in an "over reduction" of payments to LTCHs, or overpenalized the LTCH industry.

As we have stated most recently in the RY 2007 LTCH PPS final rule, we discussed a potential framework to update payments to LTCHs that would account for appropriate factors that affect efficient delivery of services and care to Medicare

beneficiaries (71 FR 27818), and we have solicited comments on the presentation of a model for such a framework presented in Appendix A of that final rule. Presently, however, in the absence of a more comprehensive update framework, we believe that it is necessary and appropriate for us to evaluate the need of applying an adjustment to the full market-basket increase, based upon the best available data and policy considerations. Similarly, we believe it is appropriate to update the LTC-DRG relative weights based on the latest available data because the more recent data ensure that the LTC DRG relative weights for FY 2007 best reflect the resources actually used in the treatment of LTCH patients.

Comment: Several commenters discussed the impact of policies that we proposed under the IPPS for short-term, acute care hospitals (that is, the adoption of severity-adjusted DRGs; and the implementation of HSRVcc (cost-based weights) methodology for calibration of DRG weights) in their evaluation of the proposed 1.4 decrease in the LTC-DRG payments based on the proposed LTC-DRG changes for FY 2007. Both commenters urged us not to implement the proposed LTC-DRG relative weights because they believe that the discussion of the severity-adjusted DRGs in the proposed rule emphasized the fact that the LTC-DRG classifications, as they currently exist, do not accurately capture the full measure of severity for LTCH patients.

One commenter commissioned a study by the Lewin Group that utilized claims data from the FY 2005 MedPAR file and cost report data from FY 2003 to simulate the HSRVcc methodology set forth in the proposed rule. The commenter stated that the result was that, rather than a estimated 1.4 percent payment reduction, the HSRVcc

method of determining LTC-DRG relative weights resulted in an estimated 1.5 percent increase in LTCH PPS payments. The commenter added that this indicates that there can be reasonable differences as to what is the most accurate method of establishing relative weights under PPSs and that the Secretary should adjust the LTC-DRG weights this year on a budget-neutral basis, thus eliminating the estimated 1.4 percent decrease based on the proposed LTC-DRG relative weights. The commenter recommended that, although the authorizing legislation contemplates that CMS use the most recently available LTC-DRG weights for an annual update, the Secretary could use his broad authority to modify the LTC-DRG payments, as appropriate, and in order to accurately reflect current LTCH patient care. The commenter believed that the FY 2006 LTC-DRG relative weights should be maintained for FY 2007 because they more accurately account for the expected resources to be used by LTCH patients in FY 2007.

Another commenter noted that, based on the discussion in the FY 2007 proposed rule, CMS believes that severity-adjusted DRGs would improve the accuracy of the DRG system under the IPPS, and consequently, the commenter believed that, for FY 2008, severity-adjusted LTC-DRGs could be considered because they may better account for differences in severity of illnesses and associated costs across hospitals. This commenter further stated that higher weighted LTC-DRGs (and the LTCHs that treat them) are more vulnerable to the payment reductions proposed for FY 2007 based on proposed LTC-DRG relative weights because payment rates for higher acuity LTCH patients will be diluted by the FY 2005 upcoding of many lower severity cases to the higher weighted DRGs. In addition, the commenter pointed to the revised short-stay outlier policy

established in the RY 2007 LTCH PPS final rule which, they believe, is intended to reduce the number of lower-acuity patients being treated in LTCHs, and stated that those LTCH patients that are not short-stay outlier cases will be more typical of LTCH patients and, therefore, have higher acuity. The same commenter also mentioned that the FY 2005 data that are being proposed to be used to reweight the LTC-DRGs for FY 2007 represent a system "still in flux" because the system is still transitioning to full payment under the LTCH PPS and only a portion of each case is being paid based on LTC-DRGs. For these reasons, the commenter urged CMS to postpone further LTC-DRG rate reductions and instead recommended that CMS address coding improvements comprehensively in FY 2008 under the LTCH PPS in the context of the improved severity measures proposed under the IPPS for FY 2008 (or earlier).

Response: We understand that the commenters are concerned with the 1.4 percent decrease in estimated aggregated LTCH PPS payments for FY 2007 due to the proposed reweighting of the LTC-DRGs. We also understand that the commenters believe that the adoption of a severity-adjusted patient classification system under the LTCH PPS applied to the LTC-DRGs and the use of cost-based weights (HSRVcc) methodology could result in a different estimated aggregate payment change for FY 2007. However, as we discussed in greater detail below, we do not agree that the FY 2006 relative weights would more accurately represent resource use by LTCH patients for FY 2007 and that it would be necessary or appropriate to postpone the finalization of the annual reweighting of the LTC-DRGs. The current (FY 2006) LTC-DRG relative weights were determined based on FY 2004 LTCH claims data from the MedPAR files.

For FY 2007, we proposed to use our existing relative weight methodology (established when the LTCH PPS was implemented for FY 2003) and FY 2005 LTCH claims data from the MEDPAR files to recalibrate the LTC-DRG relative weights, as these were currently the most recent complete LTCH claims data. As was proposed, for this final rule, we are using the March 2006 update of the FY 2005 MedPAR files because this is currently the most recent and complete LTCH claims data. We believe that the FY 2005 data are the best LTCH data available that reflect LTCHs' current treatment practice and coding patterns. Therefore, because the FY 2005 LTCH claims data better reflects current LTCH behavior than the FY 2004 LTCH claims data that was used to determine the FY 2006 LTC-DRG relative weights, we believe that using this updated (FY 2005) LTCH claims data with our existing relative weight methodology will result in LTC-DRG relative weights for FY 2007 that will best reflect the resources actually utilized by LTCHs in treating their Medicare patients.

With respect to the accuracy of the current LTCH-DRG system, we note the following. For FY 2003, we decided to adopt the current LTC-DRG system stating, "the LTC-CMS-DRG system is a system that is familiar to hospitals because it is based on the current DRG system under the acute care hospital inpatient prospective payment system. We believe that the familiarity of the LTC-CMS-DRG model may best facilitate the transition from the reasonable cost-based system to the prospective payment system as well as providing continuity in payment methodology across related sites of care (for example, an acute care hospitalization for a patient with a chronic condition)" (67 FR 55966). However, we have noted that we believed that there may be significant

advantages in the use of severity-adjusted LTC-DRGs. In fact, when we were developing the LTCH PPS for FY 2003, we seriously considered using a specially modified version of the APR-DRGs (67 FR 55966-55967). At that time, we stated:

"The LTC-APR-DRGs, a condensed version of 3M's all-patient refined DRGs (APR-DRGs) for acute care hospitals, was developed by 3M Health Information Systems, for exclusive use in LTCHs. The LTC-APR-DRG system was designed to reflect the clinical characteristics of LTCH patients. This case-mix classification model contains 26 base LTC-APR-DRGs, subdivided by 4 severity of illness levels to yield 104 classification levels. In this system, the patient's secondary diagnoses, their interaction, and their clinical impact on the primary diagnosis determine the severity level assigned to each of the 26 LTC-APR-DRGs" (67 FR 55966).

When we decided to use the same patient classification system as the IPPS, following a comprehensive analysis of both the LTC-APR-DRGs and the existing DRG system (modified by the use of quintiles for low volume DRGs) for the particular purposes of patient classification at LTCHs, we indicated that we believed that either classification system would result in appropriate payments for LTCHs under the PPS. However, we noted several issues to consider concerning the LTC-APR-DRG system, including--

"…its complexity, its clinical subjectivity, and its utility as it relates to other Medicare prospective payment systems. The LTC-APR-DRG model provides a clinical description of the population of LTCHs, patients exhibiting a range of severity of illness with multiple comorbidities as indicated by secondary diagnoses. The clinical interaction

of the primary diagnosis with these comorbidities determines the severity level of the primary diagnoses, resulting in the final assignment to a LTC-APR-DRG by the GROUPER software designed for this system" (67 FR 55966).

We further noted that ". . .determining whether particular comorbidities increase the cost of a case for a LTCH patient is complicated by the nature of the clinical characteristics of these patients. More specifically, many LTCH patients have numerous conditions that may not all be relevant to the cost of care for a particular discharge. Although the patient actually has a specific condition, including this condition among secondary diagnoses coded under the LTC-APR-DRG system may assign an inaccurate severity level to the primary diagnosis and result in inappropriate LTC-APR-DRG payment. We also believe that reliance on existing comorbidity information submitted on LTCH bills could result in significant variation in the assignment of the specific LTC-APR-DRGs" (67 FR 55967).

We concluded our explanation in the FY 2003 final rule for the LTCH PPS by stating that "[e]ven though we are using LTC-DRGs in the LTCH prospective payment system in this final rule, we may have the opportunity to propose a severity-adjusted patient classification for LTCHs in the future, particularly if the acute care hospital inpatient prospective payment system moves in this direction" (67 FR 55967). As we noted in the FY 2007 IPPS proposed rule, if and when a severity-adjusted patient classification system is adopted under the IPPS, we would need to consider whether to propose revisions to the patient classification system used under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and

comment rulemaking (71 FR 24051). Subsequently, in 2005, MedPAC recommended we refine the entire inpatient acute care CMS DRG system to take into account severity of illness and apply HSRV weights to DRGs. However, we believe that it is advantageous to the LTCH community to wait for CMS to first finalize its policies regarding any refinements to the DRG system for the IPPS so that we can fully analyze what the effects of such changes would be on LTCH PPS payments. To the extent any changes for severity-adjusted DRGs for the IPPS system have been finalized, an analysis could then be performed to determine whether it is appropriate to propose the same severity-adjusted patient classification for LTCHs. As we stated in the FY 2007 IPPS proposed rule:

"At that time, we would need to consider whether to propose revisions to the patient classification system under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking" (71 FR 24051).

The commenters cited the virtues of the severity-adjusted DRGs and one commenter commissioned the above described study to assess the validity of our proposed update to the LTC-DRG relative weights for FY 2007. In response to these comments, we reiterate that, while we understand that applying the severity-adjusted DRGs under the LTCH PPS could have an impact on setting relative weights used in determining LTCH PPS payments, we would consider their use in the LTCH PPS after we evaluate any DRG refinements for the IPPS, as noted above.

We note that while severity-adjusted DRGs had been proposed under the IPPS system for FY 2008 (or earlier), we did not propose to revise the current patient

classification system used under the LTC PPS. Because, as we explained above, we believe any refinement due to severity-adjusted DRGs for the IPPS system would need to be evaluated to determine whether it is appropriate to use the same severity-adjusted DRGs for LTCHs, we will, at that time, take into consideration such issues as the impact of treating higher acuity patients.

We have noted that some commenters believe it is not appropriate that LTCHs be impacted by decreasing payments because of the upcoding of lower acuity patients to higher weighted LTC-DRGs, as discussed in the previous responses. However, as we discussed in the FY 2007 IPPS proposed rule (71 FR 24413), many of the LTC-DRG relative weights proposed for FY 2007 are lower than the current (FY 2006) LTC-DRG relative weight because based on the latest available LTCH claims data, we continue to observe an increase in the number of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in prior years. As explained previously, we believe that using updated (FY 2005) LTCH claims data will result in LTC-DRG relative weights for FY 2007 that best reflect the resources actually utilized by LTCHs in treating their Medicare patients and thereby act to ensure appropriate LTCH PPS payments in FY 2007. The commenter is correct in noting that it was our intention, when we revised the short-stay outlier policy described above, to reduce the number or type of short-stay patients being treated in LTCHs that do not utilize the resources of "typical" LTCHs. Many of these very short stay cases require more appropriate treatment at another hospital setting, such as an acute care hospital. Therefore, we are not convinced that

reducing the number of short stay patients treated at LTCHs will necessarily result in higher LTC-DRG weights in all LTC-DRGs or even in higher weighted LTC-DRGs.

Moreover, since the implementation of the LTCH PPS in FY 2003, we have accounted for very short-stay and short-stay outliers cases in our LTC-DRG relative weight methodology. Specifically, we have removed cases with a length of stay of 7 days or less because we believed that they could "significantly bias payments against inlier cases" (67 FR 55989). In addition, the methodology includes a step to adjust charges for the effects of short-stay outliers by "counting a short-stay outlier 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 LTC-DRG." Without this adjustment, we maintained at that time that we believed that "the relatively lower charges of the short-stay outlier cases bring down the average charge for all cases within a LTC-DRG . . . [and] result in an 'underpayment' to nonshort-stay outlier cases . . ." (67 FR 55990). Therefore, we do not believe that the changes that we have made in the short-stay outlier policy in the RY 2007 LTCH PPS final rule will affect the DRG weights because our methodology has always accounted for this potential effect so that a reduction in short-stay outlier cases will not necessarily result in a significant change to the DRG weights.

During the previous 4 years, while we phased in to full payments under the LTCH PPS, we have reweighted the LTC-DRGs, with the result that for the first year, there was an estimated negligible increase in average payments based upon the reweighting of the LTC-DRGs (FY 2004 + 0.4 percent) and a negligible decrease in estimated payments based on the LTC-DRG update in FY 2005 (FY 2005, -0.5 percent). For the subsequent

2 years, there were decreases (FY 2006, -4.2 percent; proposed FY 2007, -1.4 percent). Although the LTCH PPS has been evolving, we believe that using the updated (FY 2005) LTCH claims data with our existing relative weight methodology will result in LTC-DRG relative weights for FY 2007 that will best reflect the resources actually utilized by LTCHs in treating its Medicare patients since the FY 2005 data is the best LTCH data available that reflects LTCHs' current treatment practice and coding patterns. Therefore, we do not find it either necessary or appropriate to postpone the FY 2007 update of the LTC-DRG relative weights until we consider the adoption of a classification system with "improved severity measures."

Comment: Numerous commenters suggested that CMS forgo the proposed approximately 1.4 percent decrease in estimated aggregate LTCH PPS payments and, instead, establish a policy of budget neutrality for the annual updates of the LTC-DRG relative weights. The commenters believed a policy of budget neutrality would mitigate the estimated LTCH PPS payment reductions that CMS estimates would result from the proposed changes to the LTC-DRGs and relative weights for FY 2007. MedPAC also endorsed adopting a policy of budget neutrality for the annual recalibration of the LTC-DRG weights and noted that the adoption of the budget neutrality process that CMS uses in recalibrating the annual weights for the IPPS for the LTCH would avoid the estimated decrease in payments of 1.4 percent for FY 2007.

One commenter asserted that the absence of a budget neutrality adjustment for the annual recalibration of the LTC-DRGs provides a negative incentive for efficiency, because assigning cases that appropriately use fewer hospital resources to a particular

LTC-DRG will result in a lower weight for that LTC-DRG. Therefore, the commenter urged CMS not to implement the proposed reweighting for FY 2007 prior to a full analysis of the impact of the proposed reweighting along with other payment policy changes provided in the RY 2007 LTCH PPS on the overall adequacy of payments to LTCHs. In addition, the commenters expressed eagerness to review the recommendations currently under development by RTI International for patient and facility criteria for LTCHs. Several commenters further suggested that no additional reimbursement reductions under the LTCH PPS should be imposed until the RTI report is complete and the industry works with CMS to implement its findings.

Response: We understand that the commenters are concerned with the estimated decrease in payments under LTCH PPS based upon the changes in the LTC DRGs and relative weights proposed for FY 2007. However, as discussed above, we are not postponing the proposed FY 2007 reclassification and recalibration of the LTC-DRGs. In addition, the payment policies that were finalized in the RY 2007 LTCH PPS final rule, such as the zero update to the standard Federal rate and the revised short-stay outlier policy, will be effective for LTCH discharges beginning on July 1, 2007, as established in that rule.

We further acknowledge that the commenters and also MedPAC are urging us to establish a budget neutrality requirement for the annual reclassification and recalibration of the LTC-DRGs so that, in future years, the LTCH PPS would avoid an estimated decrease in aggregate payments such as the estimated 1.3 percent based on the LTC-DRG weights that we are finalizing for FY 2007.

In the responses to comments addressed above, we have noted several reasons for the annual fluctuations in LTC-DRG relative weights that resulted in an estimated increase in aggregate payments for FY 2004, a negligible estimated decrease in aggregate payments for FY 2005, and decreases in aggregate payments for FYs 2006 and 2007. We reiterate that the LTCH PPS has existed since FY 2003, and we believe that several factors are occurring that affect the changes to the relative weights, including actual improvements in coding so that cases are appropriately assigned to LTC-DRGs. Each year, we recalibrate the LTC-DRG relative weights based on the most recent available LTCH claims data, which reflect current LTCH patient mix and coding practices. The annual recalibration of the LTC-DRG relative weights to which LTCH cases are assigned will appropriately reflect more or less resource use than the previous year's LTC-DRG relative weights.

We understand the concerns expressed by the commenters regarding this fiscal year's estimated decrease in payments based upon the proposed (and finalized) FY 2007 reweighting of the LTC-DRGs. However, we remind the commenters that establishing a budget-neutrality policy for the LTC-DRG weights would have precluded the increase in payments that occurred during FY 2004 as well as any increase that an analysis of future data may warrant.

Under the IPPS, there is a statutory requirement in section 1886(d)(4)(C)(iii) of the Act that requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the

changes. However, there is no statutory or regulatory requirement that the annual update to the LTC-DRG classifications and relative weights be done in a budget neutral manner. In addition, after FY 2003, the year that the LTCH PPS was implemented, there was no statutory requirement for budget neutrality for any component of the LTCH PPS.

However, as we have already noted, the LTCH PPS, having been first implemented for cost reporting periods beginning on or after the start of FY 2003, will soon end its transition period and payment will be based solely on the Federal rate wit cost reporting periods beginning in FY 2007. In the RY 2007 LTCH PPS final rule, we provided that we would reevaluate all payment adjustments that were originally considered for the LTCH PPS prior to its implementation and also determine the appropriateness of a one-time prospective adjustment to the standard Federal rate (§412.523(d)(3)) so that the effect of any significant differences between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the PPS for future years. Given the considerable discretion granted to the Secretary under the BBRA of 1999 and the BIPA of 2000 to develop the LTCH PPS, it is possible, however, that at the same time, the Secretary would consider using his broad authority to establish a policy of budget neutrality for the annual update of the LTC-DRG classifications and relative weights. As noted above, currently the best available LTCH data (FY 2005) are from the second full year of the PPS, and LTCHs may still be modifying their behavior to the change in payment methodology. If, upon reevaluation of our payment policies based on future LTCH data as the data become available, we find that it would be appropriate to propose making the updates to the LTC-DRGs and relative

weights in a budget neutral manner, the public will have the opportunity to submit comments on any proposed change during the rulemaking process.

The commenters mentioned their eagerness to review the recommendations currently being developed by RTI regarding the feasibility of patient and facility level admissions criteria for LTCHs. We anticipate that RTI will submit its final report and recommendations during RY 2007. We place considerable importance on RTI's work, and we will encourage a dialogue with the public based on the report. We note that, while we believe the report will have a substantial impact on future Medicare policy for LTCHs, we still believe that the retention of many of the specific payment adjustment features of the LTCH PPS presently in place and the development of additional or revised adjustments may still be both necessary and appropriate for purposes of protecting the integrity of the Medicare trust fund.

Comment: Several commenters believed that the changes to the LTC-DRG relative weights will have a more significant impact on high case-mix providers than on low-case mix providers. One commenter referred to a LTCH which, as a high acuity provider, will experience an approximate 5 percent drop in total case mix index. This commenter requested that CMS make a weighted average calculation available when it publishes the impacts of changes in the relative weights. The commenter further suggested that CMS produce an impact statement focusing on changes across all DRGs that will enable providers to understand the impacts on their individual LTCHs.

Response: We believe we published a comprehensive description of the impact of the reweighting of the LTC-DRGs for FY 2007 in the proposed rule (71 FR 24413).

Specifically, in section VII, Effects of Other Proposed Policy Changes, in subsection A, under the heading, Effects of LTC-DRG Reclassifications and Relative Weights for LTCHs, we included a detailed analysis of the impact that would result from our proposals.

In that section, we stated: "When we compared the GROUPER Version 23.0 (FY 2006) LTC-DRG relative weights to the proposed GROUPER Version 24.0 (FY 2007) proposed LTC-DRG relative weights, we found that approximately 62 percent of the LTC-DRGs would have a higher relative weight under Version 23.0, while the remaining approximately 38 percent of the LTC-DRGs would have a higher relative weight under Version 24.0. We also found that, based on FY 2005 LTCH cases, the GROUPER Version 23.0 LTC-DRG relative weights were, on average, approximately 3.1 percent higher than the proposed GROUPER Version 24.0 LTC-DRG relative weights. In addition, based on an analysis of the most recent available LTCH claims data from the FY 2005 MedPAR file, we continue to observe that the average proposed LTC-DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year.

Contributing to this increase in these relatively lower charge cases being assigned to proposed LTC-DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system to a PPS. The impact of including additional cases with relatively lower charges in LTC-DRGs that had a relatively higher relative weight in the GROUPER Version 23.0 (FY 2006) is a decrease in the average relative weight for those LTC-DRGs

in the proposed GROUPER Version 24.0. As noted above in section II.F. of the preamble to this proposed rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 526 valid proposed GROUPER Version 24.0 LTC-DRGs, 191 LTC-DRGs have no LTCH cases. In addition, another 173 LTC-DRGs are categorized as 'low volume' (that is, have less than 25 cases annually). Consequently, only about 162 LTC-DRGs are used by most LTCHs on a 'regular basis' (that is, nationally LTCHs discharge, in total, an average of 25 or more of these cases annually).

Of these 162 LTC-DRGs that are used on a regular basis, we found that approximately 60 percent of the LTC-DRGs would have higher relative weights under GROUPER Version 23.0 in comparison to proposed GROUPER Version 24.0, and the remaining 40 percent of the 162 LTC-DRGs that are used on a 'regular basis' would have higher relative weights under proposed GROUPER Version 24 in comparison to GROUPER Version 23.0. In addition, about 25 percent of the 162 LTC-DRGs that are used on a 'regular basis' would experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2004 data, which generally results in a lower relative weight. Moreover, of the 162 LTC-DRGs that are used on a 'regular basis,' approximately 63 percent of those LTC-DRGs would experience a change in the average charge per case from FY 2004 LTCH data as compared to FY 2005 LTCH data that is less than the increase in overall average LTCH charges across all LTC-DRGs from FY 2004 to FY 2005 of about 8.3 percent. Accordingly, those LTC-DRGs would also have a proposed reduction in their relative weight as

compared to the relative weight in FY 2006. For those LTC-DRGs in which the average charge within the LTC-DRG increase is less than 8.3 percent, the proposed relative weights for those LTC-DRGs would decrease because the average charge for each of those LTC-DRGs is being divided by a larger number (that is, the average charge across all LTC-DRGs). For the reasons discussed above, we believe that the proposed changes in the LTC-DRG relative weights, which include a significant number of LTC-DRGs with lower proposed relative weights, would result in approximately a 1.4 percent decrease in estimated aggregate LTCH PPS payments" (71 FR 24413).

The above paragraphs, published in the FY 2007 IPPS proposed rule, clearly indicated the impact of the reweighting of the LTC-DRGs. All of the impact percentages listed are "weighted averages," as was the proposed estimated 1.4 percent decrease in aggregate LTCH PPS payments. That is, all LTCH cases in the December 2005 update of the FY 2005 MedPAR file were used to determine the LTC-DRG impact figures presented in the FY 2007 IPPS proposed rule. Therefore, the latest data on the types of patients treated across all LTCHs were used to determine the impact and not just the proposed changes to the LTC-DRG weights. The proposed and final FY 2007 reweighting of the LTC-DRGs may indeed have a more significant impact on a high acuity provider because many of the proposed and final LTC-DRG weights in relatively high weighted LTC-DRGs would decrease compared to their current values. However, we also note that Medicare payments for several of the highest acuity LTC-DRGs have yielded substantial margins. For example, an analysis of MedPAR data from FY 2004 indicated that, for LTC-DRG 475 (Ventilator Support) with a relative weight of 2.1358

for FY 2004, average aggregate (dollar weighted) margins for all providers was 21.09 percent, and for LTC-DRG 87 (Pulmonary Edema/Respiratory Support) with a relative weight of 1.6513 for FY 2004, average aggregate margins were 26.93 percent. Even for cases requiring somewhat less resource intensity, such as LTC-DRG 416 (Septicemia) with a relative weight of 0.9191 for FY 2004, which is also one of the diagnoses most frequently found in LTCHs, the aggregate margin is 11.54 percent and for LTC-DRG 249 (After Care Musculoskeletal) with a relative weight of 0.7829 for FY 2004, the margin is 9.69 percent. Therefore, we believe that the reweighting of the LTC-DRGs for FY 2007, even for those high-acuity providers who experience a more significant impact, should not impede the efficient and effective delivery of care to Medicare beneficiaries, because, as described above, several of the highest-acuity LTC-DRGs have yielded substantial margins. Furthermore, even though the recalibration of the LTC-DRG relative weights will result in a decrease in the relative weight for some high-acuity LTC-DRGs, because the recalibration is based on the most recent available LTCH claims data (FY 2005), it ensures the most accurate payments for FY 2007 based on current LTCH treatment and coding practices.

In response to the commenter who requested impacts that reflected a weighted average calculation, as noted above, the impact of the proposed changes to the LTC-DRGs for FY 2007 presented in the FY 2007 IPPS proposed rule (71 FR 24413) are based on a weighted average calculation. That is, all FY 2005 LTCH cases in the December 2005 update of the MedPAR data were used to determine the impact figures presented in the proposed rule. This means that only the proposed changes to the relative

weights for LTC-DRGs that had LTCH cases in those DRGs based on the FY 2005 LTCH data contributed to the impact. This continues to be true for the impact of the final LTC_DRG weights which are based on the most recent update of the FY 2005 MedPAR data. It also means that, for example, LTCH cases in LTC-DRG 475 represent approximately 12 percent of all LTCH cases in FY 2005 and therefore, 12 percent of the impact presented in the proposed rule was due to the proposed change in the LTC-DRG weight for LTC-DRG 475. We believe that the commenter may have mistakenly believed that we measured the impact of the proposed LTC-DRG changes based on the changes proposed for each LTC-DRG without accounting for the volume of LTCH cases treated in each LTC-DRG. In addition, we note that if a provider is eager to determine the specific impact of the annual proposed LTC-DRG reweighting on an individual LTCH or a particular weight, the provider needs only to compare an application of the LTC-DRG weights published in the previous year's final rule (Table 11) of its cases to the proposed LTC-DRG relative weights that are published in the current year's proposed rule (Table 11; 71 FR 24395-24403) as applied to the same set of cases.

Comment: Several commenters maintained that the proposed 1.4 percent decrease in aggregate payments to LTCHs due to the proposed LTC-DRG reclassification and recalibration for FY 2007, in addition to payment cuts established for RY 2007 represent a "misinterpretation" of MedPAC's recommendation in its March 2006 Report to the Congress for a zero update for LTCHs. MedPAC cited Medicare margins for 2004 of 9.0 for the LTCH industry and projected 7.8 percent margins for 2006, but the commenters believed that these projections did not factor in the impact of the "25 percent

policy" for co-located LTCHs or the estimated payment reductions associated with the revised short-stay outlier policy.

Response: As we have noted elsewhere in earlier responses to comments, the estimated 1.4 percent decrease aggregate in LTCH PPS payments due to the proposed LTC-DRG reclassification and recalibration for FY 2007 is a data-driven result of the annual recalibration of the relative weights for LTC-DRGs based on the latest available LTCH claims data from the MedPAR files (FY 2005). Therefore, for FY 2007, based on the updated LTC-DRGs classifications and relative weights, estimated payments to LTCHs will be 1.3 percent less than they would have been based on the prior fiscal year's (that is, FY 2006) classifications and relative weights for the same LTCH cases. Similarly, LTCH claims data from the FY 2006 MedPAR files will be used to determine the proposed LTC-DRG relative weights for FY 2008, and the resulting aggregate LTCH PPS payments, absent a regulatory or statutory change implementing recalibration of relative weights in a budget neutral manner, may either decrease or increase, based upon the FY 2006 data and DRG classification changes. In setting the annual relative weights for the LTC-DRG system for FY 2007, we have followed the requirements established with the implementation of the LTCH PPS in FY 2003 (67 FR 55984-55995). Although the proposed recalibrated LTC-DRG relative weights were estimated to result in 1.4 percent decrease in LTCH PPS payments for FY 2007 (and based on final policies established in this final rule, the updated LTC-DRGs for FY 2007 are estimated to result in a 1.3 percent decrease in aggregate LTCH PPS payments for FY 2007, as noted

above), we do not believe that this adjustment is relevant to MedPAC's recommendation for the zero percent update to the LTCH PPS Federal rate for RY 2007.

The annual LTC-DRG update is separate from the Federal rate update; specifically, their purposes are different and independent. The standard Federal base rate is an estimate of the national average cost per case which is adjusted by the LTC-DRG relative weights to reflect the resource consumption of the particular case; that is, a case with a relative weight of 2.0 is twice as costly/uses twice the resources as a case with a relative weight of 1.0. The LTC-DRG relative weights are recalibrated annually based on the most recent available LTCH data to reflect resources used by LTCHs in treating each type of case. The update to the Federal rate is to adjust the Federal rate to account for various adjustments to that rate, including inflation.

MedPAC 's data analysis, in its March 2006 Report to the Congress, indicated that the average Medicare margin for LTCHs was 9.0 percent for FY 2005 and was projected at 7.8 percent for 2006. (As we stated in our RY 2007 LTCH PPS final rule, MedPAC also noted that "LTCH HwHs were found to have higher margins than freestanding LTCHs in RY 2005" (71 FR 27823).) Based on its analysis, MedPAC stated that "…evidence from the indicators we have examined suggests that LTCHs can accommodate the cost of caring for Medicare beneficiaries in 2007 without an increase in the base rate" (p. 218). Consistent with MedPAC's recommendation, after incorporating an adjustment to account for changes in coding practices that did not reflect "real" case-mix, we finalized a zero percent update for FY 2007 (71 FR 27819). As stated

earlier, this adjustment is not a function of, or related to, the update to the relative weights for LTC-DRGs.

The commenters' also reference the 25-percent threshold payment adjustment for co-located LTCHs (§412.534) established beginning in FY 2005 and the newly revised short stay outlier payment policy (§412.529) beginning in RY 2007. We believe that the commenters are seeking to connect these adjustments, which are also estimated to result in a decrease in aggregate LTCH PPS payments in the absence of a change in admission practices by LTCHs to the estimated impact of the updated LTC-DRG relative weights. However, the policies cited by the commenters are not related to the impact of the updating of the LTCH-DRG relative weights, but each independently, furthers the goal of establishing fair and reasonable Medicare payments under the LTCH PPS.

The HwH "25 percent rule," that is, the special payment provisions for LTCH HwHs and satellites, was established at §412.534 in the FY 2005 IPPS final rule. Under that policy, we provide a payment adjustment for those patients discharged from co-located LTCHs (that is, HwHs and satellites) admitted from host hospitals that exceeded a specified threshold percentage (in most cases, 25 percent). Medicare patients who reach high-cost outlier status in the host hospital are excluded from the count of the percentage of patients admitted directly from the host. As we discussed in the FY 2005 IPPS final rule, when we implemented the "25 percent rule," we were unable to estimate the impact of this policy because we anticipated behavioral changes by both the host and the co-located LTCHs resulting from the provision that exempted high-cost outliers from the percentage threshold calculation (69 FR 49771).

MedPAC further addressed this issue in the March 2006 Report, where it noted that it "…cannot foresee how HwHs/ behavior will change in response to this rule. CMS has discussed scenarios (CMS 2005). For example, patients admitted to an HwHs from the host hospital after becoming an outlier are not counted in the limit, thus HwHs may admit more outlier cases under this rule. Alternatively, host hospitals may discharge fewer patients to their HwHs because of constraints from the 25 percent rule, in which case HwHs' volume might fall. In cities where there is another LTCH, an acute care hospital might discharge patients to a different long-term care hospital than the one on its grounds. The Office of Inspector General or the QIOs may want to monitor acute care hospitals' and HwHs' behavior in response to the 25 percent rule. Because we have no evidence of how HwHs will react, we have not modeled margins incorporating this policy change." (p. 218)

Because the policy at §412.534 exempts patients admitted from the host hospital if they had already achieved high-cost outlier status under the IPPS, from the LTCHs' percentage threshold calculation (as noted above), we believe that even with some adjustments resulting in a decrease in payments to some co-located LTCHs, Medicare payments to co-located LTCHs on average will continue to exceed the Medicare costs of the inpatient hospital services provided to its patients, even with a zero percent update to the Federal rate for RY 2007 (71 FR 27823). Furthermore, we believe that the 25-percent threshold policy and the short stay outlier payment revision that that we have established, first for co-located LTCHs at §412.534 for FY 2004 and the revisions to the short-stay outlier policies at §412.529 that we finalized for RY 2007,

each have a firm and consistent basis in our general policy considerations under the LTCH PPS.

As we noted in the RY 2007 final rule for the LTCH PPS, we do not believe that the change to the short-stay outlier policy will result in an adverse impact on LTCHs. As a result of the change to the short-stay outlier payment formula, we believe that LTCHs will have an incentive to significantly reduce the number of very short-stay cases that they admit. We believe that, by paying appropriately for short-stay outlier cases and by removing the financial incentive for LTCHs to admit those very short stay cases that could otherwise receive appropriate treatment at an acute care hospital (and paid under the IPPS), LTCHs will change their admission patterns for these patients. We further believe that payment decreases to LTCHs resulting from this policy would only occur if LTCHs were to continue to admit the same number of short-stay outlier patients with very short lengths of stay. We believe this policy is needed to assure that payments for short-stay outlier cases are appropriate.

Therefore, we disagree with the commenter that we have "misinterpreted" MedPAC's recommendation of a zero percent update for 2007 in our proposed update to the LTC-DRGs for FY 2007. We maintain that the rationale for each of the policy features mentioned by the commenter, when evaluated independently, is clear and reasonable. In addition, they are independent of the DRG recalibration that occurs every year based on an established formula. We strongly disagree with the allegations that their implementation represents a "misinterpretation" of MedPAC's margin analysis and recommendation (discussed above) in the March 2006 Report to the Congress. As

discussed above, this update is not based on MedPAC's analysis and we believe that updating the LTC-DRG relative weights for FY 2007 based on FY 2005 LTCH claims data will result in more appropriate LTCH PPS payments since the relative resource intensity of each LTC-DRG (that is, the relative weight) will be determined from the most recent available LTCH data (FY 2005) reflecting LTCHs' current practice and treatment patterns.

Comment: Several commenters, including MedPAC, recommended that we adopt severity-adjusted DRGs as the patient classification system for the LTCH PPS. In particular, MedPAC analyzed FY 2004 CMS LTCH data using both standardized charges and standardized hospital-specific costs (removing the effect of local wages) using Version 23 (FY 2006) of the GROUPER and stated that, on a preliminary basis, CS DRGs are relatively homogeneous in resource use for the kinds of cases treated in LTCHs. They believed that this indicates that the CS DRGs proposed for IPPS hospitals may also "be promising for LTCHs."

Response: We are aware of the heightened interest in severity-adjusted DRGs by the provider community, and in section II.C.6.of this final rule, we discuss the revisions that we are making to the DRG classifications structure for the IPPS and our expectations for adopting severity adjustments for DRGs under the IPPS in FY 2008. We appreciate the data analysis that MedPAC produced to demonstrate the potential utility of CS DRGs for classifying patients being treated in LTCHs. It is possible that the modified version of the APR DRGs or another severity-adjusted patient classification system may account for differences in severity of illness and associated costs among hospitals. In

section II.C. of this preamble, we discuss the issues that we are dealing with respect to the adoption of a severity adjusted DRG system. Once we have addressed those issues under the IPPS, we would need to consider whether it is appropriate to propose similar revisions to the patient classification system under the LTCH PPS. As stated in the FY 2007 IPPS proposed rule, we would emphasize that any proposed changes to the patient classification system for LTCHs would be done through notice and comment rulemaking.

G. 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, §412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory

provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market 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 2005 are used to calculate the FY 2007 DRG weights in this final rule. Section 412.87(b)(2) 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 with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production had been postponed until 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 special add-on payment for new medical services or technology ceases (§412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2005

and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2008 (discharges occurring before October 1, 2007), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2008 DRG weights will be calculated using FY 2006 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2008 DRG weights.

Section 412.87(b)(3) further provides that, to receive special payment treatment, new medical services or technologies must be inadequately paid otherwise under the DRG system. To assess whether technologies would be inadequately paid under the DRGs, we establish thresholds to evaluate applicants for new technology add-on payments. In the FY 2004 IPPS final rule (68 FR 45385, August 1, 2003), 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 transformed 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 many different DRGs). Table 10 in the Addendum to the FY 2004 IPPS final rule (68 FR 45648) listed the qualifying threshold by DRG, based on the discharge data that we used to calculate the FY 2004 DRG weights.

However, section 503(b)(1) of Pub. L. 108-173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for "applying 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 1 standard deviation for the diagnosis-related group

involved." The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. We updated Table 10 from the **Federal Register** document that corrected the FY 2004 final rule (68 FR 57753, October 6, 2003), which contained the thresholds that we used to evaluate applications for new service or technology add-on payments for FY 2005, using the section 503(b)(1) measures stated above, and posted these new thresholds on our Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp. In the FY 2005 IPPS final rule (in Table 10 of the Addendum), we included the final thresholds that were being used to evaluate applicants for new technology add-on payments for FY 2006. (Refer to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084, August 11, 2004) for a discussion of a revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108-173.) Table 10 of the Addendum to the FY 2006 final rule (70 FR 47680) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2007.

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. (Refer to the September 7, 2001 final rule (66 FR 46902) for a complete discussion of this criterion.)

The new medical service or technology add-on payment policy provides additional payments for cases with high costs involving eligible new medical services or technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under §412.88, Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Pub. L. 106-554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106-1033, 106th Cong., 2nd Sess. at 897 (2000)). 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 at the same time we estimated 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.

Section 1886(d)(5)(K)(ii)(III) of the Act, as amended by section 503(d)(2) of Pub. L. 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, add-on payments for new medical services or technologies for FY 2005 and later years have not been budget neutral.

Applicants for add-on payments for new medical services or technologies for FY 2008 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, no later than October 15, 2006. Applicants must submit a complete database no later than December 30, 2006. Complete application information, along with final deadlines for submitting a full application, will be available at our Web site: http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp. To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2008, the Web site will also list the tracking forms completed by each applicant.

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 Pub. L. 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.
- 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 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 2007 before publication of the FY 2007 IPPS proposed rule, we published a notice in the **Federal Register** on December 23, 2005 (70 FR 76315) and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 16, 2006. 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 discussions

of the substantial clinical improvement criterion for each of the FY 2007 new medical service and technology add-on payment applications before the publication of the FY 2007 IPPS proposed rule.

Approximately 35 participants registered and attended the town hall meeting in person, while additional participants listened over an open telephone line. The participants focused on presenting data on the substantial clinical improvement aspect of their products, as well as the need for additional payments to ensure access to Medicare beneficiaries. In addition, we received written comments regarding the substantial clinical improvement criterion for the applicants. We considered these comments in our evaluation of each new application for FY 2007 in the proposed rule and in this final rule. We have summarized these comments or, if applicable, indicated that no comments were received, at the end of the discussion of the individual applications.

We received two general comments about application of the newness and substantial clinical improvement criteria.

Comment: One commenter encouraged CMS to amend the definition of substantial clinical improvement for the IPPS new technology provision to conform to the OPPS definition of substantial clinical improvement used in 2001. Specifically, AdvaMed requested that after "decreased pain, bleeding, or other quantifiable symptom," CMS should insert the following language: "such as convenience, durability, ease of operation or make other improvements in quality of life."

Response: We believe we addressed this concern in the FY 2006 IPPS final rule (70 FR 47360). We use similar standards to evaluate substantial clinical improvement in

the IPPS and OPPS and, in both systems, we employ identical language to explain and elaborate on the kinds of considerations that are taken into account in determining whether a new technology represents a substantial clinical improvement. We do not believe a change to the regulations text is necessary.

Comment: One commenter suggested that CMS should not use "substantial similarity" to evaluate newness without also determining whether the product is a substantial clinical improvement. The commenter argued that CMS is applying a concept that is not defined in regulations. If CMS applies the concept as part of determining whether a product is new without evaluating substantial clinical improvement, the commenter recommended that CMS should define substantial similarity through notice and comment rulemaking.

Response: We addressed this comment in the FY 2006 IPPS final rule (70 FR 47350 through 47351). We refer readers to that final rule for a detailed response to this comment.

Section 1886(d)(5)(K)(ix) of the Act, as added by section 503(c) of Pub. L. 108-173, requires that, before establishing any add-on payment for a new medical service or technology, the Secretary shall seek to identify one or more DRGs associated with the new technology, based on similar clinical or anatomical characteristics and the costs of the technology and assign the new technology into a DRG where the average costs of care most closely approximate the costs of care using the new technology. No add-on payment will be made if the new technology is assigned to a DRG that most closely approximates its costs.

At the time an application for new technology add-on payments is submitted, the DRGs associated with the new technology are identified. We only determine that a new DRG assignment is necessary or a new technology add-on payment is appropriate when the payment under these currently assigned DRGs is not adequate and the technology otherwise meets the newness, cost, and substantial clinical improvement criteria.

In this final rule, we evaluate whether new technology add-on payments will continue in FY 2007 for the three technologies that currently receive such payments. In addition, we present our evaluations of three applications for add-on payments in FY 2007.

Comment: One commenter stated that section 503 of Pub. L. 108-173 provided new funding for new technology add-on payments by no longer requiring that these payments be budget neutral. The commenter stated that this provision was enacted to ensure that the IPPS would better account for new drugs, devices, and services. However, the commenter believed that CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments.

Another commenter called upon CMS to be more willing to indicate its preliminary views regarding whether a new technology application meets the criteria for add-on payments in the proposed rule. The commenter expressed particular concern that CMS had not given a strong indication of whether any of the initial new technology applications would meet the substantial clinical improvement criterion and noted that doing so would enhance stakeholder dialogue with CMS on the evaluation of the new technology criteria during the comment period.

Another commenter believed that CMS' definition of new technology is contrary to the statute. The commenter explained that CMS uses the FDA approval date to determine newness while the statute clearly requires that new technology add-on payments begin on the date an ICD-9-CM code is issued. The commenter urged CMS to use the date an ICD-9-CM code is issued to determine whether a technology is new instead of the FDA approval date.

Response: With respect to the comment that CMS resists approval of new technologies and considers only a few technologies a year for add-on payments, we note that we encourage companies with new-technologies that believe that they may meet the new technology criteria to apply for add-on payments. In our view, we have not resisted approving new technologies or been overly stringent in our application of the criteria. Our review of new technology focuses on the merits of the application and the requirements under the statute. The experience of our review process indicates that a significant number of new technologies have met the criteria. In fact, we have approved over 50 percent (6 of 11) of applications where we had to apply judgment about whether the technology met the criteria for an add-on payment. From FY 2003 to FY 2006, we received a total of 25 applications, but only 21 were unique (four applicants applied twice in subsequent years for the same technology). Of the applications that we received, 8 were already beyond the timeline to be considered new, 1 had not received FDA approval, and 1 did not meet the cost criterion. In our view, we denied these applications using objective criteria and without having to apply any subjective judgment. Of the remaining 11 applications, 6 were approved for new technology add-on payment, while

the other 5 were not approved because we determined that these applications were not substantially different from older technologies or did not meet the substantial clinical improvement criterion. Therefore, to date, we have approved over 50 percent of applications where we needed to apply judgment about whether a new technology met the criteria for an add-on payment. These statistics obviously reflect the recent experience of new technology applications, and, depending on the ability of applications to meet the criteria in the future, will likely change. We note that the merits of each application determine whether it should be approved. The aggregate statistics reflect the ability of applicants to satisfy the criteria, and should not be construed as a measure of the appropriateness of the review process. We also note that over the years, the cost criterion has been lowered, giving applicants a lower threshold to meet the cost criterion. We encourage and welcome additional applications in future years so that we can continue to make payments for those technologies that meet the criteria and warrant new technology add-on payments.

With respect to the comment that CMS should be more willing to indicate our preliminary views regarding whether a new technology meets the criteria for an add-on payment, we provided our initial concerns regarding the two pending applications in the proposed rule. For the C-Port® System, we described our concerns about both the newness ("various forms of surgical staples and clips have been used for more than a decade in a wide range of surgical procedures") and substantial clinical improvement ("the applicant submitted evidence suggesting that device does not always produce reliable anastomoses") criteria and also indicated that the device appears to meet the cost

threshold (71 FR 24071). Similarly, for the X STOP Interspinous Process Decompression System, we indicated our belief that "the device satisfies the newness and cost threshold criteria" and described our concerns about substantial clinical improvement (71 FR 24072). As a result of information provided in the proposed rule, the applicants were afforded the opportunity to address the specific concerns we raised. For example, the applicant for the C-Port® system was able to address our concerns about similarity to predicate devices to allow us to determine that the device meets the newness criterion. Similarly, the applicant for X STOP was able to address the concerns we raised in the proposed rule about whether the device meets the substantial clinical improvement criterion during the comment period.

Finally, with respect to the comment that CMS should use the issuance of an ICD-9-CM code as the date on which "newness" would begin, we have addressed this issue several times before, including in the FY 2005 IPPS final rule (69 FR 49002) and the FY 2006 IPPS final rule (70 FR 47343).

Comment: One commenter proposed that CMS allow manufacturers to apply for a new technology add-on payment on an ongoing basis and recommended that the agency issue quarterly updates announcing the approval of new technology add-on payments, similar to the outpatient setting.

Response: Section 1886(d)(5)(K)(i) of the Act requires that new technology add-on payments be established after notice and opportunity for public comments (in the publication required by subsection (e)(5) for a fiscal year or otherwise). In addition, pursuant to section 1886(d)(5)(K)(viii) of the Act, we are also required to hold an annual

town hall meeting prior to the IPPS proposed rule to obtain public input about whether a new technology meets the substantial clinical improvement criterion. Given the requirements in the statute, it is not feasible to process applications on a quarterly basis.

Comment: Some commenters expressed disappointment that CMS has not increased the payment rate for new technology add-on payments from a maximum of 50 percent to a maximum of 80 percent of the marginal cost factor of the new medical service or technology, consistent with the outlier payment methodology. The commenters stated that increasing the marginal cost factor from 50 percent to 80 percent would offer some stability and consistency for hospitals thus enabling hospitals to more easily provide their patients access to new technologies.

Other commenters noted that CMS has approved so few technologies for new technology add-on payments that it would make more sense to compensate hospitals with a full add-on payment by paying on a cost basis using the average sales price plus six percent for FDA approved drugs and biologicals and list price plus a percentage for devices. The commenters believed that such a payment methodology would ensure that, "providers recoup their costs, Medicare pays a fair rate, and that payment is harmonized across treatment settings." Finally, one commenter requested that CMS provide clear guidance and greater transparency as to how determinations of newness will be made for a technology that already has an ICD-9-CM code but is later approved by the FDA for a new indication.

Response: We did not propose any changes to the marginal cost factor in the proposed rule. Furthermore, we continue to believe that a 50-percent marginal cost factor

is appropriate for the reasons described in detail in the new technology final rule (66 FR 46919, September 7, 2001).

Also, we have already discussed the situation in which a technology is described under an existing ICD-9-CM code, but subsequently receives approval for a new indication from the FDA. That discussion can be found in the September 7, 2001 new technology final rule (66 FR 46915) and in the FY 2005 IPPS final rule (69 FR 49011) concerning InFUSE® Bone Graft for tibia fractures.

Comment: Several commenters stated that CMS did not address how the proposed changes to the DRGs would affect new technology add-on payments. Another commenter stated that it is essential that CMS maintain new technology add-on payments for FY 2007 and beyond. Another commenter recommended that CMS broaden the new technology criteria to ensure that new technologies are accounted for within a cost-based DRG system.

Response: Although we are adopting a system of cost relative weights in this final rule (section III.C. of this preamble), we will continue to apply the cost criterion using standardized charges consistent with the statute. The statute requires that we apply "a threshold specified by the Secretary that is the lesser of 75 percent of the standardized payment amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the diagnosis-related group involved." Changes to the DRG system to better recognize severity in the DRG will also have no effect on our application of the new technology criteria. Any changes to the DRG system will merely result in us calculating different thresholds for the revised DRGs. In addition,

once a technology is approved for new technology add-on payments, we will continue to use the ICD-9-CM code to identify the technology for determining when new technology add-on payments are appropriate.

Finally, section 1886(d)(5)(K) and (L) of the Act establishes a process of identifying and ensuring adequate payment for new medical services and technologies. Because no changes have been made to this section of the statute, we will continue to make new technology add-on payments for FY 2007 and beyond for those technologies that meet the criteria.

Comment: One commenter recommended that, because CMS proposed to implement a cost-based weight DRG system, CMS should reconsider whether applicants for FY 2007 new technology add-on payments meet the cost criterion based on a revised data set.

Response: As stated above, Table 10 of the Addendum to the FY 2006 IPPS final rule (70 FR 47680) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2007. We use the thresholds contained in Table 10 that were published in the previous year's final rule (that is, FY 2006) to determine whether a technology is inadequately paid for the next fiscal year (that is, FY 2007). We publish Table 10 in the proposed rule in order to give the public notice and the opportunity to submit comments before we finalize the thresholds in the final rule. Also, it is necessary for applicants to have the thresholds from Table 10 during the application process so that both the applicants and CMS can establish if the

applicant's technology meets the cost criterion. Further, as we note above, we believe that the statute requires us to establish the cost thresholds using charges.

Comment: One commenter noted that section 503 of Pub. L. 108-173 included a provision to expand the inpatient new technology add-on payment to include a broader range of technologies. The commenter added that this legislation was made to ensure that adequate payments were made to hospitals until hospital charges include the costs for these technologies. The commenter explained that CMS' narrow interpretation has created a situation where few, if any, products can qualify for new technology add-on payments and a process that is opaque and thus, costly, especially for small companies, to apply for add-on payments. The commenter requested that CMS provide greater opportunity for technologies to qualify for add-on payments to ensure patient access to new technologies as Congress intended.

Response: Section 503 of Pub. L. 108-173 amended the law to: (1) require that we establish diagnosis and procedure codes annually on April 1 as well as October 1; (2) change the application of the cost threshold; (3) require a process for obtaining public input on new technology applications prior to the proposed rule; and (4) eliminate the budget neutrality requirement for new technology add-on payments. We believe that we have implemented section 503 as Congress intended.

As we discussed in the FY 2006 IPPS final rule (70 FR 47344), we do not believe that our criteria present an inordinately cumbersome burden for small companies that want to apply for new technology add-on payments. We have received applications for FY 2007 from relatively small companies compared to some of the companies that have

applied in the past. Further, we have already been approached by other small companies seeking new technology add-on payments for FY 2008. We encourage potential applicants to contact us before their technology is available on the market if they have questions about the new technology application process.

Comment: One commenter requested that it be given the opportunity to work closely with CMS to help refine the regulatory framework under which CMS evaluates new innovative treatments for Medicare beneficiaries. The commenter suggested ideas such as creating a pathway for small companies under FDA review to elect to meet with CMS to discuss coverage, payment, and coding issues. In addition, the commenter recommended that CMS establish a committee and annual public workshop to assist emerging technologies and small companies with the new technology add-on payment process.

Response: We have been committed to providing ample opportunity for applicants and other interested parties to make their views known to us throughout the application process, at the annual public meeting, and during the comment period on the proposed rule. We encourage interested parties to contact CMS staff for more information about the new technology add-on application process. Interested parties may contact Tiffany Swygert at (410) 786-4642 or Michael Treitel at (410) 786-4552.

Comment: One commenter requested that CMS broaden the definition of substantial clinical improvement. The commenter explained that, in the outpatient setting, CMS views as a separate factor "improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even

though they do not directly result in substantial clinical improvements." For example, technological advancements may result in improvement of a product's "convenience, durability [or] ease of operation such as the strength of materials, increased battery life, [and] miniaturization." The commenter suggested that CMS could recognize these additional improvements along with others when evaluating substantial clinical improvement in the inpatient setting.

Response: The commenter's specific reference to language that was included in the November 2, 2001 OPPS final rule was taken out of context. The language quoted above by the commenter from that OPPS final rule stated that CMS "may," under the OPPS, recognize technologies for separate payment even though they do not directly result in substantial clinical improvements. To date, under the OPPS, we have only applied the explicit substantial clinical improvement criteria to pass-through device category applications. In the OPPS context, CMS has not found any applications for technologies "that are so significant that we may wish to recognize them for separate payment (as opposed to packaged payments) even though they do not result in substantial clinical improvements" (67 FR 66783). In fact, the historical OPPS experience has indicated that, in general, highly significant advances in medical technology from characteristics such as longer battery life commonly result in substantial clinical improvements that may be appropriately evaluated according to the substantial clinical improvement criteria alone. We have not made a determination to apply these standards within the IPPS. However, as noted in the FY 2005 IPPS final rule (69 FR 49021), we

will continue to consider whether to employ specific factors such as those identified for the OPPS in the IPPS.

Comment: One commenter urged CMS not to use the FDA section 510(k) approval process as a bar to a determination of meeting the newness criterion because the "predicate" devices identified through the section 510(k) approval process are not necessarily substantially similar to the new technology; rather the approval indicates that the new device is at least as safe and effective as its predicate(s).

Response: We appreciate the commenter's concern and agree that the mere existence of a predicate device(s) identified in the FDA section 510(k) approval process should not automatically preclude a product from meeting the newness criterion. Although we may consider the predicate devices that are listed in the FDA section 510(k) approval, we will evaluate whether a new technology is substantially similar to existing products on a case-by-case basis. We refer readers to the discussion in the FY 2006 final rule (70 FR 47350-47352) for more detailed information on substantial similarity.

3. FY 2007 Status of Technologies Approved for FY 2006 Add-On Payments

a. Kinetra® Implantable Neurostimulator (Kinetra®) for Deep Brain Stimulation

Medtronic, Inc. submitted an application for approval of the Kinetra® implantable neurostimulator device for new technology add-on payments for FY 2005. In the IPPS final rule for FY 2005 (69 FR 49019, August 11, 2004), we approved Kinetra® for new technology add-on payments.

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the

market and data reflecting the cost of the technology are reflected in the DRG weights. This technology received FDA approval on December 16, 2003. Therefore, the technology will be beyond the 2- to 3-year period during which it can be considered new during FY 2007. Therefore, we proposed in the FY 2007 IPPS proposed rule (71 FR 24070), to discontinue add-on payments for the Kinetra® rechargeable, implantable neurostimulator device for FY 2007.

The manufacturer submitted a request that we consider a higher-paying DRG assignment for dual array neurostimulator pulse generator cases. We have taken this request into consideration and have reviewed the FY 2005 Medicare charge data for cases that use implantable neurostimulator for deep brain stimulation. Our findings and a full discussion of this issue can be found in section II.D.2.a. of the preamble of this final rule.

Comment: A number of commenters were concerned that the expiration of the new technology add-on payment for Kinetra® will lead to inadequate payments for full system Kinetra® implants. One commenter requested that CMS reconsider its decision to end payments for the Kinetra® implantable neurostimulator. Other commenters thanked CMS for its efforts in granting add-on payments for the Kinetra® during the last 2 years.

Response: As noted above, the Kinetra® technology will be beyond the 2-year to 3-year period during which it can be considered new during FY 2007. Therefore, we are finalizing our proposal from the FY 2007 IPPS proposed rule (71 FR 24070) to discontinue add-on payments for the Kinetra® rechargeable implantable neurostimulator for FY 2007.

b. Endovascular Graft Repair of the Thoracic Aorta

W. L. Gore & Associates, Inc. submitted an application for consideration of its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG) for new technology add-on payments for FY 2006. The manufacturer argued that endovascular stent-grafting of the descending thoracic aorta provides a less invasive alternative to the traditional open surgical approach required for the management of descending thoracic aortic aneurysms. The GORE TAG device is a tubular stent-graft mounted on a catheter-based delivery system, and it replaces the synthetic graft normally sutured in place during open surgery. The device was initially identified using ICD-9-CM procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels). The applicant also requested a unique ICD-9-CM procedure code. As noted in Table 6B of the FY 2006 IPPS final rule (70 FR 47637), new procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) was assigned to this technology.

In the FY 2006 IPPS final rule (70 FR 47356), we approved the GORE TAG device for new technology add-on payment for FY 2006. We noted that any substantially similar device that is FDA-approved before or during FY 2006 that uses the same ICD-9-CM procedure code as GORE TAG and is assigned to the same DRGs as those approved for new technology add-on payments may also receive the new technology add-on payment associated with this technology in FY 2006.

FDA approved GORE TAG on March 23, 2005. The technology remains within the 2- to 3-year period during which it can be considered new. Therefore, as we proposed

(71 FR 24070), we are continuing add-on payments for the endovascular graft repair of the thoracic aorta for FY 2007.

Comment: Some commenters supported our proposal to continue new technology add-on payments for GORE TAG for FY 2007.

Response: We thank the commenters for their support and, as noted above, we are continuing new technology add-on payments for GORE TAG for FY 2007.

c. Restore® Rechargeable Implantable Neurostimulator

Medtronic Neurological submitted an application for new technology add-on payments for its Restore® Rechargeable Implantable Neurostimulator for FY 2006. The Restore® Rechargeable Implantable Neurostimulator is designed to deliver electrical stimulation to the spinal cord to block the sensation of pain. The technology standard for neurostimulators uses internal sealed batteries as the power source to generate the electrical current. These internal batteries have finite lives, and require replacement when their power has been completely discharged. According to the manufacturer, the Restore® Rechargeable Implantable Neurostimulator "represents the next generation of neurostimulator technology, allowing the physician to set the voltage parameters in such a way that fully meets the patient's requirements to achieve adequate pain relief without fear of premature depletion of the battery." The applicant stated that the expected life of the Restore® rechargeable battery is 9 years, compared to an average life of 3 years for conventional neurostimulator batteries. We approved new technology add-on payments for all rechargeable, implantable neurostimulators for FY 2006. Cases involving these devices, made by any manufacturer, are identified by the presence of newly created

ICD-9-CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. The FDA approved the Restore® Rechargeable Implantable Neurostimulator in 2005. However, as noted above and in the FY 2006 IPPS final rule (70 FR 47358), at least one similar product was approved by the FDA as early as April 2004. Nevertheless, consistent with current policy (70 FR 47362) and decisions for prior products (that is, bone morphogenetic products and CRT-D devices), as we proposed (71 FR 24070 through 24071), we are continuing new technology add-on payments for rechargeable, implantable neurostimulators in FY 2007 because the product will be beyond the 3-year period only in the latter 6 months of the fiscal year.

Comment: Some commenters supported our decision to continue add-on payments for the Restore® Rechargeable Implantable Neurostimulator.

Response: We appreciate the commenters' support and as noted above, we are continuing new technology add-on payments for Restore® Rechargeable Implantable Neurostimulator for FY 2007.

4. FY 2007 Applications for New Technology Add-On Payments

a. C-Port® Distal Anastomosis System

Cardica, Inc. submitted an application for new technology add-on payments for FY 2007 for its Cardica C-Port® Distal Anastomosis System. The manufacturer stated

that the C-Port® System is indicated for all patients requiring a vein as a conduit during a coronary bypass operation for bypassing a coronary artery stenosis or occlusion. The manufacturer contended that the C-Port® System is specifically designed to create a reliable and consistent end-to-side anastomosis between a conduit, such as a venous graft, and a small arterial vessel during the bypass surgery. The device consists of eight stainless steel clips and a delivery system. Once the vein graft has been loaded into the device and the device positioned against the target vessel, the anastomosis is created by pushing a single button. Cardica, Inc. stated the main purpose of the device is to replace a conventional hand-sewn, distal anastomosis with an automated, compliant, mechanical anastomosis.

We received the following public comments at the new technology town hall meeting regarding whether this technology meets the substantial clinical improvement criteria:

Comment: The manufacturer argued that this technology meets the substantial clinical improvement criterion because:

- It achieves higher patency rates at 6 months compared to conventional hand-sewn anastomoses.
- Use of the device will result in less surgeon-to-surgeon variability in the quality of the anastomosis compared to hand sewing.
- The device leads to reduced operative time.
- The product allows for the creation of an anastomosis during minimally invasive surgery.

In addition, we received written comments expressing support for approval of new technology add-on payments for the C-Port® System. These commenters noted that--

- The device allows the anastomosis to be completed quickly, reducing patient complications during surgery from ischemia.
- The device will allow for smaller incisions during heart surgery and physicians will not have to position their hands in the chest cavity in order to hand-sew the anastomosis.
- The rapidly deployed anastomosis clamp provides patients with a surgical alternative where one would otherwise not be available due to the comorbidities associated with the more invasive CABG procedures.

Response: We appreciate the time and effort the applicant took to present at the town hall meeting. We indicated in the proposed rule that we would consider the information presented in the written comments and at the town hall meeting, and invoted interested parties to submit objective data that would support the assertions presented above by the commenters.

The C-Port® System was granted section 510(k) approval from the FDA on November 10, 2005. While the device appeared to meet the criteria for being considered new based on its FDA approval date, we were concerned that various forms of surgical staples and clips have been used for more than a decade in a wide range of surgical procedures. In fact, the FDA found that the C-Port® System "is substantially equivalent to the predicate devices with regard to indications, device characteristics, method of use,

labeling and materials." Thus, given its similarity to other devices currently on the market, we were concerned that the C-Port® System may not qualify as new. In the FY 2007 IPPS proposed rule, we solicited specific comments on whether this device is new and how it could be distinguished from predicate devices that perform the same or a similar function.

We received the following public comments in response to the proposed rule.

Comment: The manufacturer commented that the C-Port® System meets the newness criterion for the following reasons:

- The FDA section 510(k) approval process identifies predicate devices as having "a similar, not necessarily identical use and function."

- There is no other "fully-integrated anastomotic system cleared by the FDA for the creation of an anastomosis between a blood vessel graft and a target coronary artery." There are no "clip or staple-based automated distal coronary anastomotic devices such as [C-Port®] approved by the FDA." The manufacturer argued that while the devices they identified in the FDA section 510(k) approval process are similar to C-Port® system, none of them are identical.

- C-Port® was FDA approved in November 2005, thus enabling the device to still qualify as new based on its FDA approval date.

- There is no clinical precedence for the use of a stapling device in creating distal coronary anastomoses, and there are no ICD-9 CM codes for stapling devices--the lack of the procedure code means that CMS does not have charge data for C-Port® and that the device's costs are not reflected in the current DRG weights.

● CMS approved Kinetra® in 2004 and stated that the Kinetra® device was not "significantly different in terms of how it achieves its desired clinical results from its predecessor Soletra®." The manufacturer believed that the approval of Kinetra® sets precedence for C-Port® approval.

Response: We appreciate the manufacturer's clarification of the questions we posed in the proposed rule about whether the C-Port® would meet the newness criterion. The additional information submitted has allowed us to determine that the C-Port® meets the newness criterion.

In response to the commenter's statement about Kinetra®, we indicated that Soletra® and Kinetra® achieve the desired clinical result through the same stimulation mechanism. However, we did not find Soletra® and Kinetra® to be substantially similar products. We noted that Soletra® controls symptoms only on one side of a patient's body, while Kinetra® provides bilateral control of neurological symptoms through a single device. We determined in the FY 2005 IPPS final rule (69 FR 49019) that Kinetra® represented a substantial clinical improvement over the previous Soletra® device.

In the proposed rule, we also noted that there is currently no ICD-9-CM code used to identify how the anastomosis is performed. The surgical technique used to graft the bypass to the arterial vessel is part of the surgical procedure itself and is not separately identified in our current coding structure. Although there is not an explicit code to identify C-Port®, the hospital's charge for the device will be included on its bill. The hospital is permitted to charge for all items and services it furnishes irrespective of

whether a particular item is identified by an explicit ICD-9-CM code. The charges included on hospital bills for the device will be part of the relative weight calculation 2 years later (that is, FY 2005 hospital charge data are used to set the FY 2007 relative weights).

Comment: The manufacturer of C-Port® urged CMS to differentiate between "distinct procedures involving the creation of anastomosis" by creating the following codes: (a) anastomosis, manual; and (b) anastomosis, automated, using single or multiple clip array deployment technology. The manufacturer commented that a new code should be created for C-Port® because the C-Port® Distal Anastomosis procedure is not a typical part of the bypass procedure code and the use of the C-Port® system requires training and proctoring for physicians and OR staff to use the equipment because the C-Port® system comprises new steps and preparation in the bypass procedure. Finally, the manufacturer stated that CMS set a precedent for the creation of a new code by creating a code for a drug-eluting stent even though ICD-9-CM procedure codes already existed for stent procedures and by creating a new code to distinguish single versus dual channel-pulse generator devices (Kinetra® by Medtronic).

Response: While the use of the C-Port® device may represent a difference in technique of creating a distal anastomosis, we do not agree that it is a distinct procedure. Historically, we have subdivided procedures involving the insertion of specific devices that are designed to achieve a specific therapeutic purpose, but we have not assigned a code for specific tools used to perform surgery. Kinetra®, a stent and a pacemaker, is an example of a device that is implanted in a patient to treat an illness that is appropriately

assigned a code. To date, we have not used a code to identify a specific type of surgical tool such as a scalpel, saw, or clamp. Similarly, we view C-Port® as a surgical tool (albeit far more sophisticated or innovative than those just mentioned) that should also not be recognized by its own ICD-9-CM code.

The applicant made several arguments in support of the device meeting the cost criterion. Cardica, Inc. estimated that the cost of each device will be approximately $1,200. The applicant assumed a hospital markup of 100 percent, with an average use of 2.5 C-Port® devices per case. Therefore, it estimated that the total average charge per patient will be $6,000. The C-Port® System would be used when a coronary artery bypass graft is performed. Thus, we assessed whether it meets the cost criterion in relation to the threshold for DRGs 106 (Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty), 547 (Coronary Bypass with Cardiac Catheter with Major CV Diagnosis), 548 (Coronary Bypass with Cardiac Catheter without Major CV Diagnosis), 549 (Coronary Bypass without Cardiac Catheter with Major CV Diagnosis), and 550 (Coronary Bypass without Cardiac Catheter without Major CV Diagnosis). We note that the data analysis for this technology is slightly unusual, as the DRGs to which the technology would have been assigned in FY 2005 (the MedPAR data we are currently using) are DRGs 107 and 109. These DRGs were terminated in FY 2006, and 4 new coronary bypass DRGs were created for these cases (DRGs 547, 548, 549, and 550). The manufacturer provided estimates showing a case-weighted threshold for DRGs 106, 547, 548, 549 and 550 of $75,373. The applicant projected a 20-percent market penetration for the device in FY 2007 or its use in approximately 23,000 cases across the 5 DRGs.

The applicant submitted data showing average standardized charges for cases using the C-Port® System of $80,887. Therefore, the applicant argued that the device meets the cost threshold for a new technology add-on payment. Our internal data analysis of the technology, using the FY 2005 MedPAR data and Table 10 thresholds for FY 2005, shows a case-weighted threshold of $68,416. We identified cases using coronary bypass procedure codes 36.10, 36.11, 36.12, 36.13 and 36.14, and concluded that the case-weighted average standardized charge for these bypass cases was $79,394. Thus, our internal data also suggested that the device meets the cost threshold.

As we discussed in the proposed rule, the applicant made several arguments in support of the device meeting the substantial clinical improvement criterion. The manufacturer argued that the C-Port® creates a reliable and fully compliant end-to-side anastomosis between a vein graft and a coronary artery, in less time than is required to create a hand-sewn distal anastomosis. The applicant also stated that the C-Port® System integrates deployment of the anastomotic clips and creation of the arteriotomy, thus enabling deployment to occur without occlusion of blood flow through the target vessel. However, we note that the applicant submitted evidence suggesting that the device does not always produce reliable anastomoses; specifically, a study of 130 patients receiving 132 devices reported 13 incomplete anastomoses in 12 patients, and the study also noted that additional manual stitches were required in the majority of the patients studied. Therefore, we were concerned that these studies suggested that the C-Port® System may not represent a substantial clinical improvement over the traditional hand-sewn technique. At the town hall meeting, the applicant noted that these results were

associated with inexperience preparing the target vessel, vein thickness assessment, proper device alignment and anastomosis site selection rather than problems with the device itself. The applicant believed that these problems will become infrequent as surgeons have more experience with the device. In the FY 2007 IPPS proposed rule, we solicited further information from commenters that would suggest how the product meets the substantial clinical improvement criterion.

We received the following comment in response to the proposed rule.

Comment: The manufacturer submitted the following comments to be considered in our evaluation of whether C-Port® met the substantial clinical improvement criterion:

- Intraoperative anastomotic failures with the hand-sewn technique occur in approximately 10 percent of patients. Falk, et al., evaluated vein graft patency using a meta-analysis of 28 published studies with over 28,000 grafts and found that occlusion within 30 days occurs in about 12 percent of vein grafts while occlusion within 6 months occurs in 20 percent.

- The C-Port® device may mitigate some of the negative factors found in hand-sewn anastomoses that impact vein graft patency. Post-operative vein graft patency rates using the hand-sewn technique were 88 percent at 30 days and 80 percent at 6 months (data obtained from historical controls); whereas patency rates using the C-Port® device were 99 percent at discharge and 96 percent at 6 months.

- In the greater than 1-year followup group, none of the patients in the pivotal C-Port® study required a reintervention.

- The "10 percent failure rate" cited in a C-Port® publication referred to a failure in surgeons using the device (due to lack of experience using it), not a failure of the device itself.

Response: We are concerned that information presented by the applicant does not demonstrate that this technology is a sufficient improvement over hand-sewing the distal anastomosis. Although patency rates using the C-Port® device were reportedly higher than those found using the hand-sewn technique (99 percent at discharge and 96 percent at 6 months compared to 88 percent at 30 days and 80 percent at 6 months), we also found that the data on the hand-sewn patency rates was derived from a meta-analysis of over 28,000 bypass grafts to different coronary vessels, many of which may have been comparatively poor candidates for bypass grafting, suggesting a possible selection bias in the arteries in the C-Port® study. We believe that a clinical study demonstrating substantial clinical improvement in outcomes is necessary for this technology because the comparison is of the CABG procedure using the C-Port® device to the hand-sewn technique. In some cases, our approval of a technology was based on a clinical assessment that at least one of the criteria for evaluating substantial clinical improvement listed in the new technology final rule (66 FR 46914) was met. For example, our approval of the Restore® rechargeable neurostimulator was based on evidence that showed it decreased the "rate of subsequent…therapeutic interventions" by avoiding a surgery to replace a battery. Similarly, we approved GORE TAG because it "offers a treatment option for patient population unresponsive to, or ineligible for, currently available treatments." In these cases, we were less reliant on a clinical study to

demonstrate improvement over an existing technology than our clinical judgment that the product achieved its intended purposes which itself is a substantial clinical improvement. With C-Port® or with a hand-sewn anastomosis, the treatment is the same (a CABG for coronary artery vessel disease). Thus, clinical studies demonstrating an improvement in CABG outcomes using the C-Port® device relative to the hand-sewn technique are critical to approving the device for new technology add-on payments.

Given the relatively high rates of success of both the hand sewn and the automated technique, we were not able to determine that the C-Port® device is a substantial clinical improvement over the traditional hand-sewn technique. Accordingly, after consideration of the comments received, we are not approving the C-Port® Distal Anastomosis System for FY 2007 new technology add-on payment.

There are several potential criteria listed in the new technology final rule that C-Port® could potentially meet. For instance, it is possible that C-Port® will reduce recovery time or lead to more rapid beneficial resolution of the disease process treatment. Given the potential benefits of C-Port®, it is likely that we would approve the technology for add-on payments with a study that more definitively demonstrates substantial clinical improvement. For instance, our main concern with the study presented was that the control group and the study population used to demonstrate substantial clinical improvement may not have been directly comparable. If there was a study that showed similar improvements in patency rates between the control group and a study population where the patients were directly comparable in their coronary artery vessel disease, we

believe it would be more likely to demonstrate that the substantial clinical improvement criterion was met.

b. NovoSeven® for Intracerebral Hemorrhage

The Pinnacle Health Group in conjunction with Novo Nordisk Inc. (the manufacturer) submitted an application for new technology add-on payments for FY 2007 for NovoSeven® for Intracerebral Hemorrhage. However, the applicant withdrew its application for new technology add-on payment on June 07, 2006.

We received the following public comments regarding this application for new technology add-on payments in response to the FY 2007 IPPS proposed rule.

Comment: One commenter supported approving new technology add-on payments for NovoSeven®. The commenter believed that the availability of an add-on payment would help facilitate patient access to this important and costly therapy.

Response: We appreciate the commenter's response to the proposed rule. We note that, during the comment period, the applicant withdrew its application from consideration for new technology add-on payments for FY 2007.

We appreciate the applicant for its submittal of an application for new technology add-on payments and encourage a resubmission of an application upon FDA approval of its technology.

c. X STOP Interspinous Process Decompression System

St. Francis Medical Technologies submitted an application for new technology add-on payments for the X STOP Interspinous Process Decompression System for FY 2007. Lumbar spinal stenosis describes a condition that occurs when the spaces

between bones in the spine become narrowed due to arthritis and other age-related conditions. This narrowing, or stenosis, causes nerves coming from the spinal cord to be compressed, thereby causing symptoms including pain, numbness, and weakness. It particularly causes symptoms when the spine is in extension, as occurs when a patient stands fully upright or leans back. The X STOP device is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally invasive alternative to conservative treatment (exercise and physical therapy) and invasive surgery (spinal fusion). It works by limiting the spine extension that compresses the nerve roots while still preserving as much motion as possible. The device is inserted in a relatively simple, primarily outpatient procedure using local anesthesia. However, in some circumstances, the physician may prefer to admit the patient for an inpatient stay. The manufacturer described the device as providing "a new minimally invasive, stand-alone alternative treatment for lumbar spinal stenosis."

The X STOP Interspinous Process Decompression system received pre-market approval from the FDA on November 21, 2005. The device is currently described by ICD-9-CM code 84.58 (Implantation of Interspinous process decompression device) (excluding: fusion of spine (codes 81.00 through 81.08, and 81.30 through 81.39)). This ICD-9-CM code went into effect on October 1, 2005.

The manufacturer provided data in support of the device meeting the cost threshold criterion. The applicant stated that there would be an average of 1.6 units used per case. Each unit costs $5,500; therefore, the technology is expected to cost $8,800 per case. The device is currently assigned to DRGs 499 (Back and Neck Procedures Except

Spinal Fusion with CC) and 500 (Back and Neck Procedures Except Spinal Fusion without CC). The manufacturer projected that there would be approximately 424 patients eligible to receive the device in DRG 499 in FY 2007, while there may be approximately 1,700 patients who receive the device in DRG 500. The manufacturer also provided data for cases involved in the clinical trials. The average standardized charge for the cases in FY 2004 was $24,065. The weighted threshold for DRGs 499 and 500 is $20,096. However, the manufacturer argued that because significantly less than 20 percent of patients receiving the X STOP experienced complications or had comorbidities, the threshold should be calculated by estimating that 20 percent of patients would be assigned to DRG 499 and 80 percent would to DRG 500. The manufacturer stated in its application that, using this methodology, the applicable threshold should be $19,796. Using either calculation, it appears that the technology meets the cost threshold for new technology add-on payments.

The applicant also submitted information in support of its claim of meeting the substantial clinical improvement criterion. The manufacturer stated that the X STOP device is placed between the spinous processes to limit extension of the symptomatic level(s), yet allowing flexion, axial rotation, and lateral bending (that is, the device limits pressure on the spinal nerves and the resulting pain symptoms when the patient is in an upright position or leans backward while also preserving the patient's ability to turn side-to-side, bend forward, and to turn to either side). The applicant contended that this technology provides an alternative with improved clinical outcomes to conservative and surgical treatments. The manufacturer further stated that the device may offer a new

alternative to lumbar spinal decompression procedures such as laminectomy and laminotomy. Additional information included in the application suggested that the device preserves spinal motion and is superior to a spinal decompression procedure that requires concomitant fusion (with or without instrumentation). The applicant argued that the advantages over spinal decompression include reduced risk, shorter hospital stay, and earlier improvement in pain and function. The manufacturer further contended that disease progression at adjacent levels is minimal following X STOP implantation compared to the known risk associated with surgical decompression and concomitant fusion. The applicant stated that the X STOP is comparable to traditional surgical decompression of lumbar spinal stenosis with respect to improved quality of life postoperatively. According to the applicant, the device provides advantages over nonoperative care, including better symptom relief, improved function, and increased patient satisfaction.

We received the following public comments through the new technology town hall meeting process regarding this application for add-on payments.

Comment: The applicant asserted that the X STOP Interspinous Process Decompression system has the following advantages:

- It retains spinal anatomy and all spinal structures.
- The device allows for increased function and less pain after implantation as evidenced by radiographic measures that showed increases in the spinal canal area by 18 percent, diameter by 9 percent, and subarticular diameter (the route that the nerves exit

the spine) by 50 percent. In lateral view: area increased by 25 percent and width by 41 percent.

- The X STOP is a reversible procedure that causes no damage to facets or disks.
- The device allows for a treatment option for patients that cannot undergo surgeries with general anesthesia.
- The rate of complications associated with implantation of the device is below 1 percent.

Response: In the proposed rule, we indicated that we would evaluate these assertions as we further considered this application for new technology add-on payments for the final rule. We also noted that the study that the applicant summarized at the town hall meeting for the X STOP used a randomized study that targeted lumbar spinal stenosis patients with mild to moderate symptoms. The control group did not require operative care. In the proposed rule, we solicited information from the comments that demonstrates how the study populations showed substantial clinical improvement compared to the control group.

We believe that the device satisfies the newness and cost threshold criteria for new technology add-on payments. However, in the FY 2007 IPPS proposed rule, we expressed our concern that the information included with the application may raise issues about substantial clinical improvement. During the FDA approval process, the Center for Devices and Radiological Health (CDRH) Advisory Panel voted against premarket approval (PMA) in August 2004 because of concerns about proper patient selection as well as the lack of objective endpoints, especially radiographic endpoints. The Panel also

mentioned the overall low clinical efficacy rate in the study population. The device subsequently received PMA approval, but only on the condition that it be used in the context of a long term (5 year) follow-up study. In the proposed rule, we solicited information from commenters that addressed the concerns raised by the CDRH Advisory Panel or other information bearing on the issue of whether this product meets the substantial clinical improvement criterion.

We note that the town hall meeting produced contradictory information regarding whether this procedure is generally performed in inpatient or outpatient settings. The presenter indicated that over 90 percent of his patients were treated as outpatients. The manufacturer noted that 90 percent of non-U.S. patients and approximately two-thirds of U.S. patients since FDA approval have been treated in inpatient settings. While the setting where the procedure is typically performed has no bearing on whether the product represents a substantial clinical improvement, we noted that we believe the physician should select the most appropriate site to perform the procedure based on the clinical needs of the patient.

We received the following comments in response to the FY 2007 IPPS proposed rule.

Comment: The manufacturer commented that the contradictory information we noted in the proposed rule about whether the procedure in general performed in the outpatient or inpatient setting was likely the result of the presenter at the town hall meeting misspeaking when he said that the device was used in the outpatient setting about 90 percent of the time. Although the device may be used with local anesthesia, the

manufacturer predicted that many clinicians attending to Medicare patients will choose general anesthesia and will use the procedure in an inpatient setting. The manufacturer stated that the X STOP device is currently used in the inpatient setting about 90 percent of the time.

Response: We appreciate the commenter's clarification of this point. As we indicated in the proposed rule, the site of service has no bearing on whether we will determine the technology to be a substantial clinical improvement. However, given the similarity in the criteria we apply in the two settings for determining substantial clinical improvement, we note that a decision to approve a device for inpatient new technology add-on payment may have implications for outpatient new technology pass-through payment.

Comment: In response to our request for additional information supporting that the X STOP device meets the substantial clinical improvement criterion, the manufacturer reiterated many of the comments that it submitted through the new technology town hall meeting process. Mainly, the commenter stated that X STOP offers an alternative to surgery that is associated with fewer and less severe complications, is a reversible procedure, and offers a faster recovery time than more invasive surgery. The commenter also stated that X STOP meets the criterion when compared to other disease management modalities for lumbar spinal stenosis patients, as evidenced by symptom relief, physical functioning, treatment satisfaction, and health-related quality of life, and that use of X STOP results in--

- Comparable treatment efficacy when compared to laminectomy

- Lower rates of intraoperative complications compared to surgical decompression with or without concomitant fusion
- Lower reoperation rates for unresolved stenosis systems compared to other surgical treatments.

In addition, the manufacturer stated that it addressed the issues that the Advisory Panel to the FDA cited as reasons for voting against approving X STOP. Those issues were in regards to proper patient selection, a lack of objective endpoints, especially radiographic endpoints and an overall low clinical efficacy rate in the study population. The manufacturer claimed that it addressed the concerns of the Advisory Panel by submitting additional data and analyses to the FDA that--

- Identified patients with LSS and moderately impaired physical function at baseline as the appropriate indication.
- Supplemented "the showing of the mechanism of effect on the spine in cadavers with in vivo clinical radiographic data."
- Addressed the issue of low clinical efficacy rates, by showing that the success rates using X STOP were comparable to those of more invasive procedures that are covered by Medicare.

The manufacturer further noted that the Advisory Panel wrote in its Summary of Safety and Effectiveness document that "the X STOP device met the primary clinical study endpoint for success, exceeding the success rate of the control in every statistical analysis." Finally, the manufacturer noted that the FDA requirement that X STOP's approval was conditioned on a 5-year followup study was not uncommon for spinal implant devices and

that, over the past 10 years, all nine spinal implant FDA approvals have had similar conditional requirements. The manufacturer also commented that CMS approved the INFUSE® Bone Graft device and noted that the FDA required a 6-year followup study as a condition of its approval of that device.

Several commenters who were individual physicians who have had experience using the X STOP device indicated that X STOP provides an alternative to more invasive surgery such as a laminectomy after conservative treatment has failed. All of the commenters supported approving the device for new technology add-on payment. In addition to commenters' support that the device is minimally invasive and has short operative and recovery time, some of the commenters mentioned other positive outcomes that the X STOP procedure--

- Increases foraminal height and produces minimal reversal of the lordosis, as measured by post operative x-rays;
- Reduced the pain reported by patients by half in some cases;
- Provided alleviation of neurogenic claudication symptoms; and
- Benefited patients with significant comorbidities, including cardiothoracic problems, specifically chronic obstructive pulmonary disease or coronary artery disease

In addition, some commenters noted that the X STOP device can very easily be implanted in the outpatient setting (assuming appropriate patient-selection), thus allowing high inpatient costs to be avoided.

Response: We appreciate the commenters' submittal of comments in support of X STOP. With respect to substantial clinical improvement, we continue to be concerned

that the FDA Advisory Panel noted the overall low clinical efficacy rate in the study population and only approved the technology conditional on a 5 year followup study. Nevertheless, we note that the FDA did approve the technology, meaning that it is safe and effective (that is, it achieves its intended purpose). Further, we note that the applicant was able to address the FDA concern about lack of objective endpoints by the showing of the mechanism of effect on the spine in cadavers with in vivo clinical radiographic data. That is, the applicant was able to show that the X STOP device limits spine extension that compresses the nerve. Thus, we believe that the technology has promise for providing a less invasive alternative to procedures such as laminectomy or fusion for patients that have failed conservative treatment (exercise, physical therapy and medication). The X STOP system represents a new level of treatment on the continuum of care for patients with lumbar spinal stenosis that previously did not exist.

Accordingly, after consideration of the comments received, we are approving the X STOP Interspinous Process Decompression System for new technology add-on payment for FY 2007. However, we remain interested in seeing whether the clinical evidence from the 5-year followup study required by the FDA demonstrates that X STOP continues to be effective. Cases involving X STOP will be identified by ICD-9-CM code 84.58 (Implantation of interspinous process decompression device). These cases are generally included in DRG 499 (Back and Neck Procedures Except Spinal Fusion with CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion without CC). As noted in the proposed rule, the manufacturer submitted data to support its estimated cost

per case involving the X STOP procedure of $8,800. Accordingly, we are finalizing a maximum add-on payment of $4,400 for cases that involve this technology.

5. Interim and Final Cost Threshold Tables Due to Changes to Wage Index and Budget Neutrality Factors

Table 10 of the IPPS proposed and final rules contains the cost thresholds that are used to determine whether a technology meets the criteria for new technology add-on payments. We are publishing an interim Table 10 in this final rule. We use the national adjusted operating standardized amounts in calculating the cost threshold. As noted in section III. and in the Addendum to this final rule, the final national adjusted operating standardized amounts will be published subsequent to this final rule when the wage index and budget neutrality factors are finalized for FY 2007. Therefore, we will also publish a revised version of Table 10, containing the final thresholds for FY 2008 between August 1 and October 1.

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 2007 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B. 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 2007 is discussed in section II.B. of the Addendum to this final rule.

As discussed below in section III.G. 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 the wage index. 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 2007 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, 2006 (the FY 2007 wage index) appears under section III.C. of this preamble.

B. 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). OMB defines a CBSA, beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." The standards designate and

define two categories of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (65 FR 82235).

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters with a population of at least 10,000 but less than 50,000. Counties that do not fall within CBSAs are deemed "Outside CBSAs." In the past, OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were "Outside MSAs."

The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. (This is an increase over the minimum commuting threshold of 15 percent for outlying counties applied in the previous MSA definition.) 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, where an MSA has been divided into Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029).

The revised CBSAs established by OMB comprised MSAs and Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address:

http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html.) The revised definitions recognize 49 MSAs and 565 Micropolitan Areas, and extensively changed the composition of many of the MSAs that existed prior to the revisions.

The revised area designations resulted in a higher wage index for some areas and a lower wage index for others. Further, some hospitals that were previously classified as urban are now in rural areas. Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule (69 FR 49027 through 49034). As part of that transition, we allowed urban hospitals that became rural under the new definitions to maintain their assignment to the MSA where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007. Specifically, these hospitals were assigned the wage index of the urban area to which they previously belonged. (For purposes of the wage index computation, the wage data of these hospitals remained assigned to the statewide rural area in which they are located.) The hospitals receiving this transition will not be considered urban hospitals; rather, they will maintain their status as rural hospitals. Thus, the hospital would not be eligible, for example, for a large urban add-on payment under the capital PPS. In other words, it is the wage index, but not the urban or rural status, of these hospitals that is being affected by this transition. The higher wage indices that these hospitals are receiving are also being taken into consideration in determining whether they qualify for the out-migration adjustment discussed in section III.I. of this preamble and the amount of any adjustment.

FY 2007 will be the third year of this transition period. We will continue to assign the wage index for the urban area in which the hospital was previously located through FY 2007. In order to ensure this provision remains budget neutral, we will continue to adjust the standardized amount by a transition budget neutrality factor to account for these hospitals. Doing so is consistent with the requirement of section 1886(d)(3)(E) of the Act that any "adjustments or updates [to the adjustment for different area wage levels]...shall be made in a manner that assures that aggregate payments...are not greater or less than those that would have been made in the year without such adjustment."

Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although they will be eligible to apply for reclassification by the MGCRB both during this transition period and in subsequent years. These hospitals will be considered rural for reclassification purposes.

Consistent with the FY 2005 and FY 2006 IPPS final rules, as we did beginning in FY 2006, for FY 2007 we are providing that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, we will determine for each hospital a wage index for FY 2007 employing wage index data from FY 2003 hospital cost reports and using the CBSA labor market definitions.

C. Occupational Mix Adjustment to the FY 2007 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.

Comment: Some commenters expressed concern about the occupational mix adjustment relative to the proposed implementation of changes to the DRG system. A few stated that the purpose of the occupational mix adjustment is to ensure that hospitals are not paid through both the wage index and the resource-based DRG system for the additional resources needed for certain procedures. The commenters suggested that the occupational mix adjustment is not necessary if a robust severity-adjusted DRG system is implemented. Other commenters indicated that CMS should consider deferring the implementation of the proposed hospital-specific cost weighting methodology and severity DRGs until at least FY 2008 to alleviate the burden on hospitals that will be negatively affected by a redistribution of Medicare payments under the new occupational mix adjustment.

Response: We remind the commenters that an occupational mix adjustment to the wage index is required under section 1886(d)(3)(E) of the Act. Although we understand the commenters' concerns that some hospitals may be negatively affected by the new occupational mix adjustment, we also believe that it is important for us to move forward

with implementing changes in the DRG system that would recognize that some more complex cases may require a higher DRG payment because the services are provided by more highly skilled workers.

Comment: A few commenters opposed the occupational mix adjustment. One commenter believed that the initial application of the occupational mix adjustment had unintended results, benefiting fewer rural hospitals and more large urban hospitals than anticipated. The commenter stated that this problem has been compounded by the additional pressure from the decision in Bellevue Hosp. Center v. Leavitt, 443 F.3d 163 (2nd Cir. 2006), and, therefore, recommended that CMS approach Congress about repealing the mandate for the occupational mix adjustment. Another commenter indicated that the occupational mix survey is confusing and burdensome to hospitals.

Response: As held in Bellevue Hosp. Center v. Leavitt, 443 F.3d 163 (2nd Cir. 2006), adjusting the wage index for occupational mix is required by Congress. Therefore, commenters who believe that the occupational mix should be eliminated would need to approach the Congress with such concerns. As for the initial application of the occupational mix, we believe the unexpected outcomes may have been due to a combination of factors, including the newness of the survey and changing trends in hospital employment. We have modified the survey for 2006, and these modifications should reduce the risk of reporting and measurement errors. These modifications are based largely on suggestions we received from MedPAC and the hospital community. We understand the commenter's concern that completing the survey causes a burden to hospitals; however, the statute requires us to collect data on occupational mix every 3

years. In response to similar concerns expressed for the 2003 survey, we streamlined the 2006 survey and clarified the instructions in an effort to reduce the burden. We will continue to work with hospitals and associations to explore ways to improve the survey to ensure the accuracy of the occupational mix adjustment while reducing the reporting burden for hospitals.

1. Development of Data for the FY 2007 Occupational Mix Adjustment

In our initial FY 2007 IPPS proposed rule (71 FR 23996), we discussed our proposals for calculating the proposed FY 2007 occupational mix adjustment. We proposed to use the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics (BLS) data that we used for the FY 2005 and FY 2006 wage indices, with a few exceptions. We also proposed to adjust 10 percent of the FY 2007 wage index by a factor reflecting occupational mix. However on April 3, 2006, in Bellevue Hosp Center v. Leavitt, 443 F.3d 163 (2nd Cir. 2006) the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. The Court ordered CMS to "immediately … collect data that are sufficiently robust to permit full application of the occupational mix adjustment." The Court also ordered that all "data collection and measurement and any other preparations necessary for full application be completed by September 30, 2006, at which time the agency is to immediately apply the adjustment in full." For more information, we refer the readers to Bellevue Hosp. Center v. Leavitt, 443 F.3d 163, 179 (2nd Cir. 2006).

To comply with the Court's order, on April 21, 2006, we issued a Joint-Signature Memorandum (JSM-06412) to all Medicare fiscal intermediaries announcing our plans to collect new occupational mix data from hospitals. The Joint-Signature Memorandum is available on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS. Click on "Wage Index Files" and the link is titled: 2006 Occupational Mix Survey -- Interim Data Collection - CMS Memo to Fiscal Intermediaries.

On May 17, 2006, we also published in the **Federal Register** (71 FR 28644) a second proposed rule that proposed to revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new occupational mix data collected from hospitals. The second proposed rule also proposed to modify hospitals' procedures for withdrawing requests to reclassify for the FY 2007 wage index and for supplementing the FY 2008 reclassification application with official data used to develop the FY 2007 wage index. In addition, we proposed to replace in full the descriptions of the data and methodology that would be used in calculating the occupational mix adjustment discussed in the initial FY 2007 IPPS proposed rule.

As stated earlier, section 1886(d)(3)(E) of the Act requires us to conduct a new survey at least once every 3 years. 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)).

The revised 2006 survey provides 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 focuses 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 includes 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 provides for a 6-month data collection period, from January 1, 2006 through June 30, 2006. However, we allowed flexibility for the reporting period begin and end dates to accommodate some hospitals' bi-weekly payroll and reporting systems. That is, the 6-month reporting period must begin on or after December 25, 2005, and must end before July 9, 2006.

To comply with the order of the court in Bellevue Hosp. Center v. Leavitt, as discussed above, we proposed to collect new survey data, instead of using the 2003 survey data proposed in the FY 2007 IPPS proposed rule, to calculate the occupational mix adjustment for the FY 2007 wage index. Because hospitals were already collecting data for the revised 2006 survey, we proposed to use the first 3 months of that data (that is, from January 1, 2006, through March 31, 2006) to calculate the FY 2007 occupational mix adjustment. In order to allow sufficient time for hospitals, fiscal intermediaries, and CMS to collect, review, and correct the new data, and for CMS to perform required

analyses and apply the new data in calculating the FY 2007 occupational mix adjustment, we determined that it would be impossible for us to apply the full 6 months of data by October 1, 2006.

Comment: Several commenters stated that hospitals were sometimes unsure of the placement of certain employees on the survey. For example, hospitals were uncertain as to the category that would include surgical technicians and paramedics who are employed by the hospital and who usually work in the emergency department. The commenters urged CMS to evaluate where these employees should be placed on the survey for future collections.

The commenters also stated that they agreed with CMS' efforts to ensure consistent reporting by specifying the cost centers for collecting nursing personnel data. They agreed that the cost centers included on the survey are where the majority of nurses are employed within hospitals. The commenters added that the use of the cost centers significantly reduces the burden for hospitals by allowing them to focus on only the listed cost centers. However, the commenters urged CMS to consider refining the list of cost centers for future collections. The commenters advised that every hospital has a different method for attributing costs to cost centers; therefore, some hospitals may have a few cost centers that contain a significant number of nursing personnel that were not included in the current survey.

The commenters recommended that CMS work with the hospital community to explore potential changes to the survey occupational categories and cost centers. Even if they are warranted, the commenters suggested that CMS should not make any changes to

the ongoing survey collection, as it would necessitate the resubmission of the 1st quarter 2006 data to ensure that both 1st and 2nd quarters could be used for the FY 2008 and the FY 2009 occupational mix adjustment.

Response: We appreciate the assistance we have already received from the hospital community in developing the 2006 occupational mix survey. On May 25, 2006, in response to questions from hospitals and associations, we distributed supplemental instructions to the intermediaries, hospitals (via the intermediaries), and national hospital associations (and posted the instructions on our Web site) to clarify the placement of nursing and nonnursing personnel on the occupational mix survey. We will continue to work with MedPAC and the hospital community to determine if changes to the occupational categories and cost centers included on the survey are reasonable and necessary for future collections. We agree with not changing the instructions for the 2006 survey. As the commenters indicated, to change the survey with the 1st quarter data collection already completed would require substantial rework on the part of hospitals, fiscal intermediaries, and CMS.

Comment: A few commenters expressed concern that hospitals in States with mandatory nurse-staffing ratios for inpatient facilities and hospitals that use higher levels of registered nurses to improve the quality of care will be adversely affected by the occupational mix adjustment. One commenter stated that the current survey is designed to benefit parts of the country that make greater use of lesser skilled nurses and allied health professionals, and to reduce payment in areas that make greater use of registered nurses in nursing positions. The commenter speculated that the occupational mix

adjustment will likely reduce the payments for its hospitals, thus reducing the quality of care they can provide to Medicare beneficiaries.

Another commenter indicated that the wage index and occupational mix adjustments penalize hospitals that invest in quality and efficiency at the same time that Congress is trying to improve quality and efficiency under the Medicare program. The commenter stated that the effect of these adjustments on hospitals that use higher levels of registered nurses reduces or eliminates the annual Medicare inflation increase provided to address the increasing costs these hospitals incur. The commenter further indicated that this reduction would not be a savings to the program, but rather it would be a redistribution of Medicare payments to hospitals that have not been as efficient or as focused on improving the quality of care.

Response: As stated earlier, the statute requires implementation of an occupational mix adjustment to the wage index. In addition, the purpose of the occupational mix adjustment is to control the effect of a hospital's employment mix on its average hourly wage for the wage index. The adjustment standardizes the employment mix for hospitals so that the wage index more accurately compares wage rates among labor market areas for a constant mix of labor. As the commenters noted, the occupational mix adjustment would lower the wage index for an area employing a mix of more highly paid and skilled labor than the national average. Although we understand the commenters' concerns regarding the effect of the occupational mix on their areas' Medicare payments, we disagree that the wage index and occupational mix adjustments penalize hospitals that invest in quality and efficiency. We note that CMS is moving

toward adoption of a severity-based DRG system that will better recognize severity of illness and provide improved payments to those hospitals that need more highly skilled labor to care for more severely ill patients. Even under the current system, the labor costs incurred by hospitals that provide more highly skilled services are currently reflected in the hospital's DRG payments and illustrated through a higher case mix index. Reflecting the costs associated with more highly skilled labor in both the case mix and the wage index is essentially counting them twice.

To comply with the order of the court in Bellevue Hosp. Center v. Leavitt, as a final policy, we are adopting our proposal to use the new 1st quarter 2006 survey data to calculate the occupational mix adjustment for the FY 2007 wage index.

2. Timeline for the Collection, Review, and Correction of the Occupational Mix Data

The Joint-Signature Memorandum (JSM-06412) that we issued on April 21, 2006, instructed all fiscal intermediaries to immediately alert the hospitals they service to the changes in the schedule for submitting the occupational mix data files.

The Joint-Signature Memorandum provided hospitals and fiscal intermediaries with the revised schedule for the occupational mix survey data that would be used in the FY 2007 wage index. The schedule included deadlines for--

- Hospitals to submit occupational mix data. The deadline was June 1, 2006.
- Fiscal intermediary review of the submitted data. The deadline was June 22, 2006.
- Availability of the submitted data on the CMS Web site. The deadline was June 29, 2006.

- Hospitals to submit requests to their fiscal intermediaries for corrections to their interim occupational mix data. The deadline was July 13, 2006.

- Fiscal intermediaries to submit corrected interim occupational mix survey data for the January 1, 2006, through March 31, 2006 period. The deadline was July 27, 2006.

We noted that it was critical that hospitals provide information according to the dates provided in the schedule in order to be able to appeal any disputed calculations at a later point to the Provider Review Reimbursement Board (PRRB). The final deadline for the fiscal intermediaries to make occupational mix data available to CMS was July 27, 2006. These data would reflect fiscal intermediary review and the resolution of any errors or adjustments between the hospitals and fiscal intermediary. Once these data are available on the CMS Web site, changes to a hospital's occupational mix data would be allowed only in those very limited situations involving an error by the fiscal intermediary or CMS that the hospital could not have known about before its review of the final occupational mix data file. Specifically, neither the fiscal intermediary nor CMS would approve the following types of requests:

- Requests for occupational mix data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before July 27, 2006.

- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the June 29, 2006 occupational mix file.

Verified corrections to the occupational mix received by the fiscal intermediaries and CMS (that is, by July 13, 2006) would be incorporated into the final wage index for FY 2007, to be effective October 1, 2006.

We created the process described above to resolve all substantive occupational mix correction disputes before we finalize the wage and occupational mix data for the FY 2007 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit occupational mix data corrections or to dispute the fiscal intermediary'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 PRRB, 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 also refer the reader to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

We believe the occupational mix data correction process described above provided hospitals with the opportunity to bring errors in their occupational mix data to the fiscal intermediary's attention.

Because hospitals had access to the final occupational mix data by June 29, 2006, we believe they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2007 wage index and the implementation of the FY 2007 wage index on

October 1, 2006. We believe that if hospitals availed themselves of the opportunities afforded to provide and make corrections to the occupational mix data, the wage index implemented on October 1, 2006, will be accurate. In the event that errors are identified by hospitals and brought to our attention after July 13, 2006, we will only make mid-year changes to the wage index in accordance with §412.64(k). For a detailed discussion, see section III.J. of this preamble.

Comment: One commenter stated that the 6-month reporting period for the 2006 survey, originally planned for the FY 2008 wage index, is an improvement over the 2003 survey process. However, the commenter urged CMS to initiate a survey with a full-year reporting period for the FY 2009 wage index.

Response: We appreciate the commenter's recognition of our efforts to improve the occupational mix survey process. We also appreciate the commenter's suggestion for expanding the survey reporting period to a full year for the FY 2009 wage index. While we appreciate the willingness expressed in the comment to collect a complete year of data in order to achieve more accurate survey results, we note that hospitals are currently obligated to collect data for the period April 1, 2006, to June 30, 2006, by August 31 in order for us to use 6 months of data to apply the occupational mix adjustment for FY 2008. If we were to use a full year of 2006 survey data to apply an occupational mix adjustment for FY 2009, hospitals would have to submit data for the last 6 months of calendar year 2006. Hospitals have already been required to submit occupational mix survey data for two different 3-month periods in 2006. At this time, we believe it would be burdensome to require a third occupational mix data collection from hospitals for 2006

in order to apply the adjustment based on a full year of data for FY 2009. We also note that collecting a full year of calendar year 2007 data, from January 1, 2007, through December 31, 2007, would not provide enough time for a thorough review and correction period before the FY 2009 proposed rule would be published in April 2008. Our normal wage index review and correction process before the proposed rule publication begins in early October and ends in late February. This would mean that hospitals and intermediaries would have only approximately 2 months, from January to late February, to review and correct a year's worth of occupational mix data. We believe that such an abbreviated review and correction period would not be in the hospitals' best interest. However, we will consider expanding the survey reporting period to a full year for a future collection.

Comment: Some commenters expressed concern that the 3-month survey period for FY 2007 will lead to inaccurate results for several reasons: having no advance notice of the expedited data collection; some hospitals had not yet begun, or had just begun, to plan for the 2006 survey data collection and had little or no resources available to complete the survey for all or part of the 3-month time period; the new survey, though improved over the previous survey, is more complicated and requires more effort to complete; due to the short timeframe for developing and submitting the data (4 months), some normal review processes had to be eliminated by hospitals; not enough time was allowed for the types of corrections that can be made during the annual wage index survey process; due to the infrequent collection of the occupational mix data, many hospitals may underestimate its importance; there was not enough time for hospital

groups to review the data for individual hospitals in the area, a process that often raises questions that leads to more accurate data.

Response: We understand the commenters' concerns about the potential for inaccurate occupational mix survey data to be used due to the abbreviated data collection and reporting periods. However, CMS has established a process that we believe will maximize the opportunity for accurate occupational mix data to be used to adjust area wage indices. Hospitals were required to submit occupational mix survey data to their fiscal intermediaries by June 1, 2006. CMS provided fiscal intermediaries with a desk review program to assist in identifying erroneous or aberrant data. Fiscal intermediaries then had 3 weeks (or until June 22) to review the data and submit it to CMS. CMS made the occupational mix survey data available on the CMS Web site on June 29 to facilitate review by hospitals, fiscal intermediaries, and others. The June 29 posting of occupational survey data resulted in hospitals, State hospital associations, wage index consultants, and others identifying errors and other aberrant data. These parties then initiated action to correct the occupational mix survey data by the July 13 deadline. While there is no additional time available to correct the survey data for the FY 2007 wage index, we will, however, allow hospitals to submit any additional revisions and corrections to both 3-month periods of data for the FY 2008 wage index. We strongly encourage hospitals to take full advantage of the FY 2008 wage index correction process. Hospitals will be notified early in the Fall of 2006 regarding the revision/correction process for the FY 2008 wage index for both the cost report wage data and the 2006 occupational mix survey data.

3. Calculation of the Occupational Mix Adjustment

In the May 17, 2006 proposed rule, we proposed a series of steps to be used in calculating the FY 2007 occupational mix adjustment factor. In this final rule, we are adopting the proposed steps with one minor exception. In response to comments (discussed below), we have made an adjustment to step 7 so that the percentage of worker salaries attributable to the nursing category is based on salaries and not on hours. For 2007, we will calculate 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 would be 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 would be 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.F. 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.F. 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.

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.

Comment: MedPAC and a few other commenters noted that Step 7 of CMS' proposed calculation for the occupational mix adjustment uses the occupational mix survey's paid hours to determine the portion of the salaries and wage-related costs to adjust for occupational mix (that is, the total nursing portion) and the portion to remain unadjusted (that is, the all other occupations portion). One of the commenters stated that this approach was reasonable using the 2003 survey data because hospital-specific paid salaries data were not collected. However, the commenter also noted that the actual share of wages for either the nursing category or the all other occupations category could differ using an allocation that is based on paid hours compared to paid salaries. The commenters suggested that, since the 2006 survey provides for the collection of paid salaries data, CMS should use paid salaries instead of paid hours to more accurately determine the wage costs that should be adjusted for occupational mix and those that should not.

Response: As discussed above, we evaluated the commenters' recommendation and agree that it is reasonable to use the occupational mix survey salaries instead of hours

in computing the portion of a hospital's salaries and wage-related costs to adjust for occupational mix and the portion to remain unadjusted. Accordingly, we revised Step 7 of the final calculation for the occupational mix adjustment to reflect this change.

We received no other comments on the steps used in calculating the occupational mix adjustment. As a final policy, we are adopting the proposed calculation, with the change to Step 7, for the occupational mix adjustment to the FY 2007 wage index. Also, to comply with the order of the court in Bellevue Hosp. Center v. Leavitt, we will apply this adjustment to 100 percent of the wage index.

The table below is an illustrative example of the final occupational mix adjustment. (Note: We have revised this example from that included in the proposed rule to reflect the change in step 7 discussed above. We have added an additional column for provider occupational mix salaries and the Provider Percent by Total is determined by dividing the hospital's total nurse salaries (and separately, Total All Other Salaries) by Total Employee Salaries.

.

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 Mngt	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%**
ALLOTHER	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 Mngt	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%**
ALLOTHER	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.								

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 2007 wage index.

For the FY 2005 and FY 2006 final wage indices, we used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national nursing mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. However, an adjustment may not be equitable in situations where the hospital has a higher or lower than average occupational mix than the Nation as a whole. If the hospital's occupational mix is higher than the average for the nation as a whole, hospitals in other areas are disadvantaged by the hospital not providing occupational mix information. If the hospital's occupational mix is lower than the average for the Nation as a whole, other hospitals in the same geographic area would be disadvantaged by the hospital not providing the information.

In the FY 2005 and FY 2006 IPPS final rules (69 FR 49035 and 70 FR 47368), we noted that we would revisit this matter with subsequent collections of the occupational mix data. In the May 17, 2006 proposed rule, for the FY 2007 wage index, we proposed to use one of four options for treating the occupational mix data for nonresponsive hospitals: (1) assign the hospital an occupational mix adjustment factor of 1.0000 as we did for FY 2005 and FY 2006; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the

lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix. We requested comments on these or other alternatives for equitably addressing the situation of hospitals that are not responsive to the occupational mix survey.

Comment: A majority of the commenters believed that, in order for the wage index to be computed accurately, it is critical for all IPPS hospitals to complete the occupational mix survey. Many of the commenters suggested that CMS should penalize hospitals that did not submit a survey. However, the commenters indicated that no hospitals should be penalized for not completing the survey for the 1st quarter of FY 2006 (to be used in calculating the FY 2007 wage index) because of the short notification and timeframe for the collection of that data. Some suggested future penalties such as a 1 to 2 percent reduction in the hospital's wage index value or a set percentage of the standardized amount, whichever is administratively feasible. However, the commenters also suggested that any penalty should be hospital-specific and should not affect the wage index amounts for other hospitals in the area. Commenters suggested that CMS should first calculate the area wage index using proxy data for a nonresponsive hospital's occupational mix adjustment, and then CMS should assess a penalty on its wage index value or national standardized amount.

The commenters supported all of the ideas we raised in the proposed rule except option 3. Commenters unanimously opposed assigning the hospital the lowest occupational mix adjustment factor for its labor market area, because they believed this

option would have the most negative impact on other hospitals in the labor market area. MedPAC recommended option 4, to assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus nonteaching status and case-mix. MedPAC suggested other factors that CMS should consider, such as share of ICU days and types of services offered. Some commenters recommended an option that we did not describe. These commenters recommended that CMS substitute data from the previous 2003 survey for hospitals that did not submit 2006 survey data for the FY 2007 wage index. Alternatively, several commenters recommended that CMS could substitute the national average hourly wage (that is, option 1, an occupational mix adjustment of 1.0000) for nonresponsive hospitals in calculating an area's wage index, while others favored option 2 because it would have the least affect on the labor market area. One commenter recommended assigning the lower of the hospital's occupational mix adjustment in FY 2006 or the average for the hospital's labor market in FY 2007. The commenter believed that the best proxy for a hospital's missing FY 2007data is its FY 2006 occupational mix adjustment, even though there was a change in the formula to calculate the FY 2007 adjustment. The commenter stated that CMS should provide an exception for an exogenous event affecting all hospitals in the labor market area. In this scenario, the commenter recommended using the average FY 2007 adjustment.

Response: We agree with the commenters that hospitals that did not respond to the occupational mix survey should not benefit from the participation of others. We also agree that, due to the unusual circumstances of the Court's order and the short timeframe

that hospitals were provided for completing and submitting their data, it would not be fair to apply a penalty to nonresponsive hospitals for the 2007 wage index. However, 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 will give serious consideration to applying a hospital-specific penalty such as those suggested by the commenters if a hospital does not comply with regulations requiring submission of occupational mix survey data in future years. We will address this issue in the FY 2008 IPPS proposed rule.

Regarding the treatment of data for nonresponsive hospitals, we have chosen not to adopt option 3, because it would be punitive to other hospitals in the area that submitted occupational mix data. We also have not chosen option 1 because it does not provide an incentive for hospitals to respond if they have a higher mix of employees than the national average. We will not use data from the 2003 survey, as some commenters suggested, because the 2007 wage index, we believe, should be exclusively based on the newly collected data. In addition, there was concern about the sufficient robustness of such data to support 100 percent adjustments. We also do not believe it would be entirely feasible, for 2007, to implement MedPAC's recommendation, option 4, due to the wide range of parameters that could be used for developing proxies for the missing hospitals and the fact that the exact set of such parameters was not subject to comment. So many variables might be of relevance that our selection of any particular variables might be subject to controversy, and hospitals may wish to have an opportunity to comment on the

exact variables that would be used. MedPAC's recommendation to add more variables to further refine the analysis could be so limiting as to result in few or no hospitals to use for comparison.

For the FY 2007 wage index, we have adopted option 2 -- using the average occupational mix adjustment for the labor market area. We believe this option would have the least impact on the wage index for other hospitals in the area and does not have the disadvantages of the options discussed above. Although we believe this option is the best of the ones we considered for nonresponsive hospitals for FY 2007, we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals. If there is only one hospital in the labor market area, and that hospital failed to submit occupational mix data, or, if there are no hospitals in the labor market area, we would apply the national occupational mix factor of 1.0000 in calculating the area's FY 2007 occupational mix adjusted wage index.

Comment: Some commenters recommended that CMS allow hospitals that failed to submit their 1st quarter data by June 1, 2006, to submit that data when the 2nd quarter data is due (that is, by August 31, 2006). The commenters also suggested that CMS allow hospitals that submitted their 1st quarter data by June 1, an opportunity to correct that data when the 2nd quarter data are due. The commenters indicated that allowing hospitals to submit the data at this time would improve the survey response rate and eliminate the need for penalties for hospitals that would otherwise be nonresponsive and improve the accuracy of the data for the FY 2008 and the FY 2009 occupational mix adjustment.

Response: We agree with the commenters. Hospitals that did not submit occupational mix data for the 1st quarter of 2006 will be permitted to submit 1st and 2nd quarter data by August 31. We included the 1st quarter data for some hospitals that submitted survey data after June 1. However, submissions that were received too late to include in the FY 2007 occupational mix adjustment will be included in the desk review process for the occupational mix adjustment for the FY 2008 wage index. As we previously mentioned, we will also allow hospitals an opportunity to revise both their 1st quarter and 2nd quarter 2006 occupational mix data for the FY 2008 wage index. Further, we stated that we will notify hospitals early in the Fall of 2006 regarding the revision/correction process for the FY 2008 wage index for both the cost report wage data and the 2006 occupational mix survey data.

D. Worksheet S-3 Wage Data for the FY 2007 Wage Index

The FY 2007 wage index values (effective for hospital discharges occurring on or after October 1, 2006, and before October 1, 2007) that will be published separately from 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 2003 (the FY 2006 wage index was based on FY 2002 wage data).

The FY 2007 wage index will include 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).

• Wage-related costs, including pensions and other deferred compensation costs.

Consistent with the wage index methodology for FY 2006, the final wage index for FY 2007 also will exclude 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 final FY 2007 wage index also will exclude 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 will be excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

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.

Comment: Several commenters addressed CMS' policy of excluding data from CAHs when computing the wage index. They stated that, as of FY 2007, 1,191 CAHs

(representing approximately 24 percent of all IPPS hospitals in FY 2000, and approximately 55 percent of all rural hospitals in FY 2000) have been removed from the wage index. The commenters indicated that CAHs have lower average hourly wages than the typical IPPS hospital and eliminating their data from the wage index overstates the national average hourly wage by an estimated 0.707 percent. They added that increases in the national average hourly wage, in turn, are offset with the application of a negative budget neutrality adjustment, which understates IPPS operating payments according to the commenters. The commenters believed that the artificial increase in the national average hourly wage has lowered the budget neutrality adjustment by an estimated $1.52 billion over 5 years (2003-2007). The commenters stated that CMS should apply a one-time positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments. They did not believe similar future adjustments would be necessary because very few hospitals are expected "to convert to CAH status now that the necessary provider designation is no longer an option."

Other commenters asked that CMS use estimated CAH wage data to compute the FY 2007 wage index, and that an occupational mix factor of 1.0000 be assigned to these hospitals. The commenters noted that MedPAC has recommended that CAH data be included in the wage index, at least in computing the national average hourly wage. The commenters asserted that because CAHs in rural areas still compete with rural IPPS hospitals for scarce resources, their data should be included in the wage index.

Commenters also requested that CMS obtain wage data from CAHs and subject that data to the same rigorous review by the fiscal intermediaries as is done for IPPS

hospitals. Another commenter suggested that an alternative to including the CAHs in wage index would be to *not* factor in any increases in the national average hourly wage that are attributable to the removal of CAHs' wage data.

Response**:** In the August 1, 2003 final rule (68 FR 45397-8), we explained the reasons for our decision to remove CAH data from the wage index immediately upon conversion to CAH status, even if the hospital was paid under the IPPS during the cost reporting period used in calculating the current fiscal year's wage index. The primary reason for excluding CAHs from the wage index was that they are a separate provider type and are unique compared to other short term, acute care hospitals with respect to factors such as their location and bed size. We discussed the payment impact, mentioning the substantial negative impact CAHs typically have on the wage indexes in the areas where they are located, and the minimal impact they have on other areas. We also stated that we would not be holding other hospitals' payments harmless for this change, consistent with our general wage index policy.

As the commenters indicated, in the FY 2006 IPPS final rule, we addressed a comment from MedPAC recommending that data from CAHs be included in the wage index (70 FR 47370). MedPAC had recommended that CMS begin collecting wage data from CAHs in 2005. Although we agree with MedPAC that CAHs have recently become more similar to other rural hospitals, in structure, location, and services provided, largely due to changes in the CAH statute resulting from section 405 of Pub. L. 108-173 (MMA), the wage index must be based on data from "subsection (d)," short-term, acute care hospitals, consistent with section 1886(d)(3)(E) of the Act. Therefore, we cannot use any

wage data collected from CAHs in the IPPS wage index. Because Pub. L. 108-173 was enacted at the end of calendar year 2003, it would not affect the wage index at least until FY 2008, which would be computed from cost reporting periods beginning in FY 2004. Accordingly, we continue to believe that it has been prudent policy to remove the wage data for hospitals that later became CAHs from the wage index.

We do not believe that the elimination of these data has resulted in an overstated national average hourly wage, nor has the budget neutrality adjustment been inappropriately reduced. The national average hourly wage appropriately reflects only those wages paid by IPPS hospitals. To determine the budget neutrality adjustment for FY 2007, we equate IPPS payments using the FY 2006 and FY 2007 wage indices using FY 2005 MedPAR data that excludes any hospitals that became CAHs as of February 17, 2006. The calculation excludes CAHs from the determination of IPPS payments using both the FY 2006 and FY 2007 wage indices so the budget neutrality adjustment reflects only information from IPPS hospitals and is not overstated. Consequently, we will not apply a one-time positive budget neutrality adjustment in FY 2007.

E. Verification of Worksheet S-3 Wage Data

The wage data for the final FY 2007 wage index will be obtained from Worksheet S-3, Parts II and III of the FY 2003 Medicare cost reports. Instructions for completing the Worksheet S-3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the wage index will include FY 2003 data submitted to us as of June 28, 2006. As in past years, we will perform an

intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. While some of the edits failures were resolved, we did remove the wage data of some hospitals from the final FY 2007 wage index. For the final FY 2007 wage index in this final rule, we removed the data for 229 hospitals from our database: 189 hospitals designated as CAHs by 7 or more days prior to the posting of the preliminary February public use file, and 30 hospitals were low Medicare utilization hospitals or failed edits that could not be corrected because the hospitals terminated the program or changed ownership. In addition, we removed the wage data for 10 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. As a result, the final FY 2007 wage index is calculated based on FY 2003 wage data from 3,570 hospitals.

In constructing the final FY 2007 wage index, we will include the wage data for facilities that were IPPS hospitals in FY 2003, even for those facilities that have since terminated their participation in the program as hospitals, as long as those data do 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. However, we exclude the wage data for CAHs as discussed in 68 FR 45397.

Section 4410 of Pub. L. 105-33 provides that, for the purposes of section 1886(d)(3)(E) of the Act, for discharges occurring 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 the State. This provision is commonly referred to as the "rural floor." In the August 11, 2004 IPPS final rule (69 FR 49109), we discussed situations where a State has only urban areas and no geographically rural areas, or a State has geographically rural areas but no IPPS hospitals are located in those rural areas. As a result, these States did not have rural IPPS hospitals from which to compute and apply a "rural floor." In that final rule, we developed a policy for imputing a "rural floor" for these States, effective for the FYs 2005, 2006, and 2007 wage indices, so that a "rural floor" could be applicable to IPPS urban hospitals in those States in the same manner that a "rural floor" is applicable to IPPS urban hospitals in States that have IPPS rural hospitals. We revised the regulations at §412.64(h) to describe the methodology for computing the imputed "rural floors" for these States and to define an all-urban State. Specifically, §412.64(h)(5) defines an all-urban State as "a State with no rural areas . . . or a State in which there are no hospitals classified as rural. A State with rural areas and with hospitals reclassified as rural under §412.103 is not an all-urban State."

We have received questions as to what area wage index CMS would apply in the instance where a new rural IPPS hospital opens in a State that has an imputed "rural floor" because it has rural areas but had no hospitals classified as rural. In addition, we have been asked whether a new IPPS hospital could submit its wages and hours data to be used in computing the wage index, even though the hospital did not file a cost report as an IPPS provider for the cost report base year that is used in calculating that wage index.

A new hospital can be an entirely new facility that did not exist before, or it can be a hospital that participated in Medicare under a previous provider number, but has acquired a new Medicare provider number (such as when a CAH converts to IPPS status, or vice versa). As a new IPPS hospital (in this case, rural), the hospital would not yet have filed any wages and hours data on a Medicare cost report. Even in the situation where a new IPPS hospital previously participated in Medicare as a non-IPPS provider, wages and hours data collected as a non-IPPS provider would not be suitable for calculating an IPPS wage index because section 1886(d)(3)(E) of the Act specifies that the wage index must be based on data from "subsection (d)" hospitals. Thus, CMS could not include wages and hours from a period during which a hospital was not an IPPS provider. Furthermore, even once the hospital files its first Medicare cost report under the new IPPS provider number, that first cost report is not used in computing the wage index for the hospital's geographic area until 4 years later (for example, we use the 2003 data to compute the wage index for FY 2007). Therefore, if a new rural IPPS hospital opens in a State that has an imputed "rural floor" and has rural areas, for FY 2007, the hospital would receive the imputed "rural floor" as its wage index. The imputed rural floor is set to expire on September 30, 2007. However, we expect that we would address the 2008 implications for a new rural hospital that is the only rural hospital in the State in the FY 2008 proposed rule.

Comment**:** Two commenters stated that CMS' above policy conflicts with the policy of excluding the wage data of IPPS hospitals that convert to CAH status. The commenters also asserted that in the years before the hospital's own wage data is used,

the rural hospital will be paid at the imputed rural floor, which they contend is unrelated to the hospital's own labor market costs. The commenters also asserted that if the new rural hospital's average hourly wage is greater than the imputed rural floor, the hospital would suffer underpayments until its index could be based upon its own wage data. One commenter suggested that, at least for CAHs converting to IPPS status, CMS should use wage data filed by the hospital when it was a CAH.

The commenters urged CMS to include the wage data of a new rural IPPS hospital in the wage index "as soon as a full year's cost report with the hospital operating as a PPS hospital is available."

Response**:** We disagree with the commenters. Our consistent policy is that new hospitals must first develop their wage data and have it reviewed by our fiscal intermediaries prior to the wage data being included in the wage index. The submission and review process requires a 4-year period, in order to allow time for all hospitals to complete and submit their wage data for the fiscal year, for the fiscal intermediaries to review the data, for the fiscal intermediaries to present the results of their review to hospitals, for hospitals to review any potential errors in the wage index files, for us to resolve any disputes between the fiscal intermediary and the hospital, and finally, for the final wage indices to be calculated and published in advance of the fiscal year. For a discussion of the wage data review and correction process, refer to section III.J. of this preamble. This policy applies to all new hospitals, not just rural hospitals. Although a new rural IPPS hospital that previously was a CAH may be willing to provide CMS with wage data from the period during which it was a CAH, the wage index must be based on

data from IPPS hospitals, consistent with section 1886(d)(3)(E) of the Act. A CAH is not an IPPS hospital; thus, we cannot include the hospital's wages and hours from the period during which it was a CAH. Indeed, even if a CAH previously existed as an IPPS hospital (that is, it previously was an IPPS hospital, converted to CAH status, and then converted back to IPPS status), its historical wage data would have been submitted from years prior to the cost reports used to calculate the FY 2007 wage index (that is, the FY 2003 cost reports). If a CAH converts back to IPPS status in FY 2007, there would be no wage data for the FY 2007 wage index because such a provider did not file Medicare cost reports as an IPPS provider in FY 2003.

We recognize, as one commenter pointed out that in the past we have noted the importance of including "all" available wage data in the wage index calculation. However, our past statements to this effect were discussing the inclusion of all IPPS hospital wage data, not data from non-IPPS hospitals. In the FY 2003 IPPS final rule (67 FR 50023), we discussed our policy of including data from IPPS hospitals that have since closed. We stated that such data should be included because, "any hospital that is in operation during the data collection period used to calculated the wage index should be included in the database, since the hospital's data reflect conditions occurring in that labor market area during the period surveyed." Our statement, however, was directed at the inclusion of IPPS hospital data -- not the inclusion of data from hospitals that were not IPPS hospitals during the data collection period. As stated earlier, section 1886(d)(3)(E) of the Act requires the wage index to be based upon a survey of "subsection (d) hospitals."

Lastly, we think it is false logic to state that our policy excluding data from hospitals that become CAHs necessarily requires inclusion of data from hospitals that switch from CAH status to IPPS status. As stated in the FY 2003 IPPS final rule, we exclude hospitals that convert to CAH status because our analysis showed that the wage data for these hospitals, in general, are significantly different from other short-term hospitals (68 FR 45397). CAHs that convert to IPPS status, in contrast, could not, under the statute, be included in the wage index survey because they are not IPPS hospitals at the time of the survey.

Comment: A few commenters recommended that CMS propose now to extend the imputed rural floor to coincide with the rural floor established under section 4410 of Pub. L. 105-33, in order to place all 50 states on a level playing field.

Response: As stated above, our policy for imputing a "rural floor" is effective for the FYs 2005, 2006, and 2007 wage indices. We will determine the appropriateness of extending that policy beyond FY 2007 and state our proposal in the FY 2008 proposed rule. Commenters will be have sufficient time during the FY 2008 IPPS comment period to assess and comment on such a proposal.

Comment: One commenter suggested that CMS should select one national contractor as part of the Medicare Administrative Contractor (MAC) bidding process (provided for under section 1847A of the Act as added by section 911 of Pub. L. 108-173) to do wage index reviews. The commenter believed that the use of the MAC process to solicit a single "national" contractor would ensure that the wage data and occupational mix data reviews are handled consistently and accurately, so that all

hospitals are subject to the same policy interpretations. The commenter noted the importance of the wage index in determining Medicare payments to hospitals and indicated that any variation among contractors in the handling of hospitals' wage index data could be detrimental to hospitals in certain geographic regions. The commenter also stated that the inclusion of a 100 percent occupational mix adjustment intensifies the need for a contractor approach going forward.

Response: We appreciate the suggestion and will consider it as we develop our program acquisition strategies.

F. Computation of the FY 2007 Unadjusted Wage Index

The method used to compute the FY 2007 wage index without an occupational mix adjustment follows:

Step 1--As noted above, we based the FY 2007 wage index on wage data reported on the FY 2003 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, 2002, and before October 1, 2003. In addition, we include data from some hospitals that had cost reporting periods beginning before October 2002 and reported a cost reporting period covering all of FY 2003. 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 2003 data. We note that, if a hospital had more than one cost reporting period

beginning during FY 2003 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2002, and before October 1, 2003), we include 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 include 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. 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) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, and 8.01); (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, 2002, through April 15, 2004, 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. 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
10/14/2002	11/15/2002	1.06058
11/14/2002	12/15/2002	1.05679
12/14/2002	01/15/2003	1.05304
01/14/2003	02/15/2003	1.04915
02/14/2003	03/15/2003	1.04513
03/14/2003	04/15/2003	1.04108
04/14/2003	05/15/2003	1.03713
05/14/2003	06/15/2003	1.03325
06/14/2003	07/15/2003	1.02948
07/14/2003	08/15/2003	1.02584
08/14/2003	09/15/2003	1.02231
09/14/2003	10/15/2003	1.01878
10/14/2003	11/15/2003	1.01510
11/14/2003	12/15/2003	1.01127
12/14/2003	01/15/2004	1.00743
01/14/2004	02/15/2004	1.00367
02/14/2004	03/15/2004	1.00000
03/14/2004	04/15/2004	0.99644

For example, the midpoint of a cost reporting period beginning January 1, 2003, and ending December 31, 2003, is June 30, 2003. An adjustment factor of 1.02948 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 2003 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 is $29.6521.

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 divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $13.0915 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 Pub. L. 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. (For all-urban States, we establish an imputed floor (69 FR 49109). Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate IPPS payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2007, the areas affected by this provision, after the occupational mix adjustment is applied, will be by a footnote in Tables 4A-1 and 4A-2 that are to be published separate from this final rule.

G. Implementation of the FY 2007 Occupational Mix Adjustment to the Wage Index

For the final FY 2005 and FY 2006 wage indices, we used a blend of the occupational mix adjusted wage index and the unadjusted wage index. Specifically, we adjusted 10 percent of the FY 2005 and FY 2006 wage index adjustment factor by a factor reflecting occupational mix. We refer readers to the FY 2005 IPPS final rule at 69 FR 49052 and the FY 2006 IPPS final rule at 70 FR 47376 for a detailed discussion of the blended wage index.

As discussed in section III.C. of this preamble, for FY 2007, we are applying the occupational mix adjustment to 100 percent of the FY 2007 wage index. We will calculate the occupational mix adjustment using the first 3 months of the 2006 survey data, using the methodology described in section III.C. of this preamble.

Comment: One commenter suggested that, for the FY 2007 wage index, CMS should apply the Bellevue Hosp. Center v. Leavitt decision only to hospitals in the Second Circuit, and not on a nationwide basis. For States outside the Second Circuit, the commenter recommended that CMS apply the occupational mix adjustment at 10 percent, as it did in FYs 2005 and 2006. The commenter noted that there is a CMS (then HCFA) precedent for applying a court's order to only hospitals in the States in the Circuit where the decision was rendered, citing HCFA Ruling 97-2, pertaining to the inclusion of "eligible but unpaid" Medicaid days in the DSH calculation.

Response: The commenter did not address whether the 10-percent adjustment would use the new 2006 occupational mix survey data or the prior 2003 data. Therefore, it is not clear how the commenter is suggesting we apply the policy. Nevertheless, we

believe the most appropriate policy is to apply the occupational mix adjustment uniformly nationwide, using the same survey data and a 100 percent adjustment for all hospitals. It is important to keep in mind that the occupational mix adjustment is an adjustment to the wage index factor that represents the ratio of a labor market area's average hourly wage to the national average hourly wage. DSH adjustments, in contrast, are not based upon individual hospital information compared to a national average. If we were to use separate sets of data depending upon geographic location, hospitals located in the Second Circuit would be compared to one national benchmark, whereas hospitals located elsewhere would be compared to a different one. We believe such a policy would undermine the calculation of the wage index that is a relative measure of differences in area wage levels that uses a uniform national baseline for purposes of comparison. In addition, we note that the New York labor market area includes counties located both inside and outside of the Second Circuit. The New York-White Plains-Wayne, NY-NJ CBSA includes three New Jersey Counties: Bergen, Hudson, and Passaic Counties. These counties are located in the Third Circuit, not the Second Circuit. Therefore, applying the Bellevue Hosp. Center v. Leavitt decision only in the Second Circuit would result in two area wage index values for the New York labor market area, adding further complexity to the wage index calculation.

Comment: One commenter believed that section 1886(d)(6) of the Act requires CMS to publish its actual wage tables and other factors by August 1. The commenter also cited the Balanced Budget Act of 1997 (BBA), Pub. L. 105-33, under which Congress moved the deadline in section 1886(d)(6) of the Act from September 1 to

August 1. The commenter contended that Congress would not have needed to move the deadline if the final data were not to be published as of August 1.

Response: The relevant language of section 1886(d)(6)of the Act states: "The Secretary shall provide for publication in the **Federal Register**, on or before August 1 before each fiscal year . . . of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection." We believe the plain language of section 1886(d)(6) of the Act requires merely a description of the data and methodology that are used to compute the IPPS rates and does not require actual publication of the rates.

With respect to the comments about the statutory change that moved the deadline for the IPPS rule from September 1 to August 1, section 4644 of the BBA was an amendment to conform section 1886(h)(6) of the Act to the requirements of the Congressional Review Act. The Congressional Review Act does not allow a major rule to go into effect for 60-days unless there is an act of Congress allowing the rule to go into effect earlier. The publication date in section 1886(d)(6) of the Act was changed accordingly so that the IPPS final rule could take effect no sooner than 60 days after publication, or by the beginning of the Federal fiscal year on October 1 without Congress having to act. However, Congress did not alter section 1886(d)(6) of the Act with respect to the information that is to be included in the final rule. We agree with the commenter that it is our usual practice to publish the wage tables and other factors along with the final rule consistent with 42 CFR 412.8. However, due to our implementation of the Bellevue Hosp. Center v. Leavitt decision, it is not possible to follow this procedure for

FY 2007. In the proposed rule, we explained our intent to post the FY 2007 occupational mix adjusted wage index tables and related impacts on the CMS web site after we publish the FY 2007 IPPS final rule, and in advance of October 1, 2006 (71 FR 28652). We have modified 42 CFR 412.8 accordingly. The change we are making to §412.8 is a procedural rule that we are making effective upon publication.

Comment: A few commenters expressed concern that the new occupational mix adjustment may have a negative impact on some hospitals, and they would not know how they are affected until the final FY 2007 wage index tables are published. Some commenters recommended that CMS allow hospitals more time to review their data, comment on the survey results, and make adjustments and/or revisions to their occupational mix survey data. One commenter requested that CMS publish the occupational mix regulations and data as an interim final rule with a full 60-day comment period so that providers will have an opportunity to comment further. Another commenter urged CMS to consider either delaying the implementation of the occupational mix adjustment, or consider allowing retroactive correction to any errors discovered after October 1. A few commenters recommended that CMS use its discretionary authority to "smooth out" the impact of this change on adversely affected hospitals and apply a multiyear transition of the occupational mix survey data.

Response: As we indicated above, while we understand the commenters' concerns about the potential for inaccurate occupational mix survey data to be used due to the abbreviated data collection and reporting periods, we believe we have established a review and correction process that is intended to minimize errors. We cannot delay the

implementation of, or transition in, the occupational mix adjustment for the FY 2007 wage index because the Second Circuit Court required that all "data collection and measurement and any other preparations necessary for full application should be complete by September 30, 2006, at which time we instruct the agency to immediately apply the adjustment in full." Also, we believe that the 30-day comment period after the May 17, 2006 publication of the amended FY 2007 IPPS proposed rule provided ample opportunity for the public to comment on the new occupational mix survey data and adjustment for the FY 2007 wage index. Hospitals are usually afforded 60 days to comment on the entire IPPS rule. In addition, we cannot allow retroactive changes to the FY 2007 wage index for errors discovered after October 1, 2006, unless a hospital's correction request meets the strict criteria of §412.64(k)(1) of our existing regulations (also see section III.J. of this preamble). However, as previously mentioned, we will allow hospitals an additional opportunity to revise both their 1st quarter and 2nd quarter 2006 occupational mix data for the FY 2008 wage index.

Comment: One commenter recommended that CMS publish the corrected 1st quarter 2006 survey data as a public use file prior to the publication of the final FY 2007 wage index tables.

Response: Intermediaries are required to transmit the corrected 1st quarter 2006 survey data to CMS by July 27, 2007. Unfortunately, due to our short timeframe after July 27 for reviewing the survey data and computing, analyzing, and publishing the final FY 2007 occupational mix adjusted wage index, we cannot publish the corrected 1st quarter survey data before we publish final FY 2007 wage index tables.

The final wage index values for FY 2007 (except those for hospitals receiving wage index adjustments under section 505 of Pub. L. 108-173) will be included in Tables 4A-1, 4A-2, 4B, 4C-1, 4C-2, and 4F that are to be posted on our Web site and published in a **Federal Register** notice subsequent to this final rule.

Tables 3A and 3B in the separate issuance will list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, using the wages included in the calculation for the FYs 2005, 2006, 2007 wage indices. Table 3A in the separate issuance will list these data for urban areas and Table 3B in the separate issuance will list these data for rural areas. In addition, Table 2 in the separate issuance will include the adjusted average hourly wage for each hospital from the FY 2001 and FY 2002 cost reporting periods, as well as the FY 2003 period used to calculate the FY 2007 wage index. The 3-year averages will be 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 will be calculated based on the data available during that period.

The final wage index values in Tables 4A-1, 4A-2, 4B, 4C-1, 4C-2, and 4F and the average hourly wages in Tables 2, 3A, and 3B to be posted on our Web site and published in a subsequent **Federal Register** notice will include the occupational mix adjustment.

H. Revisions to the Wage Index Based on Hospital Redesignations

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. 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 §§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 the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Pub. L. 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 §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 new 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. The eligible counties are identified under section III.H.4. 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 is applicable both to the hospitals located in rural counties 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. In compliance with section 1886(d)(8)(C) of the Act, as well as with the rules CMS has established by regulation, 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.

• 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.

• 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.

• 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 2007 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 §412.230 through §412.280.

In the FY 2007 IPPS proposed rule (71 FR 24377), we identified hospitals that have reclassifications effective in FY 2007. As specified in §412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw an application for reclassification or terminate an existing 3-year reclassification for FY 2007. The request must be received by the MGCRB within 45 days of publication of the IPPS proposed rule.

However, as a result of our compliance with the Bellevue Hosp. Center v. Leavitt court decision, as discussed earlier, we will be recalculating wage indices using new occupational mix data and applying the occupational mix to 100 percent of the wage index. Wage tables in the IPPS proposed rule did not include the new survey data, nor did they adjust 100 percent for occupational mix. Thus, the data that hospitals might

have used to make withdrawal or termination decisions are obsolete. The necessary data (including wage indices and out-migration adjustments) hospitals generally utilize in evaluating whether to withdraw or terminate a reclassification will not be available until after this IPPS final rule has been published. Therefore, in the May 17, 2006 proposed rule (71 FR 28650), in this limited circumstance, we suspended the 45-day deadline and have established the new procedure described below to withdraw from or terminate reclassifications for FY 2007. Some hospitals may have adhered to the established process and notified the MGCRB of their decision to withdraw or terminate a reclassification, in accordance with §412.273, before publication of that proposed rule.

Because hospitals made these decisions based on information in the FY 2007 IPPS proposed rule that is now obsolete, in the May 17, 2006 proposed rule, we proposed that the MGCRB not act on these withdrawal or termination requests. Instead, we have applied the following procedures for withdrawal and termination determinations for all hospital reclassifications for FY 2007. We will make reclassification withdrawal and termination determinations based on what we perceive would be most advantageous to the hospital. We will use our best efforts to determine what would provide the hospital with the highest possible wage index. Specifically, we will choose among: section 508 reclassifications, section 1886(d)(10) reclassifications, section 505 out-migration adjustments, and certain other changes to the wage index (for example, the special exceptions policy explained in the FY 2005 IPPS rule (69 FR 49105) or Lugar status if we determine that it is in the hospital's best interest to waive the Lugar/section

1886(d)(8)(B) redesignation in order to receive the section 505 out-migration adjustment).

We also will make the final occupational mix adjusted wage indices and out-migration adjustments and our interim decisions on hospital reclassifications available to the public in the **Federal Register** and on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp after August 1, 2006, and before October 1, 2006. We will allow hospitals a 30-day period from the date the final data and our interim decisions are made available on the Web site to notify CMS in writing, with a copy to the MGCRB, of whether they wish to reverse the reclassification decision made by CMS or to choose another reclassification for which they are eligible. We will make every effort to provide the final data before September 1, 2006, so that the 30-day period to make these determinations will end before October 1, 2006, and no retroactive adjustments will be necessary. Requests to reverse a decision made by CMS must be received, in writing, no later 30 days after the data are made available on the CMS Web site at the following:

Division of Acute Care

C4-08-06

7500 Security Boulevard

Baltimore, MD 21244

Attn: Marianne Myers

AND a copy to

Medicare Geographic Classification Review Board

2520 Lord Baltimore Drive, Suite L

Baltimore, MD 21244-2670

Prior to FY 2004, hospitals had been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Section 401 of Pub. L. 108-173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with FY 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot. Although there could still be some benefit in terms of payments for some hospitals under the DSH payment adjustment for operating IPPS, section 402 of Pub. L. 108-173 equalized DSH payment adjustments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that rural referral centers and, effective for discharges occurring on or after October 1, 2006, MDHs have no cap). (A detailed discussion of this application appears in section IV.I. of the preamble of the FY 2005 IPPS final rule (69 FR 49085). The exclusion of MDHs from the 12 percent DSH cap under Pub. L. 109-171 is discussed under section IV.F.4. of this preamble.)

Comment: Several commenters asked CMS to clarify its position on withdrawing reclassifications as well as the timeframe of submitting applications for geographic reclassification.

Response: The normal timetable of 45 days after the publication of the proposed rule for hospitals to withdraw or terminate a reclassification under section 508 of Pub. L. 108-173, section 1886(d)(10) of the Act, or section 1886(d)(8)(B) of the Act (in order to receive a section 505 out-migration adjustment) does not apply for FY 2007. For this

reason, any withdrawal or termination requests submitted to the MGCRB and/or CMS following publication of the FY 2007 IPPS proposed rule are not reflected in the reclassification tables shown in this final rule.

We will make best efforts to give each hospital the highest FY 2007 wage index after reviewing applicable data using the 100 percent occupational adjusted wage index. Hospitals will have 15 days from the display date of this final rule to notify us of whether, in the absence of viewing the final 100 percent occupational mix-adjusted wage index data, they wish to choose a particular wage index for which they are eligible (such as to definitively maintain a reclassification that they received or to definitively terminate or withdraw from a reclassification). Written requests to maintain, terminate, or withdraw a reclassification, in the absence of viewing the final wage tables, must be received at the following address no later than 5:00 p.m. EDT 15 days from the date this final rule appears on public display at the Office of the Federal Register:

Division of Acute Care

C4-08-06

7500 Security Boulevard

Baltimore, MD 21244

Attn: Marianne Myers

If we do not receive notice from the hospital within such 15-day timeframe, we will make determinations for the hospital using our best efforts to determine what we believe results in the highest wage index for the hospital. If applicable, we will give the hospital its home wage index with the out-migration adjustment, if that option results in

the highest wage index. In some cases, we may determine that it is most advantageous for a hospital to terminate its Lugar/section 1886(d)(8)(B) reclassification in order to receive the out-migration adjustment. Because this termination would result in the hospital losing urban status, we will separately publish a table identifying these hospitals that move from Lugar/urban status to rural status with the out-migration adjustment. For section 508 hospital individual reclassifications, we may make half-year terminations/withdrawals on behalf of hospitals, using the procedures identified in our proposed rule. That is, for a section 508 hospital that applied for an individual reclassification under section 1886(d)(10), we would give the section 508 hospital the higher of its home wage index, section 508 or 1886(d)(10) wage index for the first half of the year. For the second half of the year, we would give the section 508 hospital the higher of its home wage index or its section 1886(d)(10) reclassification. (However, in no case could such a hospital receive its home wage indes for the first half of the year and its MGCRB reclassification for the second half, or vice versa. For group reclassifications, we will apply the higher of the home wage index or the section 1886(d)(10) reclassification for the entire year. For group reclassifications that include a section 508 hospital, we will apply the decision that was on the MGCRB application for groups that followed the procedural rules (that is, the group either: (1) withdrew from its section 1886(d)(10) reclassification for the first half of FY 2007 and will only receive a second half FY 2007 section 1886(d)(10) reclassification; or (2) the group is reclassified under section 1886(d)(10) of the Act for the entire year and the section 508 hospital withdraws from its section 508 reclassification for the first half of the FY 2007) unless

the group informs us differently after publication of the final occupational mix adjusted wage indices. Groups that include a section 508 hospital will be able to make decisions as a group, separately for the first and second half of the year. Thus, the group may decide to withdraw a section 1886(d)(10) reclassification that would be applicable only for the second half of FY 2007. Again, however, in no case could a group whose 508 hospital chose to waive its 508 reclassification (and therefore accept the MGCRB reclassification for the first half of FY 2007) withdraw its MGCRB reclassification for the first half of the year, but not the second (or vice versa).

We acknowledge that hospitals may base withdrawal/termination decisions on factors other than simply what results in the highest wage index for the upcoming fiscal year. For this reason, we will allow a hospital to change a decision that is made by CMS on its behalf. Hospitals should note that we will not recalculate the wage indices or budget neutrality factors after the final notice announcing the FY 2007 occupational mix adjusted wage indices. That is, we will not further recalculate the wage indices or standardized amounts based on hospital decisions that further revise decisions made by CMS on the hospitals' behalf.

We will post the final occupational mix adjusted wage indices, out-migration adjustments, and our interim decisions on hospital reclassification on the CMS Web site, as discussed above, sometime after August 1, 2006, and before October 1, 2006. We will post the same tables on the CMS Web site that appear in the **Federal Register** final notice of the occupational mix adjusted wage indices to be published after August 1, 2006 and before October 1, 2006. Hospitals will be able to determine the reclassification

decision applied on their behalf by reviewing Tables 9A through 9C for hospitals that are reclassified under section 1886(d)(8)(B) of the Act, section 508 of Pub. L. 108-173, or section 1886(d)(10) of the Act. The applicable wage index for these hospitals will be found on Table 2. If a hospital is not listed in Tables 9A through 9C, CMS will have made a decision not to reclassify the hospital and its home wage index will apply, including the effect of the out-migration adjustment, will be found in Table 2. The applicable out-migration adjustment for the hospital will be found in Table 4J. As indicated above, we will separately publish a table identifying hospitals that we move from Lugar/urban status to rural status with the out-migration adjustment in Table 9D. Hospitals will have 30 days after the data are placed on the CMS Web site to submit, in writing, whether they wish to revise the decision made on their behalf by CMS. Written requests to revise a decision made on behalf of a hospital by CMS must be received by CMS no later than 5 p.m. EDT, with a copy sent to the MGCRB, within 30 days from the date the information appears on the CMS Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp at the following addresses:

Division of Acute Care

C4-08-06

7500 Security Boulevard

Baltimore, MD 21244

Attn: Marianne Myers

AND a copy to

Medicare Geographic Classification Review Board

2520 Lord Baltimore Drive, Suite L

Baltimore, MD 21244-2670

If a hospital fails to notify CMS that it is revising a determination made on its behalf within 30 days from the date the information appears on the CMS Web site, the interim decision made by CMS on the hospital's behalf will be final for FY 2007. Therefore, if CMS makes a decision on a hospital's behalf to terminate or withdraw a reclassification and the hospital does not reverse or modify CMS's decision, we will deem the hospital's reclassification is withdrawn or terminated. Once CMS's decision on the hospital's behalf is in effect, it will be treated in the same manner as if the hospital(s) had made the reclassification decision on its own. Thus, for example, because a hospital cannot have overlapping reclassifications, if we decide a hospital should accept a FY 2007 through 2009 reclassification, any reclassification the hospital previously had for FY 2006 through 2008 would be permanently terminated.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change in geographic classification for a FY must submit its application to the MGCRB no later than the first day of the 13-month period ending on September 30 of the preceding fiscal year. Thus, the statute requires that FY 2008 reclassification applications be submitted to the MGCRB no later than September 1, 2006. Hospitals must submit applications for geographic reclassification for FY 2008 by September 1, 2006. However, because the 3-year average hourly wage of hospitals for the FY 2007 final rule will not be available by the September 1, 2006 deadline for submitting FY 2008 geographic reclassification applications, we will allow hospitals to supplement incomplete reclassification

applications with the official data used to develop the FY 2007 wage index after filing their initial application. As indicated above, the 3-year average hourly wage information that will be necessary for FY 2008 reclassification applications will be available subsequent to this final rule after August 1 and before October 1, 2006. The information will be available on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp and then accessing the page titled "MGCRB Reclassification Data for FY 2008 Applications". Applications and other information about MGCRB reclassifications may be obtained via the CMS Internet Web site at: http://www.cms.hhs.gov/mgcrb/, 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.

Comment: Several commenters requested a revision in the geographic reclassification rules so that in the future the occupational mix adjusted average hourly wage data is used as a point of comparison for eligibility. The commenters believed this change would make reclassification decisions consistent with the new basis for the wage index. The commenters also suggested that hospitals should not be allowed to apply for reclassification if they do not provide complete occupational mix data.

Response: Section 1886(d)(10)(D)(vi) of the Act requires the MGCRB to use the 3-year average of the average hourly wage data from the most recently published hospital wage survey data, as well as the preceding 2 fiscal years' published surveys. Because our published surveys of wage data include adjustments for occupational mix (10 percent in FYs 2005 and 2006 and 100 percent in FY 2007), the MGCRB uses mix-adjusted wage

indices in making reclassification decisions. Therefore, for FY 2008 reclassification applications, the MGCRB will use the average of the average hourly wages for FYs 2005 through 2007. These data will be based on an occupational mix adjustment of 10 percent for FY 2005 and FY 2006 and 100 percent for FY 2007.

With respect to the comment about precluding hospitals that did not submit occupational mix survey data from reclassifying, we believe that due to the unusual circumstances of the Court's order and the short timeframe that hospitals were provided for completing and submitting their data, it would not be fair to apply a penalty to non-responsive hospitals for the 2008 reclassification applications. However, as indicated earlier, we will give serious consideration to applying some sort of penalty in the future if a hospital does not comply with regulations requiring submission of occupational mix survey data.

4. Procedures for Hospitals Applying for Reclassification Effective in FY 2008 and Reinstating Reclassifications in FY 2008

Applications for FY 2008 reclassifications are due to the MGCRB by September 1, 2006. We note that this deadline also applies for canceling a previous wage index reclassification withdrawal or termination under §412.273(d). As we noted in the FY 2007 IPPS proposed rule (71 FR 24083), applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2006, on the CMS Web site at: http://www.cms.hhs.gov/mgcrb/, or by calling the MGCRB at (410) 786-1174.

The MGCRB, in evaluating a hospital's request for reclassification for FY 2008 for the wage index, must utilize the official data used to develop the FY 2007 wage index. The wage data used to support the hospital's wage comparisons must be from the CMS hospital wage survey. Generally, the source for these data is the IPPS final rule to be published on or before August 1, 2006. However, as we stated earlier, the wage tables identifying the 3-year average hourly wage of hospitals will not be available in time to include them in this FY 2007 IPPS final rule. Therefore, we will make the data available subsequent to August 1, 2006, but before October 1, 2006.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change in geographic classification for a FY must submit its application to the MGCRB not later than the first day of the 13-month period ending on September 30 of the preceding FY. Thus, the statute requires that FY 2008 reclassification applications be submitted to the MGCRB by no later than September 1, 2006. For this reason, hospitals must file an FY 2008 reclassification application by the September 1, 2006 deadline even though the average hourly wage data used to develop the final FY 2007 wage indices will not yet be available. We note that, under §412.256(c), the MGCRB must review applications and notify the hospital if it determines that the application is incomplete. We are also allowing hospitals 30 days from the date the final wage data is posted on the CMS Website to request to cancel a withdrawal or termination in order to reinstate its reclassification for FY 2008 or FY 2009, or both fiscal years. Requests to cancel a withdrawal or termination in order to reinstate a hospital's reclassification for FY 2008 or FY 2009, or both fiscal years, should be forwarded to the following addresses:

Medicare Geographic Classification Review Board

2520 Lord Baltimore Drive, Suite L

Baltimore, MD 21244-2670

AND a copy to

Division of Acute Care

C4-08-06

7500 Security Boulevard

Baltimore, MD 21244

Attn: Marianne Myers

As outlined in §412.256(c)(2), hospitals with incomplete applications have the opportunity to request that the MGCRB grant a hospital that has submitted an application by September 1, 2006, an extension beyond September 1, 2006, to complete its application. Thus, while hospitals must file an application for reclassification to the MGCRB by September 1, 2006, they will be able to supplement the reclassification application with official data used to develop the FY 2007 wage index after filing their initial application. We are providing that hospitals file a supplement to the reclassification application with official data used to develop the FY 2007 wage index no later than 30 days after the data are made available on the CMS Web site. These same rules will apply to canceling a withdrawal or termination of a geographic reclassification.

5. FY 2007 Redesignations Under Section 1886(d)(8)(B) of the Act

Beginning October 1, 1988, section 1886 (d)(8)(B) of the Act required 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 were met. Prior to FY 2005, the rule was that a rural county adjacent to one or more urban areas would be treated 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 published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and New England County Metropolitan Areas (NECMAs)), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) 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 (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying for redesignation under section 1886(d)(8)(B) for the purpose of assigning the wage index to the urban area. We provided the chart below with the listing of the rural counties designated as urban under section 1886(d)(8)(B) of the Act in the FY 2007 IPPS proposed rule. For discharges occurring on or after October 1, 2006, hospitals located 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.

The following table is subject to revision if CMS decides it is most advantageous for a county to waive its county Lugar status in order for a hospital within that county to receive a section 505 out-migration adjustment.

Rural Counties 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
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, 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

Rural County	CBSA
Cedar, IA	Iowa City, IA
Allen, KY	Bowling Green, KY
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
Granville, NC	Durham, NC
Harnett, NC	Raleigh-Cary, NC
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC
Polk, NC	Spartanburg, NC
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

Rural County	CBSA
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 Tables 4C-1 and 4C-2 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 once the final wage index data are posted on the CMS Web site.

6. Reclassifications Under Section 508 of Pub. L. 108-173

Under section 508 of Pub. L. 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 are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be effected in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. The governing regulations indicate that "if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application to the same area for either the second or third year of the 3-year period, that application will not be approved." However in the FY 2006 IPPS final rule (70 FR 47382), we stated that hospitals that indicated in their FY 2007 MGCRB applications that they agreed to waive their section 508 reclassification for the first 6 months of FY 2007 if they were granted a 3-year reclassification under the traditional MGCRB process will not be subject to the rule cited above. Thus, in applying for a 3-year MGCRB reclassification beginning in

FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

Under 1886(d)(10)(D)(v) of the Act, CMS has the authority to "establish procedures" under which a hospital may elect to terminate a reclassification before the end of a 3-year period. In the FY 2006 IPPS final rule (70 FR 47382), we discussed our decision to exercise this authority to establish a procedural rule for section 508 hospitals to retain their section 508 reclassification through its expiration on March 31, 2007, and reclassify under the regulations at 42 CFR Part 412, Subpart L, for the second half of FY 2007. We provided further detail above on how we will apply decisions regarding section 508 reclassifications in the context of the Bellevue Hosp. Center v. Leavitt court decision. Again, we will select the reclassification option that provides the highest wage index for the hospital and will give the hospital 30 days to revise the decision made on its behalf by CMS. We refer readers to the discussion above for further details about how section 508 hospitals that have applied for an individual reclassification and hospitals groups that include a section 508 hospital can revise a CMS decision.

We will apply a similar rule for purposes of the out-migration adjustment for FY 2007 discussed in section III.I. of this preamble. The statute states that a hospital cannot receive an out-migration adjustment if it is reclassified under section 1886(d)(10) of the Act. Therefore, eligible hospitals that are not reclassified during any part of FY 2007 will, by default, receive an out-migration adjustment during that time period. If

the hospital is reclassified for all of FY 2007, the hospital will be ineligible for the out-migration adjustment. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified.

The procedural rules described in the FY 2006 IPPS final rule were intended to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to provide flexibility in our regulations that would allow previously approved reclassifications to continue through March 31, 2007, and new reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. As we indicated in the proposed rule, we have received questions about the application of these special procedural rules to non-section 508 hospitals that are part of group applications that previously were awarded an individual reclassification that continues into FY 2007. These hospitals are concerned that the procedural rules imply that such prior reclassification would be terminated beginning October 1, 2006, because the rules specify that "the remainder of the group receives the home wage index" for the period October 1, 2006, through March 31, 2007, if the group reclassification application specified that the section 1886(d)(10) group reclassification would not begin until April 1, 2007. We did not specifically contemplate preexisting individual reclassifications when we drafted the special procedural rules for group reclassifications that involve section 508 hospitals. However, we did not intend to adopt a less favorable policy for

non-section 508 hospitals in a group with a pending individual geographic reclassification than we did for section 508 hospitals. Thus, we clarified our procedural rule with respect to non-section 508 hospitals with preexisting individual reclassifications that are part of group reclassifications that include a section 508 hospital. For the first half of FY 2007, we intend to either apply (a) the area wage index where the hospital is physically located if there is no reclassification pending, or (b) the hospital's individual reclassification wage index if the hospital was part of a group awarded a group reclassification and the group followed the procedural rules for postponing reclassification until April 1, 2007. However, once the hospital begins its new section 1886(d)(10) reclassification for the period April 1, 2007, through September 30, 2009, any prior reclassifications are permanently terminated, consistent with 42 CFR 412.274(b)(2)(ii). We are also reiterating that the special procedural rules that we have adopted for half fiscal year reclassifications and terminations are intended only to address the special circumstances created by section 508 of Pub. L. 108-173 with respect to reclassifications beginning and ending mid-way through a fiscal year. These special procedural rules do not change any of the permanent provisions currently in effect with respect to reclassifications under subpart L of 42 CFR Part 412.

We show the reclassifications effective under the one-time appeal process in tentative Table 9B in the Addendum to this final rule. All section 1886(d)(10) reclassifications are listed in tentative Table 9A in the Addendum to this final rule.

Comment: Many commenters stated their appreciation and support of CMS' flexibility relating to the expiration of section 508 and in facilitating the transition

between the end of section 508 and reclassifications occurring under section 1886(d)(10) of the Act.

Response: We thank the commenters for their support.

7. Wage Indices for Reclassified Hospitals and Reclassification Budget Neutrality Factor

Under the procedural rules described under section III.H.6. of this preamble, different wage indices may be in effect for the first 6 months and the second 6 months of FY 2007. Specifically, there may be different wage indices in effect for the first and second half of FY 2007 due to the special circumstances of section 508 reclassifications ending in the middle of a fiscal year and half of FY 2007 geographic reclassifications under section 1886(d)(10) beginning on April 1, 2007. This unique circumstance will not change as a result of the Bellevue Hosp. Center v. Leavitt court decision.

The half fiscal year section 1886(d)(10) reclassifications present issues related to the calculation of the reclassified wage indices and reclassification budget neutrality factor. Section 1886(d)(8)(C) of the Act provides requirements for determining the wage index values for both hospitals located in rural counties 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. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent. We proposed to issue two separate reclassified wage indices for affected areas (one effective from October 1, 2006, through March 31, 2007, and a second reclassified wage index effective April 1, 2007, through September 30, 2007).

The reclassified wage indices will be calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year. We only received public comments supporting this proposal.

The half fiscal year reclassifications also have implications for budget neutrality. The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. We apply an adjustment to the IPPS standardized amounts to ensure that the effects of geographic reclassification are budget neutral. We proposed calculating one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively, as discussed in section II.A.4.b. of the Addendum to this final rule. We only received public comments supporting this proposal.

I. FY 2007 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 Pub. L. 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 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. We employ the pre-reclassified wage indices in making these calculations.

In the FY 2007 IPPS proposed rule (71 FR 24264 through 24272), in the Out-Migration Adjustment table, Table 4J, we identified hospitals located in qualifying counties. Table 4J also listed the proposed adjustments calculated for qualifying hospitals. Hospitals that newly qualified for the adjustment in FY 2005 or FY 2006 are eligible to receive the same adjustment in FY 2007. In the FY 2007 IPPS proposed rule, we determined county eligibility based on a 10 percent occupational mix adjustment to the wage index. However, under the May 17, 2006 proposed rule discussed in section III.C. of this preamble, for FY 2007 we are applying the occupational mix

adjustment to 100 percent of the FY 2007 wage index. Therefore, we must reevaluate which counties are newly eligible for the out-migration adjustment in FY 2007 using the 100 percent occupational mix adjusted wage index data. We will publish an updated version of Table 4J showing eligible hospitals and their corresponding wage index adjustments on the CMS Web site after we publish this IPPS final rule, and in advance of October 1, 2006, using the procedures discussed in section III.H.of this preamble. We will use the same formula described in the FY 2005 final rule (69 FR 49064) to calculate the out-migration adjustment.

The adjustments calculated for qualifying hospitals will be listed in the revised Table 4J that will be issued separately from this final rule. These adjustments will be effective for each county for a period of 3 fiscal years. Hospitals that received the adjustment in FY 2006 will be eligible to retain that same adjustment for FY 2007. 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, 2006.

As previously noted, 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, or under section 508 of Pub. L. 108-173, unless they waive such out-migration adjustment. As announced in the FYs 2005 and 2006 final rules, hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act or under section 508 of Pub. L. 108-173 will be deemed to have chosen to retain their redesignation or reclassification, unless they explicitly notified

CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of the FY 2007 proposed rule.

As previously noted, 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, or under section 508 of Pub. L. 108-173, unless they waive such out-migration adjustment. Ordinarily, our rule is to presume that a hospital wishes to retain its reclassification, unless it notifies us within 45 days of the proposed rule that it wishes to receive the out-migration adjustment in lieu of the reclassification. However, for FY 2007, as stated earlier, we will be making reclassification withdrawal and termination decisions on behalf of hospitals. Thus, the ordinary 45-day rule would not apply in FY 2007. Rather, hospitals will have 15 days from the display date of this final rule to notify us of whether, in the absence of viewing the final 100 percent occupational mix-adjusted wage index data, they wish to choose a particular wage index for which they are eligible (such as to definitively maintain a reclassification which they received or to definitively terminate or withdraw from a reclassification). Otherwise, we will make withdrawal and termination decisions on behalf of the hospital (including a decision as to whether to accept an out-migration adjustment instead of a reclassification), and the hospital will then have 30 days to reverse or modify our decision, as applicable.

J. Process for Requests for Wage Index Data Corrections

In the FY 2005 IPPS final rule (68 FR 27194), we revised the process and timetable for application for development of the wage index, beginning with the FY 2005

wage index. The preliminary and unaudited wage index data for FY 2007 were made available on October 7, 2005, through the Internet on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS. In a memorandum dated October 7, 2005, we instructed all Medicare fiscal intermediaries 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 instructed the fiscal intermediaries to advise hospitals that these data are 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 7, 2005 wage index data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary by December 5, 2005. 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 file on the Internet, through the October 7, 2005 memorandum referenced above.

The fiscal intermediaries notified the hospitals by mid-February 2006 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early December 2005 change requests. The fiscal intermediaries also submitted the revised data to CMS by mid-February 2006. CMS published the proposed wage index PUFs that included hospitals' revised wage data on February 24, 2006. Also, in a memorandum dated February 14, 2006, we instructed fiscal intermediaries to notify all hospitals regarding the availability of the proposed wage index PUFs and the criteria

and process for requesting corrections and revisions to the wage index data. Hospitals had until March 13, 2006, to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary'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 transmitted any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2006. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's policy interpretations was April 21, 2006.

Hospitals were also instructed to examine Table 2 in the Addendum to the proposed rule. Table 2 contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2003 data used to construct the proposed FY 2007 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 March 1, 2006.

As discussed in section III.C. of this preamble, on May 17, 2006, we published in the **Federal Register** (71 FR 28644) a proposed rule that proposed to revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new 2006 occupational mix data. In section III.C.2 of this preamble, we discussed in detail the

timeline and process for collecting, reviewing, and correcting the FY 2006 occupational mix survey data. The 1st quarter 2006 occupational mix data PUF was released on June 29, 2006, to hospital associations and the public on the Internet at http://www.cms.hhs.gov/AcuteInpatientPPS. The release of this file superseded any and all of the 2003 occupational mix survey data that we had previously published and proposed to use for the FY 2007 wage index. Hospitals had until July 13 to submit to the intermediaries their requests for corrections to the new 2006 survey data. Intermediaries were to submit all corrected occupational mix data to CMS by July 27, 2007. Also, as discussed in section III.C., the occupational mix data could not be finalized in time to include in this final rule, so we are releasing the final occupational mix adjusted wage index data and tables after the publication of this final rule, but before October 1, 2006.

Because hospitals had access to the final occupational mix data by June 29, 2006, we believe they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2007 wage index and the implementation of the FY 2007 wage index on October 1, 2006. We believe that if hospitals availed themselves of the opportunities afforded to provide and make corrections to the occupational mix data, the wage index implemented on October 1, 2006, will be accurate. In the extent that errors are identified by hospitals and brought to our attention after July 13, 2006, we will only make mid-year changes to the wage index in accordance with §412.64(k) (see below for a detailed discussion).

The final Worksheet S-3 wage data PUF was released in May 2006 to hospital associations and the public on the Internet at http:/www.cms.hhs.gov/AcuteInpatientPPS (hereon, referred to as the May 2006 PUF). The May 2006 PUF was made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final Worksheet S-3 wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 14, 2006). If, after reviewing the May 2006 PUF, a hospital believed that its Worksheet S-3 wage data were incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final data, the hospital was to send a letter to both its fiscal intermediary and CMS outlining 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 were to receive these requests no later than June 12, 2006. (We note that the June 12, 2006 date was revised from the June 9, 2006 date originally specified in the October 7, 2005 letter to hospitals.) Requests mailed to CMS were to be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Each request also was to be sent to the fiscal intermediary. The fiscal intermediary was to review requests upon receipt and contact CMS immediately to discuss its findings.

After the release of the May 2006 PUF, changes to the hospital Worksheet S-3 wage data were only to be made in those very limited situations involving an error by the

fiscal intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor CMS would approve the following types of requests:

- Requests for Worksheet S-3 wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 14, 2006.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 24, 2006 wage index data file.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or CMS during the wage index data correction process.

Verified corrections to the Worksheet S-3 wage data received timely by CMS and the fiscal intermediaries (that is, by June 12, 2006) are incorporated into the final wage index and will be reflected in the FY 2007 final wage index tables that will be published in a separate issuance after the publication of this final rule.

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 2007 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 decision with respect to requested changes. Specifically, our policy is that hospitals that did 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 the reader also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the Provider Reimbursement Review Board for wage index data corrections.

We believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage index data to the fiscal intermediaries' attention. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 12, 2006, for Worksheet S-3 wage data, or after July 13, 2006, for the 1st quarter 2006 occupational mix data, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with §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 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 deadline for making corrections to the wage data for the following fiscal year's wage index. With regard to the FY 2007 wage index, this means by June 12 for Worksheet S-3 wage data and by July 13 for 1st quarter 2006 occupational mix data. 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, since CMS makes

the wage data available to a hospital on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries notify hospitals directly of any wage data changes after completing their desk reviews, we do not expect that midyear corrections would 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 §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 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 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, for the FY 2007 wage index, by the June 12, 2006 deadline for Worksheet S-3 data and the July 13, 2006 deadline for 1st quarter 2006 occupational mix data); and (3) CMS agreed that the fiscal intermediary 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 requests a correction to its wage index data before CMS calculates the final wage index (that is, for the FY 2007 wage index, by the June 12, 2006 deadline for Worksheet S-3 wage data and the July 13, 2006 deadline for 1st quarter 2006 occupational mix data), and CMS acknowledges that the error in the

hospital's wage data was caused by CMS's or the fiscal intermediary'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; it can only be used for the current Federal fiscal year. In other situations, we continue to believe that it is appropriate to make corrections prospectively only. 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.

K. Labor-Related Share for the Wage Index for FY 2007

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 Pub. L. 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 Pub. L. 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 believe that this reflected Congressional intent 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 frequency and 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, 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, 2006. Tables 1A and 1B which will be issued as part of a document separate from this final rule, as discussed in section III.C. of this final rule, will reflect this labor-related share. We note that section 403 of Pub. L. 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."

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, 2006. 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 2007 will be reflected in the Table 1C of the separately issued document referenced under sections III.C. and III.H. of this preamble.

Comment: One commenter suggested that, for hospitals with a wage index greater than one, CMS should use the FY 1992-based labor share of 71.1 percent rather than continue to use the FY 2002-based IPPS labor share of 69.7 percent.

Response: The labor-related share is used to determine the proportion of the national PPS based payment rate to which the area wage index is applied. For IPPS, the labor share remains constant until the market basket is rebased. As discussed in the

August 12, 2005 IPPS final rule (70 FR 47393), the labor-related share for the FY 2002-based market basket was calculated by adding the relative weights of the labor-related operating cost categories of that market basket. These cost categories are: wages and salaries, fringe benefits, professional fees, contract labor, and labor-intensive services. Their relative weights were derived from the FY 2002 Medicare cost reports, which represented the most recent and complete data available when the FY 2002-based market basket was developed.

A return to the considerably older FY 1992-based labor share, where the relative weights were determined using FY 1992 Medicare cost reports, would mean relying on outdated information and thus is not optimal.

Finally, although the wage index and the labor-related share are interrelated regarding final payments, it is important to note that the labor-related share is calculated completely independently of the wage index. For these reasons, we will continue to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2006.

L. Proxy for the Hospital Market Basket

In the FY 2006 IPPS final rule (70 FR 47387), we changed the base year cost structure for the IPPS hospital index for the hospital market basket for operating costs from FY 1997 to FY 2002. As discussed in that final rule, the IPPS hospital index primarily uses the BLS data as price proxies, which are grouped in one of the three BLS categories. The categories are Producer Price Indexes (PPIs), Consumer Price Indexes (CPIs), and Employment Cost Indexes (ECIs), discussed in detail in the FY 2006 IPPS

final rule (70 FR 47388 through 47391). We evaluate the price proxies using the criteria of reliability, timeliness, availability, and relevance. The PPIs, CPIs, and ECIs selected by us and used for this final rule meet these criteria as described in the FY 2006 IPPS final rule. We believe they continue to be the best measures of price changes for the cost categories.

Beginning April 2006 with the publication of March 2006 data, the BLS' ECI will use a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which will 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 are not making any changes to the usage at this time. However, we did solicit comments in the IPPS proposed rule on our continued use of the BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI. CMS received no comments on use of the BLS ECI data. As the SIC-based ECIs no longer exist, we will therefore adopt the proposed policy of using the BLS NAICS-based ECIs to replace the SIC-based ECIs as price proxies in the market basket.

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

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§412.64(d)(2))

1. Background

Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109-171 (DRA) sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement

section 501(b) of Pub. L. 108-173 (MMA). It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care.

Section 5001(a) of Pub. L. 109-171 revises the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New 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 will 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.

New sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act require that we expand the "starter set" of 10 quality measures that we have used since 2003. Specifically, the Secretary is required to expand, consistent with the provisions of section 5001(a) of Pub. L. 109-171, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings. In expanding these measures, section 1886(b)(3)(B)(viii)(IV) of the Act provides that we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Pub. L. 108-173[19], effective for payments beginning with FY 2007. The IOM measures include the Hospital Quality Alliance (HQA) measures (the HQA is a public-private collaboration to improve the quality of care provided by the nation's

[19] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at http://www.iom.edu/CMS/3809/19805/31310.aspx

hospitals by measuring and publicly reporting on that care), the HCAHPS® patient perspective survey, and three structural measures. The structural measures included in the IOM report 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 measures originate from the Leapfrog Group's original "three leaps," and are part of the [National Quality Forum's] 30 safe practices."

New sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, we add other quality measures that reflect consensus among affected parties, 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 has broad discretion to replace measures on the basis that they are not appropriate.

New section 1886(b)(3)(B)(viii)(VII) of the Act requires that we establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review, in advance, its data that are to be made public. In addition, this section requires that we report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Like the provisions of section 501(b) of Pub. L. 108-173, the provisions of section 5001(a) of Pub. L. 109-171 do not apply to hospitals and hospital units excluded from the IPPS, or to payments to hospitals under other prospective payment systems such as the

hospital outpatient PPS. New section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction 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.

Initially, section 1886(b)(3)(B)(vii) of the Act provided for a reduction of 0.4 percentage points to the update percentage increase for each of FYs 2005 through 2007 for any "subsection (d) hospital" that did not submit data on the starter set of 10 quality measures established by the Secretary of Health and Human Services as of November 1, 2003. Section 5001(a) of Pub. L. 109-171 limits the 0.4 percentage point reduction to FY 2005 and FY 2006, and establishes a 2.0 percentage point reduction for FY 2007 and subsequent fiscal years.

The starter set of 10 quality measures we established as of November 1, 2003 are:

Heart Attack (Acute Myocardial Infarction)

- 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 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 (PNE)

- 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?

We adopted these measures after the Secretary of HHS initiated 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, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare Research and Quality (AHRQ), as well as CMS, Quality Improvement Organizations (QIOs), and others.

This collaboration, originally known as the National Voluntary Hospital Reporting Initiative, is now known as the HQA. Hospital data are submitted through the QualityNet Exchange secure Web site (www.qnetexchange.org). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. Data from this initiative were initially used to populate the Hospital Compare Web site, 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 they provide to patients, thereby providing an additional incentive to improve the quality of that care.

This starter set of 10 quality measures, all of which have been endorsed by the NQF, is a subset of measures currently collected for the JCAHO as part of its certification program. NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process We chose these 10 quality measures in order to collect data that will: (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. Most hospitals have participated in the HQA, and are continuing to submit data to the QIO Clinical Warehouse. Since the HQA released the starter set of 10 quality measures, it has continued to release additional quality measures, and has released 11 additional NQF-endorsed quality measures to date. Many HQA-participating hospitals have been voluntarily reporting on these additional quality measures, although only the starter set of 10 quality measures were subject to potential reductions in hospitals' annual payment update percentages under section 501(b) of Pub. L. 108-173.

To implement section 501(b) of Pub. L. 108-173, we created the RHQDAPU program. Originally, the program set out the form, manner, and timeframes for hospitals to submit data regarding the starter set of 10 quality measures. For the FY 2005 payment update, we permitted hospitals to withdraw from the RHQDAPU program at any time up to August 1, 2004. Hospitals that withdrew from the program did not receive the full

payment update and, instead, received a reduction of 0.4 percentage points in their payment update. We did not establish a deadline for withdrawal for the FY 2006 payment update.

For FY 2006, in order to receive a full payment update, hospitals were required to continuously submit to the QIO Clinical Warehouse abstracted data regarding the starter set of 10 quality measures each calendar quarter according to the schedule found on the QualityNet Exchange Web site. New participants were required to submit these data using the same schedule, starting with the quarter they began discharging patients. The data for each quarter had to be submitted on time and pass all of the edits and consistency checks required in the QIO Clinical Warehouse. Hospitals that did not treat a condition or that had very few discharges were not penalized, and they received the full payment update if they submitted appropriate data on each of the 10 quality measures that they treated for patients who were discharged during the reporting periods.

2. New Procedures for Hospital Reporting of Quality Data

a. Two Percentage Point Reduction

In the FY 2007 IPPS proposed rule (71 FR 24091), we proposed to amend our regulations at §412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with requirements for reporting quality data as provided for under section 5001(a) of Pub. L. 109-171.

Comment: One commenter stated that the increase from a 0.4 percentage point reduction in the annual payment update to a 2.0 percentage point reduction was too great and that this increase could cause some small hospitals to close.

Response: The increase from a 0.4 percentage point reduction to a 2.0 percentage point reduction is mandated by section 1886(b)(3)(B)(viii)(I) of the Act.

Comment: One commenter asked if the 2.0 percentage point reduction in the market basket update would ever apply retroactively.

Response: The amount of the reduction and the payment update to which a reduction applies are governed by statute. Section 1886(b)(3)(B)(viii)(I) of the Act requires a 2.0 percentage point reduction for FY 2007 "and each subsequent fiscal year." Section 1886(b)(3)(B)(viii)(I) also provides that the 2.0 percentage point reduction "shall apply only to the fiscal year involved." Therefore, the 2.0 percentage point reduction will not affect the annual payment update for a hospital for any fiscal year prior to FY 2007.

b. New Procedures

We also revised the RHQDAPU program's procedures to reflect our experience with this program and to implement section 5001(a) of Pub. L. 109-171, including the new requirement for the reporting of an expanded set of quality measures. In addition to publication in this final rule, all revised procedures will be added to the "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist" section of the QualityNet Exchange Web site. This checklist also contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative, hospitals must follow these steps:

- Identify a QualityNet Exchange Administrator who follows the registration process and submits the information through the QIO. This must be done regardless of whether the hospital uses a vendor for transmission of data.

- Complete the revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form. All hospitals must send this form to their QIO, no later than August 15, 2006. In addition, before participating hospitals initially begin reporting data, they must register with the QualityNet Exchange, regardless of the method used for submitting data. Although, we proposed that this form be submitted by August 1, 2006, we have chosen to extend the due date to August 15, 2006 to provide hospitals with additional time to notify their QIOs regarding their intent to participate. We received no comments on this proposal.

- Continue to collect data for all 10 "starter set" quality measures (or begin collecting such data, if newly participating in the program), and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet Exchange. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals. The submission will be done through QualityNet Exchange. 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. We proposed that hospitals continue to submit data regarding the starter set of 10 quality measures because the existing data submission schedule that we

will use for the FY 2007 update relies on discharges that occurred in calendar year (CY) 2005. Because the first three quarters of CY 2005 data already have been submitted, we did not propose to require hospitals to submit any additional CY 2005 data to address the new quality measures. However, we again note that many hospitals have been providing data on these additional measures since they were first included in the HQA set, although these measures did not affect hospitals' annual payment adjustment under the RHQDAPU program implementing section 501(b) of Pub. L. 108-173.

- For the FY 2007 update, we proposed that hospitals also would be required to complete and return a written form on which they pledge to submit data on the set of expanded quality measures starting with discharges that occur in CY 2006. The proposed 21 quality measures which we included in the proposed rule are part of the HQA-released measures that the 2005 IOM report recommended we use as expanded "starter" measures, and they include the 10 measures that we originally adopted for the RHQDAPU program. As discussed above, new section 1886(b)(3)(B)(viii)(IV) of the Act requires us to begin to adopt the baseline set of performance measures set forth in the 2005 IOM report effective for payments beginning with FY 2007. We proposed that hospitals would be required to submit data on the expanded measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar quarter of 2006 (January through March discharges). We also stated that the deadline for hospitals to submit their data for first calendar quarter of 2006 would be August 15, 2007.

Comment: Over 100 commenters opposed our proposal that hospitals submit data using the expanded quality measures for discharges occurring in calendar year 2006.

Even though data for the first calendar quarter of 2006 are not required to be submitted until August 15, 2006, commenters stated that using the first calendar quarter as a starting date for submissions would create a hardship for hospitals, and require that their staff re-review records. Commenters recommended that the expanded measure set be used for future reviews only, and that all changes made to reporting should be done with a future effective date. Most of the commenters recommended that we require hospitals to begin reporting using the expanded quality measures starting with discharges occurring in the third calendar quarter of 2006.

Response: After careful review and consideration of the operational issues raised by commenters, CMS has decided to modify the starting quarter for hospital reporting of the expanded 21 quality measures. In reviewing this matter, we recognized that hospitals who concurrently abstract data may have been required to reabstract data from records that had already been completed. Others would have the burden of reconsidering the additional data elements after the timeframe for which they are preparing to submit data. Given the goal of improving quality through public reporting in an efficient manner that does not create undue burden, CMS believes it is appropriate in this instance to modify the starting quarter for the expanded measures. Therefore, hospitals will now be required to submit data on the specified expanded set of 21 quality measures to the QIO Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit this data for third calendar quarter of 2006 is February 15, 2007. The measures that are part of this expanded measure set are described below.

Comment: Several commenters stated that not all hospitals are currently submitting data on the expanded measure set. These commenters noted that hospitals that do not currently submit data using the expanded measure set may need to hire and train new staff to handle the new increased data abstraction requirements that we proposed to implement in the proposed rule. Some of these commenters suggested that reporting data on the expanded measure set should start with January 2007 discharges in order to allow hospitals additional time to make the necessary changes for the extra work.

Response: Although hospitals are not currently required to submit data on the full set of 21 quality measures identified in the proposed rule, many of them are already submitting these data on a voluntary basis under the HQA initiative. As noted in our response to the previous set of comments, we have modified our proposal in response to concerns expressed by commenters. Hospitals will now be required to submit data on a specified expanded set of measures to the QIO Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit this data for third quarter 2006 is February 15, 2007. We believe that this will provide adequate additional time for hospitals to hire or train staff regarding the expanded quality measures.

Comment: One commenter expressed concern that the proposed rule requires hospitals to start collecting data on the expanded quality measures immediately.

Response: As indicated above, we have modified our original proposal to ease the hospitals' transition to reporting using the expanded quality measures. For the expanded measures reporting requirement, hospitals will now be required to pledge to

submit data on the expanded measures beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). Hospitals are given 4½ months following the last day of a discharge quarter to submit accurate data into the QIO Clinical Data Warehouse. Therefore, under our revised policy, we believe that hospitals will have sufficient time to plan when they will begin to collect data on the expanded quality measures.

We would also like to note that we have taken steps to ensure that the burden on hospitals to submit data on the expanded measures is as minimal as possible. For example, in addition to being described in this rule, all of the measures that must be reported, including the 11 newly required measures, are also described in the "Specifications Manual for National Hospital Quality Measures," which is a manual that is jointly issued and maintained by CMS and JCAHO. The manual contains all of the specifications, data definitions, data collection rules and algorithms related to all 21 measures (the 10 RHQDAPU PROGRAM measures and the 11 measures that are being voluntarily reported under the HQA initiative). All specifications for each of these measures as used by CMS for the RHQDAPU program are identical to, or "aligned" with, those used by JCAHO. The CMS and JCAHO alignment results in a single standardized process for the reporting of measures that is accepted by both CMS and JCAHO. In an effort to reduce the reporting burden on hospitals, CMS and the JCAHO work together to refine the data collection process for hospitals for the purposes of validation, public reporting, and the RHQDAPU program. Additionally, CMS and JCAHO have agreed to

release all documents associated with data collection at a minimum of 120 days prior to implementation.

Comment: One commenter stated that the time frames for data collection in the proposed rule do not provide hospitals the opportunity to change or correct mistakes.

Response: The current data submission timeframe is designed to provide sufficient time for hospitals to meet all reporting requirements. Hospitals are given 4 ½ months following the last day of a discharge quarter to submit accurate data into the QIO Clinical Data Warehouse. We believe that this is a sufficient timeframe for the vendor, hospital, QIO or other interested party to identify data errors and submit corrections in advance of the data submission deadline. Additionally, abstractions can begin as early during the quarter as the day the patient is actually admitted. As such, hospitals actually have up to 3 months in addition to the 4½ months following the last day of the discharge quarter to collect and submit data. In addition, under §482.24 of our regulations, , all elements of the medical record (for example, documentation) are required to be complete within 30 days following discharge, so we believe that hospitals have adequate time for the record abstraction and submission.

To ensure that data submission problems are recognized and corrected early, we encourage hospitals to submit their data continuously or to conduct test transmissions prior to the quarterly posted data transmission deadlines. Testing transmissions ensures that hospitals' computer systems are equipped with the proper software and configuration required to successfully transmit data through QualityNet Exchange Web site. We note that it is a hospital's responsibility to ensure that its data are submitted successfully to the

QIO Clinical Data Warehouse. To make it easier for hospitals to verify whether their data were successfully submitted, the QualityNet Exchange Web site has a function that enables hospitals to run reports during test transmissions and after final transmission of data that indicate which records were successfully submitted, with and without errors, and/or which data were rejected by the warehouse. We recommend that hospitals run these reports following each submission of data. Submitting test files early also allows hospitals to check the reports to identify and change or correct mistakes.

Comment: Two commenters stated that the retrospective way that data are reviewed does not offer sufficient opportunity to quickly correct a problem in the hospital setting. One commenter recommended that abstracting occur concurrently with discharge, thereby preventing discharge if additional clinical requirements need to be met. The commenter suggested that a real-time data system be developed to capture this information. The system would alert health care providers when clinical requirements have not been met so that hospitals can remedy these requirements prior to discharging the patient. The commenter also suggested that CMS sponsor a demonstration project for this activity. It would give CMS the opportunity to lead the way for improved technology dissemination in hospitals.

Response: As we discussed in our discussion of value-based purchasing in the FY 2007 IPPS proposed rule (71 FR 24098), one of the challenges we face is minimizing the length of time between our receipt of, and our ability to provide feedback to hospitals on, the data they submit. We agree that hospitals also face this same issue with data they collect. CMS encourages hospitals to take steps toward the adoption of electronic

medical records (EMRs) that will allow for the reporting of clinical quality data. In general, whether to abstract on a concurrent or on a retrospective basis is a hospital's decision, although we recognize there may be a necessary period of retrospective abstraction due to the implementation of new measures. We do not believe that a demonstration project is needed.

Comment: Several commenters noted that expanding the measure set retroactively will require hospitals to re-negotiate contracts with their vendors.

Response: We disagree that our proposal to require hospitals to submit data beginning with first quarter 2006 discharges would have expanded the measure set retroactively. However, as noted above, in response to the comments we received, we will require that hospitals begin using the expanded measure set for submissions due February 15, 2007 relating to discharges occurring in the third calendar quarter of 2006. We believe that this change will afford hospitals adequate notice to prepare for reporting using the expanded quality measures. CMS provides information in a manner that is timely for purposes of meeting the requirements outlined. CMS does not comment on the contractual arrangements between private parties such as hospitals and their vendors. CMS will continue to work with all to assist with their timely performance but this issue remains a private contractual arrangements between those parties. As an alternative, CMS also provides the CART tool to ensure that hospitals may timely meet its requirements for the annual payment update.

Comment: Sixteen commenters requested that CMS consider publishing the proposal to expand the set of measures at least one full year prior to the start of the fiscal

year to which the proposal would apply. Seven other commenters requested a 6-month to 1-year lead-time to prepare for reporting additional quality measures adopted by the Secretary as part of the RHQDAPU program.

Response: We have used the rulemaking process to adopt new quality measures under the RHQDAPU program, and we believe that this process provides sufficient notice for hospitals to comply for the annual payment update. We also note that all of the measures we have adopted to date for reporting under the RHQDAPU program were previously reported by many hospitals under other voluntary reporting initiatives.

Comment: One commenter suggested that CMS publicly release a list of the hospitals that do not meet quality reporting requirements each year. This would allow the affected hospitals to know immediately that they are not in compliance with quality reporting.

Response: Hospitals that met the current CMS requirements for quality data reporting and received their full annual payment update (APU) for FY 2006 are listed on www.qualitynet.org. In the future, QualityNet will display a list of those hospitals receiving their full APU for FY 2007. CMS currently does not have a system in place for individually notifying hospitals that fail to meet the RHQDAPU program requirements. CMS is currently considering how to inform those hospitals that do not receive their full annual payment update for FY 2007.

c. Expanded Quality Measures

In the FY 2007 IPPS proposed rule (71 FR 24093), we listed 21 proposed quality measures, including the 10 "starter set" measures and 11 new measures. The expanded set of measures includes:

Heart Attack (Acute Myocardial Infarction)

- Aspirin at arrival
- Aspirin prescribed at discharge
- ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Beta blocker at arrival
- Beta blocker prescribed at discharge
- 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
- ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Discharge instructions
- Adult smoking cessation advice/counseling

Pneumonia (PNE)

- Initial antibiotic received within 4 hours of hospital arrival
- 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

Surgical Care Improvement Project (SCIP) – named SIP for discharges prior to July 2006 (3Q06)

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotics discontinued within 24 hours after surgery end time

Comment: Six commenters fully supported the progress CMS has made on the identification and reporting of quality measures.

Response: CMS appreciates the comments and looks forward to continued support for this effort.

Comment: One commenter suggested that, with regard to hospital acquired infections, CMS make it clear that process measures are an interim step prior to the reporting in the near future of the actual rates of common hospital acquired infections.

Response: CMS believes that the information obtained from both process and outcome measures (an example of which would be the rates of common hospital acquired infections) are important and complementary in stimulating the system changes necessary for quality improvement. With regard to nosocomial or hospital-acquired infections, we

appreciate the comment and would note that the NQF is currently evaluating measures of hospital acquired infections with the goal of endorsing a set of measures by 2007. The NQF is a voluntary consensus standard-setting organization established to standardize healthcare quality measurement and reporting, for its review and endorsement through its consensus development process. In addition, we are working with the Centers for Disease Control (CDC) and the AHRQ, two government agencies that collaborate with CMS on the SCIP on ways to further reduce surgical complications and infections and improve the kinds of information collected related to this goal.

Comment: One commenter urged CMS to recognize new technology promptly and appropriately to ensure that measures do not provide incentives for hospitals to keep older technologies in place after they are outdated.

Response: CMS is constantly reviewing the medical literature and maintains technical expert panels and consultants for its performance measure sets so that its measures remain up to date with current technologies. Additionally, we have regular conference calls with the relevant specialty societies, such as the American College of Surgeons, the American Society of Anesthesiologists, and the Association of periOperative Registered Nurses), to obtain their input on new evidence and changing best practices that might warrant a change to our performance measures.

Comment: One commenter stated that in small hospitals, one person may be responsible for many jobs. In this situation, the commenter felt that submitting data regarding more measures was very redundant.

Response: For each of the conditions (such as pneumonia) for which we adopt measures, the measures focus on individual aspects of care that are considered standard for every patient. The addition of measures represents a more comprehensive view of the quality of services provided to each patient. We believe that additional information from the added measures will contribute to quality improvement in patient care.

Comment: Twenty-four commenters stated that their hospitals do not currently collect data for the surgical infection prevention (SIP) measures. They contend that the FY 2007 IPPS proposed rule's requirement that they establish a procedure for abstracting and collecting these measures for first quarter 2006 would be very burdensome for hospitals. Many of the commenters requested a delay in the implementation of the collection of SIP measures until third calendar quarter of 2006. Another commenter noted that the hospital's data collecting vendor would require additional funds to collect and process data to support the SIP measure data collection for January and February of 2006.

Response: As noted above, in this final rule we have revised the implementation date for hospital reporting using the expanded quality measures (including the SIP/SCIP measures) so that reporting will begin starting with discharges occurring in the third calendar quarter of 2006. We also note that submitting data via vendors is not the only route available to hospitals. Currently hospitals have available to them three mechanisms by which to submit data into the QIO Clinical Warehouse. It is the hospital’s choice which mechanism it will utilize to report its data. The following data reporting mechanisms are available to hospitals:

- Quality Improvement Organization Program (QIO) – CMS makes available to hospitals data reporting assistance via QIOs. QIOs provide technical assistance to hospitals as they report data, and if need be will report the data on behalf of the hospital.

- Self reporting – Hospitals can report their own data. All data collection, including SIP/SCIP can be accomplished by using the CMS Abstraction & Reporting Tool (CART). This application tool is available at no charge to hospitals or other organizations.

- JCAHO vendor – A hospital may authorize a JCAHO Performance Measurement System (PMS) vendor that has met the CMS measurement specifications to transmit data into the QIO Clinical Warehouse on its behalf.

These reporting mechanisms are also described on the QualityNet Exchange Web site (www.qualitynet.org).

Comment: Nine commenters noted that the data requirement for SCIP would result in unplanned costs to hospitals including the hiring of additional abstractors, additional training, and additional medical assistance to pull the pertinent charts.

Response: Under section 5001(a) of Pub. L. 109-171, we are required to begin to adopt the baseline set of performance measures as set forth in the 2005 IOM report, which include the SIP/SCIP measures. In considering which of these measures we would adopt for the RHQDAPU program, we weighed the burden for the hospital to report additional quality data for the measure against the benefits of addressing recognized gaps in quality and providing beneficiaries with useful information on the quality of hospital

care. We believe that the SIP/SCIP measures strike the appropriate relative balance of interests.

That balance is appropriate and valuable on three levels given the potential improvements in surgical site infections that can occur through proper antibiotic use. It is estimated that over half of the 127,000 surgical site infections that are contracted by Medicare beneficiaries were preventable (Best, WR, Khuri SF, et al.; Identifying Patient Preoperative Risk Factors and Postoperative Adverse Events in Administrative Databases: Results from the Department of Veterans Affairs National Surgical Quality Improvement Program. J Am Coll Surg 2002;194:257–266. © 2002 by the American College of Surgeons).

SCIP measures are designed as a framework to help hospitals organize and coordinate care. Evidence has shown that when hospitals change their internal systems to reliably deliver the care mandated in the SCIP measures, they are more efficient and safer for patients. For example, a nationwide collaborative dedicated to improve the processes of care outlined in the proposed SCIP Infection measures demonstrated a significant reduction in surgical site infection (Dellinger EP, Hausmann SM, et al., Hospitals collaborate to decrease surgical site infections. Am J Surg. 2005 Jul;190(1):9-15.). And reliable processes of care aimed at assuring the correct deep venous thrombosis prevention as outlined in the proposed SCIP VTE measures “markedly reduced” the rates of these complications in patients at risk (Kucher, N, Koo S, et al.; Electronic Alerts to Prevent Venous Thromboembolism among Hospitalized Patients N Engl J Med 2005;352:969-77).

Comment: One commenter stated that the sample size for SCIP for large hospitals will be onerous for these facilities. The commenter requested that the sample size be calculated using the entire organization's activity rather than each specialty. Under this approach, hospitals could decide on an individual basis if they want to drill down for more information.

Response: Specialty-specific sample sizes are required to provide more precise measures by specialty. Much of the existing research about antibiotic administration is specialty-specific, and the exclusion criteria and process measure rates differ by specialty. The increased sample size is necessary to incorporate these specialty-specific differences into hospital-level estimates of antibiotic administration.

The SCIP sample is designed to provide precise hospital level measures for all SCIP measures, including the SCIP Infection 1 and 3 measures included in this rule. CMS believes that the SCIP specialty-specific sample is designed to produce precise measures for the entire SCIP expanded measure set.

Comment: One commenter agreed with the inclusion of the SIP measures. This commenter believed that there was not sufficient information provided by the two measures alone. The commenter urged CMS to include SIP-2 in the measures.

Response: We agree with the commenter. CMS will evaluate how we can include SIP 2 (SCIP 2), appropriate selection of prophylactic antibiotics, in the future.

Comment: One commenter recommended that CMS review the way some of the indicators are measured. Two commenters recommended that quality measures should conform to clinically appropriate care established by peer-reviewed literature or

professional consensus. One commenter suggested that there needs to be a more scientific method when setting up indicators.

Response: We believe that the quality measures in this rule and on Hospital Compare have a strong evidence base and represent technical guidelines from relevant stakeholder societies such as the American College of Cardiology and the American Heart Association. They are maintained by CMS working with the JCAHO through ongoing assessments of changes in the clinical literature, evaluation of trends in performance, and review by technical experts. In addition, all measures currently being reported, as well as those that we are adopting in this rule, have been endorsed by the NQF, a national consensus body whose mission is to identify a common set of standardized evidence-based measures for quality reporting. Detailed specifications for each of the measures, including information concerning the underlying literature and clinical evidence that led to their endorsement and adoption, are included in the Specifications Manual for National Hospital Quality Measures, at www.qualitynet.org.

Comment: Two commenters stated that financial incentives must allow sufficient flexibility to meet the unique needs of individual patients, and not encourage hospitals to avoid the most difficult cases.

Response: As noted in our response to the previous commenter, we have adopted evidence-based quality measures which have been endorsed by the NQF. There is no question that any payment system potentially contains incentives for unintended consequences that may be counter to the intent of those who design the system. We share the commenters' concern regarding this issue and will consider it as we monitor the

impact of hospitals reporting data to receive the full market basket update under section 5001(a) of Pub. L. 109-171, and as we develop our plan for implementing a value-based purchasing, under section 5001(b) of Pub. L. 109-171.

Comment: Eight commenters stated payment for 2007 will be reduced by 2.0 percentage points for performance indicators that have a track record of poor reliability, such as the working diagnosis of pneumonia. The commenters noted that some hospitals resort to answering working diagnosis for pneumonia as a "yes" for all pneumonia charts regardless of actual documentation, since the penalty is disproportionately more severe if the no answer is found to be incorrect. The commenters noted that a couple of mismatches on the "no" response to working diagnosis can drive the hospitals to the brink of losing 2.0 percentage points of their annual payment update.

Response: The working diagnosis element is only one of over 15 elements in a single episode of care that is used to calculate the pneumonia measures. Many of the hospitals that failed quarterly validation due to submitting inaccurate pneumonia elements did not submit additional elements used in the calculation of pneumonia measures and validation score. All hospitals are able to submit all elements potentially used to calculate validation scores, and we encourage hospitals to submit all of these elements to improve their likelihood to pass quarterly validation.

Comment: Two commenters recommended that for future measure development, CMS select measures only from those used by the HQA for public reporting.

Response: CMS strongly values its participation in the HQA, which was established as a public-private collaboration to promote voluntary hospital public reporting on quality of care. Led by representatives of the hospital industry, with membership that includes consumer groups, unions, purchasers, providers, health plans and government, accrediting and standard-setting organizations, the HQA has been instrumental in helping to identify and find common ground among the diverse interests of these stakeholders. Congress recognized the HQA's role when it included the "starter set" of 10 measures, first identified by the HQA for reporting on Hospital Compare, in the Pub. L. 108-173 RHQDAPU program provisions (section 501(b)). As we now implement section 5001(a) of Pub. L. 109-171 and expand the measure set for FY 2007 and beyond, we are asking hospitals to report on the 21 HQA-approved measures. In addition, HQA has strongly supported the development and use of the HCAHPS® tool for assessment of patient experience with care. We expect to continue to work closely with the HQA in our future efforts, as well.

In addition, we expect to add HCAHPS® measures to the RHQDAPU program's reporting set as soon as feasible. The HCAHPS® survey is designed to make "apples to apples" comparisons of patients' perspectives on hospital care including communications with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information.

Comment: One commenter requested a clear definition for antibiotic administration time. In the commenter's opinion, the current standard requiring that no

longer than one-hour pass between the administration of the antibiotic and the making of a surgical incision does not have adequate clinical support.

Response: The performance measures that we have adopted for the RHQDAPU program, including the timing of prophylactic antibiotic administration prior to surgery, are evidence-based, consensus-derived measures. The measurement specifications each of these measures includes the supporting evidence basis for the measure, and can be found in the Specifications Manual for National Hospital Quality Measures, at www.qualitynet.org. In addition, as part of our routine maintenance review of the measures, we monitor any changes in the medical literature that would require modification of the measures.

Comment: One commenter suggested "retiring" the oxygenation assessment measure. New section 1886(b)(3)(B)(viii)(VI) of the Act specifies that CMS has the ability to replace measures "where all hospitals are effectively in compliance." The commenter noted that the average performance on this measure is 99 percent and that retiring this measure would be a signal to hospitals that CMS is willing to reduce the burden of data collection as the set evolves.

Response: The commenter's points are well taken. The oxygenation measure was previously endorsed by the NQF. The NQF has recently initiated a "maintenance" review of all of its previously-endorsed pulmonary care measures, including the oxygenation measure, under which process these measures will be reevaluated by panels of experts and health care stakeholders (including CMS) to determine their continuing

technical merit. CMS will defer its decision on the oxygenation measure until after this group has completed its deliberations.

Comment: Several commenters stated that the measures recommended by the Leapfrog Group (computerized provider order entry, intensive care intensivists, and evidence-based hospital referrals) and included in the 2005 IOM report do not meet the quality measure standards necessary for inclusion in CMS' national quality measurement initiatives. In addition, commenters noted that rural hospitals have not previously been asked to comply with these measures. These commenters believe that it would be unwise for CMS to adopt these measures. Another commenter wrote in support of the use of such structural measures. This commenter noted, however, that in terms of burden on hospitals, such programs span multiple years, must be approved on an annual basis, and require board approval. They also require significant financial resources, human resources, and time to develop and implement. The commenter stated that requiring such programs, which present a challenge to either fund or risk reduction in payment, would not appear to be reasonable. For example, the commenter stated that the phased-approach implementation of computerized provider order entry for prescriptions (CPOE) for its facility is projected to be completed by 2009 with an estimated cost of up to $2 million.

Response: We thank the commenters for their input. For FY 2007, we are not proposing that hospitals submit data on the three structural measures recommended by the three Leapfrog Group and included in the 2005 IOM report. However, as we continue to expand the set of measures on which hospitals report, we will consider

whether to include these measures, as well as other structural measures and will bear the commenters' observations in mind.

Comment: Several commenters agreed that measures selected should be those that are endorsed by NQF and aligned with JCAHO's reporting requirements. The commenters also proposed that methods for maintaining measures be developed and implemented. Since medical knowledge continues to evolve, the science behind clinical practice guidelines must be monitored for changing evidence that previously accepted clinical practices no longer define the best care. Without this important step, measures cannot continue to evaluate best quality of care delivered to patients. The commenters proposed that CMS create a plan, including method and frequency for monitoring new evidence that impacts established measures, in addition to monitoring for adjustments needed to improve their implementation.

Response: We agree with the commenters. CMS continuously monitors new evidence and works with panels of experts, as well as with the relevant specialty societies and other groups that develop practice guidelines, to assure that the measures are up to date, and to verify that measures reflect best clinical practice. In addition, we work with JCAHO experts to assure that the detailed specifications and instructions for collection of data used to calculate the rates reflects the most up to date information about medications, coding, and other issues.

Comment: A commenter suggested that as new measures are added and mandated for public reporting, payment should not be based on simply the indicator percentage, but should also include the percentage change of improvement or the quarters

of sustained improvement. The commenter stated that data collected based on such process improvement would be test data until the processes being measured were stable. Just as indicators are tested and validated, process improvement provides data that is test data. Transparency of data reporting connected to payment needs to allow a test period for data to not "count" toward payment.

Response: The commenter has made several important suggestions that are relevant to our ongoing deliberations about measures for both reporting quality data and for value-based payment systems (discussed more fully in section IV.B. of this preamble). In proposing that CMS consider measures that highlight improvement over time, rather than just performance during a single time period, the commenter has offered an important suggestion that addresses our goal of identifying a set of measures that will support sustained quality improvement. We also raised this issue in the 2007 IPPS proposed rule in our discussion of value-based purchasing (71 FR 24098). As we consider further expansion of the measure set, we will consider this suggestion, as well as the commenter's suggestion that hospitals be given the opportunity to "test" the reporting of new measures before they are included in any payment incentive arrangement.

Comment: Three commenters strongly urged CMS to adopt measures identified in the 2005 IOM report as well as consider and adopt as many additional NQF-endorsed measures as can be feasibly collected, for example:

Outcomes

- 30-day heart failure mortality
- 30-day heart attack mortality

- Failure to rescue

Complications

- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical

- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Response: We appreciate the specific recommendations of the commenters and will consider them as we look to expand the set of measures.

Comment: One commenter recommended that CMS continue to work to ensure the accuracy of the information posted on the Hospital Compare Web site. The methodology adopted should be fully transparent to all stakeholders to clearly assess hospital-level reliability. The commenter recommended that we also engage representatives from the research, provider, and consumer communities to obtain input on the different potential methodologies and their impact on data validity, accuracy, and completeness.

Response: We agree with the commenter. The integrity of the information posted on the Web site depends on the accuracy of the underlying data. In the 2007 IPPS proposed rule, we solicited input on proposed revisions to our methodology, and CMS

remains open to advice and suggestions concerning how to continue to improve its processes to assess and assure hospital-level reliability.

Comment: Two commenters urged CMS to include outcome measures based on the best available science and consensus, rather than permanently focus on the process measures that it has adopted. Ultimately, consumers want to see the results of hospital practices, that is, whether the processes measured actually yield higher quality care as indicated by results, such as better mortality rates and fewer infections.

Response: We appreciate the specific recommendations of the commenter and will consider them as we look to further expand the set of measures. We are particularly interested in considering measures that have been endorsed by consensus building entities such as the NQF that take into account the issues of validity, reliability, impact and feasibility of the measures and involve a wide array of stakeholders. We also anticipate issuing a rulemaking in the near future that would propose to adopt a number of outcome measures, which may include 30-day post-admission mortality rates for patients with acute myocardial infarction and heart failure

Comment: Two commenters requested that, as we consider new measures, we involve all stakeholders in the process.

Response: CMS agrees with the commenter that stakeholder input is an essential part of the measure selection process. CMS receives input from stakeholders through multiple vehicles such as the NQF, the HQA and the notice and comment rulemaking process. CMS remains committed to the goal of including stakeholders in the process.

Comment: One commenter suggested that because CMS makes its hospital quality data public, the data should be risk adjusted, and technical standards should be applied to the data to assure fair treatment of hospitals.

Response: The set of measures currently reported on Hospital Compare are process measures for which no risk adjustment is needed, since they are constructed to reflect the proportion of cases in which a patient received the care that is appropriate for his or her clinical needs. The measures are constructed to exclude cases for which an intervention would not be appropriate. We expect that, as we consider whether to expand the set of measures to include outcome measures, we will need to address concerns about risk-adjustment and patient-mix.

Comment: Two commenters suggested that CMS develop measures that examine quality and costs of care within and across settings over time. A commenter also recommended allowing variation in the implementation of new measures due to variability across the country.

Response: We appreciate the recommendations of the commenters. As we work to expand the set of measures that hospitals report under the RHQDAPU program, we will consider such issues as how to assess care coordination both within and across hospitals and health care providers, as well as how to account for expected and unexpected variations in performance across providers.

Comment: One commenter expressed concern about the negative effects of requiring hospitals to report measures when it is actually the physician who orders the

care. This particularly happens in the case of small rural hospitals. This commenter indicated that the hospital should not be responsible for physician mistakes.

Response: Hospitals cannot abrogate their responsibility for the care that is practiced at their own facilities. Given that virtually all significant treatment decisions are initiated with a physician's order, this argument would absolve hospitals of virtually all responsibility for quality and safety.

Comment: One commenter recommended addressing the alignment of physician and hospital indicators. If alignment is not possible, the commenter recommended that we have physician-driven indicators that apply to physicians only.

Response: CMS is working collectively with the hospital and physician communities to improve the overall quality of health care for Americans. As part of this effort, CMS to use a common focus on quality by clinicians and providers to achieve improvement in the quality of healthcare.. One example of this is the Surgical Care Improvement Project (SCIP). The use of metrics that focus on surgical quality from both the physician and provider perspective offer the best opportunity to improve the surgical quality of care. In addition, CMS launched a Physician Voluntary Reporting Program (PVRP) that incorporated indicators that will align physician interests with hospitals. More information on PVRP can be found at www.cms.hhs.gov/pvrp.

d. HCAHPS® survey

As recommended in the IOM report, we will be implementing the HCAHPS® survey in October 2006 as a part of the HQA. HCAHPS® is designed to make "apples to apples" comparisons of patients' perspectives on hospital care including communications

with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information. More information on this survey can be found on our Web site: www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet200512.pdf. We intend to report the first three quarters of these survey data in late 2007 on the Web site: www.hospitalcompare.hhs.gov. HCAHPS® was endorsed by the NQF in May 2005. However, we did not propose to include HCAHPS® as a part of the revised FY 2007 "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form.

We believe that the procedures and expanded measure set that we proposed to adopt in the FY 2007 IPPS proposed rule meets the requirement of section 1886(b)(3)(B)(viii)(IV) of the Act that, "for payments beginning with fiscal year 2007, in expanding the number of measures, under subclause (III), the Secretary shall begin to adopt" the 2005 IOM report's set of baseline measures. Section 1886(b)(3)(B)(viii)(III) of the Act states that we must expand, for FY 2007 and each subsequent fiscal year, the set of measures that the Secretary determines to be "appropriate" for the measurement of the quality of care furnished by hospitals in inpatient settings beyond the original quality measures that applied in FY 2005 and FY 2006.

We believe that the statute gives the Secretary the discretion to choose what "begin to adopt" should involve in FY 2007 and the number of additional measures, if any that would be "appropriate" during this time. In proposing our revised procedures, designing the methods that hospitals will use to report during FY 2007, establishing a set

of expanded measures based on the 2005 IOM report, and revising RHQDAPU program materials, we believe that we have met the statutory requirements. We will continue to explore the feasibility of adopting additional measures for purposes of the FY 2008 update, including the HCAHPS® survey described in the IOM report and other measures that reflect consensus among affected parties, as required by new sections 1886(b)(3)(B)(viii)(III) through (V) of the Act.

Comment: One commenter expressed support for the HCAHPS® initiative, but requested that CMS make the survey available in languages other than English and Spanish. The commenter noted that in areas with diverse patient populations such as New York City, hospitals will not be able to conduct the survey adequately in only two languages.

Response: The HCAHPS® survey is currently available only in English and Spanish. We intend to solicit comments from participating hospitals and survey vendors regarding additional languages for HCAHPS®. This information can be submitted to our HCAHPS® mailbox, CMSHOSPITALCAHPS@cms.hhs.gov. Based on the information we receive, we will establish priorities for HCAHPS® translation into additional languages.

Comment: One commenter recommended that we offer hospitals sufficient time to incorporate the HCAHPS® measures into their care protocols. The commenter suggested that we establish an implementation schedule that provides for sufficient time for hospitals to become familiar with data submission, and instructions explaining how to

use the tool for feedback. The commenter noted that such an approach would allow for development of more accurate data.

Response: We agree that hospitals and survey vendors must become familiar with the HCAHPS® instrument, data collection, and data submission procedures prior to participation in the national implementation of the survey. To this end, CMS offered free training to hospitals and survey vendors in February and April of this year. Additionally, to gain experience in all aspects of the survey, hospitals that will participate in the national implementation of HCAHPS® in October 2006 were required to take part in a "dry run" of the survey in April, May, or June of this year. Data submitted to CMS from this dry run will not be publicly reported. CMS is planning to offer additional training and dry run opportunities for hospitals that will join the HCAHPS® initiative after October 2006.

Comment: One commenter recommended that the following question be added to the HCAHPS® patient survey proposed for October 2006, "Did you get an infection while you were in the hospital or after any surgery or other procedure?" The commenter stated that most patients would know about the existence of an infection, and this would be a more precise way to identify significant problems than more general and subjective HCAHPS® questions, such as questions that address the "cleanliness and quietness of the hospital."

Response: We appreciate this suggestion, but at this time we are not planning to add new items to the current version of the HCAHPS® survey (which can be found on www.hcahpsonline.org)) based on our evaluation of the survey and on comments we

received on the survey in response to multiple Federal Register notices that we published (for example, 68 FR 5889, 68FR 38346, 68 FR 68087, and 70 FR 67476). However, we will keep this suggestion in mind for future versions of the survey.

Comment: Two commenters stated that for FY 2008, CMS needs to more than merely explore the feasibility of adopting additional measures for FY 2008 update. There should be a substantial expansion of measures for hospitals to obtain the FY 2008 annual update. The commenters agreed with the Consumer-Purchaser Disclosure Project recommendations that CMS adopt the additional measures identified in the 2005 IOM report (HCAHPS® and three structural measures), as well as consider and adopt a number of other NQF-endorsed measures.

Response: We note that in addition to the expanded measure set that we are adopting in this rule, we will begin national implementation of the HCAHPS® survey in October 2006. We also anticipate further expanding the measure set for FY 2008 and will consider adopting other NQF-endorsed measures at that time.

Comment: A commenter suggested that CMS identify and develop, in collaboration with the long-term care hospital (LTCH) industry, appropriate quality measurement indicators and begin collecting and public reporting results across providers.

Response: At this time, we are not working on developing measures for the long term care hospital setting. However we will consider, in the future, the commenter's suggestions regarding the collection of quality measures from long term care hospitals. HCAHPS® has been developed for use by short-term, acute-care hospitals, which

encompasses all hospitals that are eligible to submit clinical measures for public reporting. At this time, other types of hospitals, including LTCHs, are not eligible to participate in HCAHPS®. CMS will, in the future, consider whether and how an HCAHPS® survey could be re-designed for appropriate use by other types of hospitals, including LTCHs.

Comment: Several commenters stated that there is no "no-cost" alternative to using a vendor to participate in HCAHPS®, unlike the situation of the collection of clinical chart abstraction data. They noted that this presented a significant burden to hospitals that will have no alternative to using commercial vendors to satisfy a Federal mandate. In addition, the commenters stated that a substantial number of hospitals do not currently conduct a patient experience survey and that the Federal government has committed only to providing the interface to upload data to QualityNet Exchange. Some commenters suggested that it would be helpful if we provided clear and concise guidance on HCAHPS® sampling.

Response: From the inception of the survey, CMS has been attentive to the costs to hospitals that participate in HCAHPS®. HCAHPS® has been designed to allow a hospital to either conduct the survey on its own, or to conduct the survey through the use of a survey vendor. A hospital that elects to self-administer HCAHPS® must meet a series of minimum survey requirements related to prior survey experience, capacity to conduct HCAHPS®, and its ability to satisfy quality control procedures. In addition, HCAHPS® was designed to be compatible with a range of popular survey practices. It is made available in four modes of administration (mail, telephone, mail with telephone

follow-up, or active IVR), and can be implemented as a stand-alone survey, or integrated within an ongoing patient survey. Because of the nature of the HCAHPS®, the tool developed for HCAHPS® is different from the CART tool. However, CMS has designed an HCAHPS® on-line tool that allows hospitals that self-administer the survey to enter and upload the survey data into the QualityNet Exchange data base. There is no charge for use of the HCAHPS® on-line tool.

Further, in February and April 2006 CMS offered free training on participation in the HCAHPS® survey. Among its topics, this training included detailed instruction on sampling. Additional iterations of this training program are currently being planned. CMS also provides readily available guidance on sampling and other HCAHPS® issues through its HCAHPSonline.org help desk. In addition, QualityNet Exchange maintains a help desk that provides assistance on matters related to submission to the HCAHPS® data warehouse. All of these services are available free of charge.

An independent study of the benefits and costs of HCAHPS® estimated that the average cost of HCAHPS® collected as a separate survey to be between $3,300 and $4,575 per hospital. The cost of combining HCAHPS® with an existing hospital survey would be about $978 per hospital (Abt Associates Inc.: Costs and Benefits of HCAHPS, October 5, 2005). Additionally, hospitals have the option to use a survey vendor or conduct HCAHPS on their own if they have prior survey experience.

e. Data Submission

For the FY 2007 update, we specify that hospitals must submit complete data regarding the quality measures in accordance with the joint CMS/JCAHO sampling

requirements located on the QualityNet Exchange Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of three topics (acute myocardial infarction, heart failure, and pneumonia) covered by the starter set of 10 quality measures. Hospitals are expected to continuously meet these sampling requirements for the starter set of 10 quality measures for discharges in each quarter.

We do not anticipate significant additional burden on hospitals regarding the starter set of 10 quality measures or the anticipated 21 clinical quality measures because all JCAHO-accredited hospitals are currently required to adhere to these sampling requirements in acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention for accreditation and core measure reporting purposes.

Comment: One commenter suggested that CMS consider a methodology that would allow resubmission of data in cases where incorrect data has been identified by the submitting provider, while still maintaining the integrity of the data validation process for payment purposes. The commenter suggested that this could be accomplished through the use of two databases. One database would be frozen once the final submission deadline for a quarter has passed to be used for Clinical Data Abstraction Center (CDAC) validation. However, if the providers discovered errors in its data submission after the quarterly deadline, it would be able to use a second database to submit updated data. The commenter believed that this would improve the data available on Hospital Compare.

Response: We believe that the commenter's suggestion that we create two separate databases has the potential to maintain the integrity of the validation process as well as to improve the quality of the publicly reported data. We will review the methodology and take this suggestion into consideration.

Comment: One commenter requested that CMS create meaningful and useful reports that would be available to vendors after data submission is complete each quarter. The reports should identify actionable steps that hospitals are required to take to make sure they successfully submit data for the RHQDAPU program. CMS should also modify the current Failure and Success Reports so that any data elements needed to populate or calculate measures reported for the annual payment update can be identified as a critical error and result in the rejection of the record. The hospital should be able to download the entire report, without having to download it into several reports.

Response: CMS thanks the commenter for the suggestions on how to improve the reports. The following reports are currently available to hospitals and vendors:

Title of Report	**Vendor Access**	**Provider Access**
QIO Clinical Warehouse Import Detail by Provider Provides case import status into warehouse; options for queries include topic, upload status, discharge dates, types of messages (critical, informational and **measures**) and various sort options	X	X
QIO Clinical Warehouse Import Detail by Error Code Provides case import status into warehouse; options for queries include topic, upload status, discharge dates and various sort options	X	X
QIO Clinical Warehouse Submission Summary Case submission summary	X	X
Case Status Summary Report Includes measure inclusion status and reason for exclusion	Based on hospital authorization	X

Measure Status Summary Report Summary of number of cases indicated per quality measure for cases accepted into the QIO Clinical Warehouse	Based on hospital authorization	X

CMS is currently reviewing the data submission reports and considering modifications to improve and enhance the existing feedback reports. In the interim, we released two additional reports in June 2006 to provide more detailed information to hospitals.

- QIO Clinical Warehouse Measure Status by Category; this report will provide information by measure to include total cases as well as the number of cases by measure category (A-E).

- QIO Clinical Warehouse Measure Status by Case; this report will provide by measure for each case whether the case was eligible for the denominator, passed the measure (numerator), was excluded from measure calculation and the reason for exclusion.

CMS and its contractors routinely conduct training to provide additional assistance concerning how to access and utilize QualityNet Exchange Reports. Information on these trainings can be found on QualityNet Exchange Web site.

Comment: Two commenters requested that corporate owners and vendors have access to QualityNet reports about their specific hospitals, and believe that these reports should not be provided only to hospitals. The commenters stated that having access to these reports will allow hospitals to discern whether errors in data transmission have occurred and whether data should be resubmitted before the deadline.

Response: Hospitals have had the ability to grant third parties such as health care systems and vendors permission to access select QualityNet Exchange Reports since December 2004 through QualityNet Exchange Self-Serve. Health care system users and vendors obtain permission to access hospital reports by completing a QualityNet registration form and submitting the form to the QualityNet help desk. The QualityNet help desk will process the registration form. When a QualityNet user account is assigned, the health care system or vendor user can then request access to reports through the QualityNet Self Serve. The healthcare system's or vendor's report request is then sent to the hospital for report access approval. Detailed instructions for using QualityNet Exchange Self-Serve are available in Chapter 2, Section 2 of the User Guide located on www.QualityNet.org.

Comment: One commenter opposed CMS' intent to develop measures specifications and a system or mechanism to accept data without converting it into XML.

Response: CMS does not intend to develop measures specifications and a system or mechanism to accept data without converting it into XML. Our intent is to continue to utilize the XML format for file submissions.

Comment: Four commenters disagreed with CMS' opinion that no additional burden would be placed on hospitals. The commenters noted that JCAHO participating hospitals are not required to submit the data regarding all 21 measures found in the proposed rule. Therefore, it would be an additional burden on the hospitals to have to submit more measures than are required by the current JCAHO requirements.

Response: We acknowledge this concern, but we are required by new section 1886(b)(3)(B)(viii)(IV) of the Act to begin to adopt the measures as specified in the 2005 IOM report. We believe that the measures we have selected are appropriate because we believe these quality measures will: (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.

We have also taken steps to ensure that the burden on hospitals is as minimal as possible. First, while some hospitals report through JCAHO vendors, we make available the CART tool for reporting on all of the measures in the expanded measures set, at no additional cost to the hospital. Second, our data analysis indicates that although hospitals are not currently required to submit data regarding the 21 measures identified in the proposed rule, many of them are already submitting these data as part of our HQA voluntary reporting initiative. Many hospitals have participated in the HQA, and are continuing to submit data to the QIO Clinical Warehouse. Many HQA-participating hospitals have been voluntarily reporting on the additional quality measures

Comment: One commenter stated that the additional requirements for reporting are too burdensome for rural hospitals. The commenter noted that additional resources required for this work takes away from time the staff can provide for actual care and that the costs associated with submitting the additional measures are too prohibitive for rural hospitals.

Response: Although we acknowledge that the additional reporting requirements will potentially require hospitals to begin collecting data that they have not, to date, been collecting, this potential burden must be weighed against the goals of improving quality of care and meeting the needs of patients. As we stated in response to a previous comment above, we have taken a series of steps to minimize the burden for all hospitals.

Comment: One commenter stated that the QUEST system does not provide consistent answers to questions about abstraction. This commenter stated that there are flaws in the current system. Therefore, the commenter stated that payment should not be based on this system.

Response: The QUEST system is the question and answer system that is available on the internet at QualityNet.org. Questions can be submitted by anyone and they are answered by CMS or its contractors. CMS is working to improve the QUEST system. New processes have been implemented in order to avoid inconsistent answers to questions about abstraction. However, payment is not based on the QUEST system, but is based on compliance with the full set of RHAQDAPU requirements. The primary source for abstraction clarification is the Specifications Manual for National Hospital Quality Measures, available on the QualityNet Exchange Web site.

f. RHQDAPU Program Withdrawal and Chart Validation Requirements

For the FY 2007 update, hospitals may withdraw from the revised RHQDAPU program at any time up to August 1, 2006. If a hospital withdraws from the program, it will receive a 2.0 percentage point reduction in its payment update.

For the FY 2007 update, and until further notice, we will continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule. There were no chart-audit validation criteria in place for FY 2005. Based upon our experience with the FY 2005 submissions and our requirement for reliable and validated data, in the FY 2006 IPPS final rule, we discussed additional requirements that we had established for the data that hospitals were required to submit in order to receive the full FY 2006 payment update (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, will continue and are being placed on the QualityNet Exchange Web site.

For the FY 2007 payment update, and until further notice, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2006 (third quarter CY 2005 discharges).

We use confidence intervals to determine if a hospital has achieved an 80-percent reliability aggregated over the three quarters. The use of confidence intervals allows us to establish an appropriate range below the 80-percent reliability threshold that demonstrates a sufficient level of reliability to allow the data to still be considered validated. We estimate the percent reliability based upon a review of five charts, and then calculate the upper 95-percent confidence limit for that estimate. If this upper limit is above the required 80-percent reliability, the hospital data are considered validated.

We are using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie.: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter is treated as a stratum for variance estimation purposes.

We use a two-step process to determine if a hospital is submitting valid data. In the first step, we calculate the percent agreement for all of the variables submitted in all of the charts. If a hospital falls below the 80-percent cutoff, we restrict the comparison to those variables associated with the starter set of 10 quality measures. We recalculate the percent agreement and the estimated 95-percent confidence interval and again compare to the 80-percent cutoff point. If a hospital passes under this restricted set of variables, the hospital is considered to be submitting valid data for purposes of the RHQDAPU program.

Comment: Four commenters recommended that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis.

Response: QIOs, on behalf of CMS, work to assist hospitals with all aspects of hospital reporting activity. QIOs are available to provide training and assistance to those hospitals experiencing difficulty passing the validation thresholds. This training and assistance is designed to improve the validation scores of hospitals with failing validation

scores through better performance measurement techniques and medical record documentation.

Comment: One commenter recommended using an alternative method of data validation and suggested that we use the monthly data points of each clinical measure instead of relying on chart abstraction. Under this methodology, a monthly data point that exceeds three (3) standard deviations would be considered an outlier.

Response: The current validation methodology measures abstraction accuracy of hospital submitted data elements, and thereby measures the accuracy of reported data. The suggested alternative methodology is designed to identify outlier measures at the aggregate hospital level, and does not identify the specific source of errors. CMS believes that its current validation methodology more accurately measures abstraction accuracy at the element level for the RHQDAPU program.

Comment: One commenter stated that it is incongruent to require results from the first three quarters of 2005 for validation with an effective date of the final rule that is after the data submissions.

Response: Section 1886(b)(3)(B)(viii)(I) of the Act requires an annual determination of payment eligibility, and we believe that we can make accurate payment determinations based on three quarters of validated data. In order to make timely payments to hospitals under the IPPS during FY 2007, we need to complete our payment determinations prior to the start of FY 2007 that is, prior to October 1, 2006. Data submitted in connection with discharges that occurred during the first three quarters of

2005 constitute the most current data that we can use to make our payment determination for FY 2007.

Comment: Two commenters suggested that if we are going to increase the penalties for failure, there needs to be more timely feedback allowing organizations to correct their submission errors. These commenters recommended that the validation process take into account at least 6 quarters of data to allow for learning and to accommodate the constant changes in the specifications.

Response: We use quarterly validation results in order to make a single annual determination. The first three quarters of 2005 constitute the complete set of most currently available data to determine FY 2007 payment eligibility by September 1, 2006. We believe that using three quarters of data is sufficient to allow us to make accurate payment assessments. We will continue to review whether using additional quarters of data can improve the reliability of hospital results under the RHQDAPU program. In addition, as we noted in response to an earlier comment, hospitals and their vendors can use test transmissions in order to identify problems before the submission deadlines. Also, in an effort to reduce hospital burdens, CMS and JCAHO have agreed to release aligned measure changes 120-days prior to their implementation. This allows both hospitals and vendors adequate time to prepare for those changes prior to implementation. However, hospitals are responsible for ensuring that their vendors submit accurate and timely data. It is the responsibility of each vendor, and ultimately of the hospital, to adhere to the requirements listed in the specifications manual for the set discharge time period.

Comment: One commenter recommended a provision to allow CMS and the hospital to have the flexibility to meet 2 of 3, or 3 of 4 quarters. This would provide some assurance that if and when the processes break down, hospitals are not unilaterally punished while providing quality care.

Response: The 3 quarter validation determination is designed to provide a single overall estimate of hospital abstraction accuracy over the entire period. This single overall estimate pools the quarterly samples to increase the overall reliability of the abstraction accuracy estimate for that period. The expectation is that hospitals will abstract and submit cases every quarter with consistency. The entire period would not be reflected if hospitals are allowed the flexibility to meet 2 of 3, or 3 of 4 quarters. To utilize fewer quarters decreases the overall reliability of the abstraction accuracy estimate.

Comment: One commenter suggested that the annual payment update not be tied to validation until the JCAHO and CMS have aligned the measures, resulting in making the guidelines clear and consistent.

Response: As of July 1, 2004 discharges, all data elements within the 10-starter set were CMS and JCAHO aligned. As of January 1, 2005 discharges, all data elements for the expanded 21 measure set were aligned. The changes are designed to keep the measures current with the accepted evidence base of medical research, and to improve the clarity and reliability of the abstraction instructions. CMS and its contractors have and will continue to work diligently to ensure that alignment issues do not affect a hospital's eligibility for receiving the full annual payment update.

Comment: One commenter requested that hospitals not be held responsible when data processing and communication errors, under the control of CMS or that occur as a result of actions of its contractors, cause a failure in validation.

Response: When a hospital reports data processing and communication errors, the errors are thoroughly researched. CMS has not held a hospital responsible for data processing and communication errors that were clearly under the control of CMS or its contractors. However, CMS does hold the hospital responsible for its own errors in data processing and communication. If the error is by the hospital's contracted vendor, the hospital is held responsible.

Under the standard appeal process, all hospitals are given the detailed results of CDAC reabstraction along with their estimated percent reliability and the upper bound of the 95-percent confidence interval. If a hospital does not meet the required 80-percent threshold, the hospital has 10 working days to appeal these results to its QIO. The QIO will review the appeal with the hospital and make a final determination on the appeal. The QIO receives from the hospital the element or elements that are to be evaluated during the appeal process, along with the hospital's rationale for the difference between the hospital's abstraction and the CDAC reabstraction. In this validation appeal process, the QIO reviews the appeal using the medical record to evaluate the data elements that are being appealed. This process allows for an independent review and is designed to find coding errors on the part of abstractors. QIO appeal decisions are based on the data that the hospital submitted to the QIO Clinical Warehouse. The QIO has 20 calendar days to make a final decision. The QIO can either uphold or reverse the CDAC

validation decision. If the QIO does not agree with the hospital's appeal, the original results stand. However, if the QIO agrees with the hospital, new validation results are calculated and provided to the hospital through the usual processes. This validation appeal process is described in detail at the QualityNet Exchange Web site.

Comment: Twelve commenters recommended expanding the appeal process to include any indicator, regardless of whether the overall validation score for the hospitals is at or above 80 percent. The commenters believed that this would allow hospitals the opportunity for improvement. The commenters also felt that this was significant due to the aggregations of validation results for multiple quarters, and for the resolution of discrepancies between the hospital and the CDAC.

Response: Currently the appeals process is only available to those hospitals that had an overall reliability rate of less than 80 percent for the quarter. However, CMS encourages all hospitals to use their validation results as a tool for improving abstraction accuracy.

Comment: Seventeen commenters urged CMS to review, on a case-by-case basis, any instance in which a hospital’s payment would be put in jeopardy as a result of the validation process. These commenters did not feel that the validation process is reliable enough to warrant a hospital losing its update due to faulty validation. If a hospital has made a good faith effort to submit valid data, one commenter felt that the hospital should receive its update regardless of whether the data are deemed accurate enough for display.

Response: CMS believes that the current validation process provides a reliable estimate of abstraction accuracy on an annual basis. CMS and its contractors work

closely with the CDAC regarding issues that are raised by hospitals about the validation processes. If a hospital identifies an issue where it believes that its validation score is incorrect, CMS conducts a comprehensive review. We work diligently to ensure that validation issues do not impact eligibility for receiving the full market basket update.

Comment: Two commenters requested that hospitals receive more time to file validation appeals. One commenter suggested increasing the time for filing validation appeals from 10 days to 30 days.

Response: The current time frame for a hospital to file an appeal is 10 business days after the results are posted to QualityNet Exchange. The hospital is notified by electronic mail when its validation results are posted so it receives the information quickly, and it has the full 10 business days to review and appeal the results. The QIO then has an additional 20 calendar days to review and respond to this appeal by forwarding the information to the CDAC or upholding the CDAC decision while providing education to the hospital. CMS believes this is adequate time to file an appeal. The current validation and appeal process can extend as much as 6-9 months beyond the last day of a discharge quarter. To extend the time allowed to file appeals would further lengthen this time for hospitals to receive final results.

Comment: One commenter recommended that we use an impartial party to decide appeals. The commenter felt that the CDAC should not be responsible for both the abstraction as well as reabstraction if there is an appeal.

Response: All data successfully submitted into the QIO Clinical Data Warehouse are subject to the hospital data validation process. The CDAC reabstraction process that

occurs during the appeal is a very objective process. Both the hospitals and the CDAC abstract the records using the same guidelines, the Specifications Manual for National Hospital Quality Measures. The hospital's abstraction is compared to the CDAC's reabstraction in order to determine mismatches and the validation score. A hospital that scores at least 80 percent overall for the quarter is considered to be supplying valid data for that quarter. A hospital that scores less than 80 percent overall for the quarter has the opportunity to file an appeal with its QIO. The hospital must supply to the QIO the rationale for the appeal and the QIO will review a copy of the same record the CDAC completed during its reabstraction. The QIO will then determine the final outcome of the appeal. The QIO has the final say in appeal decisions.

Comment: One commenter expressed several concerns with the validation process.

- The method that is used to construct the numerator and denominator on the summary report is unclear.

Response: We are unsure specifically which numerator & denominator the commenter is referring to. If we interpret the comment correctly, the commenter is referring to the Submission Feedback report. The denominator in the summary report refers to the number of elements in the sampled records used to calculate the measures, and the numerator refers to the number of correctly abstracted elements in the sampled records used to calculate the measures. Two measure lists are used to determine the denominator list of elements, one list for the ten starter set measures versus the second list for the expanded measure set. We believe that the documentation regarding these

reports, available on the QualtyNet.org Web site, provides clear explanation of how the numerator and denominator are determined.

- CMS does not accept documentation from hospitals after the validation results have been published.

Response: Although we do not accept documentation from hospitals after the validation results have been published., we do have several safeguards in place to prevent this from happening. The CDAC works diligently with the QIOs and CMS to ensure that the requirements for hospital reporting of quality data are efficiently and effectively being addressed. We have devoted a great deal of resources to ensuring that the CDAC process, including the receipt of documentation, is consistent, reliable and accurate. Due in part to our adherence to the fixed time schedule in the hospital data validation process, and for security purposes, the CDAC utilizes an in-house system to track and monitor the end-to-end processing of each medical record request from hospitals. The CDAC also relies on external contractors like Federal Express or the U.S. Postal Service (within HIPAA guidelines) with their tracking systems to ship and track medical records. The CDAC goes so far as to contact each provider when all requested medical records are not received.

- Hospitals have failed validation due to the CDAC not receiving all materials, although the hospital verified that all of the materials were sent in a timely manner.

Response: CMS has several safeguards in place to prevent this from happening. The CDAC works diligently with QIOs and CMS to ensure that the requirements of the QIO program are efficiently and effectively being met. We have devoted a great deal of

resources to ensuring that the CDAC process is consistent, reliable and accurate. Due in part to our adherence to the fixed time schedule in the hospital data validation process, and for security purposes, the CDAC utilizes an in-house system to track and monitor the end-to-end processing of each medical record request from hospitals. The CDAC also relies on external contractors like Federal Express or the U.S. Postal Service (within HIPAA guidelines) with their tracking systems to ship and track medical records. The CDAC goes so far as to contact each provider when all requested medical records are not received.

- There is no information to verify the reliability of abstraction.

Response: Hospitals that score below 80 percent are able to appeal abstraction results, and these results are documented. If the hospital believes that it scored below 80 percent due to an abstraction error on the part of the CDAC there is an appropriate process by which the hospital can appeal the validation results.

- For most hospitals, the sample size is too small to determine condition-specific indicator accuracy.

Response: The validation sample is designed to provide overall quarterly feedback on abstraction accuracy and to provide an annual estimate for payment eligibility determination. However, hospitals can use several quarters' validation results to estimate condition-specific accuracy.

In reviewing the hospital data, we will combine the samples for first quarter, second quarter, and third quarter (15 cases) into a single stratified sample to determine whether the 80-percent reliability level is met. This gives us the greatest accuracy when

estimating the reliability level. The confidence interval approach accounts for the variation in coding among the five charts pulled each quarter and for the entire year around the overall hospital mean score (on all individual data elements compared). The closer each case's reliability score is to the hospital mean score, the tighter the confidence interval established for that hospital. A hospital may code each chart equally inaccurately, achieve a tight confidence interval, and not pass, even though its overall score is just below the passing threshold (75 percent, for example). A hospital with more variation among charts will achieve a broader confidence interval, which may allow it to pass, even though some charts score very low and others score very high.

We believe we have adopted the most suitable statistical tests for the hospital data we are trying to validate. In the FY 2007 IPPS proposed rule, we solicited comments from hospitals on this passing threshold, the confidence interval, and the sampling approach (71 FR 24094). Based on analytical results from FY 2006, we found confidence intervals using only five charts widely varied in size. As a result of these findings, we decided to combine multiple quarters of validation samples into a single stratified sample to shrink and/or decrease the variation and produce a more reliable estimate of abstraction reliability to determine if any changes in our methodology are required. We will make any necessary revisions to the sampling methodology and the statistical approach through manual issuances and other guidance to hospitals.

Comment: Several commenters objected to our validation process. They indicated that this process places a large burden on hospitals working with vendors that require the submission of 100 percent of the hospitals' cases. Additionally, this process

will not provide timely feedback, and will only add to the burden of receiving untimely feedback while attempting to continue abstraction. Two commenters expressed concern about the accuracy of the validation process due to large fluctuations in the data dictionary guidelines. One of the commenters suggested that any modifications to the technical process should be published 120 days before the effective/implementation date and that the parameters of the validation process should be stated explicitly and documented. Several commenters suggested that hospitals should be notified about any validation rule changes at least 120 days before abstraction and that any validation process should not penalize hospitals for technical data issues.

Response: The current validation process of 5 charts per quarter is designed to provide hospitals, regardless of size, with an estimate of their abstraction accuracy. The quarterly interval is designed to minimize abstraction burden by coinciding with required submission requirements for JCAHO-accredited hospitals. Non-JCAHO accredited hospitals also need periodic feedback about their abstraction accuracy for quality improvement, and the current process is designed to provide this feedback. As noted above, CMS and JCAHO have agreed to release documents at a minimum of 120-days before implementation. All manuals contain data file submission requirements and programming formats for each quarter. Hospitals are encouraged to be aware of the release schedule and to ensure the proper Specifications Manual (data dictionary) is being used for the discharge time period specified. We will explore modifying the release date of updated Specifications Manuals to provide additional time to hospitals and vendors to incorporate these modifications.

Comment: Three commenters did not believe the validation process of using 5 charts over 4 patient populations is statistically reliable. The commenters recommended that we use 4 quarters of data to increase the number of charts. A commenter also recommended that we use as many as 25 charts.

Response: As we noted above, although we will consider using additional quarters of data, we believe that the current 3 quarters stratified sample provides sufficiently reliable results. The abstraction accuracy estimate is an element level estimate, and the chart is considered a cluster of elements. Each quarterly validation sample generally contains 50 to 100 elements clustered in 5 charts. Analysis of previous quarters of submitted data indicates that the clustering effect increases sampling variability by a relatively small proportion. However, the increase in sampling variability is so small that the sample still produces reliable validation rate estimates. The median hospital standard error using the three quarter stratified sample was about 3 percent.

Time limitations prevent us from using 2005 fourth quarter calendar year discharges for purposes of making the FY 2007 annual payment determination, since the scheduled completion date of appeals would not occur until after the September 1, 2006 scheduled release date of the list of hospitals receiving full payment update. However, we will consider using 4 quarters of validation results (that is, fourth quarter 2005 through third quarter 2006) for the FY 2008 determination. Additionally, CMS factored cost, burden, and precision of the validation results in determining the current validation sampling methodology. The goal of the chart audit validation process is to ensure that the hospital is abstracting and submitting accurate data. In order to calculate quality

measures, which are used to determine the standard of care, complete and accurate data are necessary.

Comment: Eight commenters stated that hospitals may be negatively affected by the way CMS will determine the 80 percent reliability. The stratified sampling method could result in a passing score for the first two quarters, but may result in an overall failure rating based on the results of the third quarter.

Response: The stratified sampling method is designed to produce a single estimate of abstraction accuracy using three combined quarters of validation results. CMS uses three quarters' results to provide a reliable estimate of sustained abstraction accuracy. Combining results from multiple quarters improves the reliability of the estimate, since it is possible that abstraction accuracy varies widely from quarter to quarter. Thus, it is possible that one or two quarterly validation samples achieve a passing score above 80percent, but a single quarterly validation score below 80 percent would drop the three combined quarter score below 80 percent. It is the weight of cases for a particular quarter that determines how much impact a single quarter will have on the overall reliability calculation. However, the aggregate approach improves the ability to accurately calculate the reliability of data submissions.

g. Data Validation and Attestation

For the FY 2007 update, we will revise and post up-to-date confidence interval information on the QualityNet Exchange 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.

In the FY 2007 proposed IPPS rule, we proposed that hospitals attest to the completeness and accuracy of the data submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks (71 FR 24094). In order to meet this requirement, for each quarter, hospitals will have to verify the completeness and accuracy, including the volume, of the data submitted. We plan to provide additional information to explain the data completeness requirement as well as provide the relevant form to be completed on the QualityNet Exchange Web site.

Comment: One commenter supported the requirement for hospitals to attest to the validity of their data. One commenter also suggested requiring hospitals to not only attest to the data, but to also subject a small number of hospitals to a random audit. Another commenter felt there are still significant issues with the completeness and adherence to sampling requirements.

Response: CMS appreciates the commenter's support for the attestation requirement and strives to continually improve the accuracy and reliability of the hospital quality data. In addition to the attestation requirement, CMS is currently studying the need, cost, and feasibility of alternative methods for assessing submission completeness and adherence to sampling requirements, including on-site random audits.

Comment: One commenter did not want the hospital attestations to become too burdensome. The commenter recommended that if the attestation can be a part of the review period, the QualityNet Exchange Administrator should be allowed to review the

data in the preview period, and electronically sign for its accuracy. At a minimum, the attestations should be able to be delivered electronically.

Response: We welcome this suggestion, and agree that the electronic attestation would increase efficiency and lessen the burden for hospitals. We will investigate aspects, such as operational and legal requirements for attestation pertaining to electronic submission.

Comment: One commenter requested that CMS establish and communicate to the field which quarters will be used in the calculation of the validation threshold. The commenter believes that CMS should provide notice to RHQDAPU program eligible hospitals which quarters will be included in the annual payment update prior to the beginning of the rulemaking process each year.

Response: CMS is aware of and understands the commenters concerns in regards to the calculation of the validation threshold. However, we believe that the appropriate way to announce the quarters for which data must be submitted under the program is to announce them as part of the rulemaking process.

h. Public Display and Reconsideration Procedures

We will continue to display quality information for public viewing as required by new section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as we have it recorded.

For hospitals that CMS has determined do not meet the RHQDAPU program requirements for the applicable fiscal year who wish to appeal this determination, the appeals process set forth in 42 CFR Part 405, Subpart R (a Provider Reimbursement

Review Board (PRRB) appeal) applies. However, in the FY 2007 IPPS proposed rule (71 FR 24095) we noted that we believe it may be appropriate to establish a structured reconsideration process to precede the PRRB appeal for FY 2008 and subsequent fiscal years.

Currently, a hospital may submit a letter setting out its reasons for requesting that we reconsider our decision that the hospital did not meet the RHQDAPU program requirements. We proposed to continue this process for FY 2007 RHQDAPU program decisions (71 FR 24095). However, we proposed to establish a deadline of November 1, 2006, for hospitals to make such requests related to the FY 2007 RHQDAPU program decisions, which will give hospitals a minimum of 30 days to submit reconsideration requests from the dates that the decisions are made public. Further, we proposed that the November 1, 2006 deadline also would apply to FY 2005 and FY 2006 RHQDAPU program decisions and that a November 1 deadline would apply in all future fiscal years. CMS will officially respond to the letters submitted by hospitals.

Further, we sought public comment specifically on the need for a more structured reconsideration process to precede any PRRB appeal for FY 2008 and subsequent fiscal years (71 FR 24095). We also sought comment on what such a process would entail. For example, we noted that such a process, if established, could include--

- A limited time, such as 30 days from the public release of the decision, for requesting a reconsideration;

- Who in a hospital organization can request such a reconsideration and be notified of its outcome;
- The specific factors that CMS will consider in such a reconsideration, such as an inability to submit data timely due to CMS systems failures;
- Specific requirements for submitting a reconsideration request, such as a written request for reconsideration specifically stating all reasons and factors, including specific data elements, why the hospital believes it did meet the RHQDAPU program requirements;
- Specific CMS components that would participate in the reconsideration process; and
- The timeframe, such as 60 days, for CMS to provide its reconsideration decision to the hospital.

We also solicited comments on the reasons for not establishing such a reconsideration process.

Comment: One commenter recommended a structured reconsideration process for FY 2007 RHQDAPU program decisions. This commenter supported reconsideration predicated on a written request specifically stating all reasons and factors why a hospital believes it did not meet the RHQDAPU program requirements. The commenter agreed with the deadline of November 1 for RHQDAPU program decisions, and a maximum of 60 days for a CMS response to the reconsideration.

Response: We are pleased that the commenter supports reconsideration predicated on a written request stating all reasons and factors for a hospital not meeting

the RHQDAPU program requirements and concurs with the timeframes we proposed. We expect to move forward with establishing a structured reconsideration process for future RHQDAPU program decisions.

Comment: Three commenters stated that the PRRB may not be the best review mechanism for appeals. A commenter suggested that CEOs should be able to submit their appeals in writing, stating all reasons and facts and that CMS should then establish a pre-PRRB review panel that does not involve any of the individual who make the original determination. If the pre-PRRB review panel renders a decision against the hospital, the hospital can then go before the PRRB for a review.

Response: We are pleased that the commenter support reconsideration predicated on a written request stating all reasons and factors for a hospital not meeting the RHQDAPU program requirements. We expect to move forward with establishing a structured reconsideration process for future RHQDAPU program decisions. We will examine the feasibility of using a panel structure that does not include individuals involved in the original determination. However, because of the highly technical nature of this process, it may be necessary to consult with those individuals due to their specialized expertise.

Comment: Three commenters supported establishing a process that could consider the reasons why a hospital did not meet the RHQDAPU program requirements. A commenter suggested that QIOs could be very helpful in developing and administering a reconsideration process.

Response: We appreciate these comments and will consider the suggestion that QIOs have a role in a reconsideration process as we begin to implement the reconsideration process for FY 2007 and subsequent fiscal years.

i. Conclusion

After consideration of the public comments received, because the change in the percentage point reduction from 0.4 percentage points to 2.0 percentage points is required by section 1886(b)(3)(B)(viii)(I) of the Act, we are adopting as final, without modification, the proposed changes to §412.64(d) of our regulations.

After careful consideration of the public comments received, we are adopting as final the expanded quality measures we proposed.

In response to public comments, we will require that reporting of the expanded quality measures begin with discharges occurring on or after the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit data for this quarter will be February 15, 2007. We are also setting the deadline for hospitals to complete and send the revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form to their respective QIO, as no later than August 15, 2006. With these modifications, after careful consideration of the public comments received, we are adopting these procedures as final.

3. Electronic Medical Records

In the FY 2006 IPPS final rule, we encouraged hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the EMRs 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 in the development of Federal health architecture data standards. We encouraged hospitals that are developing systems to conform them to both industry standards and, when developed, the Federal Health Architecture Data standards, and to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables high levels of performance on the measures. Hospitals using EMRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EMRs.

Due to the low volume of comments we received on this issue in response to the FY 2006 proposed IPPS rule, in the proposed IPPS rule for FY 2007 (71 FR 24095), we again invited comments on these requirements and options. In section IV.B.6. of the preamble to the FY 2007 IPPS proposed rule, we also invited comments on the potential role of effective, interoperable, health information on technology in value-based purchasing.

Comment: Most of the comments that were submitted on the adoption of electronic health records in the hospital settings focused on:

- HIT associated cost implication for hospitals.
- The time frame for implementation should be at least a 10 year window, to allow hospitals to obtain the financial and technical support needed for this initiative.

- CMS statutory authority to encourage the use and adoption of HIT without new legislation.

- Support for the initiative but recommended that CMS develop partnerships with affected parties to ensure its successful development.

Response: After consideration of the public comments received, we will continue to pursue the adoption of electronic health records for the reporting of hospital quality data. In addition, for the future we will take all comments submitted under consideration as we move forward.

B. Value-Based Purchasing

1. Introduction

CMS has undertaken a number of activities to improve the quality and efficiency of care delivered to Medicare beneficiaries. Currently, there are several different fee-for-service payment systems under Medicare that are used to pay health professionals and other providers based on the number and complexity of services provided to patients. In general, all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (for example, duplicative tests and services or services to treat avoidable complications). Therefore, we are examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In considering the concept

of value-based purchasing, we are working closely with stakeholder partners, including health professionals and providers. In the FY 2007 IPPS proposed rule (71 FR 24095), we sought public comment on value-based purchasing as related specifically to hospitals.

We discussed CMS' and Congress' initial steps toward hospital value-based purchasing, which include the Premier Hospital Quality Incentive Demonstration, the RHQDAPU program authorized by section 501(b) of Pub. L 108-173 (MMA), and the extended and expanded RHQDAPU program authorized by section 5001(a) of Pub. L. 109-171 (DRA). (The RHQDAPU program was also discussed in section IV.A. of the preamble to the proposed rule.) In addition, we discussed the issues that must be considered in developing a plan to implement a value-based purchasing plan beginning with FY 2009 for Medicare payments for subsection (d) hospitals. This plan is required by section 5001(b) of Pub. L. 109-171. For each of the required planning issues (measures, data infrastructure, incentives), we discussed CMS' activities to date and solicited comments on outstanding policy questions. Next, we discussed options for implementation of section 5001(c) of Pub. L. 109-171, which authorizes quality adjustment to DRG payments for certain conditions that were not present on hospital admission. We solicited input about detailed design considerations related to each of these issues and the advantages and disadvantages of possible approaches to planning and implementing hospital value-based purchasing.

Finally, we discussed and invited comments on how to encourage hospitals to effectively use health information technology to improve efficiency, processes, and

health care outcomes, through, for example, adopting interoperable health information technology.

2. Premier Hospital Quality Incentive Demonstration

One of the ways in which CMS is testing innovative potential approaches to improving quality is through demonstrations and pilot projects. The demonstration most relevant to hospitals is the Premier Hospital Quality Incentive Demonstration. Premier, Inc., a nationwide alliance of not-for-profit hospitals, submitted an unsolicited proposal for consideration by CMS.[20] We have partnered with Premier to conduct a demonstration that is designed to test whether the quality of inpatient care for Medicare beneficiaries improves when financial incentives are provided. Under the demonstration, about 270 hospitals are voluntarily providing data on 34 quality measures related to 5 clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements.

Using the quality measures, CMS identifies hospitals with the highest quality performance in each of the five clinical areas. Hospitals scoring in the top 10 percent in each clinical area receive a 2-percent bonus payment in addition to the regular Medicare DRG payment for the measured condition. Hospitals in the second highest 10 percent receive a 1-percent bonus payment. In the third year of the demonstration, some hospitals that do not achieve absolute improvements above the demonstration's first year composite score baseline (the lowest 20 percent) for that condition will have their DRG

[20] The Premier Hospital Quality Incentive Demonstration was authorized under section 402 of Pub. L 90-248, Social Security Amendments of 1967 (42 U.S.C. 1395b-1). This section authorizes certain types of demonstration projects that waive compliance with the regular payment methods used in the Medicare program.

payments reduced by 1 or 2 percent, depending on how far their performance is below the baseline.

Following the first year of the demonstration (FY 2004), CMS awarded a total of $8.85 million to participating hospitals in the top two deciles for each clinical area. In the aggregate, quality of care improved in all five clinical areas that were measured. Preliminary information from the second year of the demonstration indicates that quality is continuing to improve, particularly for the poorest performing hospitals. Additional information on the Premier Hospital Quality Incentive Demonstration is available on the CMS Web site at:

http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.

3. RHQDAPU Program

We believe that the acts of collecting and submitting performance data and of publicly reporting comparative information about hospital performance seem to be a strong incentive to encourage hospital accountability. Measurement and reporting can help focus the attention of hospitals and consumers on specific goals and on hospitals' performance relative to those goals.

a. Section 501(b) of Pub. L. 108-173 (MMA)

Since 2003, we have operated the Hospital Quality Initiative,[21] which is designed to stimulate improvements in hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital

[21] For more information about CMS' Hospital Quality Initiative, see http://www.cms.hhs.gov/HospitalQualityInits/.

performance. Section 501(b) of Pub. L. 108-173 authorized us to link the collection of data for an initial starter set of 10 quality measures to the Medicare annual update of the standardized payment amount for hospital inpatient operating costs (also known as the RHQDAPU program). For FYs 2005 and 2006, hospitals that met the RHQDAPU program's requirements received the full annual payment update to their inpatient operating costs, while hospitals that did not comply received an update that was reduced by 0.4 percentage points. For FY 2005, virtually every hospital in the country that was eligible to participate submitted data (98.3 percent), and approximately 96 percent of all participating hospitals met the requirements to receive the full update. The data regarding the starter set of 10 quality measures as well as additional, voluntarily-reported data on other quality measures, are available to the public through the Hospital Compare Web site at: http://www.hospitalcompare.hhs.gov.

b. Section 5001(a) of Pub. L. 109-171 (DRA)

As discussed in section IV.A. of the FY 2007 IPPS proposed rule (71 FR 24091), for FY 2007 and each subsequent year, section 5001(a) of Pub. L. 109-171 amended section 1886(b)(3)(B) of the Act and made changes to the program established under section 501(b) of Pub. L. 108-173. These changes require us to expand the number of measures for which data must be submitted, and to change the percentage point reduction in the annual payment update from 0.4 percentage points to 2.0 percentage points for subsection (d) hospitals that do not report the required quality measures in a form and manner, and at a time, specified by the Secretary. Effective for payments beginning with FY 2007, new section 1886(b)(3)(B)(viii)(IV) of the Act requires the Secretary to begin

to adopt the expanded set of performance measures set forth in the IOM's 2005 report entitled, "Performance Measurement: Accelerating Improvement."[22] Those measures include the HQA measures, the HCAHPS® patient perspective survey, and three structural measures.[23] Effective for payments beginning with FY 2008, the Secretary must add other measures that reflect consensus among affected parties and may replace existing measures as appropriate. New section 1886(b)(3)(B)(viii)(VII) of the Act requires the Secretary to establish procedures for making hospital quality data on these measures available to the public. We discuss our responses to public comments on these requirements in section IV.A. of this preamble.

4. Plan for Implementing Hospital Value-Based Purchasing Beginning with FY 2009

Section 5001(b) of Pub. L. 109-171 requires us to develop a plan to implement hospital value-based purchasing beginning with FY 2009. The plan must consider the following issues: (a) the ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (b) the reporting, collection, and validation of quality data; (c) the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments; and (d) the disclosure of information on hospital performance. Section 5001(b) of Pub. L. 109-171 also calls for us to consult with affected parties and to consider relevant demonstrations in developing the plan. Each of these issues (measure

[22] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at http://www.iom.edu/CMS/3809/19805/31310.aspx.
[23] The three structural measures are: (1) computerized provider order entry; (2) intensive care intensivists; and (3) evidence-based hospital referrals.

development and refinement, data infrastructure, incentives, and public reporting) is discussed below, along with our activities to date and outstanding policy questions.

In the FY 2007 IPPS proposed rule (71 FR 24097), we sought comments on these issue areas and outstanding policy questions. We received 50 items of correspondence, which included 37 comments from hospitals and health care systems, including the American Hospital Association and many State hospital associations, the Federation of American Hospitals, the National Association of Public Hospitals, the Association of American Medical Colleges, and the Catholic Health Association. From the purchaser and consumer perspectives, we received comments from The Leapfrog Group, the National Business Coalition on Health, the Consumer-Purchaser Disclosure Project, the National Breast Cancer Coalition Fund, and Consumers Union. The medical device and information technology industries also provided comments.

As a preliminary matter, almost half of all commenters also made recommendations on the process for developing the Medicare value-based purchasing plan. The AHA, the State hospital associations, the Voluntary Hospital Association, and the Federation of American Hospitals all stressed that the HQA be the foundation for planning. Several other commenters noted the value of an iterative process, with multiple opportunities for public comment to build consensus.

We present a summary of the comments by major issue area below and our response.

a. Measure Development and Refinement

As we explore the potential connections between performance measurement and incentives, we would like to better understand how to develop valid, meaningful, current performance measures that are aligned with other hospital measurement activities, and an enterprise for development, validation, consensus building, and maintenance of these measures. In addition, before measures could be used to compare the relative quality or cost of care provided by hospitals, we believe that the information would need to be appropriately adjusted to account for relevant differences among hospitals and among their patients. The availability of appropriate measures on which consensus might be achieved depends on the state of the art of research on measure development.

We believe that it is desirable for performance measures to be based on appropriate evidence, effectively related to desired outcomes, derived in a transparent fashion involving consultation with experts and affected hospitals, and routinely updated. MedPAC's 2005 Report to Congress[24] stated that measures should be evidence-based; that collecting and analyzing data should not be unduly burdensome for the provider or for CMS; that risk adjustment should be sufficient to deter providers from avoiding patients who might lower performance scores; that most providers should be able to improve on the measures; that measures should apply to a broad range of care and providers; that measures should capture aspects of care that are under the control of the providers being measured; and that areas of care being measured should be those needing improvement.

---

[24] Medicare Payment Advisory Commission: Report to Congress: Medicare Payment Policy, March 2005, pp. 186-187, available at: http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0.

The IOM's December 2005 report, "Performance Measurement: Accelerating Improvement"[25] recommended that measure sets should build on the work of key public- and private-sector organizations; that national performance measures that have been approved through ongoing consensus processes led by major stakeholder groups are an appropriate starting point; that the limited scope of current measures should be broadened to address efficiency, equity, and patient-centeredness; that quality, costs, and outcomes of care should be measured over longer time intervals; and that measures be applicable to more than one setting so that providers can share accountability for a patient's care (pp. 8-11).

The plan for hospital value-based purchasing mandated by Pub. L. 109-171 must address the ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings. We have worked collaboratively in defining consistent, meaningful performance measures for hospitals and other providers for a number of years. The efforts of CMS and its stakeholder partners to develop standardized performance measures increase the likelihood that the measures will be valid, reliable, and widely accepted as viable indicators of performance. Standardized measures also reduce the burden for hospitals that would otherwise have to report different measures to multiple entities, such as accrediting bodies and State agencies.

CMS and the HQA (which includes representatives from consumers, hospitals, health professionals, purchasers, and accreditation organizations) collectively selected a starter set of 10 consensus-derived quality measures for public reporting, which was

---

[25] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at http://www.iom.edu/CMS/3809/19805/31310.aspx

incorporated into the RHQDAPU program authorized by section 501(b) of Pub. L. 108-173. (See section IV.A. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24091) for a detailed discussion of the RHQDAPU program.) The measures were endorsed by the NQF, a nonprofit voluntary organization that represents a broad range of health care stakeholders and endorses consensus-based national performance standards. CMS has also worked with the JCAHO to align hospital performance measures that we share in common, thereby reducing hospitals' reporting burden.

In April and September 2005, CMS and the HQA identified additional NQF-endorsed measures of hospital performance. In section IV.A. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24093), we listed these measures and proposed to require hospital reporting on these measures under an expanded version of the RHQDAPU program authorized by section 5001(a) of Pub. L. 109-171. These measures are discussed in more detail on the CMS Web site at: http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHQA2004_2007200512.pdf. In this final rule, we have included the 20 NQF-endorsed measures currently reported on our Hospital Compare Web site, as well as two additional NQF-endorsed measures, as requirements for hospital reporting under the FY 2007 RHQDAPU program

Two additional outcome measures (30-day mortality for heart attack and heart failure) have been endorsed by the NQF for public reporting. Further, in October 2006, we will be implementing the HCAHPS® survey of inpatient perceptions of their hospital care experiences, with the intention that an aggregate HCAHPS® measure will become a

publicly reported performance measure. HCAHPS® was endorsed by the NQF in May 2005. Beyond these, we could also consider including additional measures from the Surgical Care Improvement Project, measures relating to a hospital's use of information technology that result in improved patient outcomes, implementation of data standards, and preventable readmissions as quality reporting measures under the RHQDAPU program or the hospital value-based purchasing program.

Comment: Virtually all of the commenters discussed the measures issues. The commenters focused on three major topics: (1) the use of quality versus efficiency measures, (2) the use of process versus outcome measures, and (3) the importance of including measures that capture aspects of care from the patient experience, including access, respect, and disparities/differences experienced by patients of different races and ethnic backgrounds.

From the perspective of virtually all provider associations, the hospital value-based purchasing program should focus on evidence-based process measures. The majority of commenters also believed that, for now, measures should focus solely on quality and that measures of efficiency are premature. Several commenters also stressed that the goal of the program should be to improve overall quality of care, rather than to decrease costs.

Commenters from the medical device industry raised the concern that a reliance on process measures when assessing efficiency could inhibit access to new technologies and urged that risk-adjusted outcome measures be used instead. Two provider associations urged that payment systems must ensure that evolving and improved

technologies continue to be available to all patients and that efficiency measures not inhibit the adoption of new quality-enhancing technologies.

Commenters representing the purchaser and consumer perspectives stressed the importance of including measures that reflect quality, efficiency, equity, patient experience, and structure and urged that all measures be nationally endorsed, scientifically valid, risk-adjusted, and regularly updated. Several consumer groups and safety net providers also noted the importance of including measures that could capture disparities in care experienced by patients of different races and ethnic backgrounds. On a related note, the Association of American Medical Colleges and safety net providers emphasized the importance of assuring a level playing field to account for differences among types of hospitals and patient demographics.

Several commenters noted that developing measures is a public good and that substantial funding should be provided to support the development of consumer-relevant measures to fill existing gaps, especially for measures of efficiency and equity.

Several commenters supported including measures from the Surgical Care Improvement Program (SCIP) because surgical wounds and infections are among the most common and harmful hospital-acquired infections.

Regarding information technology, the response was mixed. Some commenters supported the inclusion of measures that would encourage IT adoption, while others noted the obstacle of ongoing issues with current health IT standards.

b. Data Infrastructure

Implementing measures on which to base a value-based purchasing system would require an infrastructure that could collect appropriate information from hospitals, store and aggregate it as necessary, and prepare it for use in determining appropriate incentives. Hospitals would likely need to be able to generate appropriate data as input for calculation of the measures. For some measures, data that hospitals already submit with claims for payment or for some other administrative purpose may be sufficient. For other measures, hospitals might need to provide information regarding their structure and resources or about the specifics of medical care provided to patients or the outcomes of that care. For that information, hospitals may need special software to assist with data collection and secure channels by which they can transmit data. In the FY 2007 IPPS proposed rule, we solicited comments on how to develop an infrastructure that would facilitate the efficient transmission and storage of data, and especially, as discussed in sections IV.A.3. and IV.B.6. of the preamble to that proposed rule (71 FR 24095, 24100). We especially solicited comments on how electronic medical and health record systems could help improve care and be integrated into or facilitate the data collection process.

We did not receive any comments specific to this issue.

Implementation would require communication channels and data warehouses with sufficient capacity and flexibility to acquire and store data from hospitals. We are considering how we might validate the submitted data, determine incentives based on that data, and transmit these values to Medicare's fiscal intermediaries. The potential infrastructure would need to be extremely secure and afford the most privacy protection

permitted by law. It would also need to minimize the burden of data collection and transmission on providers. It would need to be accurate, efficient, and cost-effective for CMS to administer.

The plan for hospital value-based purchasing mandated by Pub. L. 109-171 must address the reporting, collection, and validation of quality data. Over the past few years, we have developed a data collection and reporting infrastructure for the RHQDAPU program that can transmit performance measurement data via secure channels for its submission, storage, analysis, validation, and reporting. Specifically, to facilitate data collection, we have developed the CART software to assist hospitals in the collection of clinical and administrative data used to measure performance improvement. CART, which is provided to hospitals free of charge, is a powerful application that hospitals and their designees can use to abstract clinical data needed for performance measurement from medical records. This tool was designed and developed by CMS with input from the JCAHO and the Medicare QIOs. We have also developed the QualityNet Exchange system for secure transmission of data to the QIO Clinical Warehouse. QNetExchange.org is the CMS-approved Web site for secure communications and data exchange between two or more of the following: hospitals, performance measurement system vendors, end stage renal disease networks and facilities, QIOs, and CMS.

For data warehousing, we have a claims warehouse for Medicare Part A data, which maintains the claims for the most recent 42 months. We also have a QIO Clinical Warehouse that currently contains information on the starter set of 10 quality measures collected under the RHQDAPU program, as well as additional voluntarily reported

measures. We must assess the validity of the RHQDAPU information because of its use for quality improvement, public reporting, and determining hospitals' annual payment updates under the RHQDAPU program. Validation activities assess the reliability of the data that a hospital has submitted, as evidenced by the consistency between a hospital's abstraction and reabstraction by an independent party.

We are currently using a contractor, the CDAC, to carry out the validation process under the RHQDAPU program. Hospitals are required to submit certain quality data to the QIO Clinical Warehouse within 4.5 months of the end of each quarterly reporting period. The steps in the validation process are: (1) check for duplicates; (2) draw a sample; (3) obtain copies of medical records; (4) request and complete CDAC abstraction; (5) post results on QualityNet Exchange for hospitals' review; and (6) resolve validation appeals. In the FY 2007 IPPS proposed rule (71 FR 24098), we sought comments on how the data submission and validation processes that we currently use for the RHQDAPU program might be adaptable to a hospital value-based purchasing program.

We did not receive any comments specific to this issue.

One of the key challenges we face in considering implementation of hospital value-based purchasing is minimizing the length of time between our receipt of data and our ability to provide feedback to hospitals on the data. Some of the hospitals that are participating in the RHQDAPU program and the Premier Hospital Quality Incentive Demonstration have asked for more timely feedback on their performance. We recognize that a long delay between the provision of services and feedback about the quality of

those services may impede both improvement efforts and a hospital's motivation to improve. The current lag time between the end of the quarterly reporting period and the availability of performance feedback under the RHQDAPU program is approximately 9 months. Hospitals have 4.5 months to complete their paper medical records and to submit information to the QIO Clinical Warehouse, which roughly coincides with JCAHO's timeline for submission of data to their ORYX® Core Measure Performance Measurement System. Another 4.5 months are required to accomplish the steps in the validation process.

We are considering options to decrease the overall length of time between our receipt of data and our ability to provide feedback to hospitals, and we are interested in comments on these options. First, we are considering whether more frequent data submissions, such as monthly submissions, would decrease the time between the provision of services and feedback about the quality of those services. We are aware that some hospitals and their vendors already submit quality data on a monthly basis to JCAHO. However, unless we reduced the sample size per reporting period, the process of validating each month the same number of records that are currently validated each quarter would increase costs significantly. On the other hand, if we reduced the sample size per reporting period, the monthly numbers might be too small to provide for adequate validation. Second, we could shorten the data submission period, which is a significant source of lag time. This option would require hospitals to submit information to the data warehouse more quickly, which could increase the possibility that hospitals would submit less complete data. In addition, this option would require coordination

with JCAHO to keep submission timelines congruent, which reduces hospitals' reporting burden. Third, we could eliminate the validation appeals process, which would reduce the lag time by up to 2 months. Fourth, we could create an expanded role for the third party vendors that assist hospitals with submitting quality data to CMS and JCAHO. For example, CMS could certify third party vendors to also provide standardized validation services and quick performance feedback to their hospital customers.

Comment: Approximately half of the commenters' responses included comments specific to data issues. The commenters addressed two issues in particular: (1) the data challenges confronted by small hospitals and (2) the timeliness of feedback versus the burden of submission.

A quarter of commenters raised the special challenges confronted by small, in particular rural, hospitals because of the small sample sizes they often encounter for many measures and the volatility and instability in measure results under these circumstances.

Regarding timeliness and the lag time between reporting and feedback, commenters from different stakeholder groups had opposing perspectives. Provider commenters were concerned that monthly reporting would be extremely burdensome, while purchaser and consumer advocate commenters suggested that monthly submission could improve the timeliness of data. All commenters stressed the importance of data validation. Consumers Union stressed that validation is critical and need not increase the time lag. It recommended the use of rolling publication of data with quarterly updates. Two commenters endorsed the concept that the data submission and validation processes

could be streamlined through use of electronic health records (EHRs), which could also provide an incentive for adoption of EHRs. The Federation of American Hospitals found none of the options presented in the proposed IPPS rule for reducing the lag time between submission and feedback to be acceptable.

Several commenters mentioned the benefits of augmenting billing forms with clinical data elements and cited the approach of the Pennsylvania Healthcare Cost Containment Council.

c. Incentive Methodology

While measurement of the quality of care and of resources use may be advantageous in itself, we are considering whether and what kind of incentives can further improve outcomes. The potential design of incentives in a value-based purchasing system presents many choices. The implementation plan for hospital value-based purchasing mandated by Pub. L. 109-171 must address the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments. In the FY 2007 IPPS proposed rule (71 FR 24098), we sought comments on the merits of and alternatives to all of the approaches to the design of a value-based purchasing methodology that are discussed below.

(1) How should incentives be structured?

A number of options exist for the structure of potential incentives. The incentive methodology could include differential incentives depending on whether hospitals exceed

a particular standard of performance. To reflect expectations of continued improvement among hospitals, the standard could be raised in predictable steps over time. Alternatively, incentives could be structured to reward hospitals that improve from a baseline level of performance. These approaches could be combined to develop an incentive methodology that includes both attaining benchmarks and improving care.

Comment: Approximately half of the commenters responded to at least one of the questions on incentives, and comments varied widely on these issues. Most commenters saw the combination of incentives to reward continuous improvement over time and incentives for attainment of specific benchmarks as most desirable. However, there was disagreement about the value of absolute benchmarks. Several commenters favored developing a fixed standard, rewarding hospitals that meet or exceed the standard, and when the majority achieves this standard, either raising the standard or selecting another measure with a fixed standard. They commented that the bar should be high enough to serve as an effective target, but not so high as to become attainable by only a small number of providers. By contrast, one commenter believed that a fixed benchmark discourages hospitals, particularly small and rural hospitals, because it might not reflect their unique circumstances.

Almost half of all commenters emphasized the importance of aligning hospital and physician incentives so that everyone will be working toward the same goals of improving quality and providing appropriate care.

(2) What level of incentive is needed?

Value-based purchasing incentives should be targeted to that level needed to achieve a desired level of performance. Our experience with implementing section 501(b) of Pub. L. 108-173 indicates that a targeted incentive, coupled with active management by CMS, can encourage reporting on quality measures. Nearly every eligible hospital has been willing and able to submit the required data in order to receive the full payment update under the RHQDAPU program. Similarly, our experience with the Premier Hospital Quality Incentive Demonstration indicates that a 1 or 2 percent bonus, coupled with potential reductions for poor performance, may stimulate improvement. Further experience in ascertaining how hospitals respond to incentives will be important for examining incentives over time.

Comment: A number of commenters across the stakeholder spectrum responded that the annual IPPS update is proving to be a sufficient incentive to encourage virtually all hospitals to participate in the RHQDAPU program and that the current level of a 1–2 percent incentive is appropriate. Commenters noted that an additional portion of the update could be made conditional upon achieving specified performance goals.

Many provider commenters stated that a system of rewards should increase payments or reduce regulatory burden for successful providers and urged that incentives involving penalties should not be used because the basic level of DRG payment does not now cover costs for more than one-third of hospitals. Several provider commenters suggested that rewards should be large enough to cover the costs of implementing process changes and to allow for reinvestment in quality improvement efforts. One

provider commenter also urged that incentive structures should be gradual to avoid "cliff" effects in either rewards or penalties.

(3) What should be the source of incentives?

The President's FY 2007 Budget indicates support for identifying and testing "budget-neutral incentives that will stimulate Medicare providers to improve performance on quality and efficiency measures."[26] We do not believe that providing additional aggregate funding to finance performance-based incentives is either supportable or necessary. One approach might be to examine how we could identify and apply measurable savings achieved by reducing care that is unnecessary or otherwise inappropriate. For example, we may examine possibilities of improving care coordination, whether this could produce measurable savings, and whether some of the savings generated in one payment system could be used for incentives in another, as long as these reforms do not provide inappropriate incentives to stop providing necessary care. For instance, appropriate quality of care and effective resource use in hospitals and other institutional providers might generate savings that could be used for incentives for both physicians and facilities.

Comment: Several hospital association and individual provider commenters suggested that savings from improved care coordination could be a source of funding for incentives and recommended studying whether savings generated in one payment system could be used for payments in another setting.

---

[26] Budget of the United States Government, Fiscal Year 2007, available at: http://www.whitehouse.gov/omb/budget/fy2007/.

One commenter noted the importance of assuring that funds designated for rewards be fully allocated to hospitals and urged that a program designed to reward improving quality should not become an arbitrary cost-cutting mechanism.

The budget-neutral shared savings approach currently used in the Leapfrog Hospital Rewards Program was cited by several commenters as a model worth considering, though the commenters noted that savings are harder to identify in the Medicare DRG-based system than in the commercial per diem systems where the Leapfrog Program is currently operating.

(4) What should the form of incentives be?

Potential approaches for incentives include making an add-on payment to the base payment for individual inpatient hospital services or providing periodic, lump-sum payments on a monthly, quarterly, or annual basis. Under the RHQDAPU program, hospitals that do not submit the required data receive a decrease in the standardized payment amount made for all inpatient operating costs for the applicable fiscal year. In a hospital value-based purchasing system, per-service payments might be made only in connection with the services directly associated with the particular measure for which the hospital achieved a good result. Alternatively, lump-sum payments might be made on a periodic basis to hospitals that achieve particular performance targets. The preferable approach may depend on operational concerns, the strength of incentive effects, and other aspects of the design. In the FY 2007 IPPS proposed rule (71 FR 24099), we sought comments on this issue.

Comment: We received three comments on this issue, and all commenters favored periodic lump-sum payments over other options.

(5) What should the timing of incentives be in relation to performance?

Any value-based purchasing system should seek a balance between rewarding desired performance close to when it occurs and ensuring the accuracy of both performance measurement and incentives. Given the lag times for collecting and reviewing different types of data, some measures may be calculated quickly after the period of performance, while data lag times for other measures may be longer. For instance, structural measures could affect incentives soon after they are collected. Other measures that are based on experience over a time interval may require some time for measured events to manifest. An example of this type of measure would be the rate of mortality within 30 days of hospitalization.

We did not receive any comments specific to this issue.

(6) How should we develop composite scores?

Encouraging improved performance could be facilitated by valid and reliable methods to aggregate performance data into single composite scores. Composite scoring may also improve consumer understanding of complex performance indicators by combining measures of many dimensions of care into a single score. One example of a composite scoring methodology that we used for the Premier Hospital Quality Incentive Demonstration (discussed in detail above) is a modification of the "opportunity model," which can be used to address individual weighting, missing data, and sensitivity to case volumes. For example, a hospital that has few or no cases for a particular dimension of

care could receive a low score, yet that measure is equally weighted with others in the composite. Under the opportunity model, a composite may be developed for a disease category by dividing the total number of successful interventions by the total number of opportunities for the same targeted interventions. Some of the advantages of the opportunity model are that individual measures are weighted by the volume of opportunities for the associated intervention for a particular hospital; missing values for a particular aspect of care provided by an individual hospital would not prevent that hospital from being represented in a public report; and composite measures may easily accommodate the addition of individual measures.

The "appropriate care measure" (ACM) is another composite scoring methodology, which we used in connection with the QIOs. The ACM scoring methodology is patient-centric. For a hospital to receive credit for treating a patient well, the hospital must have met the standard for every measure applicable to that patient's condition. There are also a number of proprietary composite measures, such as those used by Solucient, Healthgrades, CareScience, and U.S. News & World Report. In the FY 2007 IPPS proposed rule (71 FR 24099), we solicited comments on the use of composite scoring for hospital value-based purchasing and on the various composite scoring methodologies.

Comment: Five commenters supported the use of the "opportunity model." No comments were received regarding the "appropriate care model."

Several commenters urged that further research and consumer testing be done around the development and display of measure composites. Several other commenters

urged that while composites are useful, they should not be the only information available; instead, information should be presented in various ways, including composite scores, individual scores making up the composite, statistics supporting the score, and graphics.

Value-based purchasing methods are still under development, and anticipating their potential effects on the health care system is difficult. We understand that unintended consequences may result from the implementation of these methods. We believe that we will need to assess incentives and evaluate their effects so that we can revise them quickly as we learn more about their impact on hospitals and on inpatient hospital services provided to Medicare beneficiaries.

We did not receive any comments specific to this issue.

d. Public Reporting

The plan for hospital value-based purchasing mandated by Pub. L. 109-171 must address the public disclosure of information on hospital performance. CMS currently provides public reporting of quality information through the "Compare" Web sites for hospitals, nursing homes, home health agencies, and dialysis facilities.[27] The Compare Web sites provide comparative quality information to consumers and others to help guide choices and drive improvements in the quality of care delivered in these settings. Besides providing Medicare beneficiaries and their health professionals with information to assist them in making informed health care decisions, public reporting of comparative performance data also provides information that is useful to health care consumers who

[27] See CMS' Hospital Compare Web site, available at: http://www.hospitalcompare.hhs.gov/; Nursing Home Compare Web site, available at: http://www.medicare.gov/NHCompare; Home Health Compare Web site, available at: http://www.medicare.gov/HHCompare/Home.asp; Dialysis Facility Compare Web site, available at: http://www.medicare.gov/Dialysis.

are not Medicare beneficiaries. For example, a consumer who has a Health Savings Account can access CMS' Hospital Compare Web site to gather comparative quality information to assist in choosing a high quality hospital. CMS is contributing to the Administration's Consumer-Directed Health Care Initiative by working with our private- and public-sector partners to make health care information more transparent and available to consumers than ever before. (Refer to section IV.M. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24120) for more information.) In the FY 2007 IPPS proposed rule (71 FR 24100), we sought comments on how we can further stimulate public reporting to increase the transparency and meaningfulness of healthcare performance information.

Comment: Five commenters made recommendations regarding public reporting. One commenter stressed that informed decision-making about performance cannot occur if reported costs are divorced from information about quality. A second commenter noted the importance of providing a formal appeals process for providers that disagree with their performance ratings. Consumers Union urged CMS to use multiple approaches to get consumers more engaged in using quality information, suggesting that Hospital Compare be promoted continuously, that tools be developed to support comparisons in different ways, and that information on Hospital Compare to be updated more frequently than once a year to be relevant to the patient and fair to the hospital.

Response: We thank all commenters for their thoughtful and valuable input. We will use these comments to inform our design of the plan for Medicare hospital value-based purchasing, as mandated by Pub. L. 109-171. This rulemaking process is the

first opportunity for the public to be involved in our planning process. We will also be hosting public listening sessions in 2007 to receive public input on drafts of the plan. We encourage your participation in those listening sessions.

5. Considerations Related to Certain Conditions, Including Hospital-Acquired Infections

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length. In many cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for other cases in the same DRG. To this extent, the IPPS does encourage hospitals to manage their patients well and to avoid complications, when possible. However, complications, such as infections, acquired in the hospital can trigger higher payments in two ways. First, the treatment of complications can increase the cost of hospital stays enough to generate outlier payments. However, the outlier payment methodology requires that hospitals experience large losses on outlier cases (in FY 2006, hospitals must lose $23,600 before a case qualifies for outlier payments, and the hospital would then only receive 80 percent of its costs above the outlier threshold). Second, there are about 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC). The CC DRG in each pair would generate a higher Medicare payment. If an infection acquired during the beneficiary's hospital stay is one of the conditions on the CC list, the result may be a higher payment to the hospital under a CC DRG. (See section II.C. of the FY 2007 IPPS proposed rule (71 FR 24006) for a detailed discussion of proposed DRG reforms.)

Section 5001(c) of Pub. L. 109-171 requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the

application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present. Section 5001(c) provides that we can revise the list of conditions from time to time, as long as it contains at least two conditions. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007. In the FY 2007 IPPS proposed rule (71 FR 24100), we sought input about which conditions and which evidence-based guidelines should be selected.

We received 44 comments on this section from hospitals and health care systems, provider associations, consumer groups, purchasers, medical device manufacturers, information technology companies, and health care research organizations.

Comment: The majority of commenters addressed conceptual issues concerning the selection, measurement, and prevention of hospital-acquired infections. While most of the commenters focused on broad factors CMS should consider, some of the commenters included specific recommendations of conditions for possible inclusion in the payment changes. We found these comments very helpful and constructive, and we look forward to further input as we work towards implementation of this section. In the following discussion, we present a summary of the major themes of the commenters and list the specific hospital-acquired complications presented in the comments.

Many commenters encouraged CMS to engage in a collaborative discussion with relevant experts in designing, evaluating, and implementing this section. The

commenters urged CMS to include individuals with expertise in infection control and prevention, as well as representatives from the provider community, in this discussion.

Nearly half of the commenters expressed concern about the difficulty in distinguishing between hospital-acquired and community-acquired infections. Multiple commenters indicated that community-acquired infections often cannot be diagnosed on admission and thus would not be included as secondary diagnoses at the time of admission. These commenters indicated that it would be costly and inefficient to attempt to diagnose all community-acquired infections at the time of admission. The commenters requested that CMS provide technical guidance to assist providers in distinguishing between hospital and community-acquired infections.

Many commenters discussed the statutory requirement for hospitals to submit information regarding secondary diagnoses present on admission beginning FY 2008. Some commenters supported this requirement and suggested that it would better enable CMS and health care providers to more accurately differentiate between comorbidities and hospital-acquired complications. MedPAC, in particular, noted that this requirement was recommended in its March 2005 Report to Congress and indicated that this information is important to Medicare's value-based purchasing efforts. Other commenters suggested that CMS delay implementation of this provision, given the significant payment changes contained in the FY 2007 IPPS proposed rule.

Many commenters, including States, health care associations, and health care providers with experience in hospital-acquired infection prevention, cautioned us about potential problems with relying on secondary diagnosis codes to identify

hospital-acquired complications. These commenters indicated that secondary diagnosis codes may be an inaccurate method for identifying true hospital-acquired complications. Some of the commenters referred to research showing a wide discrepancy between hospital-acquired infections identified through claims data and hospital-acquired infections identified through active surveillance and/or chart review. According to the commenters, this research found that active surveillance conducted by trained infection control practitioners was the most accurate method for identifying hospital-acquired infections. The commenters also noted that there is currently no standardized and validated method for using claims data to identify hospital-acquired infections.

A number of commenters expressed concerns about the data coding requirements for this payment change. They asked for detailed guidance from CMS to help them identify and document hospital-acquired complications. The commenters also noted that there are currently no standard definitions or guidance to code the present on admission indicator. In addition, there was concern that the current system of bill coding does not support a present on admission indicator and that future versions of the bill coding systems may not be implemented in time to meet the data reporting requirements for this payment change. The commenters also urged CMS to allow adequate time for hospitals to implement the necessary changes to their billing and coding systems and to conduct appropriate staff training.

Almost half of the commenters expressed concern that not all hospital-acquired infections are preventable. In particular, the commenters noted that sicker and more complex patients are at greater risk for hospital-acquired infections and complications.

The commenters urged CMS to use discretion in implementing this section to ensure that the program does not punish hospitals taking care of sicker and more complex patients.

To address this issue, many of the commenters suggested that CMS include standardized infection-prevention process measures, in addition to outcome measures of hospital-acquired infections. The commenters proposed that hospitals should not be penalized if they follow evidence-based infection prevention measures. Specifically, a number of commenters referenced the Surgical Care Improvement Program (SCIP) and suggested that CMS build on this initiative. These commenters recommended that CMS include exceptions to the payment changes for cases in which the hospital performed evidence-based infection-prevention measures.

Some commenters proposed that CMS expand the scope of the payment changes beyond the statutory minimum of two conditions. They noted that the death, injury, and cost of hospital-acquired infections are too high to limit this provision to only two conditions. Commenters also recommended that CMS annually select additional hospital-acquired complications for the payment change.

Conversely, a number of commenters proposed that CMS initially begin with limited demonstrations to test CMS' methodology before nationwide implementation. The commenters specifically mentioned the Michigan Hospital Association Keystone Center, the Pittsburgh Regional Health Initiative, and the Maryland Patient Safety Center as possible models. In addition, several commenters suggested that CMS work with states that currently collect information on diagnoses present on admission.

A commenter recommended that CMS include appropriate consumer protections to prevent providers from billing patients for the non-reimbursed costs of the hospital-acquired complications and to prevent hospitals from selectively avoiding patients perceived at risk for complications.

In addition to the broad conceptual suggestions, some commenters recommended specific conditions for possible inclusion in the payment changes. The specific conditions mentioned in the comments are listed below:

- Surgical site infections. Some commenters recommended including surgical site infections because of their high frequency and cost. Commenters also noted that evidence-based measures to prevent the occurrence of these infections are currently measured and reported as part of SCIP. Many commenters suggested that CMS work with SCIP partners to identify appropriate post-surgical hospital-acquired infections for possible inclusion in the payment changes. Other commenters expressed concern that administrative data may not be a reliable source for identifying surgical site infections. Commenters also cautioned that surgical site infections often do not manifest and thus cannot be diagnosed until after the patient has been discharged from the hospital.

- Ventilator-associated pneumonia. Commenters also mentioned ventilator-associated pneumonia as a possible condition for inclusion in the payment changes because this condition is currently measured and reported through SCIP. Other commenters recommended against this condition due to the subjective and labor-intensive nature of defining the diagnosis.

● Catheter-associated bloodstream infections. Commenters recommended catheter-associated bloodstream infections, including central line infections, as possible conditions. Commenters noted that these infections are currently reported through SCIP.

● Urinary tract infections. One commenter recommended nosocomial urinary tract infection for possible inclusion in the payment change. Another commenter argued against this condition because it has limited impact on patient mortality and morbidity.

● Pressure ulcers. Multiple commenters suggested that CMS consider pressure ulcers as an alternative to hospital-acquired infections.

● Hospital falls. Several commenters suggested that CMS consider hospital falls as an alternative to hospital-acquired infections.

● Deep vein thromboses. Commenters also suggested that CMS consider deep vein thromboses as an alternative to hospital-acquired infections.

Response: We would like to express our gratitude to all of the commenters for their thoughtful and helpful recommendations. We will carefully consider their views as we move toward implementing this section. CMS will be working closely with our colleagues at the Centers for Disease Control and Prevention over the coming months to select appropriate conditions to propose for implementation. We anticipate that the next opportunity for formal public comment will be the FY 2008 IPPS proposed rule-making, which will be published in spring of 2007. We encourage the public to comment on our proposal at that time.

6. Promoting Effective Use of Health Information Technology

We recognize the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. One recent RAND study found that broad adoption of electronic health records could save more than $81 billion annually and, at the same time, improve quality of care.[28] The largest potential savings that the study identified was in the hospital setting because of shorter hospital stays promoted by better coordinated care; less nursing time spent on administrative tasks; better use of medications in hospitals; and better utilization of drugs, laboratory services, and radiology services in hospital outpatient settings. The study also identified potential quality gains through enhanced patient safety, decision support tools for evidence-based medicine, and reminder mechanisms for screening and preventive care. Despite such large potential benefits, the study found that only about 20 to 25 percent of hospitals have adopted HIT systems.

It is important to note the caveats to the RAND study. The projected savings are across the health care sector, and any Federal savings would be a reduced percentage. In addition, there are significant assumptions made in the RAND study. National savings are projected in some cases based on one or two small studies. Also, the study assumes patient compliance, in the form of participation in disease management programs and following medical advice. For these reasons, extreme caution should be used in interpreting these results.

---

[28] RAND News Release: Rand Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005, available at: http://rand.org/news/press.05/09.14.html.

There are some mixed signals about the potential of HIT to reduce costs. Some studies have indicated that HIT adoption does not necessarily lead to lower costs and improved quality. In addition, some industry experts have stated that factors such as an aging population, medical advances, and increasing provider expenses would offset any projected savings.

In his 2004 State of the Union Address, President Bush announced a plan to ensure that most Americans have electronic health records within 10 years.[29] One part of this plan involves developing voluntary standards and promoting the adoption of interoperable HIT systems that use these standards. The 2007 Budget states that "The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care."

Over the past several years, CMS has undertaken several activities to promote the adoption and effective use of HIT in coordination with other Federal agencies and with the Office of the National Coordinator for Health Information Technology. One of those activities is promotion of data standards for clinical information, as well as for claims and administrative data. In addition, through our 8th Scope of Work contract with the QIOs, we are offering assistance to hospitals on how to adopt and redesign care processes to effectively use HIT to improve the quality of care for Medicare beneficiaries, including computerized physician order entry (CPOE) and bar coding systems. In section IV.A.3. of the FY 2007 IPPS proposed rule (71 FR 24095), we again invited comments on streamlining the submission of clinical quality data by using standards-based electronic

[29] Transforming Health Care: The President's Health Information Technology Plan, available at: http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html.

medical records. (We used the term "electronic medical records" in section IV.A.3. instead of the term "electronic health records" that is used in this section in order to maintain consistency with our request for comments in the FY 2006 IPPS final rule.) Finally, our Premier Hospital Quality Incentive Demonstration provides additional financial payments for hospitals that achieve improvements in quality, which effective HIT systems can facilitate.

We are considering the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. As noted above, the Administration supports the adoption of HIT as a normal cost of doing business. Whereas payments under the IPPS do not vary depending on the adoption and use of HIT, hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings. In addition, the adoption and use of HIT may contribute to improved processes and outcomes of care, including shortened hospital stays and the avoidance of adverse drug reactions.

In the preamble to the FY 2007 IPPS proposed rule (71 FR 24101), we sought comments on our statutory authority to encourage the adoption and use of HIT. We also sought comments on the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we sought comments on promotion of the use of effective HIT through hospital conditions of participation (CoPs), perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary. We

anticipate that the American Health Information Community will provide advice to the Secretary on these issues.

We received 30 comments on this section. Below is a summary of the comments addressing: (1) CMS' statutory authority to encourage adoption of effective health information technology (HIT); (2) the role that HIT should play in value-based purchasing; and (3) whether CMS should promote the adoption of effective HIT through our CoPs. In addition to these areas in which we sought comments, we also received several comments on the challenges of implementing HIT, which were particularly focused on overcoming the high cost of implementation. We conclude the summary with additional commenter input on the adoption and use of HIT.

Comment: Seven comments addressed our statutory authority to encourage adoption and use of HIT. Two of the seven commenters stated that the HHS has the authority to encourage adoption of HIT. Those commenters referred to the Hill Burton Act, the Medicare Modernization Act, the Deficit Reduction Act, and the FY 2006 Health and Human Services Appropriations Act as bases for our statutory authority. Other commenters stated that we do not have the authority to encourage adoption and use of HIT. Those commenters pointed out the need for legislation to specifically authorize support for HIT implementation.

Nineteen commenters addressed the role of HIT in a value-based purchasing program. Only 2 of the 19 commenters stated that HIT should be directly tied to value-based purchasing. An overwhelming majority of the commenters believed that HIT funding should not be tied to value-based purchasing; rather those commenters

stated that HIT implementation should be tied to increases in hospital payment. However, nearly all of the commenters agreed that use of effective HIT could increase health care quality, efficiency, patient safety, and care coordination. A few commenters recognized that HIT will likely reduce the burden of reporting to a value-based purchasing system.

We received 14 comments on the promotion of HIT through our CoPs. Of those comments, only three were in favor of including HIT in the CoPs. Of these comments, only three were in favor of including adoption of certified, interoperable HIT in the CoPs. The majority of commenters opposed this proposal and termed such a requirement a potential "unfunded mandate.

There were a total of 19 comments addressing the high costs associated with HIT implementation. Commenters identified cost as the greatest barrier to HIT implementation and stated that the short term benefits do not justify the costs. Several commenters noted that HIT is a public good and felt strongly that funding for HIT implementation should be provided through government loan guarantees and grants. Two commenters felt that safety-net hospitals should be the primary beneficiaries of any federal funding for HIT. One commenter observed that the governments of other countries funds HIT. Nine commenters observed that the proposed rule failed to recognize that a major finding of the RAND study was that HIT investments accrue more to the payers and purchasers than to hospitals and health systems, which the commenters believed indicates that purchasers and plans should make a greater share of investment in HIT.

We received 11 comments addressing the challenges of HIT implementation beyond costs. Many of the commenters noted that HIT adoption takes careful planning and requires many internal workflow process changes. Several comments addressed the variation in health care delivery systems and the vastly different needs for HIT across systems, as well as vastly differing abilities to accomplish HIT implementation. Many felt strongly that inoperability standards must precede implementation.

Several thoughtful ideas were addressed by a small proportion of commenters. Two commenters felt that until HIT is fully implemented, hospitals should be required to report a unique identifier for each coded procedure, capture referring and ordering providers for each procedure, record vital signs at presentation, include any do not resuscitate (DNR) orders, and record time of admission. Along the same lines, another commenter felt that until HIT is in place, hospitals should be required to notify dialysis facilities via phone, fax, or e-mail, when a kidney failure patient is admitted.

Response: We thank all commenters for their thoughtful and valuable discussion of the issues. In the HIT section of the preamble to the proposed rule, we recognized the potential for effective HIT to facilitate improvements in the quality and efficiency of health care services. We also pointed out CMS' promotion of the adoption and effective use of HIT in coordination with other Federal agencies and the Office of the National Coordinator of Health Information Technology. Here, we will discuss three areas that we are emphasizing to promote the effective use of HIT, in light of the comments we received: (1) value-based purchasing, (2) the e-prescribing rule, and (3) infrastructure and interoperability standards. We believe that these activities will address the barriers to

HIT implementation that were presented by the commenters and will increase the benefits of HIT adoption relative to the costs.

We continue our work toward the implementation of value-based purchasing payment system reforms because we believe that, among other advantages, value-based purchasing can encourage hospitals to invest in activities , such as effective HIT, that have the potential to improve quality and decrease unnecessary costs. However, linking a portion of Medicare payments to valid measures of quality and effective use of resources could give hospitals more direct incentives to implement innovative ideas and approaches that may result in improved value of care. We agree with the commenters that noted that the use of effective HIT could increase quality, efficiency, patient safety, and care coordination. We also agree with the commenters that noted that effective use of HIT can be used to decrease the burden of reporting to value-based purchasing programs. However, we disagree with the commenters that recommended direct government funding of HIT. As stated in the President's 2007 Budget, "the Administration supports the adoption of [HIT] as a normal cost of doing business to ensure patients receive high quality care."

Commenters noted that multiple stakeholders in the health care system, including purchasers and payers, benefit from provider adoption and use of effective HIT and should share in the cost. CMS and OIG are in the process of issuing final rules to allow hospitals and other health care providers under some circumstances to donate electronic prescribing and electronic health records technology to physicians and others without running afoul of the Stark (physician self-referral) and anti-kickback statutes. We believe

that these rules will facilitate the adoption of HIT by physicians and other health care providers who might otherwise have been unable or unwilling to invest in the technology. We also believe that these regulatory changes will help to stimulate the adoption of effective HIT, and that, as HIT use spreads, the benefits relative to the costs of implementation may increase for all stakeholders.

The majority of commenters pointed out that the current lack of HIT infrastructure, including lack of interoperability standards, is a major obstacle to adoption and effective use of HIT. To address the lack of infrastructure, the Secretary has undertaken a national strategy that calls for Federal agencies to collaborate with private stakeholders in the development of architecture, standards, certification processes, and methods of governance to facilitate the adoption of effective HIT. In September 2005, the Secretary selected 16 commissioners to serve on the American Health Information Community (AHIC), which is a federally chartered collaborative forum of private and public interests charged with advising the Secretary on how to make health information digital and interoperable. The goals of the Community include immediate access to vital medical information at the point of care, privacy protection, better data for research, and overall cost savings. The work of the Community has been divided among four workgroups: (1) the Electronic Health Records Workgroup, (2) the Chronic Care Workgroup, (3) the Consumer Empowerment Workgroup, and (4) the Biosurveillance Workgroup. The AHIC Workgroups have made recommendations, as their initial "breakthroughs," pertaining to: an electronic medication summary and registration history; secure messaging capabilities for individuals with chronic disease;

biosurveillance monitoring; and, through secure means, broadening the availability and access to current and historical laboratory results and interpretations. More information about the Community is available at: http://www.hhs.gov/healthit/ahic.html.

In conclusion, we are not adopting at this time our proposal to require adoption of certified, interoperable HIT as a Medicare CoP. Rather, we are reserving judgment on the imposition of such a requirement and will continue to research the feasibility of doing so. We may revisit this issue in the FY 2008 IPPS proposed rule or in another rulemaking proceeding.

C. Sole Community Hospitals (SCHs) (§412.92) and Medicare-Dependent, Small Rural Hospitals (MDHs) (§412.108)

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, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, 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 §412.92.

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 that has a high percentage of Medicare discharges (not less than 60 percent in its 1987 cost reporting year or in 2 of its most recent 3 audited and 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 §412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are section 1886(d) hospitals. Like all section 1886(d) IPPS hospitals, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, 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 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment to the SCH. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary 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 payment to the hospital.

If an SCH disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

Through and including FY 2006, 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 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 is higher. However, section 5003 of Pub. L. 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) requires that an MDH use the 2002 cost reporting year as its base year (that is, the FY 2002 hospital-specific rate), if that use results in a higher payment. An MDH does not have the option to use its FY 1996 hospital-specific rate. We discussed our proposed changes to implement section 5003 of the DRA in section IV.C.4 of the preamble to the FY 2007 IPPS proposed rule (71 FR 24104).

2. Volume Decrease Adjustment for SCHs and MDHs

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 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 following the reduction in discharges (this is, the second year), which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services. Our records indicate that three to four SCHs/MDHs request this adjustment each year.

However, we believe that not all staff costs can be considered fixed costs. Using a standardized formula specified by us, 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. Fiscal intermediaries 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 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary 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 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.

The adjustment for excess staff is currently broken into two parts: the routine acute care area (excluding intensive care unit areas) excess staff adjustment and the

intensive care unit excess staff adjustment. (For purposes of this section of the preamble, any subsequent references to the routine acute care area of an SCH or MDH refer to the routine acute care area excluding any intensive care unit areas.) In order to determine whether or not the hospital is appropriately staffing its routine acute care and its intensive care unit area, the fiscal intermediary compares the hospital's actual number of nursing staff in each area with the staffing of like-size hospitals in the same census region. Currently, fiscal intermediaries obtain average nurse staffing data from the American Hospital Association's HAS/Monitrend Data Book. (More information on the HAS/Monitrend Data Book follows.) If a hospital employs more than the reported average number of nurses in the routine acute care or intensive care unit area for hospitals of its size and census region, the fiscal intermediary 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 Medicare cost report. The complete process for determining the amount of the adjustment can be found at section 2810.1 of the Provider Reimbursement Manual.

Representatives from several SCH and MDH hospitals have contacted CMS with concerns regarding the current use of the HAS/Monitrend data for determining the volume decrease adjustment for SCHs and MDHs. Because the most recent HAS/Monitrend Data Book was published in 1989 and is no longer updated, the hospitals expressed concern that the information in the publication is too outdated for current use.

Therefore, in the FY 2007 IPPS proposed rule (71 FR 24102), we presented for public comment a new methodology for calculating the adjustment for excess staff.

a. HAS/Monitrend Data

From the mid-1960's to 1989, the Healthcare Administrative Services Division of the American Hospital Association (AHA) published biannually the HAS/Monitrend Data Book, a collection of aggregate hospital statistics. Hospitals completed surveys based on 6 months of data; these data were categorized into one of five bed-size groups and into one of nine census regions. The bed size groups were 0-49, 50-99, 100-199, 200-399, and 400 or more beds. The census regions include: (1) New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); (2) Middle Atlantic (New Jersey, New York, and Pennsylvania); (3) South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia); (4) East North Central (Illinois, Indiana, Michigan, Ohio, and Wisconsin); (5) East South Central (Alabama, Kentucky, Mississippi, and Tennessee); (6) West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota); (7) West South Central (Arkansas, Louisiana, Oklahoma, and Texas); (8) Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming); and (9) Pacific (Alaska, California, Hawaii, Oregon, and Washington).

The survey collected data on nearly 400 items pertaining to utilization, resource allocation, departmental productivity, departmental direct expenses, and staffing. In order for aggregate data to be published for a category, at least three hospitals in the same

census region and bed-size group had to have responded to the survey. For the final 1989 publication, 996 acute care hospitals completed the survey. CMS has used the HAS/Monitrend Data Book since 1984 to determine the volume decrease adjustment for SCHs; the data also have been used for the volume decrease adjustment for MDHs since 1990. In particular, CMS has used the HAS/Monitrend data on the number of paid nursing hours per patient day ("paid hours/patient day") in both the general acute care area ("Medical and Surgical Units") and the intensive care unit ("Med & Surg Intensive Care Unit"). More information on the HAS/Monitrend Data Book is available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

b. HAS/Monitrend Data Book Replacement Alternative

In the FY 2007 IPPS proposed rule (71 FR 24102), we proposed an alternative method for determining an SCH's or MDH's target number of core staff using data from the Medicare cost report and the occupational mix survey. However, this methodology would only establish one combined average number of nursing hours per patient day for both the inpatient routine care and the intensive care unit areas. We proposed to use the Medicare cost report and occupational mix survey data beginning with requests for adjustments for FY 2008 cost reports. We invited comments from the public on this proposal.

(1) Occupational Mix Survey

As discussed in the FY 2007 IPPS proposed rule (71 FR 24075), the CMS occupational mix survey collects from each hospital data on the mix of employees in the areas of the hospital payable under the IPPS for a limited number of hospital occupational

categories. For the 2006 survey, these categories include 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. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, and nurses' aides 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. The data collected on the survey are used to adjust hospitals' wage data to account for each hospital's mix within the general occupational categories. Hospitals completed the first occupational mix survey using FY 2003 data. A second survey will be completed this year (FY 2006).

Under the proposed method, we would calculate the nursing hours per inpatient 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 inpatient days reported on the Medicare cost report. The results would be grouped into the same bed-size groups and census regions as the HAS/Monitrend Data Book. CMS would publish the mean number of nursing hours per patient day for each census region and bed-size group in the **Federal Register**. (We proposed to include licensed practical nurse and nursing aide hours as well as registered nurse hours to reflect the various levels of nursing staff employed by hospitals to provide direct patient care.)

The results that would be published in the **Federal Register** would be the target number of core nursing hours per patient day. 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 would multiply the SCH's or MDH's number of inpatient 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. Because we would consider registered nurses, licensed practical nurses, and nursing aides, the fiscal intermediary would calculate the excess staff adjustment by multiplying the number of excess staff by the average salary among the three groups, taking into account how many registered nurses, licensed practical nurses, and nursing aides work at the facility. (For instance, if the hospital's average salary for a registered nurse is $50,000 and the hospital's average salary for a licensed practical nurse is $30,000 and the hospital employs 5 registered nurses, 3 licensed practical nurses, and no nursing aides, the calculated average salary would be $42,500 for one FTE (((5 x $50,000) + (3 x $30,000))/8 = $42,500).

We proposed to use the results of the FY 2006 occupational mix survey and begin applying the proposed methodology for adjustments resulting from a decrease in discharges between FYs 2007 to 2008. Because the occupational mix survey is

conducted once every 3 years, we would update the data set every 3 years. We proposed to use the FY 2006 survey results and not to utilize the FY 2003 survey results to take into account comments we received in response to the first set of results from the occupational mix survey, and to ensure that hospitals have had some experience with the occupational mix survey before it is used in determining these adjustments. Because we have used the HAS/Monitrend data for so many years, we stated our belief that it was appropriate to continue to use these data for one more year and wait for the results of the FY 2006 survey. We stated that this would give hospitals an opportunity to have some experience with the occupational mix survey before it is used in these adjustments, and would allow us to compare the data from the FY 2006 occupational mix survey with the data reported in the 2003 survey, if necessary. However, for purposes of describing how we would implement this methodology, we applied the proposed calculation to the FY 2003 occupational mix survey data. While we did not propose to use the FY 2003 data, we stated our belief that it was the best data available at the time to help explain our proposed methodology.

To calculate the results below, we merged the FY 2003 occupational mix survey results into the FY 2003 cost report file. We eliminated all observations for non-IPPS providers, providers who failed to complete the occupational mix survey, and providers for which provider numbers, bed counts and/or day counts were missing. We also only included providers with 12 months' worth of data. This resulted in a pool of approximately 3,541 providers.

For each provider in this pool, we calculated the number of nursing hours by adding the number of registered nurse, license practical nurse, 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 proposed to only include observations that fall within 3 standard deviations of the mean of all observations, thus removing potential outliers in the data. Below are the results of this calculation.

We realize that, in the chart, some results may appear to be anomalous (for example, 0-49 beds for census regions 4, 6, and 8). We believe a small number of outlier data may have skewed the mean, which was the basis for identifying data within 3 standard deviations to include in the calculations. Therefore, we solicited comments on whether we should consider another method for determining the appropriateness of using available data in calculating the average number of nursing hours per patient day. For instance, in this case, the results are based on the inclusion of data within 3 standard deviations of the mean. Alternatively, we stated that we could use another measure of central tendency.

Paid Nursing Hours per Patient Day

Number of Beds	Census Region								
	1	2	3	4	5	6	7	8	9
0-49	16.38	8.33	19.26	30.76	11.72	26.70	20.50	31.00	17.39
50-99	13.71	11.07	15.66	17.37	13.69	15.53	12.51	16.63	16.11
100-199	11.98	10.99	14.38	13.44	11.93	17.03	13.91	14.33	13.32
200-399	12.40	12.19	14.19	13.00	10.57	16.20	11.35	14.06	15.33
400 or more	13.32	9.42	12.77	15.39	9.51	19.70	12.36	17.64	13.32

(2) American Hospital Association Annual Hospital Survey

In the process of evaluating different sources of data to replace the HAS/Monitrend Data Book, we considered using the results of the AHA's Annual Hospital Survey. This survey includes over 700 data fields that cover facilities and services, utilization, finances, and staffing. On average, 6,000 hospitals complete the survey each year. Section E of the Annual Survey Database includes total facility staffing data. FTE counts are available for registered nurses, practical and vocational nurses, nursing assistive personnel, and other personnel. However, FTEs in outpatient areas, excluded units, and nursing home units within the hospital are also included in the aggregated FTE counts. It is not possible to separately identify how many of the total reported nursing FTEs are attributable to the general acute care facility and how many to a distinct part unit or outpatient facility. Due to varying staffing needs in distinct part units and outpatient areas, in the proposed rule we stated our belief that it would be best for any calculation of average staffing for the inpatient acute care area to consist of data solely from the inpatient acute care area of the hospital. In the FY 2007 IPPS proposed rule (71 FR 24104), we requested comments on this issue.

We received 16 public comments on our proposal.

Comment: Many commenters believed that it is not appropriate to use the FY 2006 occupational mix survey for making determinations under the volume decrease adjustment. The commenters believed the FY 2006 occupational mix survey consists of unreliable data due to the rushed nature of the collection. The commenters suggested that CMS use the AHA Annual Survey data to determine nursing levels per patient day. One

commenter expressed concern that the data from the occupational mix survey and the hospital cost report data were not for the same time period and that annualizing the data from the occupational mix survey may distort the data. Another commenter noted that the occupational mix survey collects data from ancillary areas similar to the AHA Annual Survey data and, therefore, use of either data source would result in a similar calculation. One commenter recommended that CMS work with the AHA to develop a new survey tool to collect this information. In the interim, the commenter recommended continuing to use the latest HAS Monitrend data.

One commenter suggested that CMS no longer require fiscal intermediaries to compare a hospital's nursing staff per patient day with other hospitals of like size in the same area. Rather, the commenter suggested that fiscal intermediaries should be able to evaluate a hospital's individual needs and circumstances. The commenter also suggested that CMS only consider registered nurse and licensed practical nurse hours and eliminate nursing aide hours from the calculation. The commenter further suggested that CMS compare SCHs and MDHs to a smaller sample than the current census regions; for instance, CMS could compare hospitals in the same State.

Response: We do not agree with the commenters who stated that the occupational mix survey results are unreliable. The data is supplied solely by hospitals, and because this is the second time hospitals have completed the survey, we believe they are familiar with the requirements and are providing accurate information. In addition, although the collection may have been more hurried in 2006 due to the Bellevue decision, as explained in section III.C. of this preamble, hospitals had opportunities to review, validate and

correct their occupational mix data. For 2006, the occupational mix collection will include three months of data. Therefore, it will be necessary to annualize the data to reflect staffing levels for a one year period. We do not believe this distorts an individual hospital's average staffing levels throughout the year unless the hospital experiences a unique event that either greatly increases or reduces hospital utilization and/or the hospital's ability to recruit and maintain staff. However, it is for this reason that we require a minimum number of hospitals in each bed-size/census group to have reported staffing data before calculating an average for that category. We believe that by combining the results of at least three hospitals of like size in an area, we reduce the chance of unique events affecting individual hospitals distorting the averages.

As previously mentioned, we stated in the proposed rule that it would be best to collect nursing data from only the inpatient, acute care portion of the hospital – and that this would be a justification for using occupational mix survey data. However, in this final rule, we are correcting this statement, since the occupational mix survey – like the wage survey -- collects data on both the inpatient and outpatient areas of the hospital. Also, it is our understanding that hospital nursing staff may, and often do, rotate between the inpatient and outpatient areas of the hospital as necessary. In addition, inpatients often utilize services in the outpatient (or ancillary) areas of the hospital. Given that the occupational mix survey collects data on both outpatient and inpatient areas of the hospital, and given that most commenters stated that they preferred to use the AHA Annual Survey data and not the occupational mix data, our final policy will be to allow an SCH or MDH that has experienced a 5 percent or greater reduction in the number of

discharges from one cost reporting period to the next the option of using either the AHA Annual Survey results or the occupational mix data to compare the number of hospital's core staff with other like-sized hospitals in its geographic area.

We recognize that the AHA data includes staffing data from distinct part units and skilled nursing facilities. While it is possible to identify which hospitals have skilled nursing facilities, it is not possible to distinguish between those hospitals with distinct part units and those without. Our data indicate that there are currently 1230 hospital-based skilled nursing facilities. If we eliminated all hospitals with skilled nursing facilities from the pool of comparison hospitals that responded to the FY 2004 AHA Annual Survey, roughly 3,000 hospitals would remain. We believe this is a sufficient number of hospitals with which to calculate staffing averages and our final policy will be that when using the AHA Annual Survey, we will eliminate hospitals with hospital-based skilled nursing facilities. Also, consistent with the HAS/Monitrend Databook, we will only calculate the average number of nursing staff for a bed-size/census group if there are data available for three or more hospitals.

In order to account for staff in the distinct part units, we would include in the patient day count the number of inpatient days from these units. While this may still lower the average number of staff per patient day, as discussed in more detail later in this section, a hospital may decide whether this data most closely resembles its staffing or whether the HAS/Monitrend data or occupational mix data better represents hospitals in its bed-size/census group. In light of this, we do not believe it is necessary for the AHA

to develop a new survey tool to collect staffing information for purposes of this adjustment.

In response to the commenter who suggested that the fiscal intermediaries take into account the individual circumstances of each SCH/MDH that experiences a decrease in discharges, we note that the commenter failed to suggest how this may be achieved. In light of our goal of maintaining a uniform standard for calculating the amount of the volume decrease adjustments, we believe that it is more appropriate for the fiscal intermediaries to utilize either the same or comparable data sources for all hospitals. The AHA Annual Survey, occupational mix survey, and HAS/Monitrend Databook offer this standard. We note, however, that the AHA Annual Survey, the occupational mix survey and the HAS/Monitrend Databook are not identical data sources, as described above. Therefore, fiscal intermediaries and hospitals should work together to determine which data source best represents the staffing needs of the hospital. In addition, the fiscal intermediaries must consider any minimum staffing requirement set by the State. If the average number of nursing hours per patient day for a bed-size/census group is below the State's minimum staffing requirement, the fiscal intermediaries may not reduce the amount of a hospital's volume decrease adjustment to reflect a core number of nursing staff below what is required by law. In addition, we are continuing to employ the census areas defined by the AHA in the HAS/Monitrend Databook. The larger size of the census areas ensures that a sufficient number of hospitals respond in every bed-size category for each census region.

We have considered the commenter's statement that we should only consider registered nurse and licensed practical nurse staff when computing the number of nursing staff per patient day. However, we believe that nursing aides play an integral part in the delivery of nursing care and, therefore, should be considered part of the hospital's nursing staff for purposes of this determination. Therefore, we will continue to calculate the average number of reported registered nurse, licensed practical nurse, and nursing aide hours per patient day. As previously noted, the registered nurse, licensed practical nurse, and nursing aide FTEs in the AHA Annual Survey data include employees from outpatient areas and distinct part units of the hospital. Therefore, the fiscal intermediaries will include SCH or MDH registered nurse, licensed practical nurse, and nursing aide FTEs for all areas of the hospital, including any distinct part units, when conducting the comparison.

We had proposed to use the results of the 2006 occupational mix survey but not until FY 2008. At that time, we were not aware that we would have the results of the FY 2006 survey available to use for adjustments for decreases in discharges occurring in 2006. However, due to the shortened collection period necessitated by the decision in Bellevue Hospital Center v. Leavitt, these data will now be available for use for volume decrease adjustments for decreases in discharges between the 2005 and 2006 cost reporting periods. These data will be updated every 3 years. The results of the FY 2006 survey may be used for volume decrease adjustment calculations for decreases in discharges occurring during the 2006, 2007 and 2008 cost reporting periods.

After consideration of the public comments received, we are finalizing a policy to allow SCHs and MDHs the option of using the results of (1) the occupational mix survey, (2) the AHA Annual Survey, or (3) the HAS/Monitrend Databook for purposes of determining the amount of the volume decrease adjustment for any open adjustment requests. Beginning with adjustment requests for decreases in discharges occurring beginning with 2007, the amount of the volume decrease adjustment will be based on either the AHA Annual Survey or the occupational mix survey results. Therefore a 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.

If the SCH/MDH opts to use the results of the occupational mix survey, the fiscal intermediaries will determine the SCH's 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. As described in the FY 2007 proposed rule, we will calculate the average number of nursing hours per patient day for all IPPS hospitals that responded to the occupational mix survey. We will begin by annualizing the results. We will then divide this figure by the number of inpatient days reported on the hospital cost report. At this point, we will eliminate results that fall outside three standard deviations of the mean in order to eliminate any potential outlier data. Hospitals will then be grouped by bed-size and census area and the average number of nursing hours per patient day will be calculated. We will post the results of the occupational mix survey grouped by census division and bed-size group on the CMS

Web site. Core staffing results and salaries will be compared to the salaries reported for both the inpatient and outpatient areas of the hospital.

In place of the occupational mix survey results (or the HAS/Monitrend Databook, which may be used only for open adjustment requests) hospitals may also opt to use the AHA Annual Survey results. Where available, these AHA Annual Survey Results may be used for all open adjustment requests, as well as for requests involving decreases experienced in 2007 or thereafter. Currently, the AHA has published the annual results including the FY 2004 survey. Fiscal intermediaries will use the survey results from the year in which the decrease occurred. For instance, if a hospital experiences a decrease between its 2002 and 2003 cost reporting periods, the fiscal intermediaries will compare the hospital's 2003 staffing with the results of the FY 2003 AHA Annual Survey. We will calculate the results of the Annual Survey in a similar method to the occupational mix survey (eliminating from our data-set any hospitals with hospital-based SNFs). We will begin by multiplying the number of reported nurse FTEs by 2080 to derive the number of nursing hours per year (based on a 40 hour work week). We will then divide this number by the total number of inpatient days, including inpatient days from distinct part units, as reported on the hospital cost report. We will then eliminate all providers with results outside of three standard deviations from the mean. The hospitals will then be grouped by bed-size and census area and the average number of nursing hours per patient day will be calculated for each category. If the hospital chooses to use the results of the AHA Annual Survey, the fiscal intermediary will include the hospital's number of nursing staff in the distinct part units, as well as distinct part unit inpatient days, in the

determination. Bed-size groups will also be determined based on the total number of beds in the inpatient areas and distinct part units as reported on the hospital cost report. We will post the results of the Annual Survey grouped by census division and bed-size group on the CMS Web site. If a particular year is unavailable on the Web site or there are no results for a particular bed-size/census group, the fiscal intermediaries may contact CMS for the data.

If the fiscal intermediary determines that the SCH or MDH has a disproportionately high number of staff on a per inpatient day basis as compared to area hospitals, the fiscal intermediary will modify the amount of the adjustment to reflect the cost of the excess staff. As stated above, because we are including registered nurses, licensed practical nurses, and nursing aides in this determination, the fiscal intermediary will calculate the excess staff adjustment by multiplying the number of excess staff by the average weighted salary among the three groups, taking into account the number of registered nurses, licensed practical nurses, and nursing aides at the facility.

3. Mandatory Reporting Requirements for Any Changes in the Circumstances Under Which a Hospital Was Designated as an SCH or MDH

Under §412.92(b)(3) and §412.108(b)(4) respectively, once a facility has been designated as an SCH or MDH, the classification remains in effect without need for reapproval unless there is a change in the hospital's circumstances. Currently, the regulations do not contain an explicit requirement that an SCH report to CMS or the fiscal intermediary a change in circumstances that would affect its status as an SCH. Likewise, the current regulations for MDHs do not contain an explicit requirement that an

MDH report to CMS or the fiscal intermediary a change in the circumstances affecting its MDH status. However, the fiscal intermediary is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status.

We have become aware of several hospitals that have been paid based on SCH or MDH status even after the original circumstances that led to the respective classification changed. In the FY 2007 IPPS proposed rule (71 FR 24104), we proposed to amend §412.92(b)(3) for SCHs and §412.108(b)(4) for MDHs to require an SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed. The CMS Regional Office would then determine whether the SCH or MDH continues to meet the criteria for classification under §412.92 or §412.108. If an SCH or MDH no longer meets these criteria, the CMS Regional Office would issue a letter canceling the classification within 30 days of its determination. If the circumstances affecting a hospital's SCH or MDH classification change and the hospital does not disclose the information to the CMS Regional Office, CMS would cancel the hospital's SCH or MDH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification.

For MDHs, this reporting requirement is in addition to the fiscal intermediary's ongoing evaluations of whether a hospital continues to qualify for MDH status as set out in our existing regulations at §412.108(b)(5).

We received 41 comments on this proposal.

Comment: Most commenters agreed that hospitals that no longer meet the qualification criteria for either SCH or MDH status should not continue to be paid as SCHs or MDHs. However, several commenters disagreed with the proposed requirement that an SCH or MDH notify the CMS Regional Office when any change in the circumstances that led to their classification occurs. They contended that the fiscal intermediary should be responsible for monitoring such conditions. One commenter argued that hospitals should not be required to report changes they cannot control, such as the building of new roads or hospitals.

Another commenter noted that some of the criteria are very difficult for hospitals to monitor, such as patient stays at other hospitals in the area. The commenter stated that to monitor these criteria would impose a tremendous administrative burden on SCHs and MDHs.

One commenter suggested that if CMS is to require that an SCH or MDH report on changes in the circumstances that led to its classification, the circumstances required to be reported be limited to those for which the hospital has readily available data, such as the opening of a new hospital within an SCH's mileage criterion. One commenter suggested that CMS not finalize any reporting requirement for SCHs or MDHs.

Response: We understand that some criteria may be difficult for hospitals to monitor. However, because a hospital cannot control the changes in circumstances should not imply that the hospital not be required to report changes of which it becomes aware. We agree with the commenters who suggested that certain criteria may be excessively burdensome for a hospital to monitor because they do not have ready access

to the necessary data. For instance, we recognize that a hospital may not have the resources available to determine what percentage of patients in their service area has been admitted to other facilities in that area. For this reason, CMS often provides this data to hospitals seeking initial SCH classification. Therefore, we are modifying the change to the regulations to specify that SCHs will only be expected to report changes that would effect the distance between it and another like-hospital, its geographic classification status (urban/rural), the number of beds (if the SCH was eligible under §412.92(a)(1)(ii)), and travel time between itself and a like-provider. For instance, an SCH would be expected to report the opening of a new hospital or road, whether its geographic classification changed from rural to urban, and/or an increase in the number of beds at the hospital if the SCH was eligible under §412.92(a)(1)(ii). An MDH would only be required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban. We will not expect an SCH or MDH to have knowledge of other factors that could affect SCH or MDH status. However, if it is subsequently shown that the hospital had knowledge of those factors, we would terminate SCH or MDH status as of the date the hospital became aware of the event. For example, we would not expect an SCH to be aware of the conversion of a nearby CAH to a short term acute care hospital. However, if there is documentation clearly indicating that the SCH had prior knowledge of the CAH's conversion and the converted hospital is located within the mileage criterion precluding SCH status, we will rescind the SCH designation to the time when the documentation indicates the SCH became aware of the conversion. The SCH/MDH must report any

changes of which it becomes aware that affect SCH or MDH status within 30 days of the event occurring. We are updating the regulations text at §412.92 and §412.108 to reflect these requirements.

We are also modifying the proposed change to the regulations to require that an SCH or MDH report any changes to the fiscal intermediary and not the regional office. Fiscal intermediaries are responsible for accepting and reviewing applications for SCH and MDH designations. Therefore, we believe it is appropriate for all documentation to continue to be sent to the fiscal intermediary. The fiscal intermediary will forward the information submitted by the SCH or the MDH and its recommendation to the appropriate regional office.

Comment: Several commenters disagreed with the proposal to "retroactively" withdraw SCH or MDH classification if it could be expected that the hospital was aware of a change in the circumstances that led to its classification but did not report those changes to the fiscal intermediary. The commenters noted that such a change in reimbursement could be financially devastating to a hospital and recommended that CMS develop a prospective process for withdrawing the hospital's special payment status. One commenter suggested that an SCH or MDH in such a position lose their status immediately, but not retroactively. Several commenters requested clarification of how far back CMS would retroactively terminate SCH or MDH status.

Response: As explained earlier, we have modified the proposal to withdraw SCH or MDH status when the provider was expected to be aware of limited changes in circumstances that caused the provider to be no longer eligible for such designation or

when documentation shows that an SCH or MDH was aware of a change outside of those listed in the revised regulations at §412.92(b)(3)(ii) and §412.108(b)(4)(ii) that would affect its classification and did not report these changes to the fiscal intermediary. In those circumstances, we believe it is appropriate to withdraw the special payment rate effective with the date the change occurred or, with respect to changes that an SCH or MDH is not required to report, when the provider becomes aware of the event. However, we understand the need to establish a limit to how far back CMS may rescind SCH or MDH status. We believe that withdrawal of the classification status falls within the framework of the reopening rules at 42 CFR 405.1885. Accordingly, we will withdraw such status for cost reporting periods that are within the 3-year reopening period. Therefore, if the triggering event (as noted in the revised regulations) changes the circumstances under which the SCH or the MDH received such designation occurs within the three-year reopening period, under the reopening rules, we will withdraw the SCH or MDH designation for those periods. If the event occurred prior to the 3-year reopening period, we will only withdraw SCH or MDH designation for those cost reporting periods subject to the reopening period.

Comment: Several commenters expressed concern that an SCH or MDH would be penalized for a change in circumstances even if it were unaware of such a change.

Response: If an SCH or an MDH is not expected to be aware of a change in circumstances, they will not be penalized if one has occurred and it is not reported. We acknowledge the commenter's concern and as noted above revised the regulations to take his concern into account. If due to the change in circumstances the SCH or the MDH is

out of compliance with the criteria for classification and the change was not one of those specifically listed above and the SCH or MDH was not previously aware of the change, the provider's status will be terminated 30 days after the Regional Office has determined that the provider no longer meets the criteria for classification.

Comment: Several commenters disagreed with the termination of SCH or MDH status within 30 days of the determination that the hospital no longer met the qualifications for such status. One commenter suggested that CMS continue to pay the provider as an SCH or MDH for either 6 months or to the end of the cost reporting period, whichever comes later. Several commenters suggested that CMS extend the period to 12 months. One commenter requested that CMS only finalize these policies for future SCHs and MDHs, in effect grandfathering all current SCHs and MDHs.

Response: We do not agree that an SCH or an MDH that no longer meets the eligibility requirements for such designation should continue to receive enhanced payments. Currently, when the Regional Office determines that an SCH or MDH no longer meets the classification criteria, it issues a letter informing the provider that in 30 days the SCH or MDH status will terminate. As noted above, we will only terminate the provider's status 30 days after the Regional Office has determined that the provider no longer meets the criteria for classification if due to a change in circumstances the SCH or the MDH is out of compliance with the criteria for classification and the change was not one of those specifically listed above and the SCH or MDH was not previously aware of the change.

Comment: One commenter requested that CMS retain the current grandfathering provision for SCHs that permits any hospital that was an SCH as of December 19, 1989 to maintain that status despite any change of circumstances.

Response: Section 6003(e)(1) of Pub. L. 101-239 modified the criteria for being eligible for SCH status by reducing the number of miles between providers from 50 to 35 and by requiring the Secretary to establish a criterion that takes into consideration the travel time between two providers. Section 6003(e)(3) of Pub. L. 101-239 exempted hospitals that already had SCH status from meeting either of these requirements. In other words, any hospital that was an SCH in 1989 is protected under this grandfathering provision from the mileage criterion and whether or not it meets the criterion for classification concerning travel time at §412.92(a)(3). However, we note that this grandfathering provision is limited to these two circumstances. Hospitals with SCH designation in effect prior to 1989 can lose SCH status if they fail to meet any of the other eligibility criteria.

Comment: One commenter suggested that CMS use this rule to change the regulation at §412.92(a)(1)(i), which requires that no more than 25 percent of residents who become hospital inpatients or 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals within a 35-mile radius, or, if larger, the hospital's service area. The commenter suggested that CMS require that either an SCH initially meet this requirement but later meet a lower threshold or that the SCH be required to demonstrate compliance in two out of the three most recent cost reporting periods.

Response: We believe that this comment falls outside the scope of the proposed change in policy. However, we will keep this comment in mind when evaluating SCH policy in the future.

Comment: Several commenters requested that CMS revise the definition of "like hospital," especially in response to the growing number of specialty hospitals. Several commenters recommended that CMS not consider a specialty hospital to be a "like hospital" for purposes of determining eligibility and compliance with SCH criteria. One commenter expressed concern that the policy of considering any hospital whose number of inpatient days from units or wards generally payable under the IPPS is 8 percent or more of the total number of inpatient days from units or wards generally payable under the IPPS at the SCH a "like hospital" is arbitrary and should be reviewed. The commenter suggested that CMS increase the 8-percent threshold to at least 10 percent. Another commenter requested that CMS allow SCHs to retain its status even if a like hospital opens in its service area as long as the SCH's case mix index exceeds those of the like hospitals.

Response: While we understand the commenters' concerns, we believe that this comment is outside of the scope of the proposed policy change. However, we will keep this comment in mind when evaluating SCH policy in the future. In the meantime, we refer commenters to the discussion of "like hospital" in the preamble of the FY 2003 IPPS final rule (67 FR 50053-56). As we noted in that preamble, our goal for defining "like hospital" was to strike a balance between the need to ensure that SCHs do not lose their special status due to specialty hospitals opening nearby and the need to ensure that

only hospitals that are the sole source of short-term acute hospitals services for their community qualify as SCHs. We originally proposed to consider any hospital that overlapped on 3 percent of more of services rendered to be considered a like hospital. However, in response to the public comments received, we finalized a definition of "like hospital" as a hospital paid under the IPPS with 8 percent or more of the total number of inpatient days as the SCH.

After consideration of the public comments received, we are finalizing a change to the regulations to specify that SCHs and MDHs will be required to report to the fiscal intermediary specific changes it becomes aware of that would affect the criteria under which it was eligible for such designation. For an SCH, the changes are as follows: distance between it and another like hospital, its geographic classification status (urban/rural), the number of beds if the SCH was eligible under §412.92(a)(1)(ii), and the travel time between itself and a like-provider. An MDH will be required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban.

4. Payment Changes for MDHs under the DRA of 2005 (§412.79, §412.90(j) and §412.108)

a. Background

Under §412.108(a) of our regulations, in order to be classified as an MDH, a hospital must: (1) be located in a rural area (as defined in 42 CFR Part 412, Subpart D); (2) have 100 or fewer beds (as defined at §412.105(b)) during the cost reporting period; (3) must not be classified as an SCH (as defined in §412.92); and (4) have no less than

60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during either its cost reporting period beginning in FY 1987, or in two of the last three of its audited cost reports that have been settled.

MDHs have been eligible for a series of special payment rates under the IPPS. Section 6003(f) of Pub. L. 101-239 created the first IPPS special payment methodology for MDHs. Effective for cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993, an MDH was paid based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The Federal payment rate applicable to the MDH;
- The MDH's updated hospital-specific rate based on its FY 1982 base period costs per discharge; or
- The MDH's updated hospital-specific rate based on its FY 1987 base period costs per discharge.

Section 13501(e)(1) Pub. L. 103-66 extended the MDH payment provisions through 1994 and provided that, for discharges occurring after March 31, 1993, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment was limited to 50 percent of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate. These provisions expired effective for cost reporting periods beginning on or after October 1, 1994.

Section 4204(a)(3) of Pub. L. 105-33 amended sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act to reinstate these special MDH payment provisions, including the 50-percent limitation, for cost reporting periods "beginning on or after

October 1, 1997, and before October 1, 2001." Section 321(b)(1) of Pub. L. 106-113 made a technical amendment to these provisions of the Act (which describes the time periods for which some of the special payment provisions apply and the time periods during which a hospital may be considered an MDH under section 1886(d)(1)(G)(iv) of the Act) by striking the language "beginning on or after October 1, 1997, and before October 1, 2001" and replacing it with "discharges occurring on or after October 1, 1997, and before October 1, 2001". This change was made effective as if included in Pub. L. 105-33. Pub. L. 106-113 also provided for a 5-year extension of the MDH special payment provisions. Section 404(a) of that law further amended sections 1886(d)(1)(G)(i) and (d)(1)(G)(ii)(II) of the Act by striking the phrase "and before October 1, 2001" and inserting the phrase "and before October 1, 2006".

Section 5003(a) of Pub. L. 109-171 (DRA of 2005) amended the MDH special payment provisions in the Act. It amended section 1886(d)(5)(G) of the Act and made a conforming amendment under section 1886(b)(3)(D) of the Act to provide for another 5-year extension of the special MDH payment methodology. Under this extension, a revised special MDH payment methodology will apply for discharges occurring on or after October 1, 2006, and before October 1, 2011.

As stated earlier, MDHs currently are paid using whichever rate yields the greatest aggregate payment: the Federal payment rate or, if higher, the Federal payment rate plus 50 percent of the difference between the Federal payment rate and the updated hospital-specific rate based on FY 1982 or FY 1987 base period costs per discharge.

Section 5003(b) of Pub. L. 109-171 provides that, for discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH's updated hospital-specific rate will be the FY 2002 base period costs per discharges if the FY 2002 based hospital-specific rate results in a payment increase. In cases where no payment increase results from using FY 2002 hospital-specific rate, an MDH will continue to be paid based on the higher of its updated FY 1982 or FY 1987 hospital-specific rates, if using one of those rates results in a payment higher than that under the Federal payment rate. (Unlike an SCH, an MDH does not have the option of using its updated FY 1996 hospital-specific rate.)

Under section 5003(c) of Pub. L. 109-171, for discharges occurring on or after October 1, 2006, and before October 1, 2011, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment is limited to 75 percent (as opposed to the previous 50 percent) of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate.

Section 5003(d) of Pub. L. 109-171 enhances the DSH adjustment for MDHs for discharges occurring on or after October 1, 2006. Further discussion concerning the implementation of this provision can be found in section IV.F.4. of the preamble to the FY 2007 IPPS final rule.

b. Regulation Changes

In this FY 2007 IPPS final rule, we are amending our regulations to implement section 5003(a) through (c) of Pub. L. 109-171. We are adding a new §412.79 that describes how we will compute and update the MDH hospital-specific rate based on its

FY 2002 base period. In addition, we are revising §412.90(j) to reflect the extension of the MDH special payment provisions to discharges occurring before October 1, 2011. We also are amending §412.108 by revising paragraph (a) and adding a new paragraph (c)(2)(iii) to reflect the changes to the special payment methodology effective for discharges occurring on or after October 1, 2006, and before October 1, 2011.

Comment: One commenter pointed out that the proposed language in the new §412.79(a) in the proposed rule differs from the language provided in section 5003 of the statute. That is, the proposed regulatory language reads "ending on or before October 1, 2001"; however, the commenter believed it should read "beginning on or after October 1, 2001" as specified in the statute.

Response: We agree with the commenter that the regulatory language should mirror the statutory language and are making the appropriate changes to the regulatory language in this final rule.

Comment: One commenter supported the proposed changes made as well as CMS' timely implementation of the provisions from the DRA of 2005.

Response: We appreciate the commenter's support.

We received no other comments on these proposed changes. Therefore, we are adopting the proposed changes to the regulations as final, with the indicated change to the regulatory text to reflect the FY 2002 base period statutory language.

In addition, as we proposed, in this FY 2007 IPPS final rule, as a part of the amendments to §412.90(j) and §412.108(a), we are making two technical corrections. Section 412.90(j) describes when an MDH may receive a special payment adjustments,

while §412.108(a) discusses the definition of an MDH. Each of these sections now refers to "cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006". However, as noted above, sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act, the provisions of the Act from which these time periods were drawn, were amended by Pub. L. 106-113. Sections 321(b)(1) and 404(a) of Pub. L. 106-113 amended sections 1886(d)(5)(G)(i) and (d)(5)(ii)(II) of the Act so that the phrase in each section "beginning on or after October 1, 1997, and before October 1, 2001" was replaced with the phrase "discharges occurring on or after October 1, 1997, and before October 1, 2006". (Section 5003(a)(1) of Pub. L. 109-171 changed the ending date in these provisions from "before October 1, 2006" to "before October 1, 2011".)

Therefore, we are removing the incorrect phrase "beginning on or after October 1, 1997" from each of these regulations and inserting the phrase, "discharges occurring on or after October 1, 1997", to conform the regulations to the statute.

We did not receive any public comments on these technical changes.

5. Technical Change

As we proposed, in this final rule, we are correcting the spelling of the word "adjustment" in paragraph (b)(2)(iv) of §412.92, by changing it to "adjustment".

We did not receive any public comments on this technical change.

D. Rural Referral Centers (§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 a rural referral center. For discharges occurring before October 1, 1994, rural referral centers 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, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108-173 raised the DSH adjustment for other rural hospitals with less than 500 beds and rural referral centers. Other rural hospitals with less than 500 beds are subject to a 12-percent cap on DSH payments. Rural referral centers 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). Rural referral centers 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 106 percent of the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Pub. L. 105-33 states, in part, "[a]ny hospital classified as a rural referral center by the Secretary . . . for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent year." In the August 29, 1997 final rule with comment period (62 FR 45999), we also reinstated rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost rural referral center 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 a rural referral center and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as a rural referral center. Otherwise, a hospital seeking rural referral center 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 rural referral center 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 a rural referral center 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)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center 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 will establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional CMI values is set forth in regulations at §412.96(c)(1)(ii). The national median CMI value for FY 2007 includes all urban hospitals nationwide, and the regional values for FY 2007 are the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in §412.105(f)). These values are based on discharges occurring during FY 2005 (October 1, 2004 through September 30, 2005) and include bills posted to CMS' records through March 2006.

In the FY 2007 IPPS proposed rule (71 FR 24106), we proposed that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least--

- 1.3365; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in §412.105(f)) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the proposed FY 2007 IPPS proposed rule at 71 FR 24106.)

Based on the latest data available (FY 2005 bills received through March 2006), in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least--

- 1.3132; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in §412.105(f)) 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)	1.2313
2. Middle Atlantic (PA, NJ, NY)	1.2619
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3252
4. East North Central (IL, IN, MI, OH, WI)	1.3118
5. East South Central (AL, KY, MS, TN)	1.2926
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2344
7. West South Central (AR, LA, OK, TX)	1.3872
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3877
9. Pacific (AK, CA, HI, OR, WA)	1.3366

Hospitals seeking to qualify as rural referral centers 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. 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 will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center 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 2007 IPPS proposed rule (71 FR 24106), we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2003 (that is, October 1, 2002 through September 30, 2003), which is the latest available cost report data we had at that time.

Therefore, in the FY 2007 IPPS proposed rule (71 FR 24106), we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, must have as the number of discharges for its cost reporting period that began during FY 2003 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. (See the table set forth in the FY 2007 IPPS proposed rule at 71 FR 24106.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that began during FY 2003, the final median number of discharges for urban hospitals by census region area are as follows:

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,366
2. Middle Atlantic (PA, NJ, NY)	10,307
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,546
4. East North Central (IL, IN, MI, OH, WI)	9,200
5. East South Central (AL, KY, MS, TN)	7,519
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,441
7. West South Central (AR, LA, OK, TX)	7,239
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	10,419
9. Pacific (AK, CA, HI, OR, WA)	7,965

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 rural referral center status for cost reporting periods beginning on or after October 1, 2006, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2003.

Comment: Commenters indicated the case-mix index values that are used as criteria for rural referral center status have been fluctuating significantly in the past few years (2005 through 2007), where they had been relatively stable in prior years. They questioned the methodology used to calculate the values.

Response: While we agree that there have been changes in the case-mix index values over the past few years, in our view, they have not been significant. The methodology for determining the case-mix index values for rural referral center status has not changed. The FY 2007 final case-mix index values are based on a more complete file than the proposed values and are more in line with the prior year's values. Although the methodology for calculating the indices has not changed, in response to the commenters' concerns, we will continue to evaluate whether there are other factors that would cause the observed shift in the values.

Comment: One commenter recommended that CMS clarify the last sentence of the "Case-Mix Index" section which states that "In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment." The commenter believed it would be inappropriate to include discharges paid under the LTC DRG payment system. The commenter recommended that, assuming that discharges paid under the LTC DRG-based payment system are excluded, this sentence should be changed to specify "under the inpatient PPS DRG-based payment system."

Response: We agree with the commenter and have revised the preamble language in this final rule. The sentence now states, "In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to the IPPS DRG-based payment."

Comment: Two commenters addressed the issue of which cost reporting period is to be used to determine the number of discharges of a hospital applying for initial rural

referral center status. One commenter referenced 42 CFR 412.96(c)(2)(ii), which states that an osteopathic hospital applying for rural referral center status "must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion." This commenter believed that the preamble language in the proposed rule should be corrected to reflect the use of the hospital's most recently completed cost reporting period, rather than a cost reporting period specified by a fiscal year. The second commenter expressed an opposite view and stated that the cost reporting period specified by a fiscal year in the rule should apply and not the "most recently completed cost reporting period" specified in the regulations.

Response: We have considered this issue and have decided to clarify the regulations to be consistent with our longstanding practice as well as the policy we proposed in the FY 2007 IPPS proposed rule of using the same cost reporting period used to develop the regional medians. In this way, we derive the regional medians (to which the hospital's discharges may be compared) as well as the hospital's own discharge data using the same time period. Because we use the FY 2003 data for developing the regional medians, we will also use this data for determining the hospital's own discharges. This is in keeping with our longstanding and consistent policy of publishing in our preamble a specific cost reporting period that we consider to have the latest available cost report data at the time of publication of the rule. We have made technical revisions to §412.96 to reflect our proposed policy. The language at §412.96(c)(2)(i) will now state, "the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under

paragraph (i) of this section." We are also making similar revisions to the references to "the hospital's most recently completed cost reporting period" in §412.96(c)(2)(ii) and 412.96(i)(3). In addition, in §412.96(c)(2)(ii), we are deleting the last sentence that references "the triennial review."

E. Indirect Medical Education (IME) Adjustment (§412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment 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, a hospital's unweighted FTE count of residents 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, the limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997. A similar limit is effective for direct GME purposes for cost reporting periods beginning on or after October 1, 1997.

2. IME Adjustment Factor for FY 2007

The IME adjustment to the DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated 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 Pub. L. 108-173 modified the formula multiplier *(c)* to be used in the calculation of the IME adjustment. Prior to the enactment of Pub. L. 108-173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter. In the FY 2005 IPPS 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). In the FY 2007 IPPS proposed rule (71 FR 24107), we specified that for any discharges occurring during FY 2007, the statutorily mandated formula multiplier is 1.32. Previously, for FY 2007, the mandated formula multiplier was 1.42. We estimate that application of the mandated formula multiplier for FY 2007 will result in an increase of 5.35 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio.

Comment: While acknowledging that the formula multiplier for FY 2007 is mandated in law, several commenters expressed opposition to the reduced IME payment resulting from the application of the formula multiplier.

Response: As noted by the commenters, the schedule of formula multipliers to be used in the calculation of the IME adjustment is mandated in law. In this rule, we are simply reiterating that, for any discharges occurring during FY 2007, the formula multiplier is 1.32.

3. Technical Change to Revise Cross-Reference

In the FY 2007 IPPS proposed rule (71 FR 24107), we proposed to revise the cross-references included in paragraph (f)(1)(ii)(C) of §412.105 that specify the criteria for counting FTE residents who spend time in nonprovider settings for IME payment adjustment purposes. Currently, this paragraph only cites the criteria set forth in §§413.78(c) or 413.78(d). We should have also cited the provisions of §413.78(e), which state that the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if other applicable conditions specified in paragraph (e) are met.

We did not receive any specific public comments on the proposed addition of a cross-reference to §413.78(e) to §412.105(f)(1)(ii)(C) and are therefore adopting it as final without modification.

We note that in sections IV.H.2.,3.,4., and 5. of the FY 2007 IPPS proposed rule (71 FR 24111), we discussed other policy changes and clarifications to the methodology for counting FTE residents for the purposes of direct GME payments, which also would be applicable to IME payments.. We respond to public comments received on those proposals below in the specified sections.

F. Payment Adjustment for Disproportionate Share Hospitals (DSHs) (§412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as "Pickle hospitals." The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two fractions: the "Medicare fraction" and the "Medicaid fraction." The Medicare fraction is computed by dividing the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period.

$$\text{DSH Patient} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

Percentage

2. Technical Corrections

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to make a technical correction to §412.106(a)(1)(iii) to reflect the statutory requirement at section 1886(d)(8)(E) of the Act that, as of January 1, 2000, hospitals reclassified under §412.103 are considered rural for purposes of this DSH regulation. We also proposed to correct the regulation to eliminate the reference to §412.62(f). These corrections reflect current policy and already-existing statutory requirements.

We did not receive any public comments regarding the proposed corrections to §412.106(a)(1)(iii) to reflect the statutory requirement that section 1886(d)(8)(E) of the Act that hospitals reclassified under §412.103 are considered rural for purposes of this DSH regulation and to eliminate the reference to §412.62(f). Therefore, we are adopting the corrections as final without modification.

3. Reinstatement of Inadvertently Deleted Provisions on DSH Payment Adjustment Factors

In an interim final rule published in the **Federal Register** on June 13, 2001 (66 FR 32174 and 32194) (which was finalized in the **Federal Register** on August 1, 2001 (66 FR 39827)), we incorporated into our regulations at §412.106(d)(2) the provisions of section 211(b) of Pub. L. 106-554. Section 211(b) amended section 1886(d)(5)(F) of the Act to revise the calculation of the disproportionate share percentage adjustment for hospitals affected by the revised DSH qualifying threshold percentages specified in section 211(a) of Pub. L. 106-554. When the section 211 changes were

incorporated into the Code of Federal Regulations at §412.106(d)(2), the regulation text at §412.106(d)(2)(v) was inadvertently deleted during the transcribing of the new text into the existing regulations. Section 412.106(d)(2)(v) specifies the payment adjustment factors for hospitals that meet the following criteria under §412.106(c)(2) for discharges occurring on or after April 1, 1990, and before October 1, 1991, and on or after October 1, 1991: hospitals located in an urban area, that have 100 or more beds, and that can demonstrate that, during their cost reporting period, more than 30 percent of their net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to reinstate the inadvertently deleted text of §412.106(d)(2)(v). We noted that this is a correction to the regulations; we did not propose to change the payment adjustment factors for hospitals that meet the criteria under §412.106(c)(2).

We did not receive any public comments on this proposal and are, therefore, adopting it as final without modifications.

4. Enhanced DSH Adjustment for MDHs

The DSH adjustment factor for most categories of hospitals is capped at 12 percent. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, and rural referral centers, are exempt from this cap.

Section 5003(d) of Pub. L. 109-171 (DRA of 2005) amended section 1886(d)(5)(F) of the Act to revise the DSH payment adjustment factor for MDHs, effective for discharges occurring on or after October 1, 2006. Specifically, section

5003(d) amended section 1886(d)(5)(F)(xiv)(II) of the Act to exclude MDHs from the 12-percent DSH adjustment factor cap.

For all discharges occurring on or after October 1, 2006, the fiscal intermediary will not apply the cap when calculating the DSH payments. These payments will be subject to revision upon final settlement of the cost reporting period. We note that this change will not affect the calculation of the disproportionate patient percentage.

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to amend the regulations at §412.106 to include this provision under proposed new paragraph (d)(2)((iv)(D).

We did not receive any public comments of the proposed addition of §412.106(d)(2)(iv)(D) to our regulations to reflect the revision to section 1886(d)(5)(F)(xiv)(II) of the Act made by section 5003 of Pub. L. 109-171. Therefore, we are adopting the proposed revision as final.

G. Geographic Reclassifications (§§412.103, 412.230, and 412.234)

1. Background

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). As a result of legislative changes under section 402(b) of Pub. L. 108-7, section 402 of Pub. L. 108-89,

and section 401 of Pub. L. 108-173, the standardized amount reclassification criterion for large urban and other areas is no longer necessary or appropriate and has been removed from our reclassification policy. We implemented this policy in the FY 2005 IPPS final rule (69 FR 49103). As a result, hospitals can request reclassification for the purposes of the wage index only and not the standardized amount. Implementing regulations in Subpart L of 42 CFR Part 412 (§§412.230 et seq.) set forth criteria and conditions for reclassifications for purposes of the wage index from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Under section 1886(d)(8)(E) of the Act, an urban hospital may file an application to be treated as being located in a rural area if certain conditions are met. The regulations implementing this provision are located under §412.103.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at §412.230(d)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2007, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 12, 2005 IPPS final rule (70 FR 47508). These average hourly wages are taken from data used to calculate the wage indexes for

FY 2004, FY 2005, and FY 2006, based on cost reporting periods beginning during FY 2000, FY 2001, and FY 2002, respectively.

2. Reclassifications under Section 508 of Pub. L. 108-173

Under section 508 of Pub. L. 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). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be achieved in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. In applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

We refer readers to section III.H. of this preamble for a discussion of our updated procedural rules established under section 1886(d)(10)(D)(v) of the Act in which a section 508 hospital may retain its section 508 reclassification through its expiration on March 31, 2007, and accept a reclassification approved by the MGCRB for the second

half of FY 2007 (April 1, 2007, through September 30, 2007). We also clarified the procedural rules for an already individually reclassified hospital that is part of a group that includes a section 508 hospital. For nonsection 508 hospitals in a group with a pending individual geographic reclassification, we will apply one of the following for the first half of FY 2007: (a) the area wage index where the hospital is physically located if there is no reclassification pending, or (b) the hospital's individual reclassification wage index if the hospital was part of a group awarded a group reclassification and the group followed the procedural rules for postponing reclassification until April 1, 2007. Final Table 9B will include a final list of section 508 reclassifications for the 1st half of FY 2007 and will be included in a subsequent **Federal Register** notice as well as posted to the CMS Web site after August 1, 2006, and before October 1, 2006.

3. Multicampus Hospitals (§412.230 (d)(2)(iii))

Subsequent to the publication of the FY 2005 IPPS final rule, we became aware of a situation in which, as a result of the new labor market areas implemented in FY 2005 for the IPPS, a multicampus hospital previously located in a single MSA is now located in more than one CBSA. Under our existing policy, a multi-campus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the MSA (or Metropolitan Divisions, where applicable) in which the campus of the hospital is located. Prior to FY 2006, the criteria for a hospital being reclassified to another wage area by the MGCRB did not address the circumstances under which a single campus of a

multicampus hospital may seek reclassification. The regulations require that a hospital provide data from the CMS hospital wage survey for the average hourly wage comparison that is used to support a request for reclassification. Because a multicampus hospital is required to report data for the entire hospital on a single cost report, there is no wage survey data for the individual hospital campus that can be used in a reclassification application.

In the FY 2006 IPPS final rule (70 FR 47444 through 47446 and 47487), we modified the reclassification rules at §412.230(d)(2)(iii) to allow campuses of multicampus hospitals located in separate wage index areas to support a reclassification application to an area where another campus is located using the average hourly (composite) wage data submitted on the cost report for the entire multi-campus hospital as its hospital-specific data. This special rule applies for reclassification applications for FY 2006, FY 2007, and FY 2008 and will not be in effect for FY 2009 reclassification requests and beyond. Because reclassification applications to the MGCRB for FY 2009 must be filed in September 2007, or 1 month before the effective date of the FY 2008 IPPS rule, we addressed whether to extend the special rule for multicampus hospitals beyond FY 2008 in this FY 2007 final rule. In the FY 2006 IPPS final rule, we indicated that we would continue to explore options that would allow individual campuses of multi-campus hospitals to submit wage data necessary for geographic reclassification and also monitor the number of multi-campus hospitals affected by this provision (70 FR 47445 and 47446).

After reviewing this situation further, we are finalizing our proposed policy. Beginning with FY 2009 reclassifications, we will no longer allow a campus of a multicampus hospital to use the average hourly wage the entire hospital system to support its reclassification application. Because a cost report is filed for an entire hospital, the campus would have to obtain a separate provider number and be treated for Medicare payment purposes as an independent entity in order to be able to provide wage data for the specific campus. If a hospital were to make a change in FY 2007 to its organizational structure to provide campus specific data to support a reclassification application, the earliest fiscal year that the campus would be eligible to reclassify would be FY 2012 because the cost report data that are used for geographic reclassification precede the payment year by 5 years (that is, FY 2003 cost report data will be used to determine the FY 2008 geographic reclassifications).

To our knowledge, only one hospital has used the special rule for multicampus hospitals. This hospital has since joined a successful FY 2007 urban county group reclassification application to the same area to which it was approved under the multicampus hospital rule. Thus, this hospital is no longer required to meet the multicampus hospital rule. Given that there is only one hospital that has used this rule and this hospital was able to reclassify under the normal reclassification rules, we believe the special reclassification rule that applies to multi-campus hospitals is no longer needed. We proposed in the FY 2007 IPPS proposed rule, to not extend the special rule beyond FY 2008. After considering comments (discussed below) we have decided to adopt the proposal not to extend the multicampus rule beyond 2008. For reclassification

requests for FY 2009 and thereafter, a campus of a multicampus hospital would be required to obtain a separate provider number in order to provide the required wage data from the CMS hospital wage survey for the average hourly wage comparison in its MGCRB reclassification application.

Comment: Several commenters requested that CMS continue to allow multi-campus hospitals to use the average hourly wage for the entire hospital system as its wage data to support a reclassification application to an area where another one of the campuses is located. One commenter argued that, once the new census data are available, there may be more hospitals in need of the provision. Two commenters asked CMS to retain the provision because they believed eliminating the multi-campus hospital rule will preclude both reclassifications of groups from areas where one of the hospital campuses is located as well as a campus of a multicampus provider from reclassifying as an individual hospital. These commenters argued that the multicampus hospital rule is necessary in order for an individual campus of a multi-campus hospital to provide wage data to join a group reclassification. Given how few hospitals are expected to use this option, the commenters asked that CMS extend the current rule for at least 5 more years.

Response: The next decennial census is in 2010. Using past experience as a guide, we would not be developing new labor market areas based on the decennial census until FY 2014 or FY 2015 and it is unknown whether such a special rule will be needed at that time. We do not believe a special time limited rule that was intended to give us time to address the particular circumstances of a situation should be retained for nearly 10 more years merely on the possibility that it will be needed. We can reconsider

whether to reestablish this special rule if necessary when OMB publishes new MSA definitions following the 2010 Census. Further, as stated in the proposed rule, we believe that hospitals should have to support an individual reclassification application with their own data.

With respect to the comments about group reclassifications, we believe the commenters misunderstand our current rules on reclassification. We are not changing these already existing rules, under which a satellite campus of a multicampus hospital located in a CBSA different from the main hospital would not be required to provide campus-specific wage data in order to join the group and for the MGCRB to approve a group reclassification application. (When a campus of a multicampus hospital joins a group reclassification, the group uses average hourly wage information for the county that was used to develop the wage index for the labor market area. These data do not include wage information for an individual campus of a multicampus hospital.) As we stated in the proposed rule, a campus of a multicampus hospital can join a group reclassification under our normal rules (71 FR 24109). That is, the special rule for multicampus hospitals would not be needed when a campus of a multicampus hospital joins a group reclassification application. As we allow for new hospitals that are part of group reclassifications, an individual campus of a multicampus hospital may join a group reclassification under 42 CFR 412.234 without having to provide campus-specific wage data. The rationale for this policy was explained in the proposed rule and is the same for both new hospitals and individual campuses of multicampus hospitals that join group reclassifications (71 FR 24110).

After consideration of the public comments received, we are not making any further changes in this final rule to our policy relating to multicampus hospitals.

4. Urban Group Hospital Reclassifications (§412.234(a)(3)(iii))

Section 412.234(a)(3)(iii) of the regulations sets forth criteria for urban hospitals to be reclassified as a group for FY 2007 and thereafter. Under these criteria, "hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation."

Last year, several commenters brought to our attention that, while the CSA standard allows for urban county group reclassifications in large urban areas throughout the United States (including 10 of the 11 CBSAs containing Metropolitan Divisions), the CSA standard precludes urban county group reclassifications between three Metropolitan Divisions within one CBSA in Florida. They urged us to modify our policy to also allow hospitals located in counties that are in the same CBSA (in the case of Metropolitan Divisions) as the area to which they seek redesignation to be considered to have met the proximity requirement. We agree with the commenter's proposed modification. The proximity standard for group reclassifications is intended to allow all of a county's hospitals to reclassify to an adjacent area where there is sufficient economic integration that there can be an expectation that both areas are competing in a similar labor market area. We believe there is sufficient economic integration between Metropolitan Divisions within a CBSA that urban county reclassifications within a CBSA or a CSA should be

permitted. A CBSA, as defined by the OMB, is a "geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties."

Therefore, in the FY 2007 IPPS proposed rule (71 FR 24110), we proposed to revise §412.234(a)(3) by adding a new paragraph (iv) to expand the proximity criteria to allow urban county groups to apply for reclassification to another area within the same CBSA. We proposed to require that, beginning with FY 2008, hospitals must be located in counties that are in the same CSA or CBSA (under the MSA definitions announced by OMB on June 6, 2003) as the urban area to which they seek redesignation to qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

Comment: Several commenters supported CMS' proposal to allow hospitals located in counties that are in the same CBSA as the county in which they seek redesignation to be considered to have met the proximity requirement for an urban county group reclassification. These commenters indicated that use of the CBSA criteria appropriately recognizes economic integration among different metropolitan divisions for purposes of applying the proximity standard within the urban county group reclassification regulations. Commenters further indicated that the new proximity criteria should be applied retroactively and be effective for urban group reclassifications beginning on October 1, 2006 (as opposed to October 1, 2007) under specified circumstances.

Response: We appreciate the commenters' support for our proposed change to the regulations, but we do not believe the changes should be made retroactively. The IPPS system, including any wage indices associated with a hospital's geographic classification or reclassification is a prospective system. In addition, under section 1886(d)(10) of the Act, the MGCRB makes decisions about reclassifications, not CMS. Applications for reclassifications for a fiscal year are required to be submitted in September, 13 months before the reclassification would go into effect (for example, a reclassification application for FY 2007 would have had to be submitted by September 2005). Reclassification decisions issued through the statutory process are final and binding and are not subject to judicial review. Making a reclassification criterion retroactive would interfere with the prospective nature of the MGCRB reclassification decisions, and we believe would conflict with the prospective nature of the entire IPPS system. In addition, it could require a recalculation of the budget neutrality adjustment required by section 1886(d)(8)(C) of the Act. Modifying the FY 2006 reclassification budget neutrality adjustment for all hospitals nationwide, we believe would not be feasible at this late date.

After consideration of the public comments received, we are adopting as final, without modification, the proposed revision to §412.234(a)(3) to add a new paragraph (iv) to expand the proximity criteria to allow urban county groups to apply for reclassification to another area within the same CBSA.

5. Effect of Change of Ownership on Urban County Group Reclassifications (§§412.230, 412.234, and 489.18)

We have received questions asking for clarification of our policy regarding whether newly constructed hospitals and hospitals that do not accept assignment of the previous owner's provider agreement can join an urban county group reclassification.

The Medicare regulations at §412.230 require that, for individual hospital reclassifications, a hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. Section 489.18(c) of the regulations provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner when there is a change of ownership as defined in the rules. Section 412.230(d)(2)(iv) of the regulations specifies that, in situations where a hospital becomes a new provider and the existing hospital's provider agreement is not assigned under §489.18, the wage data associated with the previous hospital's provider number will not be used in calculating the new hospital's 3-year average hourly wage. This policy is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. The regulations also state that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

While the regulations preclude a new provider from individually reclassifying until the hospital accumulates at least 1 year of wage data from the CMS hospital wage survey used to determine the wage index, a new provider may join a group reclassification under §412.234. Under §412.234, all hospitals in an urban county must

apply for redesignation as a group. If we did not permit a new hospital to join group reclassifications, all hospitals in the county would not be part of the reclassification application and the urban county group would be precluded from reclassifying for 3 years until the new hospital accumulated at least 1 year of wage data. We believe it would be inequitable to preclude a group reclassification merely because there was one newly constructed hospital or one hospital in the county changed ownership and did not accept the prior owner's provider agreement. Alternatively, we believe that allowing group applications without a new hospital would be inconsistent with our regulations and unfair to new hospitals because it would put them at a competitive disadvantage with other hospitals in the county. Because such reclassifications are effective for 3 years, a new hospital that was not allowed to join a group reclassification would have to accept a lower wage index than all other hospitals in the county with which it competes for labor for up to 3 years.

Comment: One commenter suggested that where there is already an approved group reclassification, the new provider should be automatically granted the wage index of all the other hospitals in the county. Alternatively, the commenter suggested that the Secretary could use the broad authority provided in the statute to grant an urban county group reclassification already in progress to a new hospital in the same county.

Response: There is currently no provision that allows a hospital to join a county-wide group reclassification already in effect. The existing regulations at §412.234 provide that all hospitals in an urban county must apply for redesignation as a group. The MGCRB decision applies to only those hospitals listed on the application. However, it is

possible that the urban county group can apply for another reclassification to a different area with the new provider.

6. Requested Reclassification for Hospitals Located in a Single Hospital MSA Surrounded by Rural Counties

In the FY 2006 IPPS final rule (70 FR 47448), we presented a commenter's concern about the special circumstances of a hospital located in a single hospital MSA surrounded by rural counties in relation to the wage index and the rules governing geographic reclassification. The commenter stated that an isolated hospital in a single hospital MSA is at a competitive disadvantage because the rural hospitals that surround the hospital have been reclassified to higher wage index areas or have been designated as rural referral centers, SCHs, MDHs, or CAHs. The urban hospital is ineligible for reclassification to a higher wage index area either as an individual hospital or as part of a group under the existing regulations. The commenter emphasized that this concern is especially significant given the fact that an isolated hospital in a single hospital MSA is the only hospital in its urban area, and, therefore, has an even greater obligation to the communities it serves.

The commenter advocated a change to the urban county group reclassification regulations whereby a hospital in a single hospital MSA surrounded by rural counties would be able to reclassify to the closest urban area that is part of a CSA located in the same State as the hospital. We did not adopt this suggested policy for FY 2006 because we did not believe it would be prudent to adopt the suggested policy in a final rule

without first soliciting public comment. In the FY 2007 IPPS proposed rule, we solicited comments on this issue.

Comment: Commenters supported allowing a hospital that is the only hospital in its MSA to reclassify to the closest urban area that is part of a CSA located in the same State, when the hospitals in surrounding areas have all been reclassified to and/or are located in areas that receive wage index reimbursement significantly higher than the surrounding hospitals' actual wages. Without this reclassification, the commenters indicated that the hospital must continually work to keep wages competitive, purchase new technology, and provide services needed by Medicare beneficiaries in its community. The commenters also stated that a single hospital in an urban county must offer a broad range of services to meet the needs of the Medicare beneficiaries in its large service area, while potentially competing with hospitals that offer fewer services yet receive increased reimbursement due to their ability to reclassify. Some commenters also recommended that proximity criteria should focus more on competition as demonstrated through economic connection, rather than location. The commenters argued that there is an anomaly in the reclassification rules that allows a reclassified hospital to receive a wage index that is higher than its own average hourly wage. Such a hospital has an advantage relative to its competitors in the single hospital MSA by being able to take the excess revenue and invest in technology and services. One commenter stated that making an exception for the hospital addressed here would be an unnecessary expansion of the geographic reclassification provisions. The commenter indicated that it was not unsympathetic to the situation described of a hospital that is surrounded by rural hospitals

that have all received special payment status. The commenter opposed allowing the hospital to reclassify to a distant area but indicated that it might support some accommodation that was particularized to this situation.

Response: We disagree with the notion that receiving a higher wage index than a hospital's own average hourly wage is an anomaly of reclassification. The wage index represents an average of all hospitals in a labor market area. Using the commenter's logic, such an "anomaly" would not be limited to reclassification. It would also be a feature of the wage index in a labor market area with multiple hospitals. Some hospitals would have higher wages than the labor market area average, and others, lower. The only policy option for addressing such a concern would be to have a hospital-specific wage index. We believe such an option would not be permitted under the section 1886(d)(3)(E) of the Act, which requires us to adjust IPPS rates for "area differences in hospital wage levels" to reflect the "relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The statute clearly directs the Secretary to use area, and not hospital-specific, differences in wage levels in creating the wage index.

We believe that allowing hospitals in single hospital MSAs surrounded by rural counties to reclassify to the closest urban area that is part of a CSA located in the same State as the hospital would be an unnecessary expansion of the geographic reclassification provisions. If we adopted the commenters' change to the reclassification provisions, we would be allowing a hospital group to reclassify to a labor market area that is farther away from, rather than closer to, urban market areas. Such a change would

be inconsistent with the geographic reclassification regulations that require a hospital to demonstrate proximity to the area where it requests reclassification. For individual hospital reclassifications, the proximity requirement is demonstrated by either meeting a mileage requirement or showing that at least 50 percent of the hospital's employees reside in the area to which it wishes to reclassify. For group reclassifications, the proximity requirement is met if the county demonstrates that it is adjacent to the area where it is seeking reclassification and has a sufficient degree of economic integration to suggest that both areas compete for the same labor. The commenter's approach would allow a hospital to reclassify to a labor market that is more than 75 miles away from the requested area. In general, we believe it is highly unlikely that two areas more than 75 miles apart compete for the same labor.

In accord with the comment from a national hospital association, we agree that the geographic reclassification rules should not be revised to accommodate this situation. However, as suggested in the comment, we considered an accommodation to address the particular circumstances of this situation. In this situation, a number of the surrounding hospitals benefit from being an MDH, SCH, or RRC. There are also two hospitals within approximately 35 miles of the hospital in the single hospital urban area that do not receive special payment under these provisions but receive a special wage index under section 508 of Pub. L. 108-173. Therefore, the hospital in the single hospital urban area has neighboring hospitals that either receive special payment provisions such as RRC and SCH status or benefit from the special circumstances of section 508 that provided them with temporary higher wage indices. The section 508 reclassifications were special

one-time reclassification provisions that permitted certain hospitals to reclassify that ordinarily would not be able to. Thus, the reclassification of the two neighboring hospitals, in conjunction with the special payment of the other surrounding hospitals, represents a situation that would not ordinarily occur under our reclassification of labor market area rules. Due to the combination of these factors and the unique circumstances surrounding the section 508 reclassifications, we are invoking our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act for this situation. 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." We believe it is appropriate in these circumstances to give the hospital in the single hospital urban area the same wage index as the nearby 508 hospitals until the expiration of the provision on March 31, 2007. We note that in somewhat analogous circumstances, we used the special exceptions authority to address hospitals co-located with other hospitals that received a special temporary wage index increase. In that case, a special exception was granted where individual hospitals were part of a failed group application, where a significant proportion of the group (one-third) was able to otherwise reclassify, and where the hospitals that did reclassify received wage indices at least 10 percent higher than the wage index of the MSA where the hospital was located (69 FR 49105).

Comment: One commenter indicated that when competing hospitals are geographically located in two separate MSAs they may experience large differences in their wage indices, thus leading to reimbursement differentials. The commenter stated

that a hospital in a single hospital MSA could not rectify its situation simply by increasing labor compensation, thereby resulting in a higher hospital-specific wage index, because the wage index is based on wage data from 3 years earlier and, in addition, the wage index is only paid on the labor-related share of the standardized amount. Thus, the commenter concluded, a hospital could not receive dollar-for-dollar returns on its own labor costs for any particular year, even though it receives a wage index based on its own wage data.

Response: We disagree with the commenter's suggestion that the use of MSAs do not provide a sound basis for identifying hospital labor market areas. As noted in the FY 2005 IPPS final rule (69 FR 29027), exhaustive research has been completed since the mid-1990's on use of alternatives to using MSA definitions for inpatient hospital labor market. While individual hospitals may sometimes be disadvantaged by the use of OMB statistical area definitions for the Medicare IPPS labor market areas, there has been no consensus among interested parties that there are any better alternatives. Dividing the country into geographic areas used to determine wage indices, as is required by section 1886(d)(3)(E) of the Act, will necessarily result in different wage indices across different labor market areas. The commenter is correct that hospitals can neither change the proportion of their payment that is adjusted by the wage index nor shorten the period between when hospitals pay wages to their employees and when those wages are used in determining the wage index. However, these circumstances are not unique to hospitals in single-hospital MSAs. All hospitals experience a delay between the date hospital wage

costs are incurred and the date those costs are used to determine the wage index. Similarly, all hospitals are paid based upon a set labor-related share.

Comment: Commenters provided the following suggestions for revising the reclassification rules for single hospital MSAs:

- Exempt the hospital from the requirement that its wages be at least 108 percent of the average hourly wage of all other hospitals in its area, since a single hospital alone in its MSA could not, by definition, meet this test.

- Combine single hospital areas with neighboring MSAs, for the same reasons CMS treated micropolitan areas as rural when it adopted new labor market areas in FY 2005.

- Allow urban hospitals that qualify to be SCHs or rural referral centers other than being located in a rural area to reclassify using the special rules that apply to hospitals with such a status.

Response: We are not adopting any of the above recommendations in this final rule. We do not believe the reclassification rules should be modified to abolish the 108 percent test in the case of a hospital in a single-hospital MSA. The 108-percent test exists precisely to create a specific threshold for reclassifying and to ensure that a reclassifying hospital's own wages are significantly higher than the wages used in calculating the index of its home area. Allowing a hospital receiving 100 percent of its area wages to be exempt from this test, we believe, could potentially undermine the 108-percent test for all hospitals, and we are not certain how we would distinguish between a hospital with wages at, for example, 105 or 107 percent of its area wages and

the single hospital with a wage index at 100 percent of its area wages. We note that section 1886(d)(10)(D)(i)(I) of the Act specifically directs us to include in our reclassification guidelines "guidelines for comparing wages. . . in the area in which the hospital is classified."

We also disagree with the suggestion that we should combine adjacent urban areas into one labor market area where one of the MSAs has a single hospital. As we indicated above, the MSAs have consistently been used by CMS to designate geographic areas and there has been no consensus among interested parties in favor of any alternatives. Combining MSAs could also potentially disadvantage hospitals in the urban area with multiple hospitals. For the same reason, we also disagree with the suggestion of the commenter that indicated a hospital that meets all of the requirements to be an SCH or a rural referral centers except rural status should be able to take advantage of the special reclassification provisions that apply to hospitals with these designations. As rural hospitals, these hospitals are afforded advantages that do not apply to urban hospitals. Congress has repeatedly recognized the special circumstances of rural hospitals. For example, Congress, in section 1886(d)(10)(D)(iii) of the Act, exempted rural referral centers from certain wage comparison rules used in reclassification.

Finally, hospitals in single hospital MSAs already have another reclassification option available where the 108-percent test does not need to be met. A hospital in a single hospital MSA can apply to an adjacent area using the group reclassification rules. Under these rules, the hospital must be located in a county that is in the same CSA or CBSA as the urban area where they are seeking reclassification. The CSA and CBSA

requirement is intended to identify economic integration among different areas. To be part of an optional CSA, the OMB standard requires that there be at least a 15-percent employment interchange between the areas (25 percent for CBSAs). We do not see a need to exempt a hospital in a single hospital MSA from wage data comparison because it can apply to an adjacent MSA within the same CSA using the group reclassification rules without having to meet the 108-percent test. If a hospital in a single hospital MSA cannot meet group reclassification criteria because of the CSA standard, it means there is not a sufficient degree of employment interchange to suggest that the areas compete for the same labor.

7. Special Adjustment for Hospital Group Reclassification Denied on the Basis of Incomplete CSA Listing

In this final rule, we are also invoking our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act to adjust the wage index of a hospital group that failed to reclassify on the basis of incomplete OMB guidance for FY 2007 only. The hospital group in question timely applied to the MGCRB for geographic reclassification. On December 5, 2005, the OMB issued a bulletin, Bulletin 06-01, listing the MSAs that comprise various CSAs throughout the country. The bulletin did not include the hospital group's county as being part of the CSA to which the group sought reclassification. CMS regulations at 42 CFR 412.234 require a group to be in the same CSA as the urban area to which it seeks reclassification. Thus, the MGCRB properly denied the hospital group's request.

However, subsequent to the MGCRB denial, the OMB corrected its December 5, 2005 bulletin. On April 25, 2006 and then again on May 26, 2006, OMB issued correction bulletins stating that it had omitted from Bulletin 06-01 certain MSAs that should have been part of the CSA listing. The correction bulletin resulted in the hospital group becoming part of the same CSA as the urban area to which it had sought reclassification. However, by the time OMB issued its correction, the deadline for appealing the MGCRB denial to the Administrator (15 days from the date of the MGCRB decision) under 42 CFR 412.276(a) had passed. In addition, the time for the Administrator to issue a decision on his or her own motion (105 days following the issuance of an MGCRB decision) had also expired. As provided under §412.276(b), MGCRB decisions are final and binding unless reviewed and changed by the Administrator.

Four other hospital groups were affected by OMB's correction bulletin(s). However, all of these groups were able to receive a positive determination by the Administrator. In one case, the Administrator was able to toll the timeframe for deciding the group's appeal under §412.278(f)(2)(i). In the other three cases, the Administrator affirmed the MGCRB's decision but then amended the decision on May 30 within the 15 days allotted under §412.278(g)(2).

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." We believe it is appropriate in these circumstances to adjust the hospital group's wage index to reflect the reclassification it would have received had

OMB's initial CSA listing been complete. First, of the five hospital groups affected by the OMB bulletin(s), four were granted reclassifications under the procedures for Administrator review. Only the remaining hospital group was unable to reclassify because the deadline for the Administrator discretionary review expired on May 17, 2006, and the OMB did not issue its correction bulletin until May 26, 2006. The circumstances of the five cases are identical in that each was denied reclassification by the MGCRB by virtue of not meeting the CSA standard that was later corrected by OMB. We believe it would be inequitable for the one remaining hospital group to be the only group of the five similarly situated not to benefit from the correction of the errors to OMB Bulletin 06-01. Second, the MGCRB's decision was based upon an incomplete OMB listing. We do not believe the hospital group should experience an adverse determination solely on the basis of OMB omissions. Third, OMB issued its correction only 9 days after expiration of the discretionary review period for the Administrator to take review. Taken in conjunction, we believe that these three factors, the reclassification of all other similarly situated hospital groups; the governmental omission; and the closeness in time between OMB's correction and the expiration of the Administrator discretionary review period, support a special adjustment. We note that we are not retroactively granting a reclassification to the hospital group in question. Rather, we will adjust payment to reflect the wage index it would have received (for example, we will give the hospital group that wage index for hospitals reclassified to the requested area). The hospitals in the group will not receive the section 505 out-migration adjustment in FY 2007.

Finally, we note that the hospital group in question may reapply for geographic reclassification to the same area for the period FY 2008 through FY 2010. As specified in section III.H. of the preamble of this final rule, the deadline for FY 2008 reclassification applications is September 1, 2006. We encourage hospitals to closely review the special instructions provided in section III.H. of this preamble elsewhere in this final rule affecting the procedures for applying for reclassification for FY 2008, considering the unique circumstances of occupational mix wage adjusted average hourly wages not being available until after August 1 and prior to October 1.

H. Payment for Direct Graduate Medical Education

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99-272) and implemented in regulations at existing §§413.75 through 413.83, establishes a methodology for determining payments to hospitals for the costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act, as added by COBRA, 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 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 beginning 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 (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated each year for inflation. However, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that train primary care and obstetrics and gynecology residents, as well as nonprimary care residents in FY 1994 or FY 1995, have two separate PRAs: one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

Pub. L. 106-113 amended section 1886(h)(2) of the Act, effective October 1, 2000, to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000. Specifically, Pub. L. 106-113 established a "floor" for FY 2001 such that a hospital-specific PRA should not be less than 70 percent of the locality-adjusted national average PRA. In addition, it established a "ceiling" that froze or limited the annual inflation adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of Pub. L. 106-554 increased the "floor" established by Pub. L. 106-113 to equal 85 percent of the locality-adjusted national average PRA for PRAs in existence in FY 2002. Existing regulations at §413.77(d)(2)(iii) specify that, for purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor (for FY 2001 and FY 2002) and the ceiling (for FY 2001 through 2013) to determine whether a hospital-specific PRA should

be revised. We note that, under existing regulations at §413.77(c), if a hospital-specific PRA for FY 2001 or FY 2002 is revised due to application of the floor PRA, the revised PRA is the starting point for the PRA in future years, subject to the annual inflation adjustment and any other applicable adjustments.

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 Pub. L. 108-173 added section 1886(h)(7) of the Act which provided for one-time reductions 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 one-time "redistribution" of 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. Determination of Weighted Average Per Resident Amounts (PRAs) for Merged Teaching Hospitals (§413.77)

As stated in the background section above, in accordance with section 1886(h) of the Act, Medicare pays teaching hospitals for the direct costs of GME based on the per resident direct GME costs in a base year. For most hospitals, the base year is FY 1984 (cost reporting periods beginning between October 1, 1983, and September 30, 1984). Although section 1886(h) of the Act provides for the establishment of a PRA for a

hospital that trained residents in the 1984 base year, the statute does not address how to treat the PRA(s) of teaching hospitals that subsequently merge.

Our policy has always been that when two or more teaching hospitals merge, we determine a weighted average PRA for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each teaching hospital involved in the merger. This policy was detailed in Questions and Answers on Medicare GME Payments issued on November 8, 1990: "[When] two hospitals merge . . . the merged hospital's per resident amount . . . [is] based on the weighted average of the per resident amounts of both hospitals." We believe this is an equitable way to determine a PRA for the surviving merged hospital because it is based on the relative costs and sizes of the GME training programs in the respective facilities. Moreover, we believe this policy minimizes the role Medicare GME payments play in the choice of the surviving hospital entity. For example, there is no incentive to choose the surviving hospital based in part on the hospitals' relative PRAs.

To calculate the weighted average PRA for the merged entity, the fiscal intermediary begins by determining the base year PRAs and the base year FTE resident counts of the hospitals that merge. The weighted average PRA is calculated by adding the product of each hospital's base year PRA and its base year FTE resident count, and dividing that number by the total number of the base year FTE residents for those hospitals.

When our current methodology was first established for calculating the new PRA for a merged hospital, we adopted a policy to use base year PRAs and FTE resident

counts. It was appropriate and workable to use data from the PRA base year because the base year data (usually for the 1984 fiscal year) associated with the hospital-specific PRAs were easily accessible. However, these data are now often over 20 years old and it has become administratively burdensome for both CMS and the fiscal intermediaries to access base year information in calculating the weighted average of the PRAs for merged hospitals.

In addition to it being administratively burdensome to use base year cost report data, where a hospital has two PRAs (one for primary care and obstetrics and gynecology residents and another for nonprimary care residents), these two PRAs are not being taken into account in developing the weighted average PRA for the merged hospital. As discussed earlier, hospitals that were training nonprimary care residents in FYs 1994 and 1995 have a separate nonprimary care PRA because there was no update for inflation applied to the PRA for nonprimary care residents in those years (§413.77(c)(2)). Accordingly, many teaching hospitals currently have two PRAs: one for primary care and obstetrics and gynecology residents and one for all other residents. (Hospitals that first train residents after FY 1995 would only have a single PRA, even if they train both primary care residents and nonprimary care residents.) Because the current methodology for calculating the weighted average PRA for a merged teaching hospital is based solely on data from the PRA base year (which is usually prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents), this methodology does not take into account that the merged hospitals may currently have more than one PRA.

In the FY 2007 IPPS proposed rule (71 FR 24111 through 24113), we proposed, effective for cost reporting periods beginning on or after October 1, 2006, rather than using the direct GME FTE resident count and PRA from hospitals' base year cost reports, to simplify and revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. We believe it is less administratively burdensome to use these data because these data are more recent and, therefore, more accessible. In addition, these data would reflect both a primary care and obstetrics and gynecology PRA and, if applicable, a nonprimary care PRA.

We noted that, prior to FY 2003, our policy for calculating the PRA for a new teaching hospital was to calculate the PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same geographic wage area, as that term is used under the prospective payment system (existing §413.77(e)(1)). (For ease of discussion, we refer to a hospital that did not participate in Medicare or that did not have any approved medical residency training programs during the period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a "new teaching hospital.") The weighted average PRA of teaching hospitals within a particular geographic wage area was determined using the base year PRA and the base year FTE resident count of each respective teaching hospital within the geographic wage area. However, as discussed in the August 1, 2002 IPPS final rule (67 FR 50067) effective

October 1, 2002, we revised our policy to use PRAs and FTE resident data from the most recently settled cost reports of teaching hospitals in the same CBSA as the new teaching hospitals, rather than data from the 1984 base year (existing §413.77(e)(1)(ii)(B)). We revised this policy for establishing PRAs for new teaching hospitals because it is less administratively burdensome to use data from the hospitals' most recently settled cost reports and because the more recent data takes into account that hospitals have a primary care PRA and a nonprimary care PRA. In the FY 2007 IPPS proposed rule, we proposed a similar policy revision for establishing a merged teaching hospital's PRA.

We proposed that the fiscal intermediaries would use the following steps to calculate the weighted average PRA for the merged teaching hospital:

Step 1: Identify the primary care and obstetrics and gynecology FTE resident count, the nonprimary care FTE resident count for hospitals with two PRAs, or the single FTE resident count for hospitals with a single PRA, for each teaching hospital involved in the merger. (Use the sum of the FTE resident counts from Line 3.07, Line 3.08, and Line 3.11 of the hospital's most recently settled Medicare cost report, CMS 2552-96, Worksheet E-3, Part IV.)

Step 2: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA or, if applicable, a hospital's single PRA) from the most recently settled cost report for each hospital involved in the merger, and update the PRAs using the CPI-U inflation factor to coincide with the fiscal year end of the surviving teaching hospital. For example, if the surviving teaching hospital's fiscal year end is December 31, 2006, and the most recently settled cost report of the teaching

hospital(s) involved in the merger is June 30, 2003, the PRAs from this cost report would be updated for inflation to December 31, 2006.

Step 3: Calculate the weighted average PRA for the single merged hospital using the PRAs and FTE resident counts from Step 1 and Step 2. For each teaching hospital in the merger:

(a) For hospitals with two PRAs, multiply the primary care PRA by the number of primary care and obstetrics and gynecology FTE residents.

(b) For hospitals with two PRAs, multiply the nonprimary care PRA by the number of nonprimary care FTE residents.

(c) For hospitals with a single PRA, multiple the single PRA by the hospital's total number of FTE residents.

(d) Add the products from applicable Steps 3(a), (b), and (c) for all teaching hospitals that merged.

(e) Add the number of FTE residents from Step 1 for all hospitals.

(f) Divide the sum from Step 3(d) by the sum from Step 3(e). The result is the weighted average PRA for the merged hospital.

As mentioned above, many hospitals currently have two PRAs, one for primary care residents and another for nonprimary care residents. An advantage to using data from the most recently settled cost reports of the hospitals involved in a merger is that the two PRAs are taken into account in determining the weighted average PRA for the merged hospital. Because two PRAs would be taken into account under this proposal, we considered whether a primary care PRA and a nonprimary care PRA should, therefore, be

determined for the merged hospital. Although it would be possible to determine and retain two PRAs for a merged hospital when one or more hospitals involved in the merger had two PRAs, we did not propose to do so. We proposed that a single PRA also be determined for the merged hospital in this situation because it is more administratively straightforward for the fiscal intermediaries and the merged hospitals and since the merged hospital itself was not in existence in the years that the two PRAs were established (FY 1994 and FY 1995), we do not believe it is necessary to retain the two PRAs. Furthermore, because the two existing pre-merger PRAs are taken into account when establishing the single PRA for the merged hospital, and the statutory provision that resulted in the creation of two PRAs has no continuing effect (because the updates were prohibited only for FY 1994 and FY 1995), we see no compelling reason to continue to carry two PRAs for a merged hospital.

The following was presented as an example of how to calculate a weighted average PRA under the proposed revised methodology:

Example: Assume that Hospital A, Hospital B, and Hospital C merge and Hospital B with a fiscal year end of December 31, 2006, is the surviving hospital. In their respective most recently settled cost reports, Hospital A has 200 primary care and obstetrics and gynecology FTE residents and 150 nonprimary care FTE residents, and Hospital B has 50 primary care and obstetrics and gynecology FTE residents and 60 nonprimary care FTE residents. Hospital C became a teaching hospital in 2000 and has 25 FTE residents. After updating the primary care and nonprimary care PRAs for inflation by the CPI-U to December 31, 2006, Hospital A has a primary care PRA of

$120,000 and a nonprimary care PRA of $115,000, Hospital B has a primary care PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital C has a single PRA of $90,000.

(a) Primary care:

Hospital A: $120,000 x 200 FTEs = $24,000,000

Hospital B: $100,000 x 50 FTEs = $5,000,000

(b) Nonprimary care:

Hospital A: $115,000 x 150 FTEs = $17,250,000

Hospital B: $97,000 x 60 FTEs = $5,820,000

(c) Single PRA: Hospital C: $90,000 x 25 FTEs = $2,250,000

(d) $24,000,000 + $5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000

(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs

(f) $54,320,000/485 FTEs = $112,000, the weighted average of the hospitals involved in the merger for fiscal year end December 31, 2006.

Comment: One commenter commended our proposal to revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using direct GME FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. However, the commenter suggested that because a teaching hospital's reimbursement is calculated using the hospital's rolling average FTE count, and not the hospital's current year FTE count, the rolling average FTE count of merging hospitals (Lines 3.16 and 3.22 of Worksheet E-3, Part IV) should be used to determine a

merged teaching hospital's PRA. The commenter also pointed out that a new teaching hospital's FTE count only appears on Lines 3.16 and 3.22 and in the case where one of the hospitals involved in a merger is a new teaching hospital, if CMS were to use the current year FTE counts, the new teaching hospital's PRA would not be taken into account in the weighted average PRA determination for the merged hospital.

Response: We appreciate the commenter's support for the proposed policy revision; however, we disagree with the commenter's suggestion. The intent of the policy revision is to ease the administrative burden for hospitals and fiscal intermediaries by using more accessible cost reporting data for determining a merged hospital's weighted average PRA. We do not believe it is appropriate to change which FTE counts are used to make a PRA determination for a merged hospital. While it is true that the statute requires that direct GME payment be determined based on a 3-year rolling average of the hospital's FTE counts, that provision is intended by Congress to moderate the impact of year-to-year changes in hospitals' FTE counts. However, to calculate a weighted PRA for merging teaching hospitals, we believe it is appropriate to weight each hospital's PRA based on the FTE resident count for each hospital's current year. We do agree with the commenter that in the case of a merger that involves a new teaching hospital or an existing teaching hospital which, in accordance with 42 CFR 413.79(d)(5), included residents in "new teaching programs" on Lines 3.16 and/or 3.22 of Worksheet E-3, Part IV, the merged hospital's weighted average PRA will be computed by including the "new teaching program" FTE residents from those lines.Comment: One commenter suggested that a separate primary care PRA and nonprimary care PRA be determined for

a merged hospital. The commenter believed that because most existing teaching hospitals currently have two PRAs, it would be appropriate to determine two PRAs for a merged teaching hospital as well. In addition, the commenter believed that determining one PRA for a merged hospital might result in inaccurate reimbursement should the surviving hospital's mix of primary and nonprimary care residents or programs change significantly.

Response: Although we initially proposed to determine a single PRA for the merged hospital, after considering this comment, we are convinced that it is appropriate to determine two PRAs for a merged teaching hospital. Although we do not believe the determination of a single PRA for a merged hospital would necessarily result in "inaccurate reimbursement," we do recognize the commenter's point that the application of a single PRA for a merged hospital would be inconsistent with the application of two PRAs for most other teaching hospitals (typically, a lower one for residents in nonprimary care specialties), and could produce some unintended incentives. Specifically, we recognize that the two PRAs have the continuing effect of discouraging shifts from primary care and obstetrics and gynecology programs to nonprimary care programs. Therefore, we are revising the steps for calculating the weighted average PRAs for a merged teaching hospital. The following steps should be used by fiscal intermediaries to calculate the primary care weighted average PRA for a merged teaching hospital for mergers that occur on or after October 1, 2006:

Step 1: From the most recently settled cost report of each hospital involved in the merger, identify the primary care and obstetrics and gynecology FTE resident count (Line 3.07 and "new program" residents from Line 3.22 of Worksheet E-3, Part IV).

Step 2: From the most recently settled cost report of each hospital involved in the merger, identify the hospital's primary care and obstetrics and gynecology PRA (or a hospital's single PRA when applicable). Update the hospitals' PRAs to the midpoint of the surviving provider's cost reports that precede the cost report in which the merger occurs using a special CPI-U inflation factor obtained from the CMS Central Office. All of the merging hospitals' PRAs should be updated to coincide with the surviving hospital's fiscal year end for the cost reporting period prior to the merger. (For example, if the surviving teaching hospital's cost reporting period fiscal year end prior to the merger is December 31, 2006, and the most recently settled cost report of the teaching hospital(s) involved in the merger is June 30, 2003, the PRAs from this cost report would be updated for inflation to December 31, 2006).

Step 3: Calculate the weighted average primary care PRA for the merged hospital using the PRAs and FTE resident counts from Steps 1 and 2.

(a) For hospitals with two PRAs, multiply the primary care PRA by the number of primary care and obstetrics and gynecology FTE residents.

(b) For hospitals with a single PRA, multiply the single PRA by the number of primary care FTE residents.

(c) Add the products from each hospital from Steps 3(a) and (b).

(d) Add the number of FTE residents from each hospital from Step 1.

(e) Divide the sum from Step 3(c) by the sum from Step 3(d). The result is the weighted average primary care PRA for the merged hospital.

Fiscal intermediaries will follow these same steps to calculate the weighted average nonprimary care PRA for a merged teaching hospital. For the weighted average nonprimary care PRA, the merging hospitals' nonprimary care FTE counts (Lines 3.08 and 3 11 and "new program" residents on Line 3.22 from Worksheet E-3, Part IV) and nonprimary care PRAs (or a single PRA for a hospital with one PRA) should be used.

Comment: One commenter requested that CMS provide a detailed example that includes the merger date and the fiscal year ends for each merging hospital's cost report.

Response: The following is a detailed example of how a weighted average primary care PRA would be determined for a merged hospital. The changes to the proposed policy revision discussed previously have been incorporated into this example.

Example: Assume that Hospital A, Hospital B, and Hospital C will merge on February 1, 2007. On their most recently settled cost reports, Hospital A has 200 primary care and obstetrics and gynecology FTE residents, Hospital B has 50 primary care and obstetrics and gynecology FTE residents, and Hospital C has 10 primary care and obstetrics and gynecology FTE residents. The surviving hospital is Hospital C whose fiscal year end prior to the merger is December 31, 2006. Hospital A's and Hospital B's most recently settled cost report is September 30, 2002 and Hospital C's most recently settled cost report is December 31, 2003. Since Hospital C is the surviving provider and Hospitals A and B have fiscal year ends (that is, September 30, 2006) that differ from the fiscal year end of Hospital C (that is, December 31, 2006), Hospitals A and B's PRAs

must be made concurrent with the PRA of Hospital C for fiscal year end December 31, 2006. The fiscal intermediary should contact the CMS Central Office for special update factors and for instructions on making the PRAs concurrent. Additional special update factors will be necessary to determine the direct GME payment, pre-merger and post-merger, as indicated in response to the next comment. After updating the PRAs for inflation by the appropriate CPI-U update factor to December 31, 2006, Hospital A has a primary care PRA of $120,000, Hospital B has a primary care PRA of $100,000, and Hospital C has a single PRA of $90,000.

(a) Hospital A: $120,000 X 200 FTEs = $24,000,000

Hospital B: $100,000 X 50 FTEs = $5,000,000

(b) Hospital C: $90,000 X 10 FTEs = $900,000

(c) $24,000,000 + $5,000,000 + 900,000 = $29,900,000

(d) 200 + 50+ 10 = 260 total FTEs

(e) $29,900,000/260 FTEs = $115,000, the weighted average primary care PRA for Hospital C, the surviving hospital, effective February 1, 2007, the date of the merger. The weighted average nonprimary care PRA would be calculated using the merging hospitals' nonprimary care FTE counts and nonprimary care PRAs (or single PRA for Hospital C).

Comment: One commenter requested clarification on how CMS would treat a merger that occurs in the middle of the surviving hospital's cost reporting period. More specifically, the commenter questioned whether, in such a situation, the surviving hospital would have two PRAs, a pre-merger PRA and post-merger PRA.

Response: In the case described by the commenter, the surviving hospital would indeed be reimbursed with two sets of PRAs, a set of pre-merger PRAs and a set of post-merger PRAs. To calculate the direct GME payment for the surviving hospital for the cost reporting period in which the merger occurred, the fiscal intermediary performs a series of off-the-cost-report calculations, treating the pre-merger and post-merger periods of the surviving hospital's cost reporting period as if they are two short cost reporting periods. The fiscal intermediary would first calculate the direct GME reimbursement for the surviving hospital for the portion of the cost reporting period prior to the merger using only the surviving hospital's FTEs and PRA(s) and Medicare utilization rate. Second, the fiscal intermediary would calculate the surviving hospital's post-merger direct GME reimbursement using the weighted average PRA(s) updated with special CPI-U factors, a combined rolling average FTE count reflecting the merged hospitals' FTEs, and a combined Medicare utilization rate reflecting the portion of the cost reporting period after the merger. Then the fiscal intermediary would add the pre-merger and post-merger payments to determine the surviving hospital's total reimbursement for that cost reporting period. (Note that, although not the topic of this discussion, similar pre-merger and post-merger calculations are done for the resident-to-bed ratio for IME purposes as well).

Comment: One commenter believed that varying methodologies have been used in the past to determine the PRA for a merged teaching hospital and that our statement in the proposed rule that CMS' policy "has always been that when two or more teaching hospitals merge, we determine a weighted average PRA for the surviving merged

hospital" is inaccurate. The commenter further believed that the reference to the 1990 GME questions and Answers is poor evidence that CMS' current policy is to determine a weighted average PRA for the surviving merged hospital. Finally, the commenter believed that CMS should promulgate a policy that gives latitude to a merged hospital to have a PRA determined that takes into consideration the surviving hospital's post-merger operations. The commenter suggested that CMS adopt a policy that provides a merged hospital the option of having its PRA determined as the weighted average PRA or the surviving provider's PRA.

Response: We disagree with the commenter's assertion that varying policies have been used in the past to determine the PRA for a merged hospital. In addition to the 1990 Questions and Answers on Medicare GME Payments, we have consistently expressed our policy to determine a weighted average PRA for a merged hospital. For example, our policy was clearly cited in the May 12, 1998 **Federal Register** (63 FR 26239) in which we state that "in implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger." We have worked with numerous fiscal intermediaries in determining weighted average PRAs for merged hospitals and are unaware of any instance that a weighted average PRA was not determined for a merged hospital.

Our current policy, as revised by this final rule, applies prospectively for cost reporting periods beginning on or after October 1, 2006. Our main concern in making

these clarifications and changes to our policy is to adopt a policy that can be applied consistently and that recognizes the nature of a merger of hospital entities. We believe it is appropriate to adopt a policy that takes into account each of the various merging hospitals' preexisting, statutorily established PRAs. We have adopted a policy under which the PRA(s) determined for a merged hospital is based on the weighted average of the different merging hospitals' PRAs precisely because it takes all of the merging hospitals' PRAs into account. We do not believe it is appropriate to provide a merged hospital the option of adopting the surviving hospital's PRA instead of the average weighted PRA because, aside from the fact that such a policy would ignore the fact that the merger is a result of multiple hospitals with individual PRAs joining together, such a policy could inappropriately provide an incentive to choose the surviving hospital based on which surviving hospital's PRA would yield the highest reimbursement.

Comment: Several commenters requested that this policy revision be included as a provision in the regulatory text of §413.77, the regulation that deals with the determination of PRAs.

Response: We agree with the commenters. In this final rule, we are revising §413.77 by adding a new paragraph (h) to reflect the policy on determining the PRA for the surviving hospital when multiple hospitals merge, effective October 1, 2006.

3. Determination of Per Resident Amounts (PRAs) for New Teaching Hospitals (§413.77(e))

As we discussed earlier in the background portion of this section, the hospital-specific, base-period PRA used in the payment methodology for determining

Medicare direct GME payments is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of residents in that base period. In the case of a hospital that did not train residents in its FY 1984 cost reporting period, a PRA is determined by comparing and taking the lower of a PRA based on direct GME costs and FTE residents in a base year or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. For ease of discussion, we refer to a hospital that did not participate in Medicare or have any approved medical residency training programs during the base period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a "new teaching hospital." A new teaching hospital's PRA is established by using the lower of its hospital-specific PRA based on the actual allowable direct GME costs and FTE residents during a base period as defined in §413.77(e) or the updated weighted mean value of PRAs of other teaching hospitals in the same geographic area.

Existing regulations at §413.77(e) specify that the base year for establishing a PRA for a new teaching hospital is the first cost reporting period in which the new teaching hospital participates in Medicare and the residents are on duty during the first month of that period. If the new teaching hospital begins training residents but does not have residents on duty during the first month of the first cost reporting period in which training occurs, the new teaching hospital is paid on a reasonable cost basis under §413.77(e) for any GME costs incurred by that hospital during that period. The intent of this policy for new teaching hospitals is to make a more accurate determination of a PRA

based on the hospital's per resident direct GME costs in a cost reporting period in which GME costs have been incurred for that entire period. As we noted in a response to comments in a final rule published in the **Federal Register** on September 29, 1989 (54 FR 40310), we believe that where the new teaching hospital's cost reporting period begins on a date other than July 1 (the beginning of the academic year), for example, October 1 or January 1, the cost reporting period that includes costs and resident counts from the first year of the training program may not be reflective of the actual average costs per resident of the program because the full complement of residents might not be on duty, and those that are on duty might be receiving a salary for as few as 1 or 2 months of the cost reporting period. In the usual case, training in the program would continue into the following cost reporting period and residents would thus be on duty in the first month of this next cost reporting period. Consequently, our existing regulations at §413.77(e)(1) specify that the PRA is to be determined by using the cost and resident data from the first cost reporting period during which residents are training in the first month of the cost reporting period.

It has come to our attention that, in rare instances, it is possible for a new teaching hospital, either through happenstance or by purposeful gaming of the policy, to continue to be reimbursed for direct GME costs on a reasonable cost basis even beyond the first cost reporting period during which residents begin training at the hospital as long as no residents are on duty at the new teaching hospital in the first month of the subsequent cost reporting period(s). We believe this scenario is contrary to the statutory intent of section 1886(h) of the Act, which instructs that instead of payment on a reasonable cost basis, the

Secretary is to determine and base direct GME payments on a PRA for each hospital with a residency program. For that reason, in the FY 2007 IPPS proposed rule (71 FR 24113), we proposed to revise §413.77(e)(1) and (e)(1)(i) to provide that we will make a PRA determination even where residents are not on duty in the first month of a cost reporting period but where residents began training at the hospital in the prior cost reporting period. We proposed that, effective for cost reporting periods beginning on or after October 1, 2006, if a new teaching hospital begins training residents in a cost reporting period beginning on or after October 1, 2006, and no residents are on duty during the first month of that period, the fiscal intermediary establishes a PRA for the hospital using the lesser of: (1) the cost and resident data from the cost reporting period immediately following the one for which GME training at the hospital was first reported (that is, the base period); or (2) the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. We note that, as with existing policy, the base year need not be a full cost reporting year.

Comment: One commenter noted that CMS should clarify that the PRA will be based on "the lesser of" the cost and resident data from the cost report, or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area.

Response: We agree with the commenter and have revised the language in the preamble of this final rule accordingly.

After consideration of the public comments received, we are adopting as final, without modifications, the proposed changes to §413.77(e)(1) and (e)(1)(i) to provide that "effective for cost reporting periods beginning on or after October 1, 2006, if a new

teaching hospital does not have residents on duty during the first month of that period, the PRA will be determined using information from the cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital even if the residents are not on duty during the first month of that period."

4. Requirements for Counting and Appropriate Documentation of FTE Residents: Clarification (§§412.105(f), 413.75(d), 413.78(b) and (e), 413.80, and 413.81)

Despite the fact that current policies concerning the counting of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions on the proper counting and appropriate documentation for FTE residents for IME and direct GME payment purposes. As a result of these continuing questions, in the FY 2007 IPPS proposed rule (71 FR 24113), we included a clarification of policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes.

In the existing regulations at §413.78(b) for direct GME payments, we specify that no individual may be counted as more than one FTE, and that a hospital cannot claim the time spent by residents training at another hospital. Therefore, if a resident spends time training in more than one hospital, the residents counts as a partial FTE based on the portion of time the resident trains at the hospital (and a nonhospital setting if the hospital meets the requirements of §413.78(e)) to the total time worked. (The same provisions apply to part-time residents as specified in §413.78(b)). A similar policy exists at §412.105(f)(1)(ii) and (iii) for purposes of counting FTE residents for IME payment

purposes. As we have explained in previous **Federal Register** documents (55 FR 36064 and 67 FR 50077), these policies apply even when a hospital actually incurs the cost of training the resident(s) at another hospital(s). For example, during a cost reporting year, a full-time resident trains at Hospital A for 6 months and trains at Hospital B for 6 months. Hospital A is paying the salary and fringe benefits of the resident for the entire year. In this case, each hospital would only count 0.5 of an FTE at the most for that resident. Hospital A would not be able to count the entire FTE for that resident, regardless of the fact that it incurred all of the training costs for the resident during that training year.

We also have become aware of issues that have arisen due to a hospital's failure to document the number of FTE residents claimed on its cost report. Proper documentation is required so that Medicare fiscal intermediaries can determine where and when a resident(s) is training and to allow the fiscal intermediary to make payment to the hospital based on the time the resident(s) spends at the hospital, which may be a percentage of the total time trained. A rotation schedule is the primary documentation that can be used to support the direct GME and IME resident counts but other similar documentation may be acceptable. The following is a situation about which we learned that illustrates how inadequate documentation resulted in inappropriate counting of FTEs. Two hospitals, Hospital C and D, were "associated" with each other, with residents training at both hospitals. However, instead of differentiating between the number of FTEs and the actual amount of time spent at each hospital, Hospitals C and D split the FTEs 50/50. Since, in reality, the number of residents actually training at each hospital

differed, splitting the FTE count 50/50 resulted in inappropriate payment to both hospitals. Hospitals are not permitted to decide among themselves how their FTEs will be counted. A hospital may not count a greater number of FTE residents than is actually training at the hospital (or its nonhospital sites) during the year. Each hospital must have documentation which demonstrates, for the entire cost reporting period, the amount of time that the resident trained at the hospital and, if applicable, a nonhospital site. Furthermore, to the extent that residents train in nonhospital sites, the hospital claiming the FTEs in the nonhospital site must meet the requirements at §413.78(e).

Situations such as the one described above involving Hospital C and Hospital D are particularly harmful when one or more of the hospitals involved incorrectly reported FTEs in the cost reporting period used to establish one or more of the hospitals' FTE resident caps, and as a result, the caps were established incorrectly. Unless the incorrect caps can be revised pursuant to our regulations regarding review and revision of agency determinations, those caps must be applied to the hospital(s) in future years. For instance, we have learned of situations where a hospital's FTE resident caps were established incorrectly a number of years earlier and, due to administrative finality of settled cost reports, can no longer be adjusted. However, going forward, that cap will be applied to the hospital’s count of FTEs, which must reflect the number of FTE residents actually training in the hospital (or in nonhospital sites where applicable).

In order to ensure that FTEs are being properly counted, hospitals are required to furnish specific documentation to support the number of FTE residents included in the hospital’s FTE count. Section 413.75(d) specifies the requirements concerning

documentation of FTE residents. Proper documentation must include the following information: the name and social security number of the resident; the type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs; the dates the resident is assigned to the hospital and any hospital-based providers (similar to the rotation schedule); the dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any; and the name of the employer paying the resident's salary. In addition, the documentation should include the name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation, and whether the resident is a foreign medical graduate, including documentation concerning whether the resident has satisfied the regulatory requirements for foreign medical graduates at §413.80. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program. Again, proper documentation on where and when a FTE resident is training during a cost reporting period is essential in order for the hospital to receive direct GME and IME payments based on the correct number of FTE resident(s). Inaccurate, incomplete, or inappropriate documentation will lead to Medicare disallowing certain FTE residents from being counted for purposes of direct GME and IME payments. We note that we are <u>not</u> expanding or making any changes to current policy for proper documentation of FTEs. Rather, we are clarifying the existing regulations concerning proper counting and documentation of FTEs.

Comment: Several commenters noted that the issue of proper documentation has been a frequent topic of discussion between teaching hospitals and fiscal intermediaries and that concerns involving the "lack of uniform standards" for documentation, burdens related to "duplicative documentation requests," and matters pertaining to the "Medicare audit process" have been communicated to the CMS central office. Several commenters asserted that the Medicare Intern and Resident Information System (IRIS) is used by many teaching hospitals as a means of documentation and verification of FTE resident rotations and counts. One commenter noted further that since teaching hospitals and fiscal intermediaries use the IRIS "...as the key reporting tool for resident information..," CMS should contribute further resources and consideration to maintaining the IRIS and ensuring that the program itself and its technical support systems are “state-of-the-art.” Specifically, the commenter stated that because CMS is the agency responsible for the management of the Medicare program, it has the responsibility to update the IRIS so that it is a "user-friendly" tool for teaching hospitals. In addition, the commenter noted that because the IRIS has not recently been updated, teaching hospitals have had to rely on private software in order to use the IRIS. The commenter stated that it is inappropriate that teaching hospitals have had to rely on private software to make the IRIS work. The commenter suggested that CMS form an IRIS task force comprised of "...CMS policy staff, CMS audit staff, and industry and intermediary representation..." to attend to concerns involving the IRIS.

Response: We believe that §413.75(d) clearly specifies the documentation that is required to allow a hospital to count FTE residents for Medicare payment purposes.

However, we encourage hospitals and fiscal intermediaries to contact CMS with questions they have about proper documentation. With regards to the use of the IRIS in determining a hospital's FTE resident count and as a source for documentation purposes, we note that currently the IRIS does not contain all of the specific documentation requirements cited under §413.75(d) and §412.105(f)(1). Furthermore, the IRIS does not serve as the evidence/documentation that supports the accuracy of the FTE resident counts reported in the cost report, which is the subject of section IV.H.4. of this preamble. The hospitals prepare the IRIS using actual records (for example, rotation schedules or similar documentation) that could be proper evidence/documentation to support the accuracy of the FTE resident counts reported in the cost report. In addition, we are aware that, for whatever reasons, the FTE resident counts computed using the IRIS information do not always match the FTE resident counts reported in the related cost reports. Thus, the IRIS is not, in itself, a sufficient mechanism for hospitals to meet their obligation to furnish information required under §413.75(d) to support the FTE resident counts reported in the cost report. We emphasize that rotation schedules or other similar documentation should stand as the primary evidence to support hospitals' FTE resident counts. Regarding the commenter's assertion that it is inappropriate that teaching hospitals have had to rely on a private software program for IRIS use, we note that CMS does not mandate that fiscal intermediaries purchase separate software packages to supplement the IRIS. Where the hospitals or the fiscal intermediaries utilize a private software program for the IRIS, those fiscal intermediaries can use the IRIS in

conjunction with the rotation schedule or similar documentation as an audit tool to identify duplicates, that is, the counting of the same resident by more than one hospital.

Comment: One commenter noted that in order for hospitals and intermediaries to determine proper GME reimbursement improved guidance and reporting systems are necessary, and that, without better guidance, mistakes will continue to be made by hospitals and intermediaries. Furthermore, the commenter stated that in order to maintain a cost effective policy, GME payment policy should be evaluated from time to time "…to determine operational efficiency and effectiveness." The commenter stated that maintaining a cost effective approach includes limiting disagreements between teaching hospitals and fiscal intermediaries which requires that Medicare direct hospitals and fiscal intermediaries, "...on the spirit and intent of the law." The commenter stated that, although the law imparts that payment be rooted in rules of nongovernmental organizations, "...such as the American Council of Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS)," the rules of these organizations "...are not enforced rigidly and do not have the force of the law." The commenter understands that policy cannot cover every issue but stated that "...financial auditors will not allow a situation unless it is specifically addressed in regulation and other directives."

The commenter asserted that, "improper payment is usually due to the intermediaries' lack of knowledge about a policy or misunderstanding about the GME rules and, [t]o remedy the fact that intermediaries are not well versed in many of the basic principles required for GME audit work, there is a need for Medicare GME payment

specialists." In addition, the commenter stated that hospitals must deal with inconsistencies from year to year due to different auditors and the auditors' requirements for documentation. The commenter further stated that Medicare policies established to adhere with the law are instituted without an adequate understanding of how teaching programs and hospitals function. The commenter asserted that it is time to provide further guidance to fiscal intermediaries and hospitals on Medicare GME payment policy and one way CMS could provide further guidance is to revise the Provider Reimbursement Review Manual (PRM) instead of issuing instructions through multiple **Federal Registers**.

In addition, the commenter stated that a cost effective measure to take to correctly count FTE residents would be to modify the IRIS because the system currently does not incorporate sufficient information to meet the regulatory requirement to report all training locations for an individual resident, and only identifies a range of dates where some FTE time is counted for the same resident by more than one hospital. Furthermore, the commenter stated that fiscal intermediaries interpret software limitations as the need for hospitals to provide supplementary documentation. The commenter noted that "[i]n practice, neither the intermediary nor the hospitals have followed the regulatory requirement to report all training locations of a resident" and therefore recommended that "…CMS clarify that hospitals must obtain a report from the entity sponsoring the training program that lists each resident's training location." Furthermore, the commenter asserted that "[t]he intermediary's level of acceptable documents has been increasingly stringent..." and that there have been occasions where disallowances have occurred

because the submitted documentation did not meet individual intermediary requirements. The commenter also provided other examples of situations where auditors have disallowed FTE residents.

Response: We acknowledge that the PRM should be revised and updated to incorporate current GME policies. However, we disagree with the commenters' assertion that not enough guidance is provided to teaching hospitals concerning Medicare's GME payment policies. In addition to clarifying policy through public Q&As and **Federal Registers**, we meet with teaching hospitals and intermediaries on hospital-specific issues and with associations representing teaching hospitals in order to clarify GME policy. We urge hospitals and fiscal intermediaries to contact us regarding questions they have about appropriate documentation. With regards to the use of the IRIS in determining a hospital's FTE resident count, we note that the IRIS is only intended to serve as an audit tool to help identify duplicates and does not contain all of the specific documentation requirements listed under §413.75(d) and §412.105(f)(1) and, therefore, additional documentation is required. As previously mentioned, the fact that the IRIS does not meet the regulatory provision to report all training locations for an individual resident is not the only reason that the IRIS cannot serve as the evidence/documentation to support the accuracy of the FTE resident counts reported in the cost report. Modification of the IRIS would not eliminate the need for auditable evidence to support the cost report and the information included in the IRIS. We specified in the preamble background and the previous response in this section that CMS considers the rotation schedules or similar documentation as the primary evidence to support the FTE resident counts. In response

to the commenter's recommendation that sponsoring institutions submit documentation listing residents' training locations, the rotation schedules are prepared by the Director of the GME program of the sponsoring institution. These types of rotation schedules should be used by the hospital to determine the cost report FTE resident counts and be furnished by the hospital to the fiscal intermediary when requested for audit purposes.

Comment: One commenter noted that the documentation submitted in accordance with §413.75(d) needs to be certified by an official of the hospital or by an official responsible for administering the residency program. The commenter was unclear as to what exactly needs to be certified, and in what format, and asked if submission and certification of the IRIS report meets the certification requirement.

Response: The IRIS report does not contain all the information listed in §413.75(d) or §412.105(f)(1). Therefore, in itself, it does not meet all the requirements of these sections regardless of whether it is certified or not. Therefore, in addition to submitting the IRIS report, the hospital must submit the other documentation elements specified in §413.75(d), and those must be certified by a hospital or GME program official.

Comment: One commenter expressed concern over the policies regarding the proper counting of FTE residents. Specifically, the commenter expressed dismay that a hospital can count resident training time for GME payment purposes when the resident rotates to a nonhospital site but not when a resident is training at another hospital even if the teaching hospital is incurring all the training costs of that resident at that other hospital. The commenter noted that this policy is particularly detrimental to emergency

medicine. The commenter stated that the Accreditation Council for Graduate Medical Education (ACGME) sets forth a required case volume for residency training in emergency medicine and that this volume requirement limits the number of rural emergency medical residency training programs. The commenter noted that in an effort to provide residents in emergency medicine with experience in rural practice, attempts have been made to expand training to rural hospitals. The commenter noted that since few small rural hospitals "…want to undertake the burden of becoming teaching hospitals in their own right…," the major teaching hospitals have continued to pay the costs of those residents training at the rural hospitals. The commenter stated that the current policy opposes efforts of governmental agencies to increase training in rural areas and further stated that more residency program directors would make rural training available if they were permitted to continue to count residents that were rotating to rural hospitals. The commenter urged CMS to change its policy to allow payment to the primary teaching institution for resident time spent in rural hospitals in situations where it is not economically feasible for the rural hospital to become a teaching hospital.

Response: We agree that efforts should be made to ensure that residency training is occurring at rural facilities so that residents are prepared to work in these environments upon completion of their residency training programs. However, we do not believe that it is consistent with the requirements at sections 1886(d)(5)(B)(IV) and 1886(h)(4)(E) of the Social Security Act to expand the policy to allow hospitals to count residents training at rural hospitals even if the hospital seeking to count the resident is paying the cost of training for those residents rotating to the rural hospital. In addition, section

1886(h)(4)(B) of the Social Security Act requires that the regulations take into account individuals who serve as residents simultaneously in more than one hospital. Therefore, we believe that the statute contemplates allowing a hospital to count only those residents actually training in that hospital. We do not believe it is appropriate for the "primary" teaching hospital to include time spent by residents at other hospitals in its FTE count, even when the "primary" teaching hospital is incurring the costs of training the residents.

Comment: One commenter stated that fiscal intermediaries may be using the IRPs set forth in the August 30, 1996 **Federal Register**. The commenter noted that in the August 30, 1996 **Federal Register**, CMS set an IRP of 2 years for podiatry residency programs. The commenter noted, however, that since at least 2003, the Council on Podiatric Medical Education (CPME) has stated that there exists both a 2-year podiatric medicine and surgery-24 program and a 3-year podiatric medicine and surgery-36 program. The commenter requested that all intermediaries use the most recent information regarding the length of the relevant training programs as set forth by the relevant accrediting organizations, in this case the CPME.

Response: We did not propose any changes in policy regarding IRPs in the FY 2007 IPPS proposed rule. We consider this comment out of the scope of the proposed rule. Therefore, we are not responding to this comment at this time.

5. Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Programs (§§413.9 and 413.78(a))

In section IV.H.4. of this preamble, we discussed the importance of properly documenting where and when residents are training in a particular hospital or nonhospital

site, in order for that hospital to count those FTE residents for purposes of direct GME and IME payment. In addition, it is important for hospitals to be able to document the activities in which residents are engaged because there are certain activities that are not allowable for direct GME or IME payment purposes, even though those activities may be performed as part of an approved residency program. Specifically, it has come to our attention that there may be some confusion in the provider community as to whether the time that residents spend in nonpatient care activities that are part of the approved residency program may be counted for the purpose of direct GME and IME payments. We have most recently received questions as to whether the time residents spend in nonhospital sites in didactic activities such as journal clubs or classroom lectures may be included in determining the allowable FTE resident counts. To respond to these inquiries and to resolve any confusion, in the FY 2007 IPPS proposed rule (71 FR 24114 and 24115), we included a clarification of our policy concerning the counting of time spent in nonpatient care activities for the purpose of direct GME and IME payments in both hospital and nonhospital settings.

With respect to training in nonhospital settings, the time that residents spend in nonpatient care activities as part of an approved program, including didactic activities, cannot be included in a hospital's direct GME or IME FTE resident count. This longstanding policy is based on the statutory requirements for counting FTE residents training in nonhospital sites. For the purpose of direct GME payments, providers have been allowed since July 1, 1987, to count the time residents spend training in nonhospital sites under certain conditions. Section 1886(h)(4)(E) of the Act specifies that the

implementing regulations concerning computation of direct GME for training in nonhospital sites "shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting" (emphasis added).

For IME payment purposes, hospitals were first allowed to count the time residents spend training in nonhospital sites for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended by Pub. L. 105-33 in 1997 to provide that "all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting" (emphasis added).

We understand that, as part of an approved medical residency program, residents are often required to participate in didactic and "scholarly" activities such as educational conferences, journal clubs, and seminars. Some of these activities may take place in nonhospital sites, such as freestanding clinics or physicians' offices, or in conference rooms at nonhospital settings. In implementing section 1886(h)(4)(E) of the Act for direct GME payment purposes, we specifically stated that "only time spent in activities relating to patient care may be counted [in nonhospital sites]" (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents

to be counted in nonhospital sites for IME, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). While we have not explicitly defined in regulations "patient care activities," we have applied the plain meaning of that term. In addition, we note that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary "patient care." The longstanding regulation at 42 CFR 413.9, entitled "Costs related to patient care," states that "all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." Thus, the scope of costs recognized as reasonable under Medicare had been limited to those relating to "patient care," or to those relating to covered services for the care of beneficiaries. Although the agency appears to have made a conflicting statement in a letter directed to a particular individual implying that didactic time spent in nonhospital settings could be counted for direct GME and IME, that statement was inaccurate. We have applied and continue to apply the plain meaning of the statutory terms "patient care activities" and "activities relating to patient care" in the context of approved GME programs. That is, the plain meaning of patient care activities would certainly not encompass didactic activities. Rather, the plain meaning refers to the care and treatment of particular patients, or to services for which a physician or other

practitioner may bill. Time spent by residents in such patient care activities may be counted for direct GME and IME payment purposes in the nonhospital site. Time spent by residents in other activities in the nonhospital site that do not involve the care and treatment of particular patients, such as didactic or "scholarly" activities, is not allowable for direct GME and IME payment purposes.

We note that there is a difference in the rules for counting FTE resident time for IME and direct GME payments when residents are training in a hospital. For direct GME payment purposes, under §413.78(a), "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 **Federal Register** document (54 FR 40286), the hospital complex consists of the hospital and the hospital-based providers and subproviders. Therefore, the distinction between patient care activities and nonpatient care activities is not relevant to direct GME FTE count determinations when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at §413.9, only time spent in patient care activities in the hospital may be counted. It has been our longstanding policy that, regardless of the site of training, "…we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care…" (66 FR 39897, August 1, 2001).

Comment**:** Many commenters took issue with CMS's "clarification" that FTE resident time spent in didactic activities while training in the hospital could not be counted for purposes of IME payment, and while training in a nonhospital site could not be counted for either direct GME or IME payments. The commenters urged CMS to

"revert" to the position expressed in a letter in 1999, and questioned whether, in light of that 1999 letter, CMS is actually "clarifying" its policy rather than changing existing policy. One commenter suggested that to "avoid challenges" to CMS's policy, a definition of "patient care activities" should be promulgated under the Administrative Procedures Act (APA). Another commenter argued that it is "improper" for CMS to exclude nonpatient care time from the IME count for fiscal years prior to 2001 (as the April 25, 2006 proposed rule would) because CMS did not enact regulations requiring the exclusion of nonpatient care activities from the IME count until 2001. The commenter observed that in the April 25, 2006 proposed rule, as in the 2001 rule (66 FR 39898), CMS stated that the rule excluding nonpatient care time from the IME count was "longstanding" policy and applies to periods prior to 2001. The commenter asserted that it is inappropriate for the agency to apply the policy expressed in the April 25, 2006 proposed rule retroactively (as was done in 2001) because it "amends the agency's policy prior to 2001 without notice and comment rulemaking as required by the APA." Another commenter noted that, as justification for CMS's "longstanding policy" concerning patient care activities, CMS quoted from the August 1, 2001 final rule (66 FR 39897) which states that "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care . . .." The commenter stated that CMS "failed" to include the remainder of the text, which states "but are instead engaged exclusively in research." The commenter argued that the excluded phrase indicates that CMS only meant to exclude research activities that are not patient-related from the IME count, and that "nowhere is the word 'didactic' ever mentioned."

Response**:** We disagree with the commenters' assertion that the provision in the proposed rule concerning the time residents spend in nonpatient care activities is a change in policy, rather than a clarification of existing policy. With respect to residency training occurring in nonhospital settings, in the April 25, 2006 proposed rule (71 FR 24115), we enumerated several examples to illustrate that the requirement for residents to spend time in patient care activities is fundamental to including the FTE resident time in the count for direct GME and IME purposes. Specifically, in implementing section 1886(h)(4)(E) of the Act, which allows hospitals to count time spent by residents training in nonhospital sites for direct GME payment purposes under certain circumstances including that the resident time be spent in activities related to patient care, we reiterated that "only time spent in activities relating to patient care may be counted" (54 FR 40292, September 29, 1989). In 1998, when we implemented section 1886(d)(5)(B(iv), which first allowed hospitals to count time spent by residents in nonhospital sites for purposes of IME under certain conditions including that the resident time be spent in patient care activities, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). In addition, we noted in the April 25, 2006 proposed rule that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments.

While we have not explicitly defined "patient care activities" in regulations, we have consistently used the plain meaning of that term. This is the case despite the

agency's erroneous response to a question on this issue in a September 24, 1999 letter. The commenters refer to this 1999 letter to support their argument that the "clarification" in the proposed rule demonstrates that CMS has changed its position since 1999. In the September 24, 1999 letter, CMS (then HCFA) wrote:

"HCFA interprets the phrase 'patient care activities' broadly to include any patient care oriented activities that are part of the residency program. . . . [T]his can include resident participation in "1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and 2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty."

As we stated in the April 25, 2006 proposed rule (71 FR 24115), in this September 24, 1999 letter, we inaccurately stated our interpretation of the phrase "patient care activities," implying that didactic time spent in nonhospital settings could be counted for direct GME and IME purposes. While there is no explanation of the phrase "patient care activities" in the conference report language accompanying the change in the laws allowing the counting of FTE residents in nonhospital sites in 1987 for direct GME and in 1997 for IME, we believe that Congress intended to limit in some meaningful way the types of activities for which FTE resident time could be counted in the nonhospital setting. If the term "patient care" in the statutory phrase "only time spent in activities relating to patient care" (section 1886(h)(4)(E) of the Act) was to be interpreted as broadly as suggested in the agency's September 24, 1999 letter, there would be virtually

no limit to the types of activities that could be counted, rendering the entire phrase, and particularly, the word "only," meaningless. If Congress had desired that *all* FTE time as part of an approved program be counted in nonhospital sites, then it need not have added the limiting language concerning patient care. It could have stated simply that time spent in an approved program at a nonhospital site should be counted. We do not believe that Congress would have included a superfluous phrase in the statute. As the commenters point out, CMS had not defined the term "patient care" prior to the enactment of either of the statutory provisions in 1987 and 1997. Therefore, we believe that when Congress used the term "patient care", it meant to give the term its plain meaning. Such a *plain meaning* of the statutory language is in direct conflict with the exceedingly broad definition of "patient care activities" articulated in the September 24, 1999 letter. We do not believe it would be appropriate to adopt a broad definition of patient care activities as was expressed in the 1999 letter when that definition would conflict with the plain meaning of a limiting phrase in the statue—to the extent that it would give little or no meaning to the statutory phrase. Moreover, we believe it would be particularly inappropriate to adopt such a broad construction when the definition has not been promulgated through notice and comment rulemaking, but rather, expressed in a single letter directed to a single individual.

We also question whether the provider community would actually have relied as heavily as commenters suggest on the September 24, 1999 letter when it was clearly directed to a single attorney in response to his specific inquiry, and not to a broader audience, nor was it (nor any similar guidance) disseminated by the Agency to its fiscal

intermediaries. Furthermore, although we believe that the letter responding to this attorney contained an inartful and incorrect expression of the policy concerning nonpatient care activities, we do not believe that expression should be used to permit the indiscriminate inclusion of FTE resident time spent in nonpatient care activities in nonhospital sites.

With respect to residency training in the hospital, our policy limiting the IME count to only time spent in patient care activities is rooted in the creation and the purpose of the IME adjustment. The IME adjustment is a payment to a teaching hospital for its higher costs of patient care. Before Congress passed the 1983 law that included the IME adjustment in the IPPS, the Secretary submitted a report to Congress in 1982 that (in part) explained that, "the indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs" (Report to Congress required by the Tax Equity and Fiscal Responsibility Act of 1982, December 1982, pp. 48-49, italics emphasis added). Similarly, in passing the IPPS legislation in 1983, the House Committee on Ways and Means acknowledged the link between higher patient care costs and teaching hospitals, and noted that the IME adjustment was important due to concerns about whether the PPS could adequately account for factors such as the severity of illness of patients utilizing the more specialized treatment programs at teaching hospitals. Thus, the reasons for the IME adjustment enumerated by Congress and by the Secretary are directly linked to the involvement of residents in patient care. The August 1, 2001 final rule (66 FR 39897) also lists discussions in other Federal Register notices in the 1980s that clearly state that the indirect costs of medical education

are the additional operating costs that teaching hospitals incur in furnishing patient care. We reiterated this longstanding policy in the August 1, 2001 final rule and stated that, ". . . consistent with the purpose of IME payments and general Medicare reimbursement principles, in determining the FTE count with respect to the IME adjustment, it has been our longstanding policy that we do not include residents to the extent that the residents are not involved in patient care [but are instead engaged exclusively in research]" (66 FR 39897). One of the commenters stated that, in the discussion in the April 25, 2006 proposed rule (71 FR 24115), "CMS failed to include the remainder of the text which states 'but are instead engaged exclusively in research.' These excluded words put in context what CMS was trying to convey in that rule--that in terms of research activities, only those that are patient-related may be counted. Nowhere is the word 'didactic' ever mentioned." We did not include the remainder of that text in the proposed rule because the focus of the discussion in the proposed rule was on didactic activities, not research. However, we reiterate that, just as residents engaged in activities that are exclusively research are not engaged in patient care activities, and are not included in the IME count in the hospital, residents in the hospital engaged in didactic, nonpatient care activities are also not counted for the purpose of IME.

Comment**:** Several commenters pointed to what they believe is an "inconsistency of logic" concerning CMS' position regarding the time that may be included in the resident count at nonhospital settings, and the policy concerning the time for which a hospital must incur the costs relating to a teaching physician in those settings. On the one hand, CMS argues that in order for hospitals to receive direct GME and IME

payments relating to residents training in nonhospital settings, the hospital must pay for the costs of the time spent by teaching physicians in educating residents, even when the activities are not associated with patient care. On the other hand, CMS precludes hospitals from counting FTE resident time not spent in patient care activities. According to the commenters, these "conflicting positions" where the hospitals must pay for costs of training time that they cannot count for purposes of direct GME and IME payments will result in confusion in the provider community.

Response**:** We are aware of what the commenter views as a paradox in the requirements concerning the time that residents train in nonhospital settings. Nevertheless, the statute clearly requires that hospitals must incur "all, or substantially all, of the costs for the training program" in the nonhospital setting in order to count any FTE residents training at a nonhospital site for IME and direct GME purposes (§1886(d)(5)(B)(iv) and §1886(h)(4)(E) of the Act). The definition of "all or substantially all of the costs for the training program in the nonhospital site" at §413.75(b) is consistent with what CMS (and previously HCFA) has always considered to be "direct costs" of a GME program, inlcuding "the residents' salaries and fringe benefits . . . and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME." The direct costs of GME associated with teaching physicians were historically paid for under Part A of the Medicare Trust Fund, while payment for billable, patient care services provided by residents supervised by teaching physicians are generally paid under Medicare Part B. Therefore, the costs associated with patient care activities in which the teaching physicians are involved are *not* included

in the direct costs of the GME program. Yet, in allowing hospitals to count FTE residents training in nonhospital sites, the statutory provision regarding direct GME also states that "only time spent in activities relating to patient care shall be counted . . ." (§1886(h)(4)(E) of the Act). Similarly, the statutory provision regarding IME states, "all the time spent by an intern or resident in patient care activities . . . shall be counted . . ." (§1886(d)(5)(B)(iv)). Consequently, hospitals are not permitted to count a portion of the FTE resident time (that is, the nonpatient care time) even though they must incur the training program costs associated with that time.

Comment**:** Several commenters stated that the IME and direct GME statute pertaining to nonhospital sites supports the counting of didactic activities, and that Congress wanted to encourage, not limit, residency training in nonhospital sites. The commenters believe that the reference to "patient care activities" in the IME and direct GME nonhospital statutes refers generally to patient care *settings,* such as physicians' offices and other ambulatory care sites. One commenter cited the statutory language as the reason why hospitals exclude extended periods of time spent exclusively in "bench" research outside of the hospital, or time spent by preventive medicine residents in state and local public health departments from the IME and direct GME FTE counts, since these activities do not involve "patient care." Another commenter implied that didactic time in nonhospital sites is allowed for IME purposes since the conference agreement accompanying the legislative language in the BBA states, "The conference agreement includes new permission for hospitals to rotate residents through nonhospital settings, which include primarily ambulatory care settings, **without reduction indirect medical**

education funds" (emphasis added). Commenters also stated that Congress was "well aware" that residency training involves didactic components, and Congressional actions in both COBRA 1986 (enacting the direct GME nonhospital site provision) and BBA 1997 (enacting the IME nonhospital site provision) make it clear that Medicare would allow hospitals to count time spent in nonhospital sites for purposes of direct GME and IME.

Response**:** We believe the commenters have erroneously concluded that because Congress desired to encourage increased residency training in nonhospital sites, the nonhospital IME and direct GME statutes must, therefore, also support the counting of FTE residents engaged in didactic activities in nonhospital sites. In fact, despite the lack of an explicit explanation of what was intended by the term "patient care activities," when the Conference committee report language is viewed in conjunction with the statute, we believe the obvious and correct conclusion is that Congress wanted to encourage more training in nonhospital settings, but only for the purpose of increasing patient care training in outpatient, ambulatory settings. This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that ''[s]ince it is difficult to find sufficient other sources of funding [other than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] assignments to these settings are discouraged [under the pre-enactment payment scheme]. It is the Committee's view that

training in these settings is desirable, because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care.'' (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).) Thus, from the start of the provision allowing hospitals to count FTE resident training in nonprovider sites, we believe Congress intended to create a monetary incentive (or remove the disincentive) for hospitals to rotate residents from the hospital to the nonhospital settings for the purpose of treating patients in those ambulatory settings, not for the purpose of spending time in didactic activities in those settings. We believe this is the reason why Congress specifically added the "patient care activities" requirement to the direct GME (and later, the IME) statute. Similarly, in the Conference committee report accompanying the provision of Pub. L. 105–33 on counting resident training time in nonhospital settings for IME, Congress stated that ''[t]he conference agreement includes new permission for hospitals to rotate residents through nonhospital settings, without reduction in indirect medical education funds" (emphasis added, H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).) We believe that by the phrase "without reduction in indirect medical education funds," Congress intended that when hospitals send residents to nonhospital sites for training, the IME payments relating to those FTE residents would not cease; that is, the hospitals would continue to receive IME, in addition to the direct GME payments they were already receiving when residents rotate from the hospitals to nonhospital settings. Furthermore, as we stated in the August 1, 2003 final rule in the context of redistribution of cost and community support principles (68 FR 45436), legislative intent becomes even more evident when the nature

of the IME adjustment is considered. Because the IME adjustment is a payment for patient care costs that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital, "the authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting" (68 FR 45436). Given the nature of IME as a patient care payment, surely Congress would not have made IME payments available for training in nonhospital settings to encourage movement of didactic training from the hospital to nonhospital sites. To the contrary, we believe Congress clearly intended to encourage hospitals to shift only residency training that involves patient care activities from the hospital to outpatient ambulatory settings.

Comment**:** One commenter alleged that, "in a very misleading fashion in the proposed rule, CMS does not quote the entire section of the relevant portion of the Medicare statute, which reads in full:

"Counting Time Spent in Outpatient Settings. Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted toward the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training in that setting." (Emphasis added). Section 1886(h)(4)(E) of the Social Security Act."

The commenter argued that Congress and CMS are well aware of the language that can be used to describe care directly provided to individual patients; that is "direct patient care." The commenter included a list of mostly regulatory (and 2 statutory) cites where the term "direct patient care" is used and noted that the statutory language regarding GME does not use the term "direct patient care," but rather, uses the much broader language of "activities relating to patient care." Further, the law states that "all the time so spent by a resident under an approved medical residency training program shall be counted . . . without regard to the setting in which the activities are performed" (emphasis added.) The commenter added that Medicare regulations also define "direct medical and surgical services" of physicians in a teaching setting as "services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital …" (42 CFR 415.152), and that in all these situations, the idea of "direct patient care" can be more narrowly defined than "activities relating to patient care."

Response**:** It appears that the commenter has overlooked the paragraph on page 24115 of the April 25, 2006 proposed rule where we did, in fact, quote the entire section of the statutory language pertaining to direct GME payments for nonhospital training. We also believe the statutory language is intended to be read differently from the way the commenter has suggested, resulting in a significantly different policy. Specifically, the commenter quotes and emphasizes the statute as follows: "all the time so spent by a resident under an approved medical residency training program shall be counted . . . without regard to the setting in which the activities are performed . . ." The commenter

uses this language to suggest that CMS must allow the time spent in didactic activities in nonhospital sites. However, we believe the correct reading of the statute in its entirety is:

"Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident . . . shall be counted toward the determination of full-time equivalency, without regard to the setting in which the activities are performed . . ." (§1886(h)(4)(E) of the Act).

In other words, only a subset of the time that residents spend in nonhospital settings can be counted. Specifically, only all of the time so spent in activities relating to patient care can be counted, not necessarily all of the time spent training in the nonhospital site. Similarly, the IME statute states, "*all the time spent by an intern or resident in patient care activities* . . . shall be counted . . ." (§1886(d)(5)(B)(iv) of the Act). Furthermore, as we stated in response to previous comments, if "patient care" in the phrase "only time spent in activities relating to patient care" (section 1886(h)(4)(E) of the Act) is interpreted as broadly as suggested by the commenter, there would be virtually no limit to the types of activities that could be counted, rendering the entire phrase, and particularly the word "only," meaningless. In addition, we note that the definition of "direct medical and surgical services" at §415.152 of regulations relating to physicians in a teaching setting is consistent with our definition of the plain meaning of "patient care activities." Just as the definition of "direct medical and surgical services" refers to services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician, our definition of "patient care activities" refers to the care and treatment of particular patients, or to services for

which a physician or other practitioner may bill. Therefore, the terms "direct medical and surgical services" and "direct patient care" are, for all intents and purposes, synonymous with the phrase "patient care activities."

Comment**:** We received many comments expressing strong opposition to the clarification in the proposed rule, some of which were quite passionate and included ominous predictions of the dire consequences of such a policy on GME programs. Generally, commenters urged that we rescind the provision in the proposed rule, on the grounds that there is a very close connection between the didactic activities that residents engage in and the delivery of patient care. They argued that with the exception of extended periods of time spent doing "bench research" which is excluded from the IME count, every activity that the residents are engaged in is integral to patient care activities. The commenters argued that there is no distinction between patient care and other activities in which residents participate during their residency training. Rather, the distinction is more appropriate when comparing undergraduate medical training and post-graduate residency training. The commenters noted that the emphasis in medical school is didactic education, while the focus in residency training is patient care delivery, with continued didactic education in the context of furnishing patient care. The commenters argued that the didactic activities are an important part of the ACGME's required curriculum since it is now widely recognized that physicians should be competent in "medical knowledge about established and evolving biomedical, clinical, and cognate . . . sciences and the application of this knowledge to patient care" (ACGME Institutional Requirements, III(E)(1)(b)). Several other commenters pointed out that the ACGME

competencies are intended to address "exactly what the IOM has criticized our training professions for," and therefore, didactic sessions are necessary to improve the quality of residency education. These commenters stated that their program (family medicine) currently evaluates their residents "in all these competencies as a continuing quality improvement process during patient care" (emphasis in the original). Commenters representing osteopathic residency programs stated that all osteopathic training programs are required to teach certain core competencies by 2006. Another commenter stated that, in an effort to improve the residents' skills in delivering patient care, the teaching physician "looks for every opportunity, in whatever physical setting for the 'teachable moment' to review a critical point or two to hone the learner's skills." Commenters also asserted that most didactic activities are relatively short, and residents often continue to have direct patient care responsibilities during the didactic time, and are often paged to respond to emergencies or to tend to their assigned patients during scheduled didactic periods. They noted generally that current patients are often used as a springboard for discussions at lectures, and it would be extremely difficult to track when the "patient care" ends and the didactic time begins. In addition, residents are required to attend simulation programs, which prepare them for "real-time" patient care experiences using advanced technologies. A commenter urged CMS to promote and encourage investment in such technologies and activities that are intended to improve the quality of patient care, rather than "create reimbursement disincentives for institutions that may be struggling to afford it." Many commenters indicated that if CMS finalized this rule, teaching faculty "will be caught up in the productivity race with no time for" valuable discussions with

their residents, at a time when family physicians need to be "exceptionally well trained" in order to meet the needs of underserved, vulnerable patient population who need chronic disease management. The commenters warned that CMS's proposal "lowers the standards of care for Medicare patients" and is "dangerous for our current and our future patients." One commenter asked that we reconsider rule changes that will "rob Peter to pay Paul," while another commenter urged that we "please [do] not allow anything to occur that might reduce the attractiveness" of medical school graduates pursuing primary care specialties. One commenter added that with the recent loss of funding for primary care education in Title VII of the Public Health Act, this ruling could "literally spell the end of primary care practice in the United States." Another commenter asked if "perhaps [CMS] could refocus [its] efforts toward educating doctors instead of spending so much of [its] time identifying new ways of withholding funding." We also received a comment that stated that reimbursement for direct GME and IME is "sufficiently restricted" by limits on increases to per resident amounts (PRAs) and FTE resident caps, and there is no need to impose additional "burdensome recordkeeping requirements with the sole apparent intent of further reducing such payments."

Response**:** We are sympathetic to the commenters' arguments that the didactic activities in which the residents are required to participate contribute to the development of more highly skilled, proficient, well-rounded clinicians, and we are not in any way minimizing the importance of such activities, nor are we advocating a position that would deny all GME payments for these activities. However, we note that Medicare GME payments were never intended to cover the total costs of medical education, as is

evidenced most obviously by the fact that direct GME payments are based on Medicare's share of the costs of training an FTE resident. Rather, we are merely distinguishing between activities that concern the treatment and diagnosis of particular patients (that is, patient care), and activities that are didactic in nature (that is, not patient care), as this distinction is necessary to ensure that Medicare funds for medical education are paid appropriately. Direct GME has historically been considered to be the payment for the direct costs of education. Accordingly, the direct educational costs incurred by a hospital in providing didactic activities are more appropriately paid for via the direct GME payment. We note that the methodology used to determine hospitals' base year direct GME PRAs included the allowable costs and FTE time of didactic activities occurring within the hospital complex. The IME adjustment serves an entirely difference purpose. Specifically, the IME adjustment is a payment under the IPPS to recognize the higher operating costs that teaching hospitals incur in furnishing patient care; it is intended to pay a teaching hospital for those additional indirect patient care costs, not the direct costs associated with didactic learning.

Furthermore, while we do not dispute that didactic activities are essential to and integrated with the residents' patient care experience, this does not mean that the didactic activities *are* patient care activities. In addition, the didactic activities are not an insignificant portion of a resident's training. These activities are required by the accrediting organizations, and are necessary for board certification, and therefore, even though it may not be an unusual occurrence for a resident to be called out of a conference to tend to a patient care emergency, the resident surely must satisfy his/her minimum

requirements of didactic training over the course of the entire academic year. A random search on the internet of individual hospitals' program requirements revealed that *many* programs schedule didactic activities for their residents of an hour or more in length every single day. In fact, many comments we received were from commenters who included detailed descriptions of the nonpatient care activities in which their residents are required to participate. We are also aware of rotations that are administrative or didactic in nature that are more lengthy (for example, 2 weeks or 6 weeks), but are scheduled less frequently. Such rotations are surely not patient care. Therefore, we are not convinced by the commenters' arguments that since didactic time is frequently integrated with patient care activities, it *is* patient care and, therefore, the time should be allowed for IME purposes in the hospital, and for direct GME and IME purposes in the nonhospital site.

Comment**:** One commenter noted that direct GME and IME payments are based on allowable "full-time equivalent" (FTE) counts, and that the regulations do not specify the number of hours that comprise one FTE. Rather, the regulations for IME state that "full-time equivalent status is based on the total time necessary to fill a residency slot" (§412.105(f)(1)(iii)(A)), and the direct GME regulations have a similar requirement (42 CFR §413.78(a)).

Response**:** The commenter is correct that a hospital's allowable FTE count is "based on the total time necessary to fill a residency slot" (§412.105(f)(1)(iii)(A). As the regulations state, the concept of the total time necessary to fill a residency slot is used to determine the part-time or full-time status of the resident. If it is determined that the resident is not working the number of hours necessary to fill a residency slot (between all

the resident's hospital and nonhospital training sites), the resident would be considered part-time, and the proportion of total time the resident is working in all training sites would be adjusted accordingly. For purposes of determining a hospital's count of FTE residents, the important word in the regulatory phrase is "based." That is, the starting point (denominator) for determining the allowable FTE count is the total time necessary to fill a residency slot. However, the hospital must then subtract (from the numerator) all nonallowable training time, such as time spent at other providers, time spent in IPPS-excluded distinct part units (for IME), didactic activities (for IME), and so on. Thus, while a hospital's allowable FTE count is certainly "based" on the total time necessary to fill a resident slot, the total time is often greater than the FTE time a particular hospital is permitted to count for IME and direct GME payment purposes.

Comment**:** One commenter noted that the average resident's workweek is 80 hours, and if CMS were to count an FTE resident for GME purposes based on a 40 hour workweek as is done for the Medicare IPPS wage index, the exclusion of didactic activities would not affect the overall FTE count.

Response**:** The total number of hours recorded as worked by residents for the purpose of the wage index adjustment to the IPPS represents a compromise, and is irrelevant in the context of determining the FTE resident count for GME payment. Historically, the actual number of hours worked by residents (often more than 80 hours per week) was included in the average hourly wages of hospitals used to compute the wage index. However, teaching hospitals argued that the excessive number of resident hours relative to the hours worked by other employees skewed their average hourly wage

downward, and placed them at a disadvantage relative to non-teaching hospitals. Therefore, CMS (then HCFA) determined that it would be appropriate to count interns and residents for wage index purposes based on a 40-hour workweek. Thus, the 40-hour workweek actually benefited teaching hospitals for wage index purposes. In any case, beginning with the FY 2000 wage index (which was based on cost reporting periods starting on or after October 1, 1995 and ending on or before September 30, 1996), the wages and hours of interns and residents were phased out of the wage index, since Medicare payments for the salaries and fringe benefits of interns and residents are made by Medicare through the direct GME payment (based on the PRA), and not the IPPS. (Beginning with the FY 2003 wage index (cost reporting periods beginning on or after October 1, 1999), we removed 100 percent of the interns' and residents' wage data from the wage index). For purposes of determining what portion of an FTE resident a hospital may count for a resident that is training at the hospital (after first determining whether the resident is a part-time or full-time resident based on the total necessary to fill the residency slot), it is important and necessary to first determine the actual total time worked by the resident. Accordingly, if 80 hours per week is established as the total time necessary to fill the residency slot, and if a resident works an 80-hour week and works 40 hours per week at each of two hospitals, each hospital would count no more than one half of an FTE for the resident. The FTE determination for that resident cannot be based on 40 hours, since that would result in both hospitals counting the same resident as a full FTE. Thus, in calculating the FTE count, it would be inappropriate to compare the time

spent in patient care activities to a 40 hour week and not to the total time worked by the resident.

Comment**:** Some commenters asserted that just as the direct GME statute for residency training in the hospital does not include a reference to patient care, and therefore, all training in the hospital is countable for direct GME, the IME statute for hospital training also does not refer to patient care, and therefore, all the training in the hospital should be counted for IME too. One commenter asserted that the proposed rule is "ultra vires" and is therefore, "unconstitutional" because the IME statute for training in the hospital does not exclude time spent in nonpatient care activities, and that the IME adjustment is only the "best proxy" for teaching hospitals' increased training costs—it was not intended to measure the "actual costs" of training residents. The commenter argued that the Congress did not "intend that CMS parse apart or exclude certain time" from the FTE count, and doing so is beyond the scope of the agency's authority. Another comment stated that "we are unaware of any Medicare directive that distinguishes patient care activity in a hospital and nonhospital site." One commenter stated that he is "not aware that the fiscal intermediaries made disallowances for educational activities when calculating hospitals' PRAs in the 1984 base year." The commenter also refers to the 1990 Q&As issued by CMS (then HCFA) to the CMS Regional Offices and the fiscal intermediaries for use in computing the base year PRAs, and argues that "CMS makes numerous references to educational activities as allowable costs and does not once specify that these costs and the associated resident time were to be carved out if the activity took place in the nonhospital setting." The commenter quoted part of a response

(to one of the 1990 Q&As) which stated, "If the hospital, rather than the related school, directly incurs the costs associated with these educational activities, they should be recognized as allowable graduate medical education costs and included in the per resident amount."

Another commenter noted that the provisions at section 2120 of the Provider Reimbursement Manual, Part I, titled Reimbursement for Costs of Interns and Residents, which described the cost method of reimbursement for GME programs, do not distinguish between training types or training location, and therefore, Medicare allowed costs of residents when they trained in didactic activities in nonhospital locations.

Commenters also argued that CMS's "overly rigid" interpretation of "patient care activities" ignores CMS's longstanding definition of "costs related to patient care," which is the basis for much of CMS's analysis, because educational activities like conferences and seminars for hospital employees have always been allowable costs under Medicare, and therefore, should be allowed for purposes of the IME as well. [see PRM-I, chapter 21, sections 2108.1, 2128, 2136.1, 2138.1, 2138.2, 2144.4, and 2144.6]. Another commenter contended that to exclude didactic time from the IME calculation would be inconsistent with Congress's purpose in instituting the IME adjustment. Congress's reason for enacting this provision was to address factors that contribute to the higher costs incurred by teaching hospitals, such as more acutely ill patients, more specialized treatments, and the additional costs associated with training residents such as the ordering of additional tests and extra staffing demands. The commenter argued that during the time the residents are involved in didactic activities, "these costs are in no way

reduced," since the "patients remain just as ill as they were before, the hospital continues with its resident-related inefficiencies, the hospital continues to provide specialized services, and the services are just as intense. Thus, all of the costs that the IME adjustment is intended to compensate continue unabated no matter what the resident is doing."

Other commenters quoted the Committee report language accompanying the PPS legislation, which stated that purpose of the IME adjustment was to address "serious doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (emphasis added, U.S. House of Representatives, 1983)."

In light of this Committee report language, the commenter believed that the language in the proposed rule defining the "plain meaning" of patient care as related to the care and treatment of a specific patient or to services for which physicians can bill is "patently incorrect."

Response: After reading the numerous comments challenging CMS' position that only the time spent by residents in patient care activities in the hospital may be counted for IME purposes, it has become apparent to us that there actually has been a good deal of confusion in the teaching hospital community regarding our longstanding policy with respect to IME and patient care activities. Nevertheless, we do believe that the

commenters are misconstruing and confusing CMS' position on, and the purpose for, the direct GME payments and IME payments, respectively. By including a provision in the April 25, 2006 proposed rule clarifying our position on the time residents spend in nonpatient care activities, we were (and still are) distinguishing between activities that concern the treatment and diagnosis of particular patients (that is, patient care), and activities that are didactic in nature (that is not patient care), as this distinction is necessary to ensure that Medicare funds for medical education are paid appropriately. As stated in response to a previous comment, historically, direct GME has been considered to be a payment for the direct costs of education. The conference report accompanying the original Medicare legislation (Public Law 89-97) stated:

"Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program" (S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)).

Accordingly, educational activities of hospital employees, particularly those in "formally organized or planned programs of study" as they were described in the original regulations first published on November 22, 1966 (31 FR 14814, and 20 CFR 405.421)

(later redesignated as 42 CFR 405.421 on September 30, 1977 and as 42 CFR 413.85 on September 30, 1986)), were recognized as Medicare-allowable costs and implicitly included in the definition of "costs related to patient care" at 42 CFR 413.9. These specific payments for medical education activities were the basis for what later evolved into the direct GME payments, as established by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272). That is, direct GME (and also, payments for approved nursing and allied health education programs under 42 CFR 413.85) is a payment for education because it explicitly pays hospitals for the *direct* costs of these formally organized programs, such as the stipends of trainees and teachers. Additionally, as early as 1971, Chapter 4 of the Provider Reimbursement Manual, Part I, stated that "any costs of usual patient care" are excluded from the definition of approved educational activities (Section 404.2 of the PRM-I). Clearly, the early medical education payments, in which current direct GME payments are rooted, were not intended to be a payment for caring for patients, but rather were (and are still today) payments to hospitals for education costs. Medicare made then, and still makes, payments for usual patient care as part of the hospital's operating costs and as direct payment to hospital-based physicians under Medicare Part B. Therefore, to the extent that residents engage in nonpatient care didactic activities as part of their approved programs, the costs of those didactic activities are allowed and paid by Medicare through the direct GME payment, based on the PRA. The commenter is indeed correct that the costs of didactic activities were included as allowable costs by the fiscal intermediaries when determining the base year PRAs. However, the commenter should not conclude

that didactic activities that occurred outside of the hospital were included in the determination of the PRAs. Under Medicare's previous reasonable cost method of payment for approved medical education activities, any costs incurred by a hospital for resident training that took place outside of the hospital setting were not allowable costs to that hospital (66 FR 3371). In establishing PRAs, fiscal intermediaries used a count of FTE residents for the 1984 base period that reflected "the average number of FTE residents working in the health care complex during the GME base period" (54 FR 40299). Section 9314 of Pub. L. 99-509 changed the law to allow resident time spent training in nonhospital settings to be counted for the first time for purposes of direct GME payments on and after July 1, 1987. Furthermore, regarding the specific language from the 1990 Q&As quoted by the commenter, neither that question, nor the answer provided by CMS (then HCFA) gives any indication of where the educational activities took place. Therefore, the fact that CMS stated that the costs of educational activities incurred directly by a hospital are included in the PRA does not mean that the costs incurred by a hospital for all educational activities are allowable, regardless of the location in which they occurred. Similarly, just because the FTE time associated with certain costs is allowable (according to the statute) does not mean that the *costs* of a particular activity are necessarily allowable. Certainly, if the Congress had not changed the law in 1987 to allow residents training in nonhospital settings to be counted (for direct GME purposes), then even the time spent in direct patient care activities in nonhospital sites would not be allowed to be counted by a hospital. The relevant point, however, is that educational costs incurred by a hospital in providing didactic activities to

residents in approved programs are paid by Medicare via the direct GME payment, which is a payment for costs of education.

The purpose of the IME adjustment is different from that of direct GME in that it is designed to adjust the IPPS payment to teaching hospitals for the higher operating costs they incur in furnishing patient care. It is intended to pay a teaching hospital for those additional patient care costs that are an indirect result of the presence of the teaching program at the hospital, and not the direct costs associated with didactic learning. Although the commenters argue that didactic activities have long been recognized by CMS as "related to patient care," despite the fact that none of these activities involves the "care and treatment of individual patients" or "services for which a physician or other practitioner may bill," we believe that because IME is a payment specifically for patient care costs, the regulations and subregulatory guidance concerning "costs related to patient care" are not sufficient for determining what actually constitutes patient care and is therefore, an activity for which FTE resident time in the hospital may be counted for IME. As stated in response to a previous comment, with respect to residency training in the hospital, our policy limiting the IME count to only time spent in patient care activities is rooted in the creation and the purpose of the IME adjustment. Before Congress passed the 1983 law that included the IPPS and an IME adjustment, the Secretary submitted a report to Congress in 1982 that (in part) explained that, "the indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs" (Report to Congress required by the Tax Equity and Fiscal Responsibility Act of 1982, December 1982, pp. 48-49, italics emphasis added).

Similarly, in passing the IPPS legislation in 1983, the House Committee on Ways and Means acknowledged the link between higher patient care costs of teaching hospitals, and noted that the IME adjustment was important due to--

". . . serious doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (U.S. House of Representatives, 1983)."

Essentially, Congress listed two reasons for the IME adjustment, similar to those stated in the Secretary's 1982 report: 1) teaching hospitals typically offer more technologically advanced treatments to their patients, and therefore, patients who are sicker and need more sophisticated treatment are more likely to go to teaching hospitals, and 2) the presence of inefficiencies associated with teaching residents resulting from the additional tests or procedures ordered by residents and the demands put on physicians who supervise, and staff that support, the residents. That is, because teaching hospitals attract sicker patients, they incur higher costs in caring for those sicker patients– whether due to additional tests ordered by residents or more intensive treatments provided in an educational setting. The Secretary and Congress recognized that the learning process in which the residents are engaged results in more intensive, and therefore more costly, treatment. Thus, the purpose of the IME adjustment is clearly limited to the unique characteristics and conditions of teaching hospitals that directly relate to the delivery of

patient care.[30] Since the purpose of the IME adjustment is rooted in patient care, there is a clear and compelling reason to limit the FTE resident time that can be counted for IME to time spent by residents in patient care; that is, in the care and the treatment of particular patients, or in furnishing services for which a physician or practitioner may bill.

Commenters argued that during the time the residents are involved in didactic activities, higher costs incurred by teaching hospitals "are in no way reduced," and emphasized the language in the Committee report describing the purpose of the IME adjustment as addressing (in part), " . . . the additional costs associated with the teaching of residents." To address these comments, we refer to the August 1, 2001 final rule (66 FR 39898), in which we reiterated our policy that IME is a payment for patient care, and we also included an example from that rule to illustrate how the FTE resident count for IME should be determined in a manner that would properly reimburse a hospital with residents that are engaged in non-patient care research activities. Although the discussion in the August 1, 2001 **Federal Register** focused on research, this example is useful for this discussion on nonpatient care didactic activities. In the example (66 FR 39898), a hospital has 20 FTE residents who were furnishing patient care in the areas of the hospital subject to the PPS, and 4 FTE residents engaged exclusively in research. We stated that the IME payment to the hospital should reflect the additional operating costs

[30] Similarly, to the extent that the higher costs are caused by other factors such as a greater relative share of medically complex or indigent patients, the IPPS includes payments in the form of the outlier and disproportionate share hospital (DSH) adjustments to specifically compensate for those costs. (Health Care Financing Review, Winter 1992, Vol. 14, No. 2, p. 69, and Health Care Financing Review, Spring 1990, Vol. 11, No. 3, pp. 31-41).Therefore, the additional indirect medical education costs that remain after controlling for outlier and DSH payments are the essentially the higher patient care costs resulting from the presence and involvement of residents in patient care.

resulting from those 20 FTE residents delivering patient care, and would not include the 4 FTEs engaged exclusively in research, as those 4 FTE residents did not contribute to the hospital's higher operating costs. While it may be that the existence of the research activities did contribute in some marginal way to the higher operating costs of the hospital, for instance, by attracting more severely ill or uninsured patients to the hospital for non-research treatment, those residents engaged exclusively in research are not involved in and do not contribute to more intensive or inefficient patient care, and therefore, their presence does not result in higher allowable operating costs. We believe the same holds true for the time residents spend in didactic activities—during this time, the residents are not participating in or contributing to more intensive or inefficient patient care. Moreover, we believe that it is the combination of the factors enumerated by the Secretary and Congress as the reasons for the IME adjustment that contribute to the higher operating costs of teaching hospitals. We believe the Congress' reference to "additional costs associated with the teaching of residents" refers to the presence of inefficiencies associated with teaching residents resulting from the additional tests or procedures ordered by residents and the demands put on physicians who supervise, and staff that support, the residents; and not to costs associated with research or didactic activities. Since direct GME payments are made to teaching hospitals to cover the explicit educational costs of training residents, we do not believe Congress intended for the IME adjustment to duplicate those educational payments. In fact, it first became evident that an adjustment to payments for teaching hospitals was necessary, in addition to the cost-based GME payments, after 1972 when Congress instituted what became

known as the "section 223" limits to hospitals' routine operating costs. Since the agency's analyses showed that the section 223 cost limits adversely impacted teaching hospitals, a calculation based on a regression formula was computed to adjust the routine operating cost limits of teaching hospitals. Consequently, the IME adjustment was instituted to address the higher patient care costs not sufficiently compensated under the cost limits, and later the DRG system. In the example above, the inclusion of the four FTE residents engaged in nonpatient care research in the resident count for IME would vastly overcompensate the hospital for any marginal contribution to operating costs resulting from the presence of those FTE residents. Similarly, a resident that is participating in a seminar or a conference is not contributing to the higher patient care costs of the hospital. Thus, although it would be appropriate to count such nonpatient care time in calculating direct GME payments, it would not be appropriate to count that time for purposes of the IME adjustment. Accordingly, we believe it is appropriate and fully consistent with Congressional intent to apply the plain meaning of the term "patient care activities" and to limit the FTE resident count to time spent in patient care activities for IME for training in the hospital, and for both IME and direct GME for training in nonhospital sites. That is, only time spent in the care and treatment of particular patients, or in providing services for which a physician or other practitioner may bill, may be counted.

Comment**:** One commenter said that independent research activity rotations were included in the allowable FTE count used to determine hospitals' direct GME base year PRAs. The commenter said that these research electives, which are part of the ACGME

approved program, "may happen at the hospital's medical library" or "may happen at home at the resident's study desk," but "all of it has been included in the FTEs used to calculate the PRA amount." The commenter suggested that, by the clarification in the April 25, 2006 proposed rule, CMS is adopting a "change in accounting method," and that, therefore, CMS should consider adopting a change in the PRAs for hospitals that "exclude these newly excluded" FTEs.

Response**:** We believe the commenter is confusing our policy of including the FTE time spent in research activities in the denominator of the PRA calculation, and, in the FTE count in years subsequent to the PRA base year, our policy of excluding the costs of research activities from the numerator of the PRA. As we explained in the September 29, 1989 **Federal Register** and again in the August 1, 2001 **Federal Register** (66 FR 39898 through 39899), each hospital's PRA is determined by taking the hospital's total allowable graduate medical education costs (which do not include costs allocated to the nursery cost center, research, and other nonreimbursable cost centers) in a base year and dividing the costs by the number of FTE residents working in all areas of the hospital complex in the base year (§413.77(a)(1)(i)). In the case of research and other nonreimbursable cost centers, costs were excluded from the PRA calculation because they were nonreimbursable in the base year, consistent with longstanding Medicare policy on Medicare cost reimbursement to teaching hospitals. Ideally, residents participating in research electives would also have been excluded from the base year FTE count used in the PRA calculation. However, for a number of hospitals, the FTE count for the base year did include residents engaged in such research because the 1984 base year

information available from hospitals when the PRAs were determined in 1990 did not consistently distinguish between residents involved in furnishing patient care services and residents engaged in nonpatient care research. The inclusion of such additional FTEs in the denominator of the PRA calculation lowered the PRAs for these hospitals.

In order to avoid disadvantaging these hospitals, in making direct GME payments for a given year, we included and continue to include residents engaged in nonpatient care research in the direct GME FTE count both in the base year PRA calculation and in the FTE count in subsequent payment year calculations. This policy was adopted to "offset" the effects of the inclusion of such FTE residents in the denominator of the direct GME PRA calculation (no such "offset" is warranted in the context of IME). Thus, there has been no "change in accounting method," and it is not necessary to consider changing the PRAs of hospitals that exclude independent research rotations, as the commenter suggests. Furthermore, because the nonreimburseable costs were excluded in calculating the PRA, the end result is that the direct GME payment does not encompass the costs of residents engaged exclusively in research. Therefore, as with the IME payment, Medicare is not and has not been reimbursing teaching hospitals under direct GME for costs the hospital incurs associated with resident time spent in nonpatient care research.

Comment**:** One commenter disputed CMS' policy to exclude nonpatient care time from the IME count on the grounds that the IME statute states that "the Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment

for such costs under regulations (in effect as of January 1, 1983) . . ." (section 1886(d)(5)(B) of the Act). The commenter maintained that because the regulations in effect as of January 1, 1983, did not exclude nonpatient care activities from the IME count, the plain meaning of the statute requires that this time continue to be included in the IME resident count.

Response**:** The exclusion of time spent in nonpatient care activities from the IME count is longstanding CMS policy, and consistent with the rules in effect as of January 1, 1983. The statute implementing the IME adjustment at section 1886(d)(5)(B) of the Act requires that, "[t]he Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) . . .").

For the initial analysis of the operating costs of teaching hospitals versus non-teaching hospitals that was used to develop the IME adjustment, while analysts could distinguish between allowable and non-allowable costs, they did not have a method to consistently and accurately isolate all the time spent by residents in nonpatient care activities. Therefore, no consideration was given to where the residents were training in the hospital or what the residents were doing (that is, patient care or other activities). Prior to the implementation of the IPPS, under the reasonable cost system of reimbursement, the concept of an "FTE resident" had little, if any, relevance. Thus, for this analysis, an "FTE" simply distinguished between a resident that was employed at the hospital on a full-time basis and a resident that was employed at the hospital only part-

time. Accordingly, while only allowable costs were considered in the analysis, the time spent by residents in non-reimbursable activities or areas of the hospital was not excluded from the analysis.

The April 1, 1980 **Federal Register** implementing the initial IME adjustment specified simplistic requirements for hospitals to report FTE residents to the fiscal intermediaries for purposes of receiving the IME adjustment to their cost limits, consistent with the relatively crude resident counts CMS used in computing the IME adjustment (45 FR 21484). The rules in effect as of January 1, 1983 concerning determining the resident count for IME required, in part, that only residents in approved programs could be counted (47 FR 43310 (September 30, 1982)). Once the IPPS was effective, CMS took certain steps to modify the rules concerning FTE resident counts for the resident-to-bed ratio to more appropriately adapt the IME adjustment to the new prospective payment methodology under which only inpatient operating costs were reimbursed. (Other types of costs, such as direct GME and outpatient hospital costs were specifically excluded from payment under the IPPS, and continued to be paid under existing mechanisms.) A distinction was drawn, for payment purposes, between the acute inpatient hospital (subject to the IPPS), and distinct part units and hospitals not paid under the IPPS. Since reasonable cost payments to these "IPPS excluded" providers and units already included the indirect costs of medical education, in order to avoid a "double" payment that would result from counting residents in those IPPS-excluded settings, CMS clarified in regulations that the IPPS IME adjustment does not apply to any hospitals or distinct part units not paid under the PPS, and consequently, both the number

of beds and the time spent by residents in those areas could not be included in the resident-to-bed ratio (48 FR 39844). The agency modified the rules for counting FTE residents and hospital beds for purposes of the IME adjustment so that the adjustment would be more closely tailored to reflect the higher allowable patient care costs of teaching hospitals under the prospective payment system for inpatient acute care hospitals.

In the September 3, 1985 final rule, CMS responded to comments regarding its proposal to exclude FTE resident time spent in outpatient departments from the numerator of the resident-to-bed ratio. CMS had proposed this exclusion "because outpatient departments also are not subject to the prospective payment system and because the additional operating costs of outpatient departments associated with interns and residents are already recognized through reasonable cost reimbursement for hospital services furnished to outpatients" (50 FR 35681 through 35682). The commenters stated that CMS was required to count residents training in outpatient departments since section 1886(d)(5)(B) of the Act requires that the IME adjustment be "computed in the same manner" as set forth in the regulations on January 1, 1983. The commenters further argued that in the September 1, 1983 interim final rule, CMS said that residents in outpatient departments would be counted so as to avoid "altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factors and subsequently standardizing hospital costs based on that factor" (48 FR 39778).

In response to those comments, CMS stated that the agency believed that in excluding residents training in the outpatient departments from the FTE count, it was computing the adjustment "in the same manner" as previously, since the adjustment continued to be based on a resident-to-bed ratio. CMS noted that, although the statute purports to refer to regulations in effect on January 1, 1983, there were no specific regulations in effect on that date, and, although the September 30, 1982 **Federal Register** (47 FR 43310) contained a description of the method to be used, the agency believed that "Congress, in enacting the prospective payment system, intended that the methodology in effect be adopted rather than the entire description published in that notice" (emphasis added). CMS further noted that the agency had already made changes to the methodology for counting interns and residents in the January 3, 1984 and August 31, 1984 final rules (the latter in response to a provision in Pub. L. 98-369) to "adapt the previous system to the prospective payment system more effectively." (In fact, the Agency had also made changes in the September 1, 1983 **Federal Register** (48 FR 39844) to exclude FTE training time in distinct part units that are excluded from the PPS). We noted that, in response to the refinements the agency made in 1983 and 1984 to the rules for counting residents for purposes of the IME adjustment, Congress could have made adjustments to the IME multiplier, but chose not to do so even though it passed legislation (Pub. L. 98-369) dealing specifically with indirect medical education payments. In response to comments, the agency observed that "the current [IME] adjustment itself is no longer entirely consistent with the original factor" (50 FR 35682). We concluded that, "if the deletion of time furnishing services to outpatients, which

decreases the count of interns and residents, invalidates the indirect medical education adjustment, it should follow that the expansion of programs that took place since the current factor was developed also should have invalidated the adjustment. However, especially since Congress did not mandate that the factor be recalculated, we believe that if there are, as here, overriding concerns, the revision to the method of counting interns and residents is justified" (50 FR 35682).

We acknowledge that soon after publication of this rule, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) (Pub. L. 99-272) on April 7, 1986, which included a provision (section 9104(a)) that addressed the agency's regulation, and required that time spent by residents training in outpatient departments "will continue to be counted for purposes of determining the indirect teaching adjustment" (See 51 FR 16773, May 6, 1986). We note further, however, that although Congress addressed CMS's rule on excluding time spent in outpatient departments, Congress could have, but did not, also address the agency's regulations concerning the exclusion of training time in distinct part psychiatric and rehabilitation units. Congress has considered and taken legislative action with respect to the IME adjustment many times since 1986, but has not found it necessary to modify the agency's policies with respect to the counting of FTE residents for IME purposes. We do not believe that we are obligated to adhere rigidly to the rudimentary methodology of counting FTE residents for IME purposes that was in effect prior to and in the early days of the IPPS. Rather, since the IME adjustment is a payment for additional patient care costs, we believe there is a clear and compelling reason to limit the FTE resident time counted for IME purposes to

the time spent by residents in the care and the treatment of particular patients, or to services for which a physician or other practitioner may bill.

Comment**:** One commenter argued that CMS' position in the April 25, 2006 proposed rule that nonpatient care activities must be excluded from the IME FTE count "flies in the face of" the United States District Court's decision in Riverside Methodist Hospital v. Thompson, Case No. C2-02-94 (S.D. Ohio 2003). In Riverside, the hospital appealed the fiscal intermediary's disallowance of time spent in the hospital in journal clubs and seminars from the IME FTE count. In that decision, the Court ruled "1) that the 2001 rule excluding nonpatient care time from the FTE count must not apply retroactively and 2) that resident time spent on nonpatient care activities should be included in the IME FTE count." The commenter contended that CMS' position in the proposed rule is "an unconstitutional attempt to use the regulatory process to overturn the decision of an Article III court." Another commenter claimed that the Court in Riverside affirmed Congress' intent that the IME adjustment should compensate teaching hospitals for more than just the direct costs of residents' involvement in patient care because those higher operating costs are difficult to separately identify and measure precisely. The commenter quoted part of the ruling in the Riverside case: "It is precisely because the indirect costs cannot be adequately itemized and quantified that Congress devised a formula based on the degree of teaching intensity in a particular hospital, as a substitution for any other method of reimbursing such costs. If Congress had believed that the indirect medical education costs of a teaching hospital could be separately identified and quantified, and that higher direct patient care costs could be so determined from the

hospital's records, then Congress could easily have qualified its formula for reimbursement to restrict the number of FTE residents to a number based only on hours that residents spent providing 'patient care.' It obviously did not do so".

Response**:** The first commenter is correct that the Court in the Riverside case ruled to reverse the fiscal intermediary's disallowance of time spent by the hospital's residents in nonpatient care activities from the IME FTE count. We respect and will give full effect to that Court's decision. However, we do not read that decision to restrict the Secretary's discretion to promulgate regulations on the issues litigated in that case. Although we acknowledge the Court's recognition that the statute did not specify that the IME formula be based only on hours spent in providing patient care, we believe, as explained above, that such a limitation is appropriate and in accordance with the purpose of the IME payment, as well as Congressional intent, under the IPPS. It is also noteworthy that Congress has not acted to modify the agency's policies with respect to counting FTE residents even though Congress has recently enacted several provisions relating to IME and direct GME in the MMA. We would also note that the cost report at issue in the Riverside case was from Fiscal Year *1996,* which is clear evidence that the agency's policy to disallow the time spent in nonpatient care activities from the IME FTE count in the hospital is, indeed, longstanding.

Comment**:** Many commenters voiced their concern that if CMS were to "inappropriately" require that all didactic activities must be excluded for IME purposes in the hospital, and for direct GME and IME purposes in the nonhospital sites, it would result in a "quagmire of administrative difficulties," and enormously increase teaching

hospitals' documentation burdens. It would mean a "sea change" for many hospitals, as rotation schedules are often weekly or monthly, and vary widely not only from hospital to hospital, but also from program to program. Especially for very large teaching hospitals, reporting residents' activities in hour-long increments is "literally not achievable." One commenter alleged that CMS's "nefarious" separation of patient care time from didactic activities which "devolve[s] to discussions of particular patients seems a capricious exercise in futility." With respect to training in nonhospital settings, one commenter warned that CMS' proposal would have a "chilling effect" on training outside the hospital. The commenter believed that hospitals will be "forced to demand" that nonhospital sites closely monitor the portion of time that is spent in nonpatient care activities, which may be difficult to distinguish from the patient care activities. The commenter believed that physicians will refuse to supervise residents in nonhospital sites if the documentation requirements become too burdensome, which would "frustrate" Congress' intent in enacting the IME nonhospital site payment provision. Another commenter expressed concern that CMS' "short-sighted" approach "penalizes" hospital-based residency programs that provide their residents with nonhospital training experiences, "exacerbating other recent CMS policy changes that disadvantage training programs conducted outside the hospital."

Response**:** We have carefully considered the comments, and we recognize that providing hour-by-hour schedules for, in some cases, more than 1,000 residents, could be a daunting task. We would point out, however, that nowhere in the preamble discussion of the April 25, 2006 proposed rule did we explicitly require hourly rotation schedules.

We did say that "it is important for hospitals to be able to document the activities in which residents are engaged because there are certain activities that are not allowable for direct GME or IME payment purposes, even though those activities may be performed as part of an approved residency program" (71 FR 24114). Although we need to ensure that Medicare payments are paid accurately, it is not our desire to impose unreasonably complicated and time-consuming recordkeeping requirements. It has always been the general practice of fiscal intermediaries to use rotation schedules as the primary source of documentation to determine whether residents' time is allowable for IME and direct GME payment purposes. However, we are sympathetic to the fact that up to this point, hospitals have been inconsistent in their reporting of nonpatient care activities, either because of confusion surrounding our FTE-counting policy, or because of differing approaches to developing and maintaining rotation schedules. Therefore, we believe it is appropriate from an administrative perspective to distinguish between the treatment of cost reports for cost reporting periods beginning prior to October 1, 2006, and cost reporting periods starting on or after October 1, 2006, with respect to documentation requirements. Prospectively, (for cost reporting periods beginning on or after October 1, 2006), to ensure consistent reporting by hospitals and auditing by fiscal intermediaries, we believe it is appropriate to require all teaching hospitals to document residents' time at some minimum level of detail. Specifically, for cost reporting periods beginning on or after October 1, 2006, for training occurring either in the hospital or in nonhospital settings, we are instituting a "one workday" threshold for documentation purposes. That is, we are not requiring that hospitals overhaul their current rotation

schedules, nor are we mandating that rotation schedules be in one-day increments. Rather, if a resident's workday consists entirely of scheduled didactic activities and no scheduled patient care activities (for example, no care and treatment of individual patients, or no services which are billable) then, for documentation purposes, that workday must not be recorded as "patient care" (or, as occurring in a patient care unit such as ICU or Pediatrics, etc.). Instead that workday must be identified as nonpatient care and the time must be subtracted from the allowable FTE count (for IME if the training occurred within the hospital complex, and for both IME and direct GME if the training occurred in a nonhospital site). In other words, as long as an entire workday is not scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities. For example, if a hospital maintains rotation schedules in monthly blocks for each resident in a particular program, and if a resident that is otherwise assigned to the Coronary Care Unit (CCU) for the month of January was scheduled to attend an all day conference on January 10 and not to participate in any planned patient care activities on that day, then the hospital must note on the rotation schedule that it submits to the fiscal intermediary that this resident was not in "patient care" on January 10. The hospital would subtract that time from the resident's allowable IME and/or direct GME FTE count accordingly. We believe this "one workday" approach to documentation of residents' time is an appropriate administrative measure that will assist our fiscal intermediaries in enforcing the policy concerning time spent in nonpatient care activities for cost reporting periods starting on or after October 1, 2006, while not overburdening hospitals with excessively detailed recordkeeping requirements.

However, our policy continues to be that only time spent in patient care activities may be counted for IME purposes in the hospital complex, and for direct GME and IME purposes in nonhospital sites. Accordingly, we are amending §413.75(b) to add a definition of the term "patient care activities" which means, "the care and treatment of particular patients, including services for which a physician or other practitioner may bill." (We note that in the proposed rule, we defined patient care activities as "the care and treatment of particular patients *or* services for which a physician or other practitioner may bill" (emphasis added). In this final rule, we are changing the word "or" to "including," because we did not mean to imply that the phrase "the care and treatment of particular patients" and "services for which a physician or other practitioner may bill" are mutually exclusive. Rather, services that are billable are a subset of the more general category of activities involving the "care and treatment of particular patients," and are indicative of patient care delivery). In addition, we are amending the IME regulations at §412.105(f)(1)(iii) to add a paragraph (C) to state that "In order to be counted, a resident must be spending time in patient care activities, as defined in §413.75(b)."

Comment**:** One commenter requested that if CMS decides to implement the policy expressed in the proposed rule, CMS should clarify that "only planned activities expressly undertaken to meet programmatic requirements should be included as part of the approved residency program." The commenter was concerned that without such a clarification, CMS may interpret "spontaneous" encounters at nonhospital settings (such as unplanned lunch meetings with a teaching physician and a resident where they "happen" to discuss a medical topic) as nonpatient care time. Another commenter listed

several residency training scenarios that he believed would need further clarification with respect to whether the time could be counted for IME and/or direct GME purposes, if CMS's policy is finalized. The scenarios included the time that a resident is called out of a conference to care for a patient, lunch time lectures, and requires courses of study or activities that the resident may complete at home or at a faculty member's home.

Response**:** As we stated in response to the previous comment, as long as an entire workday is not scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities. Of course, activities must be part of the approved residency training program in order to be counted for IME and direct GME payment purposes and a resident must be training within the hospital complex or in a nonhospital site. If a hospital documents that time was spent studying at a resident's or a teaching physician's home, this time is not permitted to be included in the IME count because it is not time spent in patient care, nor is it permitted to be included in the direct GME count because it did not take place in the hospital complex.

Comment**:** One commenter stated that if CMS decides to implement the policy in the proposed rule in some form (although the commenter believed CMS shouldn't), then the final policy would represent a change that must be modified formally through the process of notice and comment rulemaking, and therefore, should only apply prospectively for rotations beginning on or after July 1, 2007.

Response**:** Although we recognize that there has been some misapprehension of our policies among the teaching hospital community, in particular with respect to the counting of FTE residents training in the hospital for purposed of IME, the only change

we are making to current policy is the "one workday" approach to identifying nonpatient care time spent by residents. We do not believe it is necessary to wait until July 1, 2007, to implement our recordkeeping policy. We believe that an effective date stated above, for cost reporting periods beginning on or after October 1, 2006, provides hospitals with sufficient time to either modify their rotation schedules to reflect the "one workday" approach or to find other comparable documentation that can be used by the fiscal intermediaries in auditing cost reports.

Comment**:** A commenter said that it is unclear how CMS intends to exclude nonpatient care time for cost reporting purposes; that is, just from the time allowable as part of a hospital's resident count (that is, the numerator), or from the total time worked (in all locations) by the resident (that is, the denominator). The commenter observed that the statute quoted by CMS in the proposed rule states that "only time spent in activities relating to patient care shall be counted" (emphasis added, section 1886(h)(4)(E) of the Act). The commenter believed that to be "counted", the time appears both in the allowable time claimed by the hospital and the total time worked by the resident in a given year, and conversely, if the activities do not relate to patient care, then the time should not be counted either as allowable time or as part of the total time worked. The commenter requested that CMS specify that these activities are not to be included at all in IRIS, either as allowable or unallowable, so as not to dilute the total resident count that may be claimed by all of the hospitals training the resident.

Response**:** The effect of the commenter's request would be to ignore portions of training time spent by residents in approved residency training programs with the result

that, in total, less than a full-time equivalent resident would be counted. We do not believe such a policy would be appropriate or comport with Congressional intent. Section 1886(h)(4)(A) of the Act states that, "The Secretary shall establish rules consistent with this paragraph for the computation of the number full-time equivalent residents in an approved medical residency training program" and the remainder of the subsection is replete with references to "full-time equivalent" residents. Accordingly, the regulations at §412.105(f)(1)(iii)(A) for IME and §413.78(b) for direct GME indicate that, in computing the FTE count of a hospital, for each resident, the denominator consists of the total time necessary to fill a residency slot, which constitutes full-time equivalent status. Full-time equivalent status, in turn, is based upon the total amount of training time necessary to fulfill the requirements of the approved medical residency training program in a given academic year. Therefore, the denominator must consist of the total time worked by a resident throughout the academic year in activities that are part of the approved program, whether or not the time is permitted to be counted for IME or direct GME payment purposes. As stated in response to a previous comment, the starting point (denominator) for determining the allowable FTE count is the total time necessary to fill a residency slot consistent with the requirements of the approved residency program. However, the hospital must then subtract all non-allowable training time, such as time spent at other providers, time spent in IPPS-excluded distinct part units, nonpatient care activities (for example, research, didactic time), and so on, and only include the allowable time in the numerator. Thus, while a hospital's allowable FTE count is certainly "based" on the total time necessary to fill a resident slot that total time

is often greater than the FTE time a particular hospital is permitted to count for payment purposes. Furthermore, certainly no FTE resident time that is outside the scope of the approved program would be included in either the numerator or the denominator of the FTE computation.

Comment**:** A commenter noted that CMS uses the definition of "hospital complex" as explained in the September 29, 1989 **Federal Register** to determine which residents may be included in a hospital's direct GME count. Specifically, the September 29, 1989 **Federal Register** (54 FR 40286) states that the hospital complex consists of the hospital and hospital–based providers and subproviders. The commenter observed that CMS's regulations concerning the requirements for provider-based status are at §413.65, and stated that it is their understanding that if a facility qualifies as provider-based under these regulations, the facility will be considered part of the hospital complex. The commenter requested that the connection between "hospital complex" and "provider-based" be clarified in the final rule, since the September 29, 1989 **Federal Register** seems to imply that only facilities such as SNFs and HHAs (facilities that bill Medicare and have direct patient care activities) can qualify as provider-based. The commenter noted that, for example, a separate building where only research is conducted may qualify for provider-based status and should be included as part of the hospital complex.

Response**:** The commenter is correct that the regulations that would be used to determine if a facility is part of the hospital complex (that is, provider-based) for direct GME purposes, are at §413.65. As the commenter pointed out, it may be necessary to

determine for direct GME purposes if a facility in which no patient care is provided is "provider-based," even though a provider-based determination would not otherwise be made for such a facility. The example mentioned by the commenter of a separate building in which only research is conducted would be an instance where it would be appropriate for the fiscal intermediary to use the criteria at §413.65 to determine if a facility is part of the hospital complex for direct GME purposes. Thus, training that occurs in facilities that meet the provider-based criteria at §413.65 is training "in the hospital", and training that occurs in facilities that do not meet the provider-based criteria is training "in nonhospital settings," (and, of course, in the case of the training in nonhospital settings, the hospital must meet certain requirements in order to count any FTE resident training time spent in that setting).

Comment**:** Some commenters urged CMS not to distinguish between direct GME and IME payments based on hospital versus nonhospital locations. One commenter argued that "geography" is irrelevant, particularly in the era of telephone and internet communications. Another commenter believed that distinctions between provider-based versus freestanding practices or medical school facilities are "founded on legal, structural, or financial issuances." The commenter stated that hospital and nonhospital locations might be "across the hall or on the next floor from each other" with no difference between the patient care and learning experiences in each place. The commenter believed that CMS has recently distinguished between these sites for reimbursement purposes based solely on who is bearing "all or substantially all" of the costs of the residency program, which has created "confusion, complexity, and

controversy" in the provider community. Further "clarifications" of payment based on location or on type of activity are "unnecessary and onerous."

Response**:** We understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However, as the commenter indicated, hospitals, nonhospital sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes. To put it simply, a hospital is not a medical school, and a medical school is not a hospital. As we stated in response to the previous comment, the criteria to be used in determining if a facility is provider-based are in the regulations at §413.65. Facilities that meet the provider-based criteria are part of the hospital, and facilities that do not meet the provider-based criteria are nonhospital sites, even if they are located on the same campus as the hospital. Additionally, while there is no requirement that hospitals incur the costs of residents training in a hospital in order for those residents to be counted for IME and direct GME purposes, hospitals are required by statute (not merely by CMS regulations, as the commenter implies) to incur "all, or substantially all of the costs" of a residency training program in a nonhospital site (such as a medical school) in order to count any of the resident FTE training time spent in those nonhospital sites for IME and direct GME purposes. Similarly, the statutes for IME and direct GME clearly indicate that only training in patient care activities may be counted in the nonhospital sites. Since the statute makes these distinctions, we do not believe we have created "unnecessary" and

"confusing" distinctions between where the residents are training, or the type of activities in which the residents are engaged.

Comment**:** Many comments from members of an academy of family medicine in a particular State indicated that they were informed that "CMS is considering the disallowance of faculty development activity in the calculation of IME and DME reimbursement." Some of the activities they listed as being at risk included development, review, and delivery of curriculum, scholarly activities such as written publications and faculty development conferences, resident evaluation, faculty training, and alumni evaluation and research. The commenters were concerned that future physicians cannot be properly trained "without support for the educational aspects of their experience." Another group of commenters, also teaching faculty for family medicine programs, stated that they were attracted to a profession in family medicine because "the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of future physicians." These teaching physicians stated that less than one-third of their academic time is compensated, and if funding for their work on program development, clinical research, writing critical reviews, and evaluating resident performance is reduces, then they may find it necessary to return to full time clinical practice, since the "thought of being told by a program that [we] will need to see more patients to pay for the time [we are] developing and delivering curriculum will be unacceptable." The commenters concluded by wishing CMS "the best of luck" if CMS implements this rule, and stated that they would not continue as faculty members.

Another commenter cautioned that "with every additional burden placed" on residency training by CMS or the ACGME, more valuable teaching physicians will be lost.

Response**:** It appears the commenters have confused the time that residents in approved programs spend in nonpatient care activities, with the time that teaching faculty spend in nonpatient care activities. While the direct GME payments, through the PRAs, do compensate teaching hospitals for the portion of the teaching physicians' salaries and fringe benefits attributable to GME activities, only the FTE time of residents participating in approved programs is included in the hospital's FTE resident count for both IME and direct GME. Accordingly, the activities listed by the commenters in which teaching faculty engage either on behalf of, or independent of, the residents they supervise are not affected by the rule that only time spent by residents in patient care activities may be counted for IME purposes in the hospital, and for IME and direct GME purposes in the nonhospital sites.

Comment**:** One commenter, a hospital system, said that their understanding, which has been "reaffirmed time and again by our annual fiscal intermediary audits," is that, with respect to direct GME, time spent in a nonpatient care activity, "no matter where it took place (on site or off), was allowed to be counted if that activity was needed for Board certification." The commenter stated that it seems CMS "largely agrees" with this position "If the nonpatient care activities occur on site, but doesn't if the activity is offsite" (emphasis included in the original). The commenter believes this is "illogical" considering that the hospital continues to bear the direct costs of the resident in either case. The commenter concluded that, although they were commenting on the

implications for direct GME, "at least for IME, [CMS's] position is consistent—nonpatient care activities are not allowed whether one is on site OR offsite" (emphasis included in the original).

Response**:** As we indicated in response to a previous comment, although our position with respect to IME and FTE time spent in nonpatient care activities is a longstanding policy as we explained in greater detail above, it has become apparent to us that there actually has been significant confusion regarding this policy in the teaching hospital community. Our policy has been to apply the plain meaning of the term "patient care activities," which means that, even if the nonpatient care activities that occur in nonhospital sites count toward Board certification (that is, they are part of the approved program), such time must not be included in the direct GME or IME count. With respect to training in the hospital, resident time spent training in didactic activities that are part of an approved program can be counted for direct GME purposes, but not for IME. It makes no difference whether the hospital is paying the residents' salaries when the training occurs in the hospital complex; whether a hospital incurs the costs for the residents it trains in the hospital is *irrelevant* for purposes of both IME and direct GME. The requirement to incur the costs of the residency training program only applies in the instances where hospitals wish to count FTE residents that are training in nonhospital settings. In that case, the hospital must incur all or substantially all of the costs of the training program in the nonhospital site (and meet certain other requirements) in order to count any FTE residents training in that site.

In summary, we are finalizing the clarification of our policy that only time spent in patient care activities may be counted for IME purposes in the hospital complex and for direct GME and IME purposes in nonhospital sites. We are amending §413.75(b) to add a definition of the term "patient care activities" which means, "the care and treatment of particular patients, including services for which a physician or other practitioner may bill." In addition, we are amending the IME regulations at §412.105(f)(1)(iii) to add a paragraph (C) to state that "In order to be counted, a resident must be spending time in patient care activities, as defined in §413.75(b)." We are also making conforming changes to the regulations text at §412.105(f)(1)(iii)(C), and §413.78(c)(1), (d)(1), and (e)(1) for residency training in nonhospital settings. Lastly for cost reporting periods beginning on or after October 1, 2006, we are implementing a "one workday" approach to documentation of residents' time, where, if a resident's workday consists entirely of scheduled nonpatient care activities, that workday must be identified as nonpatient care time and must be subtracted from the allowable FTE count (for IME, if the training occurred in the hospital complex, and for both IME and direct GME, if the training occurred in a nonhospital site).

6. Medicare GME Affiliated Groups: Technical Changes to Regulations

In the FY 2005 IPPS final rule (69 FR 49112 and 49254 through 49265), we redesignated the contents of §413.86 (which contained the regulations governing Medicare payment for direct GME) as §§413.75 through 413.83 and made corresponding cross-reference changes in the text of these regulations. We have discovered that under the definition of "Medicare GME affiliated group" under §413.75(b), we incorrectly cited

the cross-reference to the rotation requirements for GME affiliated groups in paragraphs (1), (2), and (3), as "§413.79(g)(2)". In the FY 2007 IPPS proposed rule (71 FR 24115), we proposed to correct the cross-reference for the rotation requirements in paragraphs (2) and (3) of the definition to read "§413.79(f)(2)".

We did not receive any public comments on this proposed technical change and, therefore, are adopting it as final.

In the FY 2006 IPPS final rule (70 FR 47457 and 47489), we made additional changes to certain sections of the GME redesignated regulations to correct cross-references to other parts of 42 CFR Chapter IV relating to the definitions of the "urban" and "rural" location of a hospital. In one of the corrections, in paragraph (1) under the definition of "Medicare GME affiliated group" under §413.75(b), we inadvertently dropped the language in that paragraph relating to the rotational requirements for these groups, including the incorrect cross-reference to §413.79(g)(2). In the FY 2007 IPPS proposed rule (71 FR 24115), we proposed to correct the language of paragraph (1) under the definition of "Medicare GME affiliated group" under §413.75(b) by adding the dropped language and correcting the cross-reference to read "§413.79(f)(2)."

We did not receive any public comments on this proposed technical change and, therefore, are adopting it as final.

In the FY 2006 IPPS final rule (70 FR 47454 and 47489), we revised §413.79(e)(1)(iv) to provide that a new urban teaching hospital that qualifies for an adjustment to its FTE cap for a newly approved program may enter into a Medicare GME

affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are "positive adjustments." We specified in the preamble of that final rule that this provision is effective for affiliation agreements entered into on or after October 1, 2005. However, we inadvertently did not include this effective date in the regulation text. In the FY 2007 IPPS proposed rule (71 FR 24115 and 24116), we proposed to revise §413.79(e)(1)(iv) to include the effective date as part of the text of that section.

In addition, we proposed to correct a cross-reference in the introductory text of paragraph (f) of §413.79 relating to Medicare GME affiliated groups. The cross-reference to "paragraph (e)(3)" of §413.79 should read "paragraph (d)" of that section. This proposed change is necessary to accurately cite the reference to our rules regarding the 3-year rolling average.

We did not receive any public comments on the proposed technical change and cross-reference change and, therefore, are adopting them as final.

I. Payment for the Costs of Nursing and Allied Health Education Activities: Clarification (§413.85)

In addition to direct GME and IME payments to hospitals for the direct and indirect costs incurred for their graduate medical education programs in medicine, osteopathy, dentistry, and podiatry, Medicare makes payments to hospitals for two other categories of education-related costs for which different payment policies apply:

- Approved nursing and allied health education programs operated by the hospital. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of the per discharge

payment rates for hospitals paid under the IPPS, or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and "passed through" (that is, paid separately, on a reasonable cost basis).

- All other costs that can be categorized as educational programs and activities (for example, continuing education, on the job training, or seminars). These costs are considered to be part of the hospitals' normal operating costs and payment for these costs is included in the per discharge payment amount for hospitals subject to the IPPS, the IRF PPS, or the LTCH PPS and the prospective per diem payment amount for facilities under the IPF PPS. Similarly, these costs are considered to be part of the hospitals' normal operating costs and are included as reasonable costs that are subject to the TEFRA rate-of-increase limits applicable to hospitals that continue to receive payments subject to those limits, including cancer and children's hospitals.

Regulations governing payment for the costs of approved and allied health education activities are located at 42 CFR 413.85.

In the FY 2004 IPPS final rule (68 FR 45429), we revised the regulations at §413.85(h)(3) to further clarify the difference between provider-operated and continuing education programs. We revised the regulations to state that, effective October 1, 2003, programs in which employees participate that do not lead to the ability to practice and begin employment in a nursing or allied health specialty are also treated as normal operating costs. We now realize that when we revised §413.85(h)(3) to include this clarification, we inadvertently did not specify that the provision was applicable to

trainees as well as employees. In the preamble of the FY 2004 IPPS final rule, we stated that because §413.85(h)(3) refers to education that will not lead to the ability to practice and begin employment, we intended the provisions to apply not only to employees but to trainees as well. Therefore, in the FY 2007 IPPS proposed rule (71 FF 24116), we proposed to make a technical change to §413.85(h)(3) to make it applicable to both employees and trainees. We proposed this technical change to clarify that the educational activities in which employees or trainees participate, but that do not lead to the ability to practice and begin employment in a nursing or allied health specialty, are treated as normal operating costs. We noted that we did not propose to expand or make any changes to the current payment policy for nursing and allied health education activities; rather, we merely proposed to clarify the language of the existing regulations.

Comment: One commenter requested that, in response to CMS' clarification of the regulations pertaining to normal operating costs, CMS make "…a regulation revision to reflect that trainees are included in the normal operation costs to avoid confusion."

Response: We agree with the commenter and note that as we proposed, we are revising the regulations at §413.85(h)(3) to read: Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

In this final rule, we are adopting as final, without modifications, the proposed technical change to §413.85(h)(3) to make it applicable to both employees and trainees.

J. 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 proposed 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 medical conditions, 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), Pub. L. 99-272. Congress enacted these antidumping provisions in the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services because of a perceived inability to pay.

Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be liable for 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 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.

2. Role of the EMTALA Technical Advisory Group (TAG)

Section 945 of Pub. L. 108-173 (MMA) required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. Section 945 of Pub. L. 108-173 further required that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG was first established in 2005 and held three meetings during that year. At each of its meetings, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. As explained more fully below in sections IV.K.3. and 4. of this preamble, in the FY 2007 IPPS proposed rule (71 FR 24116 through 24118) we proposed to revise the EMTALA regulations at §489.24 based on the recommendations adopted and forwarded to the Secretary by the EMTALA TAG.

3. Definition of "Labor"

As noted in the background portion of this section, the EMTALA statute and regulations require that if an individual comes to a hospital emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital is obligated to provide that individual with an appropriate medical screening examination within the capability of the hospital. If the individual is found to have an emergency medical condition, the hospital is obligated by EMTALA to provide either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

Section 489.24(b) of the regulations defines the key terms used in the section. The term "emergency medical condition" is defined as--

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health and safety of the woman or the unborn child."

This definition closely follows the definition of "emergency medical condition" in section 1867(e)(1) of the Act with the exception that the regulation text further expands on "acute symptoms of sufficient severity" by including "psychiatric disturbances and/or symptoms of substance abuse" in addition to severe pain. In recognition of the fact that this definition gives special consideration to women in labor, the term "labor" is itself defined, in paragraph (b) of §489.24, to mean "the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta." The definition further states: "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable period of observation, the woman is in false labor." A woman found to be in false labor is considered not to have an emergency medical condition and that finding thus means that the hospital has no further EMTALA obligation to her.

The CMS interpretative guidelines used by State surveyors in EMTALA investigations provide that once an individual has presented to a hospital seeking emergency care, the determination as to whether an emergency medical condition exists is made by the examining physician(s) or other qualified medical person (s) actually caring for the individual at the treating facility. The guidelines further provide that the

medical screening examination must be conducted by one or more individuals who are determined to be qualified by the hospital bylaws or rules and regulations and who meet the hospital condition of participation in 42 CFR 482.55 regarding emergency services personnel and direction. (Of course, these individuals would not be expected or permitted to perform any screening functions other than those which they are allowed to perform under State scope of practice laws.) However, consistent with the definition of "labor" at §489.24(b), the guidelines also state that if a qualified medical person other than a physician determines that a woman is in false labor, a physician must certify the diagnosis. The guidelines permit this certification to be made based either on actual examination of the patient or on a telephone consultation with the qualified medical person who actually examined the patient. (Medicare State Operations Manual, Appendix V—Interpretive Guidelines—Responsibility of Participating Hospitals in Emergency Cases, TAG A-406.)

At its meeting held on June 15-17, 2005, the EMTALA TAG heard testimony from representatives of both physician and nonphysician professional societies regarding the competence of practitioners other than physicians to certify false labor. In particular, a representative of the American College of Nurse-Midwives stated that the current requirement that allows only a physician to certify false labor is overly restrictive and does not adequately recognize the training and competence of certified nurse-midwives. Testimony was also presented by the American College of Obstetricians and Gynecologists, which recommended amending the EMTALA regulations to allow

certified nurse-midwives and other qualified medical persons to determine whether a woman is in false labor.

After extensive consideration of the issue, the members of the EMTALA TAG voted to recommend to the Secretary that the definition of "labor" at §489.24(b) be amended to permit certified nurse-midwives and other qualified medical personnel to certify false labor. The TAG recommended deleting the second sentence, which states that 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 agree with the TAG's recommendation that other health care practitioners besides physicians should be allowed to certify false labor, and believe that the recommendation is consistent with CMS' current policy regarding who may conduct medical screening examinations. However, we do not believe such a change can be best accomplished by simply deleting the second sentence of the current definition of "labor" in the existing regulations because doing so would also remove the explicit statement that a woman experiencing contractions is in labor unless she has been found to be in false labor. To achieve the principal objective of the EMTALA TAG recommendation without compromising the protections of EMTALA for women having contractions, in the FY 2007 IPPS proposed rule, we proposed to modify the definition of "labor" in §489.24(b) by revising the second sentence of that definition to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of

observation, the woman is in false labor. The effect of this change would be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition.

Comment: Several commenters expressed approval of the proposed change to the regulations to allow nonphysician practitioners to certify when a woman is in false labor, pursuant to State law and hospital bylaws. The commenters stated that this change to the regulations would provide hospitals greater flexibility in staffing and help ensure access to necessary services.

Response: We appreciate the commenters' support for this change to the regulations and have kept their remarks in mind while finalizing this proposal.

Comment: One commenter disagreed with the proposed change to the regulations. The commenter stated that one cause of higher rates of premature labor and malformed and malpresented neonates in the United States than among other industrialized nations is the use of nurses for labor and delivery services. The commenter recommended that CMS not only continue to require that a physician determine when a woman is in false labor but also that such physician be specialized in obstetrics.

Response: While we understand this commenter's concerns, the commenter has not provided evidence to support the allegation that there is a higher rate of premature labor and malformed and malpresented neonates in the United States than other industrialized nations. Nor has the commenter demonstrated that the problems as cited are directly linked to nonphysician practitioners' involvement in labor and delivery services. Therefore, we are not modifying the proposed change based on this comment.

Comment: One commenter expressed approval of the concept of allowing practitioners other than physicians to certify false labor, but objected to the use of the phrase "qualified medical person" in §489.24(b) to describe the kind of individual who may perform this function. The commenter stated that use of the term "medical" could suggest, incorrectly, that only a physician could certify false labor. The commenter recommended that the term used be "other qualified health care professional".

Response: The term "qualified medical person" is used in section 1867(c)(1)(A)(ii) of the Act and in current regulations at §489.24 (e)(1)(C). Both statutory and regulatory usages of this term make reference to a "qualified medical person" as an individual other than a physician who is authorized to sign a certificate outlining the risks and benefits of transfer in the absence of a physician. Thus, we do not believe the language in our proposed revision will be misleading. However, we will keep the commenter's concern in mind as we draft conforming revisions to the EMTALA program instructions and other issuances, to make it clear that a qualified medical person need not be (and in fact will not be) a physician.

After consideration of the public comments received, we are adopting as final, without modifications, the proposed change in the definition of "labor" in §489.24(b).

4. Application of EMTALA Requirements to Hospitals Without Dedicated Emergency Departments

Section 489.24(b) of the regulations outlines when a hospital will be considered to be a hospital with a "dedicated emergency department" and makes it clear that only a hospital with a dedicated emergency department has an EMTALA responsibility with

respect to an individual for whom no appropriate transfer is sought but who comes to the hospital seeking examination or treatment for a medical condition. However, it has come to CMS' attention that our policy regarding the application of EMTALA to hospitals that have specialized capabilities but are without dedicated emergency departments may be less well understood as it relates to individuals for whom an appropriate transfer is sought.

It has been CMS' longstanding policy that any Medicare-participating hospital with a specialized capability must, in accordance with section 1867(g) of the Act, accept, within the capacity of the hospital, an appropriate transfer from a requesting hospital. This policy has been applied to hospitals without regard to whether they have dedicated emergency departments. In fact, in the past, CMS has taken enforcement actions against hospitals with specialized capabilities that failed to accept appropriate transfers under EMTALA when the hospitals had the capacity to treat the transferred individuals.

At its meeting held on October 26-28, 2005, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA compliance by specialty hospitals that typically do not have dedicated emergency departments. After extensive consideration and discussion of the issues raised and views presented, the members of the EMTALA TAG voted to recommend to the Secretary that hospitals with specialized capabilities (as defined in §489.24(f) of the regulation) that do not have a dedicated emergency department be bound by the same responsibility to accept an appropriate transfer under EMTALA as hospitals with a dedicated emergency department.

We agree with the EMTALA TAG's assessment. We believe that the recommendation is consistent with CMS' current policy and highlights the need to clarify CMS' policy regarding hospitals with specialized capabilities. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to modify the regulations at §489.24(f) to specifically indicate that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We noted that the proposed revision does not reflect any change in current CMS policy. We further noted that the revision would not require hospitals without dedicated emergency departments to open dedicated emergency departments nor would it impose any EMTALA obligations on those hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Although the proposed revision sought only to clarify, rather than change, current policy, we nevertheless, solicited comments on what effect, if any, commenters believe the proposed clarification might have on EMTALA compliance and patient health and safety.

Comment: Several commenters expressed approval of the proposed change to the regulations to clarify that hospitals with specialized capabilities have an obligation under EMTALA to accept appropriate transfers within their capabilities whether or not the hospital has a dedicated emergency department, including all physician-owned limited service facilities.

Response: We appreciate the commenters' support for this change to the regulations and have kept their remarks in mind while finalizing this proposal.

Comment: Several commenters requested that CMS provide additional guidance on the definition of "specialized capabilities or facilities."

Response: We refer these commenters to the regulations at §489.24(f) for a partial list of specialized capabilities or facilities. These include, but are not limited to, burn units, shock-trauma units, neonatal intensive care units, and certain referral centers. We recognize that this list is not exhaustive and would include physician-owned limited service facilities with special capabilities. We also would note that the EMTALA TAG is currently considering whether the definition of "specialized capabilities" should be further revised. However, no expansion of the list of specialized facilities or capabilities was specifically proposed in the proposed rule published on April 25, 2006. In view of this fact and in consideration of the fact that the EMTALA TAG may make recommendations relating to this issue, we have decided not to make any further revision to the list of examples noted above. However, we will consider carefully any recommendations made by the EMTALA TAG on the issue and may propose changes in the future.

Comment: Several commenters asked CMS to emphasize that all physician-owned limited service facilities are required to maintain adequate on-call panels to comply with the Medicare hospital conditions of participation. In addition, the commenters requested that CMS require these hospitals to have preexisting transfer agreements with any community hospital to which it may send patients for emergency

services. Two commenters suggested that the Secretary establish the terms of such agreements. The commenters recommended three issues to be addressed in the agreements: procedures for an appropriate transfer for patients not covered under EMTALA; continuity of care; and support for maintaining full-time emergency capacity at the community hospital, including on-call coverage. The commenters also requested that CMS require physicians who practice at such hospitals to participate in on-call panels at the community hospitals with which their hospital has a transfer agreement.

Response: While physician-owned limited service hospitals certainly are required to maintain compliance with the hospital conditions of participation, those regulations set forth in 42 CFR Part 482 do not include an explicit on-call requirement. Thus, we are not including a revision in this final rule to include the specific change requested by the commenter. However, we note that the conditions of participation relating to a hospital's governing body at §482.12(c)(3) requires that all Medicare-participating hospitals have a doctor of medicine or osteopathy either on duty or on call at all times. In addition, the governing body condition of participation and the condition of participation for medical staff found at §482.22 include various other requirements that make the hospital governing body and medical staff accountable for providing adequate physician services for hospital patients. These requirements also apply to physician-owned limited service facilities, including those that do not operate emergency departments, on the same basis as to community and other hospitals.

In general, we believe the comments concerning transfer agreements are outside the scope of the proposed change to the regulations. In addition, the terms of transfer

agreements between hospitals are decided upon by the individual hospitals party to the agreement. However, we will refer these comments to the EMTALA TAG for further consideration, and may propose some further change in Medicare regulations on these topics in the future if they are warranted.

5. Clarification of Reference to "Referral Centers"

The language of the existing regulations at §489.24(f) duplicates the language of section 1867(g) of the Act in that it identifies, as an example of a hospital with specialized capabilities, "(with respect to rural areas) regional referral centers identified by the Secretary in regulation)". Because the term "regional referral centers" is not used elsewhere in the Medicare regulations, it is unclear whether the reference is to referral centers as defined in 42 CFR 412.96, which must be located in rural areas and meet other criteria spelled out in that section, or to any facilities that are located in rural areas and accept patients on referral. To maintain consistency in the Medicare regulations and avoid confusion as to which facilities are considered to have specialized capabilities for purposes of EMTALA, in the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to amend §489.24 by clarifying that "regional referral centers" are those centers meeting the requirements of §412.96.

We did not receive any public comments on this clarification and, therefore, are adopting, as final without modification, the amendment to §489.24 to clarify that "regional referral centers" are those centers meeting the requirements of §412.96.

K. Other Technical Changes

1. Cross-Reference Correction in Regulations on Limitations on Beneficiary Charges (§412.42)

In the FY 2007 IPPS proposed rule (71 Fr 24118), we proposed to amend §412.42 to correct an obsolete cross-reference. Paragraph (d) of §412.42 contains a cross-reference to "§405.310(k)." This section was redesignated as §411.15(k) in 1989 (54 FR 41737, October 11, 1989). We proposed to amend paragraph (d) of §412.42 to delete the obsolete cross-reference and insert the correct cross-reference.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

2. Cross-Reference Corrections in Regulations on Payment Denials Based on Admissions and Quality Reviews (§412.48)

In the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to amend §412.48 to correct an obsolete cross-reference. Paragraph (b) of §412.48 contains a cross-reference to "§§405.330 through 405.332". Section 405.330 was redesignated as §411.400, and §405.332 was redesignated as §411.402 in 1989 (54 FR 41746, October 11, 1989). (There was no §405.331.) We proposed to amend paragraph (b) of §412.48 to delete the obsolete cross-references and to insert the correct cross-references.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

3. Cross-Reference Correction in Regulations on Outlier Payments (§412.84)

On June 9, 2003, we published a final rule in the **Federal Register** (68 FR 34494) that amended the portion of the hospital IPPS regulations that sets out the methodology

for determining payments for extraordinarily high-cost cases (outliers). We changed the methodology because we concluded that, in certain cases, hospitals were dramatically and inappropriately increasing charges, thereby inflating CCRs, resulting in overestimation of these hospitals' costs per case, a critical factor in determining outlier payments.

As a part of these methodology changes, we required that outlier payments be reconciled using a hospital's settled cost report for the cost reporting year in which the outlier discharge occurred. This approach meant that there would be some delay in computing the final outlier payment. To address this issue, we added §412.84(m), which provided that reconciled outlier payments would be adjusted to account for the time value of any underpayments or overpayments.

We inadvertently included in paragraph (m) of §412.84 a cross-reference to paragraph (h)(3) of §412.84. The cross-reference should be to paragraph (i)(4), which sets out the requirement for reconciling outlier payments when the cost report for the year in which the discharge occurred is settled. In the FY 2007 IPPS proposed rule (71 FR 24118 and 24119), we proposed to amend paragraph (m) of §412.84 to correct the cross-reference to read "paragraph (i)(4)" of §412.84.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

4. Removing References to Two Paper Claims Forms

Section 1862(a)(22) of the Act generally requires electronic submission of initial Medicare claims requesting payment for items and services. Section 1862(h) of the Act

provides for limited exceptions when paper claims still may be used. Our existing regulations at 42 CFR 424.32 set out the requirements for submitting electronic and paper claims for payment, as well as when the exceptions apply and paper forms still may be used. Our existing regulations at paragraph (b) of §424.32 list six forms that are to be used for submitting paper claims.

We have evaluated the use of two of these forms, Form CMS-1490U (Request for Medicare Payment by Organization) and Form CMS-1491 (Request for Medicare Payment – Ambulance). We found that these forms have limited use, we would incur expensive costs in redesigning these forms to comply with other reporting requirements, and that an alternate form is available to claim payments. For these reasons, we intend to no longer use these forms. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24119), we proposed to remove the references to these forms from paragraph (b) of §424.32.

Form CMS-1490U is a paper claim form used by employers, unions, employer-employee organizations that pay physicians and suppliers for their services to employees, group practice prepayment plans, and health maintenance organizations. Form CMS-1490U is used to claim payment from carriers for bills already paid by these entities. We concluded that this form should no longer be used for several reasons. It is duplicative of Form CMS-1500 (Health Insurance Claim Form), which also may be used to claim payment for these services. We have encouraged suppliers to submit their paper claims using the Form CMS-1500. Unlike Form CMS-1500, Form CMS-1490U cannot accommodate an additional reporting requirement, the National Provider Identifier (NPI), without an expensive redesign. Finally, according to our records, relatively few suppliers

currently use the form. The CMS component that supplies blank copies of this form for users reported that, between 2002 and 2005, only 2,550 copies of Form CMS-1490U were ordered by carriers. A 2005 survey of Part B carriers indicated that requests for the form are very low and that receipts of the form vary from very few to none.

Form CMS-1491 is a paper claim form used by ambulance suppliers to apply for payment for ambulance services. We concluded that this form should no longer be used for several reasons. It also is duplicative of Form CMS-1500, which also may be used to claim payment for ambulance services. In addition, we have encouraged suppliers to submit their paper ambulance claims using the Form CMS-1500. Unlike Form CMS-1500, Form CMS-1491 cannot accommodate the NPI without an expensive redesign and usage of this form is low. A recent survey of carriers, initiated by Joint Signature Memorandum RO-2324, Request for Information Concerning the CMS-1491, issued October 30, 2003, from the Centers for Medicare Management, was conducted to ascertain the usage of Form CMS-1491. The results of the survey showed that fewer than 2 percent (1.71 percent) of all suppliers of ambulance services currently use the Form CMS-1491. CMS received approximately 240,000 ambulance claims using Form CMS-1491 during the period from October 1, 2002, to September 30, 2003. These data were used for the most recent OMB renewal under the Paperwork Reduction Act. Since the last OMB renewal approval in 2001, CMS has printed a total of 1,620,000 forms at a cost of $42,890.

We did not receive any public comments on our proposal. Therefore, we are adopting, as final without modification, the proposed removal of the references to the identified forms from paragraph (b) of §424.32

L. Rural Community Hospital Demonstration Program

In accordance with the requirements of section 410A(a) of Pub. L. 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.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Pub. L.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 for FY 2007. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have withdrawn from the program; they have become CAHs.)

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. 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 Pub. L. 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 the nine 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 2007, 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 and FY 2006 IPPS final rules (69 FR 49183 and 70 FR 47462), 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 2007, using cost report data for FY 2003, adjusted to account for the increased estimated costs for the remaining nine participating hospitals, we estimate that the adjusted amount would be $9,197,870. 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 will be required to ensure the budget neutrality of the demonstration program for FY 2007 in section II.A.4. of the Addendum to this final rule.

We did not receive any public comments on the provisions of the demonstration program discussed in the proposed rule.

M. Health Care Information Transparency Initiative

The United States faces a dilemma in health care. Although the rate of increase in health care spending slowed last year, costs are still growing at an unsustainable rate. The United States spends $1.9 trillion on health care, or 16 percent of the gross domestic product (GDP). By 2015, projections are that health care will consume 20 percent of the

GDP. The Medicare program alone consumes 3.4 percent of the GDP; by 2040, it will consume 8.1 percent of the GDP, and by 2070, 14 percent of the GDP.

Part of the reason health care costs are rising so quickly is that most consumers of health care--the patients--are frequently not aware of the actual cost of their care. Health insurance shields them from the full cost of services, and they have only limited information about the quality and costs of their care. Consequently, consumers do not have the incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price. Reducing the rate of increase in health care prices and avoiding health services of little value could help to stem the growth in health care spending, and potentially translate into fewer individuals who are unable to afford health insurance. Part of the President's health care agenda is to expand Health Savings Accounts (HSAs), which would provide consumers with greater financial incentives to compare providers in terms of price and quality, and choose those that offer the best value.

In order to exercise such choices, consumers must have accessible and useful information on price and quality of health care items and services. Typically, health care providers do not publicly quote or publish their prices. Moreover, list prices, or charges, generally differ from the actual prices negotiated and paid by different health plans. Thus, even if consumers were financially motivated to shop for the best price, it would be very difficult at the current time for them to access usable information.

Similarly, individuals have very little information available to them about the quality of care that they receive. Although there are preliminary steps underway to rectify that fact, including the hospital quality reporting initiative in which a significant number of acute care hospitals are participating (see sections IV.A and IV.B of this preamble), those data are nascent and consumers lack sufficient information on which to base a judgment about where to receive care based on quality of care.

For these reasons, in the FY 2007 IPPS proposed rule (71 FR 24120), we announced that the Department intends to launch a major health care information transparency initiative in 2006. This effort will build on steps already taken by CMS to make quality and price information available. For example, we currently collect quality information and publish it through the CMS Hospital Compare Web site, which we reference in other parts of this final rule. We also make available unprecedented information on the prices of drugs to beneficiaries in the Medicare prescription drug plan for each pharmacy in the United States.

In the FY 2007 IPPS proposed rule, we also stated that we intend to take further steps to collect and publish useful information on quality and cost. The Department intends to identify several regions in the United States where health care costs are high, and where there is significant interest in reducing health care costs and improving health care quality. The Department will use its leadership role in health care policy to help lead change in those areas.

The Secretary also has significant regulatory authority as well. In the FY 2007 IPPS proposed rule, we solicited comments on several proposals that the Secretary might

adopt to increase the transparency of quality and pricing information, and how this can be used to attenuate the growth in health care costs. In addition, we solicited comments from the public on additional ways that we could use our regulatory authority to enhance transparency of quality and pricing information.

In the FY 2007 IPPS proposed rule, we addressed several possibilities that we believe exist. First, we could publish a list of hospital charges either for every region of the country or for selected regions of the country. In addition, we could publish the rates that Medicare actually pays to a particular hospital for every DRG or for selected DRGs that could be adjusted to take into account the hospital's labor market area, teaching hospital status, and DSH status. Some might argue that publishing these payment rates does not provide meaningful information to consumers because Medicare payment rates are not set by the market, but rather by a statutory payment formula. In addition, providing information on hospital payments only does not disclose the true cost of an episode of care because it would not take into account the cost of physician services, laboratory tests, and other procedures that go along with hospital charges. On the other hand, Medicare payment rates may provide a helpful benchmark, especially for uninsured individuals, to determine whether the charges they see on a hospital bill bear any relationship to what third-party fee-for-service payors pay to the hospital.

A second option would be for the Secretary to use his authority to establish conditions of participation for hospitals to propose a rule that relates to charges for uninsured patients. For example, the conditions of participation could include a

requirement that hospitals post their prices and/or post their policies regarding discounts or other assistance for uninsured patients.

Yet another alternative to posting Medicare DRG payment rates would be to make publicly available the total Medicare payments for an episode of care. For example, one of the most common inpatient hospital procedures under the Medicare program (based on total dollars spent) is hip replacement surgery. Under this proposal, we could make publicly available the expected total payment for an episode of care for hip replacement surgery, including the inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as services provided in an IRF, SNF, or LTCH. In the proposed rule, we indicated that we are currently assessing methods for making such information available and were seeking comments on how to do so as quickly and effectively as possible.

We solicited comment on any ways in which the Department can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiatives or through regulatory requirements. We also sought comment on the Department's statutory authority to impose such requirements. We indicated that discussion of particular options in the proposed rule should not be taken as an indication that the Department will adopt any of these proposals. Rather, the proposals were included to foster comment on possible options to promote the aims of transparency of quality and pricing information and the Department's authority and ability potentially to implement these options. We indicated that the Department is anxious to receive comments on any of these proposals, or on other options that may be available that the

Department could adopt either through voluntary initiatives or through its regulatory authority.

Thirty-eight commenters made more than a hundred specific comments on the transparency discussion in the FY 2007 IPPS proposed rule. We received comments from providers, practitioners, and their representatives or associations, including hospital associations, physician associations, and organizations representing other health care professionals, as well as the medical device industry. We also received comments from organizations that promote quality measures in health care, from employers, and from health care-related companies. We found these comments to be extremely helpful and constructive as we seek to promote transparency in the health care system.

Listed below are the eight issue areas related to transparency that we identified in the comments and which generated the greatest number of comments:

- Features of transparency;
- Types of pricing information;
- Leadership/stakeholder participation;
- Medicare Conditions of Participation;
- Limited effectiveness of transparency efforts to address uninsured and safety net providers;
- Physician-identifiable Medicare claims data;
- Concerns regarding the June 1, 2006 posting of payment information on the 30 common elective procedures by DRG; and

- The link between value-based purchasing and making the health care system more transparent.

Comment: The majority of commenters provided comments on what types of transparency features would be important to consumers with the end goal of providing consumers with meaningful, easily accessible information for health care decision-making. Many commenters suggested conducting research on what information consumers would want. For example, ease of use and ease of access to posted price information (which may include a web-based tool), common definitions and language to describe pricing information, and offering explanations of the potential sources of variation in price are features that numerous commenters identified. They also noted that the integration of price and quality information is critical and that price should only be one consideration in consumers' decision-making process. Several commenters highlighted the importance of a feasible approach to implementation, specifically highlighting the complexity of hospital pricing. One commenter noted that physician ownership in specialty hospitals should be transparent to the public. One commenter suggested that transparency should promote the continuum of care. Finally, several commenters noted that promoting the use of health information technology as well as further developing quality measurements are important factors in advancing transparency.

Response: We agree that it is important to understand what information beneficiaries want, how they use the information, whom beneficiaries consult in making decisions, and the needs of different types of users of information. Particularly with regard to Medicare beneficiaries—many of whom face challenges in accessing and

understanding information—CMS has strived to provide information on quality in a way that is accessible and meaningful to beneficiaries and to those who assist beneficiaries in making health care decisions. CMS and AHRQ have sponsored research in this area and will continue to examine these issues. We will continue to improve the web-based tools currently in use (such as Hospital Compare and Nursing Home Compare), and will continue to explore other means of improving our ability to disseminate information and means of encouraging the use of available information.

We recognize the complexities involved in attempting to present pricing information in an accurate and useful manner that is accessible for the intended users. We agree that in making health care decisions, consumers must have access to both cost and quality information and that information must be available across the continuum of care. Consumers also must have access to other types of information that may be considered relevant when they are making decisions about their health care. While CMS has recently begun releasing information on Medicare payments to hospitals by procedure, and we plan to make pricing information available for other types of providers and practitioners, we recognize that an education effort is required to enable the best use of pricing information. Similarly, from the provider and practitioner point of view, there are many complexities involved in the reporting of information on price and quality. We agree that standardizing terminology and greater use of health information technology would support transparency by reducing reporting burdens. The ideal is to design a system that is feasible and accomplishes its intended goals in the most efficient manner possible.

Comment: We received a significant number of comments on what types of pricing information should be made publicly available based on reliable claims data. Many commenters recommended making both hospital charges and out-of-pocket costs available, and several commenters recommended this as a Federal requirement. However, some commenters cautioned against using hospital charges since they do not reflect consumers' expected costs. Commenters noted that it is important to help consumers understand that there are price variations that reflect factors such as additional payments to fund teaching and research missions, caring for the under- and uninsured, and other costs. Several commenters noted the importance of measuring costs and quality across settings and over appropriate timeframes using evidence-based protocols. One commenter recommended displaying CCRs. Another commenter recommended reporting national average charges for certain common procedures. One commenter noted that the cost of nursing care is not shown as a separate cost to patients. One commenter noted that costs of supplies and services should be transparent as well. With regard to possible studies of costs in areas of the country where there are relatively high health care costs, one commenter recommended that a studied region be homogenous, but heterogeneous outside of the study area.

Response: As mentioned previously, we recognize the complexities involved in attempting to present pricing information in an accurate and useful manner that is accessible for the intended users. As also noted above, we agree that in making health care decisions, consumers must have access to both cost and quality information, as well as other information that may be considered relevant when consumers are making

decisions about their health care. As noted above, while CMS has recently begun to release information on Medicare payments to hospitals by procedure as well as the number of procedures performed by the hospital, and we plan to make pricing information available for other types of providers and practitioners, we recognize that an education effort is required to enable the best use of pricing information. Consumers must take into account the many factors noted by commenters which are components of the prices that consumers (or insurers) will pay for care. For example, consumers may want to know the costs of all the services they received in an episode-of-care when determining the total costs for a course of treatment. Similarly, with an episode-of-care approach, consumers also may want information about the quality of care at each point in the continuum of care when multiple providers and practitioners are involved.

With regard to beneficiary out-of-pocket costs, the current pricing tools available to Medicare beneficiaries—the Medicare Personal Plan Finder and the tools beneficiaries use in evaluating Part D drug plans—are intended to give beneficiaries important, accurate information about their expected out-of-pocket costs when faced with various choices. At the same time, we believe it is desirable for consumers to know how much their insurer—or the Medicare program (and therefore taxpayers)—is paying for a person's care. The cost of care to the primary payer should be a factor when a person is attempting to make judicious decisions about his or her health care.

Comment: A considerable number of commenters addressed the importance of leadership and stakeholder participation in efforts to bring greater transparency to the health care system. Many commenters noted the success of existing public-private

partnerships and recommended that CMS continue to build on these partnerships. Many commenters recommended that the further expansion of hospital quality information should be accomplished through the Hospital Quality Alliance. Also, commenters noted that the AHRQ is best suited to conduct research on what consumers want in helping them with health care purchasing decisions. Several commenters suggested collaborative efforts though workshops. Several commenters recommended a hospital-led effort to create consumer-friendly pricing language. One commenter suggested that insurance companies are best positioned to be advisors to patients and to provide information on the expected costs for an entire episode of care. One commenter supported a hospital-led effort in making transparent information available to consumers, rather than a government-led initiative.

Response: The views of many of the commenters are consistent with CMS' current practices in the development and dissemination of quality measures for Medicare beneficiaries, and are consistent with our future direction with respect to transparency in providing price and quality information. Many of the tools and measures that CMS currently uses in providing information on quality have been developed through public-private collaborations. CMS has used a collaborative approach for many years, and CMS actively participates in efforts such as the Hospital Quality Alliance, the Ambulatory Care Quality Alliance, the National Committee on Quality Assurance, the National Quality Forum, and numerous other organizations whose mission is to improve the quality of health care by making valid, reliable information available to providers and consumers. In particular, CMS is supporting pilot programs in Boston, Indianapolis,

Minneapolis-St. Paul, Wisconsin, Phoenix, and California, in conjunction with the Hospital Quality Alliance and Ambulatory Care Quality Alliance, to identify and implement effective ways of providing better information on quality and improving quality. As the commenters noted, the AHRQ is a leader in this arena, and CMS will continue to work with AHRQ to ensure that there is continuing progress in providing information on quality. A broad, collaborative approach to the development and dissemination of information also promotes improvement in the usefulness of the information and improvement in the mechanisms of dissemination.

As noted above, we agree that it is important to understand the information needs of Medicare beneficiaries, and we will continue to examine that issue as it pertains to beneficiaries. As more information on quality continues to be made available, and as pricing information becomes more commonly available, we need to understand whether the new information and the manner in which it is disseminated is effectively serving the needs of beneficiaries and the needs of other individuals and entities that assist beneficiaries in their decisionmaking processes.

Comment: Several commenters opposed the option which suggested that we modify the Medicare conditions of participation to require hospitals to post price information on assistance programs for the uninsured. Commenters noted that hospitals provide community financial assistance to the uninsured in their service areas based on local patient demographics and the local poverty level. They believe that as patient demographics and poverty levels vary from community to community, so must charity care policies. One commenter noted that without Congressional action, CMS does not

have the authority to require hospitals to produce price information unrelated to Federal program beneficiaries. This commenter also advocated that CMS allow the current hospital pricing marketplace, that includes the provision of charity care to the uninsured, to continue to operate without Federal interference.

Response: Although we are not adopting our proposal to amend the Medicare conditions of participation to require hospitals to post price information, including information on assistance programs for the uninsured at this time, we have not abandoned the idea and may consider it in the future. As noted in the FY 2007 IPPS proposed rule, we are considering several options to achieve greater transparency in the health care system. We agree that any transparency policy must take into consideration the current programs operated by hospitals across the country to provide financial assistance to the uninsured and the variances in the patient demographics that are addressed by these programs. However, we believe that providing true cost transparency in the health care system will require making available price information across populations through public-private collaboratives, such as the AQA pilots. We appreciate the current efforts of the hospital and insurance industries to work with CMS towards greater transparency in the health care system.

Comment: Two commenters suggested that pricing transparency will not address the problem of the uninsured and will have a marginal impact on costs. Specifically, the commenters argued that the complexity of, and variances in, hospital charge structures make price comparisons among hospitals nearly impossible; and therefore posting hospital-specific charges will not accomplish CMS' transparency goals. Rather the

commenters stated that CMS should work with Congress to expand Medicaid and other safety net programs. Alternatively, the commenters supported the expansion of CMS' current efforts to report national average charges for certain common procedures, as this information would allow patients to encourage their local hospitals to align their charges with national averages. The commenters also noted that for the privately insured, the relevant financial information is the amount that is the patient's responsibility.

Response: We believe by increasing the transparency of health care costs and providing cost and quality information to consumers to make better-informed health care choices, overall costs to the health care system should decrease and the quality of care will improve. Greater health care efficiency is critical for the long-term sustainability of the health care system, including the ability to deliver care to the uninsured population. As we continue to develop policies to support transparency in the health care system, CMS is committed to ensuring that the needs of the uninsured population and the safety net providers that serve them are addressed.

Comment: Three commenters recommended the release of physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.

Response: Those making this comment suggest that releasing physician-identifiable Medicare claims data to the public would increase the scope and breadth of performance measures. CMS is firmly committed to increasing the scope and breadth of performance measures in all settings of care in which Medicare patients receive care. Specifically, in this regulation, CMS is requiring hospitals to report on a broader set of

quality measures to receive the full payment update. We agree that physician-identifiable claims are an important source of information and are evaluating the potential to use physician-identifiable Medicare claims in this initiative.

Comment: One commenter noted that the June 1, 2006 CMS posting of payment information on the 30 common elective procedures by diagnosis-related group (DRG) does not include information on the quality of care delivered within each specific DRG.

Response: We agree that both quality and cost information must be used to assess the value of health care. We disagree with the commenter's view that CMS is not releasing information for beneficiaries on both quality and cost on the same conditions. Many of the patients who would receive care for the high-utilization condition for which payment information has been posted would be the same patients whose care would be assessed for Hospital Compare quality measures. Further, the HQA surgical measures would apply to some of the surgical procedures for which payment information was posted. Many quality measures, such as the Hospital Consumer Assessment of Healthcare Providers and Systems Survey® (HCAHPS®), are not specific to certain procedures and may be just as important to beneficiaries and other consumers as condition-specific clinical measures. Other information included in the posting, such as how many patients a hospital treats for a certain condition, also adds to the information that people can use to make better decisions on their care.

Comment: Several commenters supported the link between value-based purchasing and making the health care system more transparent.

Response: We agree that financial incentives can be a powerful tool to encourage quality improvement. Almost all hospitals chose to report and improve on certain quality measures when Congress determined that reporting them should be a condition of receiving the full payment update for inpatient care. Further, the initial results from the Premier Hospital Quality Incentive Demonstration show that participating hospitals, on average, improved on the quality measures upon which they were assessed for purposes of receiving a payment bonus. In addition to these efforts, CMS has embarked on a variety of initiatives that use public reporting to provide useful information to beneficiaries and to improve the quality and value of care. Payers, beneficiaries, and providers share a common interest in having consumers make informed health care decisions. Providers who deliver high quality services at a lower cost than others should be given the opportunity to be publicly acknowledged for their efforts.

V. Changes to the PPS 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 PPS established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the PPS for hospital inpatient capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 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).

Federal fiscal year (FFY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for most acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in §412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) x (DRG Weight) x (Geographic Adjustment Factor (GAF)) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska and Hawaii) x (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.

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 August 1, 2002 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 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 PPS transition period. Hospitals eligible for special exceptions payments were 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), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS 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, see the August 30, 1991 final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital PPS 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 we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), 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. (Refer to the August 1, 2001 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.)

Section 412.374 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 PPS, 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 PPS Puerto Rico rate and the applicable capital PPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital PPS rate that consisted of 75 percent of the capital PPS Puerto Rico specific rate and 25 percent of the capital PPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating PPS blend percentage for Puerto Rico hospitals required by section 4406 of Pub. L. 105-33, we revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital PPS Puerto Rico rate and 50 percent of the capital PPS Federal rate. Similarly, in conjunction with the change in operating PPS payments to hospitals in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108-173, we again revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be

based on a blend of 25 percent of the capital PPS Puerto Rico rate and 75 percent of the capital PPS Federal rate effective for discharges occurring on or after October 1, 2004.

B. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

In the FY 2007 IPPS proposed rule (71 FR 24122), we proposed technical changes to §§412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under §412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These changes were proposed to reflect our historic policy that hospitals reclassified as rural under §412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established §412.64, which incorporated the CBSA-based geographic classifications, we revised §412.316(b) and §412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under §412.64. However, §412.64 does not reference the provisions of §412.103 regarding the urban-to-rural reclassifications, as was previously found in §412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under §412.103 would be considered rural.

We did not receive any public comments on our proposal. Therefore, we are adopting as final, without modification, the proposed changes to §§412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) which specify that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under §412.103 would be considered rural.

C. Other Technical Corrections Relating to the Capital PPS Geographic Adjustment Factors

In the FY 2007 IPPS proposed rule (71 FR 24122) we proposed to make technical corrections to the regulations under paragraphs (a) and (c) of §412.316. Specifically, we proposed to make a technical change under §412.316(a) to correct the cross-reference to "§412.63(k)" to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. We proposed to cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety.

We did not receive any public comments on our proposal. Therefore, we are adopting as final without modification the proposed technical change under §412.316(a)

to correct the cross-reference to "§412.63(k)" to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. We cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety. This technical correction does not change any current payment policies because the regulation, as written, makes clear that the GAF adjustment for local cost variation under the capital PPS is based on a hospital's operating PPS wage index value. Thus, the same payment policies that are in effect prior to FY 2007 (that is, the GAF is based on a hospital's operating PPS wage index value) will continue in effect for FY 2007 and beyond; the only change in the regulation is a correction of the erroneous cross-reference.

In addition, we proposed to make a technical correction under §412.316(c) to correct the cross-reference to "§412.115" to clarify that, for hospitals located in Alaska and Hawaii, the same COLA factor that applies to these hospitals under the operating PPS is used to determine the COLA factor under the capital PPS. The existing regulation erroneously references the COLA factor used to determine payment under §412.115, which is not related to the operating PPS COLA factor or any other payment factors. Again, we proposed to cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety.

We did not receive any public comments on this proposal. Therefore, we are adopting as final, without modification, the proposed technical correction. This technical correction does not change any current payment policy; rather it makes clear that the capital PPS COLA factor is based on the hospital's COLA factor under the operating

PPS. This technical correction reflects our historic policy that the COLA factor under the capital PPS is based on the hospital's operating PPS COLA factor, which is how the capital PPS COLA factor has been determined since the implementation of the capital PPS in FY 1992. Thus, the same payment policy that has been in effect prior to FY 2007 (that is, the use of the operating PPS COLA factor as shown in the table in section II.B.2 of the Addendum of this final rule in determining a hospital's capital PPS COLA factor) will continue to be in effect for FY 2007 and beyond; the only change in the regulation is a correction of the erroneous cross-reference.

VI. Changes for Hospitals and Hospital Units Excluded from the IPPS

A. Payments to Excluded Hospitals and Hospital Units (§413.40)

1. Payments to Existing and New 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 (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.) For IRFs, IPFs, and LTCHs, reasonable cost payment provisions changed significantly for cost reporting periods beginning on or after October 1, 1997.

Section 1886(b)(3)(H) of the Act established caps on the target amounts for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, for certain existing hospitals and hospital units excluded from the IPPS. Section 413.40(c)(4)(iii) of the implementing regulations states that "In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section." Accordingly, in general, for "existing" IPFs, IRFs, or LTCHs for the applicable 5-year period, the target amount is the lower of: the hospital-specific target amount (§413.40(c)(4)(iii)(A)) or the 75th percentile cap (§413.40(c)(4)(iii)(B)).

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, an IRF, considered "existing" under section 1886(b)(3)(H) of the Act would have no portion of its payment subject to §413.40(c)(4)(ii) of the regulations for cost reporting periods beginning on or after October 1, 2002.

For cost reporting periods beginning on or after October 1, 2002, to the extent an IPF or LTCH has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the payment are determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at §413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, "Subject to the provisions of [§413.40] paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period unless the provisions

of [§413.40] paragraph (c)(5)(ii) of this section apply." Thus, because §413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of §413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, the target amount for FY 2003 was determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount in FY 2002, the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor). As discussed below, IRFs, IPFs, and LTCHs are now paid under separate PPSs, although some are subject to transition payment provisions.

In addition, a new method of determining the payment amount for "new" excluded providers for cost reporting periods beginning on or after October 1, 1997. Section 413.40(f)(2)(ii) of the implementing regulations states that, ". . . the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long term care hospital that was not paid an excluded prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the nation median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted for the difference in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second const reporting period is subject to the same target amount as the first cost reporting period." For the third cost reporting period, the target amount determined for the preceding cost reporting period is updated to the third cost reporting period. (See §413.40(c)(4)(v).)

The 110 percent of the national median payment limits for new providers under TEFRA (§413.40(f)(2)(ii)) do not apply to those IPFs or LTCHs, whose first cost reporting period begins on or after the date the particular class of hospitals implemented their respective PPS because they are paid 100 percent of their Federal PPS rate. IRFs are paid 100 percent of the Federal rate under the IRF PPS for cost reporting periods beginning on or after October 1, 2002. Therefore, the 110 percent of the median payment limitations are not applicable to IRFs for cost reporting periods beginning on or after that date.

2. Separate PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Pub. L. 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 Pub. L. 106-113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by IRFs and to establish classes of patient discharges by functional-related groups. Section 305 of Pub. L. 106-554 further amended section 1886(j) of the Act to allow IRFs, subject to the blend 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.

3. Separate PPS for LTCHs

In accordance with the requirements of section 123 of Pub. L. 106-113, as modified by section 307(b) of Pub. L. 106-554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC-DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC-DRG with additional adjustments applied.

On May 7, 2004, we issued in the **Federal Register** a final rule (69 FR 25673) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July l, 2004 through June 30, 2005. For the LTCH PPS rate year of July 1, 2005 through June 30, 2006, we issued in the **Federal Register** a final rule (70 FR 24168) that further updated the payment rates and made policy changes. For the LTCH PPS rate year of July 1, 2006 through June 30, 2007, we issued in the **Federal Register** a final rule (71 FR 27798) that further updated the payment rates, discussed the

LTC-DRG classifications and relative weights which remain linked to the inpatient DRG system, and made several policy changes. The 5-year period for LTCHs to transition from a PPS payment consisting of a blend of reasonable cost-based reimbursement and the adjusted Federal prospective payment rate to a payment based on 100 percent of the Federal prospective rate ends with cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006. LTCHs with cost reporting periods beginning on or after October 1, 2006, are paid entirely on the adjusted Federal prospective payment rate.

4. Separate PPS for IPFs

In accordance with section 124 of the BBRA and section 405(g)(2) of Pub. L. 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 final rule, we compute 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 have established a 3-year transition period during which IPFs whose first cost reporting

periods began before January 1, 2005, will be paid based on a blend of reasonable cost-based payment and IPF PPS payments. For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount.

5. Grandfathering of Hospitals-Within-Hospitals (HwHs) and Satellite Facilities

Existing regulations at 42 CFR 412.22(e) define a hospital-within-a-hospital (HwH) as 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. In order to be paid as an excluded hospital, an HwH is required to demonstrate compliance with requirements at §412.22(e)(1) through (e)(3), as applicable, which were established to create operational and organizational separateness between the HwH and the host hospital with which it is co-located.

The existing regulations at §412.22(h), relating to satellite facilities of hospitals excluded from the IPPS, define a satellite facility as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.25(e), relating to satellite facilities of excluded hospital units, defines a satellite facility as a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

There are significant similarities between the definition of a satellite facility and the definition of an HwH as it relates to their co-location with other Medicare

hospital-level providers (hosts). There are also similarities in our policy concerns with the potential for patient-shifting (and its consequences for the Medicare program) between the co-located entities and their hosts. Regarding HwHs and satellite facilities, particularly LTCH HwHs and satellite facilities of LTCHs, which were the original entities that we regulated beginning with FY 1995, we have repeatedly expressed our concerns (for example, in the FY 2005 IPPS final rule (69 FR 49191)) that an HwH's or a satellite facility's "configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare." (69 FR 48916 and 49191). We further believe that "the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care." (69 FR 48916 and 49191). Therefore, we established "separateness and control" criteria to govern these relationships with host hospitals, at §412.22(e) for HwHs, and at §§412.22(h) and 412.25(e) for satellite facilities of excluded hospitals and satellite facilities of hospital units, respectively. Moreover, for HwHs and satellite facilities, we provided for the "grandfathering" of existing facilities, thereby exempting those that were in existence prior to the establishment of the "separateness and control" requirements from compliance with the criteria. At §412.22(f), we provided for the grandfathering of HwHs that were in existence on or before September 30, 1995, as long as the hospital continues to operate under the same terms and conditions. We also provided for grandfathering HwHs that changed the terms and conditions under which they operated between September 30, 1995 and before October 1, 2003, but subsequently continued to

operate under the terms and conditions in effect on September 30, 2003. At §412.22(h)(3) and (h)(4) we grandfathered satellite facilities that were part of a hospital, that were in existence on September 30, 1999, and that met certain other conditions. Further, at §412.25(e)(3) and (e)(4), we grandfathered satellite facilities that were part of a hospital unit, were in existence on September 30, 1999, and that met certain other conditions. The purpose of our grandfathering certain existing HwHs and satellites was to reflect reliance interests and settled expectations that existed on the part of these facilities at the time the separateness and control requirements were created.

The regulations addressing "separateness and control" policies for each of the above types of entities are presently not entirely uniform. This situation has arisen, in part, because the policies were implemented at different times and also because there are differences among the types of entities. (For example, in the FY 2003 IPPS final rule (67 FR 49982 and 50105**),** we included a detailed discussion of the "performance of basic functions" test utilized for HwHs and how this test was not applicable to satellite facilities.) There are also differences between specific features of the grandfathering provisions for HwHs and satellite facilities, despite the fact that, as noted above, the intent of each of the grandfathering provisions was the same (for HwHs at §412.22(f), for satellite facilities of hospitals at §412.22(h)(3)(i) and (h)(4), and for satellite facilities of hospital units at §412.25(e)(3) and (e)(4)). The regulations exempt certain HwHs and satellite facilities from compliance with the "separateness and control" criteria governing the relationships with their host hospitals as long as they continue to operate under the same "terms and conditions," including the number of beds and square footage

considered to be part of the hospital or satellite facility as of the date that they were grandfathered.

This particular policy was adopted because we believed that those entities that were designated as grandfathered, versus those that were required to meet the "separateness and control" requirements, should not be permitted to alter their operations from the "snapshot in time" taken when they were grandfathered and thus benefit even more from this status. In other words, we believed that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities--namely, they were free from compliance with the "separateness and control" regulations and we did not want to allow these entities to realize additional economic advantages by expansion that would increase their Medicare payments by virtue of their grandfathered status. Furthermore, it has been our policy that if a grandfathered HwH or satellite facility of the HwH chooses not to operate under the same terms and conditions in effect as of its grandfathering, it could still be paid under the applicable excluded hospital payment system if it changed its relationship with its host to the extent that it has come into compliance with the applicable "separateness and control" requirements. In addition, our rationale for the separateness and control requirements (and limiting the grandfathering provision) was to prevent abusive gaming of the Medicare payment system by co-located hospitals.

Because the underlying rationale for the grandfathering policies for both HwHs and satellite facilities of HwHs is the same, upon review of these various provisions, we believe that, where appropriate, the grandfathering provisions should be consistent. Under the authority of section 1871(a)(1) of the Act, which authorizes the Secretary to

prescribe such regulations as may be necessary to carry out the administration of the Medicare program, in the FY 2007 IPPS proposed rule (71 FR 24124) we proposed the following revisions to make the policies consistent. We proposed to revise the HwH provision at §412.22(f) to include an exception to the requirement that a grandfathered HwH be operated under the terms and conditions in effect on October 1, 2003, that corresponds to the existing exceptions for satellite facilities of hospitals and for satellite facilities of hospital units at §412.22(h)(4) and 412.25(e)(4), respectively. (As provided in §412.22(f), the original September 30, 1995, "snapshot in time" date for grandfathered HwHs was extended to hospitals that changed the terms and conditions under which they operated between September 30, 1995, and before October 1, 2003, in the FY 2004 IPPS final rule (68 FR 45462).) Specifically, we proposed a corresponding change to the HwH grandfathering provision at §412.22(f)(3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH that are needed for specific circumstances beyond the control of the facility. We proposed to specify that increases or decreases in square footage or decreases in the number of beds that are required because of the relocation of a facility to permit construction or renovation necessary for compliance with Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes. (64 FR 14535) We also proposed to add a provision for grandfathered hospital satellites and satellites of units at §412.22(h)(5) and §412.25(e)(5) respectively, allowing a decrease in square footage or numbers of beds for consistency with the proposed

regulations for grandfathered HwHs at §412.22(f)(3)(i) and we proposed to amend §412.22(h)(4)(i) to mirror to the language in §412.25(e)(4)(i).

The comments we received on our proposals, and our responses, are set forth below.

Comment: All of the commenters, including commenters representing grandfathered HwHs,including grandfathered LTCHs, children's hospitals, a cancer hospital, and an IRF, hospital associations, legislators, and industry consultants, endorsed our reexamination of the existing restrictions on grandfathered HwHs changing the "terms and conditions" under which they operate. A number of commenters questioned whether or not HwHs would lose their grandfathered status if they were required by Federal, State, or local law, or catastrophic events to increase or decrease their square footage or to decrease their number of beds in ways that did not involve relocations of the facilities. Two commenters described hypothetical situations that could result in a need for an increase in square footage for the grandfathered HwH such as the following: making necessary repairs to the existing physical plant that are now governed by building standards established by the American Institute of Architects (AIA) or the Americans with Disabilities Act (ADA) since the facility was established (and now required by law); compliance with privacy and security requirements of the Health Insurance Portabilitiy and Accountability Act of 1996 (HIPAA); or meeting fire or safety codes that not in existence when the facility was built.. The commenters requested that CMS clarify its grandfathering policies in light of such scenarios.

Response: We thank the commenters for their support for our proposals. After reviewing the comments, we agree that there are indeed situations not related to the relocation of a facility that could make it necessary to add or reduce square footage, or decrease the number of beds in a grandfathered facility. Moreover, after consideration of this concern and of the comments we received on our proposals, and for the reasons summarized below, and in accordance with our authority in section 1871(a)(1) of the Act we have decided to revise our regulations on grandfathering of HwHs, satellites of IPPS-excluded hospitals, and satellites of IPPS-excluded hospital units to allow these facilities more flexibility to adjust their square footage upward or downward or to decrease their number of beds. Specifically, in this final rule, for cost reporting periods beginning on or after October 1, 2006, we are revising the regulations in §§412.22(f)(3)(applicable to HwHs), 412.22(h)(4)(applicable to satellites of IPPS-excluded hospitals), and 412.25(e)(4)(applicable to satellites of IPPS-excluded units) to allow these facilities to increase or decrease the square footage of the facility or to decrease the number of beds in the facility without affecting the facility's grandfathered status. Under the final rule, such changes could be undertaken for any reason and would not be limited to situations involving changes in Federal, State, or local laws or catastrophic events. Such changes also would not be limited to cases in which a facility must be relocated. Therefore, we have not finalized our proposed provisions that specified such exceptions for HwHs, and in the case of satellites hospitals, we have restored the existing terminology of §412.22(h)(4) for cost reporting periods beginning before October 1, 2006. This is the case because under our finalized policy, which is

effective for cost periods beginning on or after October 1, 2006, as discussed in detail below, we are not restricting grandfathered HwHs at §412.22(h)(3) and grandfathered satellites at 412.22(h)(5) from increasing or decreasing their square footage or decreasing their number of beds. As discussed elsewhere in these response, even though grandfathered satellite units will also be permitted to increase or decrease their square footage or decrease their number of beds at §412.25(e), such facilities are subject to the existing regulations regarding changes in size of excluded units unless the change in size is necessitated by relocation of the unit to permit construction or renovation necessary for compliance with a law affecting the physical facility or because of catastrophic event.

As noted above, in establishing grandfathering provisions generally, we intended to protect certain existing hospitals and satellite facilities from "the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program" (68 FR 45463). However, they were not intended to establish a separate class of providers. Moreover, it was our intention that our "snapshot in time" policy prevented grandfathered entities that were advantaged more than their nongrandfathered peer facilities as a result of their protected status from realizing additional benefits by changing their "terms and conditions" in ways that could increase their Medicare reimbursement. It also helps prevent the program abuse associated with co-located facilities that may result from patient shifting whereby Medicare makes two separate payments for what is essentially a single episode of care.

Recently, several grandfathered LTCH HwHs and satellite facilities questioned whether a <u>decrease</u> in their square footage or their number of beds would result in

negating their grandfathered status, because compliance with each of the above cited grandfathering provisions requires that they continue to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital, the satellite facility, or the hospital unit in effect on the day that the grandfathering policy was implemented. We also have been urged to modify our policies to allow these grandfathered entities to increase in square footage and number of beds without requiring compliance with the "separateness and control" policies discussed above. Clearly, under existing regulations, an increase or a decrease in square footage or number of beds would result in a loss of status as a grandfathered HwH or hospital satellite facility (unless §412.22(h)(4) or §412.25(b)(3) applies) because the existing regulations prohibit any change in the terms and conditions of operation, as described above.

As stated above, under our broad authority in section 1871(a)(1) of the Act, we have now decided to revise the regulations in §§412.22(f) (applicable to HwHs), 412.22(h)(4) and (h)(5) (applicable to satellites of IPPS-excluded hospitals) and 412.25(e)(4) and (e)(5) (applicable to satellites of IPPS-excluded units) to allow these facilities for cost reporting periods beginning on or after October 1, 2006, to increase or decrease the square footage of the facility or to decrease the number of beds in the facility at any time without affecting the facility's grandfathered status.

We made this decision following a review of public comments on our proposed rule, as summarized below. In reaching this decision, we recognize that allowing increases in the square footage of those grandfathered facilities could, in some cases,

increase their reimbursement under Federal health insurance programs administered by CMS. For example, any increase in the square footage of a grandfathered facility could result in increased operating costs. Therefore, an increase in square footage in a grandfathered HwH that is paid for services to Medicare beneficiaries under the TEFRA system could lead to an increase in Medicare payments. We recognize that this result is not fully consistent with our objective of not allowing a grandfathered facility to make changes that would lead to increased costs to the Medicare program. However, we believe it is necessary to weigh the importance of this objective against the need, described by many of those whose comments are summarized below, for hospitals and other grandfathered facilities to have the flexibility to upgrade their facilities and services to incorporate new technology or additional services to meet patient needs or to comply with applicable new laws.. After considering these two competing objectives in relation to one another, we concluded that allowing increases in square footage is justified even though in a very limited number of cases (as explained below), it may result in some additional cost to the Medicare program.

We note that with the exception of children's and cancer hospitals, the only IPPS-excluded facilities are IRFs, IPFs, and LTCHs. The payment methodologies applicable to IRFs, IPFs, and LTCHs use prospectively determined rates, so that payments to an individual facility are not affected by increases in the square footage of that facility. Children's and cancer hospitals are paid through the use of a TEFRA system under which increases in the square footage of a facility would increase the facility's Medicare payments. However, there is only one grandfathered cancer HwH and only

three grandfathered children's HwHs. For this reason, we believe that the total Medicare cost increases, if any, will be very small.

Comment**:** Several commenters requested that we establish a policy that would enable them to maintain their grandfathered status while also being permitted to increase square footage to accommodate advancements in patient care, and improvements in medical technology that have evolved since they were grandfathered, and that would also permit expansion for administrative or nonpatient related care activities. The comments focused on each facility's need for additional space (square footage) which would allow them the ability to expand to accommodate dialysis, rehabilitation, telemetry, and hyperbaric services, isolation areas, and additional diagnostic equipment which are essential in order to maintain high quality patient services. A number of commenters also noted that their needs for additional space for administrative activities, professional instruction, and computer hardware had grown since they were grandfathered. These commenters argued that such expansions of square footage are essential in order to efficiently deliver the highest quality care to Medicare beneficiaries and, furthermore, would not result in any increased costs to the Medicare program.

Several of the commenters asserted that the legislative intent of section 4417(a) of the BBA of 1997, which established grandfathering for those LTCH HwHs that were certified to participate in the Medicare program on or before September 30, 1995, and that were co-located with another hospital, was to protect these hospitals and not limit their functioning. These commenters maintained that Congress did not intend for a grandfathered HwH to lose the ability to participate in the Medicare program as a hospital

excluded from the IPPS if they added beds or increased square footage in order to better serve Medicare beneficiaries. Another commenter stated that the issue of how Medicaid payments might be impacted by grandfathering of certain LTCHs was not contemplated by the grandfathering provision in the BBA of 1997, and asks CMS to clarify the application of the HwH rules to an excluded hospital's participation in the Medicaid program.

Response: When we established the basic grandfathering requirements for HwHs, we had two objectives. As we have noted above, we believed the grandfathering provision enacted by Congress reflected a legitimate interest in protecting certain existing hospitals that were co-located with other hospitals from "the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program" (68 FR 45463). The grandfathering provisions are an exception to the separateness and control requirements that reflect reliance interests and settled expectations that existed at the time the rule was set into place. Grandfathering provisions for these facilities allowed existing HwHs to continue to be paid outside of the IPPS, despite the fact that, among other factors, they did not demonstrate operational or organizational separateness between these grandfathered entities and their host hospitals. However, the second objective was to ensure that these entities would not make changes that would lead to increased costs to the Medicare program or that could encourage inappropriate patient shifting by co-located hospitals. This particular policy was adopted because we believed that those entities that were designated as grandfathered should not be permitted to alter their operations from the "snapshot in time" taken when they were

grandfathered and thus benefit even more from this status than those facilities that were required to meet the "separateness and control" requirements. As noted above, an HwH could change its terms and conditions under which it operates after September 39, 1995 but before October 1, 2003, after which time its terms and conditions may not further change. (See FY 2004 IPPS final rule (68 FR 45462).) In other words, we believed that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities--namely, they were free from compliance with the "separateness and control" regulations and we did not want to allow these entities to realize additional economic advantages by expansion that could increase Medicare payments by virtue of their grandfathered status.

With respect to section 4417(a) of the BBA, we believe its purpose was to protect LTCH HwHs that existed prior to September 30, 1995, from losing their IPPS excluded status because they failed to meet the separateness and control requirements recently promulgated by the Secretary. We do not believe that it is reasonable to assume that by creating a limited exception for these hospitals, Congress was immunizing these facilities from any further regulation by the Secretary as to their growth and financial impact on the Medicare program. We do not believe Congress was establishing a separate class of providers. Furthermore, contrary to commenter's assertions, grandfathered facilities continue to remain free to add beds or square footage at any time, as long as they meet the separation and control requirements outlined in these regulations. Consequently, it is inaccurate to suggest that a grandfathered HwH would lose its ability to participate in the Medicare program as an excluded hospital if it increases the number of beds or square

footage since complying with the separateness and control requirements remains an option for these facilities.

In response to the comments stating that the issue of Medicaid payments is not contemplated by the grandfathering provision in the BBA of 1997 and asking us to clarify the application of the HwH rules to an excluded hospital's participation in the Medicaid program, we note that the grandfathering rules' impact on the Medicaid payments to a hospital, to the extent there is an impact, will depend on the particular payment methodology adopted by the State in its State Medicaid plan. In general, if a State pays grandfathered HwHs under a predetermined prospective rate which is unaffected by changes in square footage, then individual hospitals would not be directly affected by increases or decreases in their square footage. By contrast, if the State were to pay grandfathered HwHs under the TEFRA system used by Medicare or under another cost-based system, payment could be directly affected by changes in square footage. With respect to changes in the numbers of beds, to the extent a hospital seeks to increase its number of beds because it is already operating at or near its State licensed and Medicare-certified bed capacity, increasing the number of beds would lead to a proportionate increase in utilization and payment. We believe that it is appropriate to consider the impact of revisions in Medicare policy on the Medicaid payment system.

We continue to believe that it is entirely reasonable and appropriate for to us regulate the growth of HwHs that have been otherwise favored by exemptions from the more rigorous "separateness and control" provisions that we have implemented for non-grandfathered co-located providers. We also note that the issue here, namely our

reexamination of our grandfathering policies, is an exception to a general rule to permit reliance on expectations that existed at the time the rule was put in place. However, we do understand that, in order to provide the highest level of patient care, any hospital will have to respond to advancements in patient care, some of which may involve the introduction of new technology requiring an increased need for space, such as new imaging equipment or the installation of a hyperbaric chamber. We also understand that a hospital may also have reasonable need to create additional administrative space for a number of reasons, among which are instructional space, updated computer hardware, and record storage.

We believe that these commenters have presented cogent arguments for our reconsideration of the preclusion against a grandfathered HwH expanding square footage. We have evaluated the impact on the Medicare program of allowing an increase in square footage for grandfathered HwHs and have determined that we believe that such a policy change will not result in additional Medicare payments to those grandfathered HwHs that are paid under the excluded hospital PPSs (LTCH, IRF, and IPF). For those grandfathered HwHs that are still reimbursed under the TEFRA payment system (that is, certain cancer and children's hospitals) square footage is used to allocate certain costs, so there may be a corresponding increase in Medicare payment for those costs. However, we believe (as we discuss in greater detail below) that because there is only one grandfathered cancer HwH and three grandfathered children's HwHs, the increased costs will be "de minimus" and we see no reason, therefore, to distinguish them from other grandfathered HwHs in a way that might discourage them from making necessary and

appropriate changes to their facilities that would result in increases in their square footage. Therefore, we believe the de minimus costs to the Medicare program associated with increases in square footage are outweighed by the benefits associated with advancements in technology and other patient care enhancements that may be achieved through changes to hospital facilities that concurrently increase the square footage of the facilities. Even though it is likely that any increase in the square footage of a hospital or satellite paid under the TEFRA system will increase the costs upon which Medicare payment is based, certain improvements, such as the adoption of new technology or modernization of a physical facility, may also result in reduced operating costs that partially or entirely offset any cost increases.

Therefore, in this final rule, we are revising the policy that we proposed at §412.22(f)(3) to specify that a grandfathered HwH may increase or decrease its square footage or decrease its number of beds, or both, without affecting its exception from the "separateness and control" requirements for HwHs at §412.22(e). However, as explained below, we continue to believe that an increase in the number of beds, which could have a much more significant impact on the level of payments to the facility under the Medicare programs, is a change to the facility that should be a basis for terminating its grandfathered status. This policy will be effective for cost reporting periods beginning on or after October 1, 2006. Although we considered allowing increases in square footage to situations involving new technology or new laws affecting hospitals' physical facilities, we concluded that such a policy would be overly prescriptive and that its enforcement would not be cost effective in light of the limited increases in Medicare spending we

expect to result from this change. Thus, we have not included any provision restricting the reasons for which such changes may be made.

In the interest of consistent treatment of HwHs, hospital satellite facilities (as defined in §412.22(h)), and satellite facilities of units (as defined in section 412.25(e)(1)), and because similar considerations underlie our policies with respect to each type of grandfathered facility, we are also applying this policy to satellites, effective for cost reporting periods beginning on or after October 1, 2006. To accomplish these changes, we are revising §§412.22(f), 412.22(h), and 412.25(e) as set forth below.

In the case of facilities that are satellites of IPPS-excluded units, we note that there are existing rules in §412.25(b)(1) and (2) which govern changes in the square footage and number of beds in an IPPS-excluded unit and where applicable, the regulations that we are finalizing for the increase or decrease in square footage of the decrease in number or beds of a grandfathered satellite unit will be subject to these rules. Section 412.25(b)(1) permits increases in the square footage or number of beds of a unit to be made only at the start of a cost reporting period. However, as we have discussed previously, in these finalized revisions of our grandfathering policy, while we are allowing for an increase in square footage of grandfathered satellite units, we are not allowing these facilities to increase their number of beds. Therefore, we specify in §412.25(e)(5)(i), a grandfathered unit structured as a satellite facility may only increase in square footage at the beginning of a cost reporting period. Further, existing regulations for excluded hospitals at §412.25(b)(2) permit reductions in the square footage or number of beds of a unit to be made only with 30 days' advance written notice to the fiscal

intermediary and CMS, requires maintenance of sufficient information to accurately determine costs, and specifies that reductions in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the remainder of that period. Since our finalized policy at §412.25(e)(5)(i) allows for both reductions in square footage or bed number for grandfathered satellite units, under circumstance other than those specified at §412.25(e)(4) we are requiring that any such decreases by these facilities be subject to existing regulations for units of excluded hospitals at 412.25(b)(2). We believe that these requirements are reasonable and necessary because changes in the square footage or a decrease in the number of beds in a satellite of a unit may affect the bed size or square footage of the facility of which it is a part. We believe this requirement is needed to avoid confusion and provide for equitable and consistent treatment of all excluded units.

However, under existing regulations at 412.25(e)(4), a grandfathered satellite of a unit would be able to increase or decrease its square footage or decrease its number of beds at any time, for purposes of relocation of the facility to permit construction or renovation necessary for compliance with changes in the law affecting the physical facility, or because of catastrophic events.

Comment: Several commenters stated that if the proposed revisions allowing for a decrease in square footage, but not an increase, were finalized, their grandfathered HwHs would face the very onerous choice of either not making necessary operational or clinical improvements to their facilities or of having to disrupt longstanding favorable relationships with the administration of their host hospital.

Response: As we have stated above, under the policy in this final rule, we are not attempting to prescribe the reasons for which changes in the square footage of grandfathered HwHs and satellites may be made. We believe this approach will give the hospitals and satellites the flexibility they need to increase or decrease square footage in response to technological innovation, changes in hospital practice patterns, shifts in the types of services required by the hospital's or satellite's patients, and other factors relevant to the operation of the facilities, without having to alter their historic relationship with their host hospital.

Comment: One commenter stated that our proposed regulations indicated a new flexibility to our implementation of grandfathering rules for HwHs but found no logic in why we would allow certain changes in "terms and conditions" but not others.

Response: Although we are making significant changes to the proposed revisions of our grandfathering policy for HwHs and satellite facilities in this final rule, as noted throughout these responses, we believe that the rationale underlying our determinations is quite apparent. We are permitting grandfathered HwHs and satellite facilities an increase in square footage because we believe that there have been significant clinical advances, some of which are detailed elsewhere in these responses, reasonably requiring a hospital to increase its physical space in order to accommodate new equipment or treatment modalities so that it could continue it to offer the highest level of medical care to its patients. We could also envision circumstances under which changing administrative or otherwise nonclinical needs could require additional space, and we have noted that we understand that an increase in square footage by those HwHs and satellite facilities paid

under the TEFRA system may result in a de minimus increase in Medicare costs. However, we do not believe that any of these changes require the establishment of additional beds. Because the number of beds is directly related to hospital capacity, adding bed capacity will significantly increase costs to the Medicare program across all excluded providers. This case is unlike that of an increase in square footage because square footage increases would increase Medicare spending only for services of those hospitals paid under the TEFRA system. By contrast, increasing the bed capacity of a grandfathered HwH or unit would allow increased utilization not only in TEFRA facilities but in HwHs and satellites paid under the prospective payment systems applicable to IRFs,IPFs, and LTCHs. To the extent that any of these systems provides a higher level of payment for certain services than the IPPS, allowing bed size increases by grandfathered facilities might lead to the shifting of utilization from less expensive to more expensive settings, thereby inappropriately increasing Medicare spending.

Furthermore, a significant increase in the number of beds could dramatically alter the size and character of the facility, thereby defeating one of the primary purposes of grandfathering which was, as noted above, to capture the "snapshot in time" for the grandfathered facility. By allowing existing co-located facilities (HwHs or satellite facilities) to continue to function as they had been, we were enabling these facilities to continue to function as they were, without having to make the organizational and operating changes necessary for compliance with our separateness an control policies. Therefore, in answer to the commenter, we believe that our rationale for the changes that we are finalizing to the grandfathering regulations is apparent. We are permitting

changes that relate directly to the quality of patient care and services and we are not allowing changes that we believe could substantially and inappropriately increase costs to the Medicare program. In addition, we note that we have never adopted a policy that would preclude one of these facilities from changing other terms and conditions under which it operates, including its bed size. We would only require that such a facility begin to comply with the separateness and control requirements.

Comment: Several hospitals requested that we allow them to increase their bed numbers. One commenter, a children's hospital, noted that it wanted to establish mental health beds for children and adolescents. Another commenter suggested alternatives to our preclusion of increase in bed size for grandfathered HwHs: that CMS allow a "modest" increase in beds equivalent to those permitted during the 18-month moratorium established by Congress in section 507 of Pub. L. 108-173 for physician-owned specialty hospitals or if the grandfathered HwH admitted a "de minimus" percentage (for example, 10 percent or less) of patients from its host. This commenter and one other commenter, a grandfathered LTCH co-located with an IRF from which the commenter stated that the LTCH receives a minimum of admissions, suggested that CMS establish another exemption from the bed size increase preclusion of the grandfathering regulations if the inpatient facility with which the grandfathered HwH is co-located is not an acute care hospital, but rather is an IRF or an IPF or if the HwH is located on a campus of the host acute care hospital but is not physically co-located with an acute care hospital. The commenters believed that this particular exemption is reasonable because, in the view of

the commenter, our most significant concern regarding HwHs is inappropriate shifting of patients from a host acute care hospital to a LTCH HwH.

Response: In considering these comments, we believe it is important to recall that grandfathered HwHs, as well as satellite facilities, are organized and operated in ways that make them unable to meet the minimal tests of separateness and control applicable to nongrandfathered facilities, so that they effectively function as units of their host facilities. Because of this, we continue to believe that, in grandfathering HwHs and satellites facilities, we have conferred a significant advantage on them as compared to like facilities that are required to meet our "separateness and control" requirements and are closely monitored. Therefore, although we are finalizing regulations that will allow grandfathered HwHs and satellite facilities the ability to increase their square footage, we are not allowing grandfathered facilities an increase in the number of beds because such an increase would result in unjustifiable additional payments to the grandfathered HwH and inappropriate additional costs to the Medicare program.

With respect to the childrens' hospital that indicated that it wanted to be able to add additional beds to its hospital in order to establish mental health beds for children and adolescents, we note the following. First, grandfathered HwHs are not precluded from increasing the number of beds, and in fact, they may do so at any time, so long as they comply with the separateness and control requirements. In addition, the fiscal intermediary for the grandfathered childrens' HwHs that commented on this issue has indicated that based upon the hospital's average inpatient census figures, there appear to

be sufficient beds available at the hospital to establish inpatient mental health services for children and adolescents without adding additional beds.

In response to the commenter's suggestions of either allowing a "modest" increase in bed numbers equivalent to that permitted for physician-owned specialty hospitals under Pub. L. 108-173 or of 10 percent, or allowing an increase in bed numbers if the grandfathered HwH was only admitting a "de minimus" percentage of patients from its host, we do not believe that allowing any increase in the number of beds for a grandfathered HwH is either necessary or appropriate. We also do not believe that it is appropriate to establish a distinction between grandfathered HwHs depending upon the hospital category of the host, as did the commenters referring to a LTCH HwH that is co-located with an IRF. Nor do we believe that it would be appropriate to broaden this commenter's suggested exemption to grandfathered HwHs that are on the campus of an acute care hospital but are physically co-located with IRFs or IPFs. Our intent in establishing the grandfathering provisions for HwHs and satellite facilities was never to establish separate classes of grandfathered providers. Rather, it was to protect settled expectations that existed at the time that the grandfathering rules were put in place. In addition, in each of these configurations, an increase in bed size could result in a significant increase in Medicare utilization and payment and given the close integration between a grandfathered HwH or satellite and its host hospital, we believe the potential for inappropriate Medicare spending increases exists.

As discussed above, although the original "separateness and control" regulations focused on the particular configuration of an acute care host being paid under the IPPS

and a LTCH being paid under the TEFRA system (59 FR 45389 through 45393), the regulations were extended for FY 1998 (62 FR 46014) to include all hospitals excluded from the IPPS and not just those that were co-located with an acute care hospital. (In the FY 1999 IPPS final rule, among other rules, we established "separateness and control" requirements for satellites (65 FR 41532 through 41535)). Thus, contrary to the commenter's assertion, our concern with HwHs is not limited to an acute care hospital co-located with a LTCH HwH.). Despite the fact that the LTCH HwH commenter received very few patients from its host IRF, we do not believe that the behavior of one grandfathered HwH can be generalized to indicate the behavior of an entire LTCH industry or the behavior of all grandfathered facilities. Although we endorse the behavior that the commenter describes, we do not believe that it is necessary or appropriate to establish an additional exemption that would allow a grandfathered HwH that is already advantaged by not having to comply with "separateness and control" regulations to expand its number of beds solely because it is not "gaming" the system but rather it is functioning within accepted Medicare policies and procedures.

Comment: One commenter asked us to clarify whether CMS would permit a grandfathered HwH that reduced its size and bed number from the number that it had at the time at which it had been grandfathered to return to that original size and bed number at a future time without threatening its grandfathered status. A number of commenters asked CMS to specify that grandfathered HwHs would be able to add or discontinue direct patient care services in the same manner as any other hospital and whether the scope and amount of those services would be limited to those that were in place when the

HwH was grandfathered. Specifically, commenters asked whether a grandfathered HwH could provide outpatient services or establish provider based services.

Response: After considering the question raised by the first commenter, we have decided to adopt a policy under which a grandfathered HwH that reduced its bed number from the point at which it had been grandfathered would be permitted to return at a future time to the number of Medicare-certified beds that existed at the time it was grandfathered, as governed either by §412.22(f)(1) or (f)(2), without threatening its grandfathered status. Specifically, we are revising §412.22(f)(3) to provide that if a hospital decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long is the resulting total number of beds considered to be part of the hospital does not exceed the number in effect on September 30, 1995 (for hospitals that continue to operate under the same terms and conditions in effect on that date, as described in §412.22(f)(1)) or the number in effect on September 30, 2003, as described in §412.22(f)(1) (for hospitals that changed the terms and conditions under which they operated after September 30, 1995 but before October 1, 2003), as described in §412.22(f)(2). We are including similar changes in §412.22(h)(4) (applicable to satellites of IPPS-excluded hospitals) and §412.25(h)(4) (applicable to satellites of IPPS-excluded units). We believe this policy is consistent with our stated intent to allow hospitals that were in existence prior to the implementation of the HwH or the satellite rules to continue to operate under the same terms and conditions they had operated under at the time those provisions were implemented. Allowing a hospital that had decreased its number of beds

below the number it had as of the date of the implementation of the HwH and satellite provisions to increase its number of beds up to the level it had on the implementation date, allows the hospital to maintain its original "terms and conditions". These changes, like the rest of our revisions to sections 412.22 and 412.25, will be effective for cost reporting periods beginning on or after October 1, 2006.

In response to the question as to whether a grandfathered HwH could provide outpatient services or establish provider-based services, we wish to note that the statutory provisions of section 1886(d)(1)(B) of the Act govern Medicare payment for inpatient hospital services of hospitals and units that are excluded from the IPPS. Our HwH regulations at §412.22 address the relationship between an inpatient acute care hospital payable under the IPPS and an inpatient hospital that is excluded from the IPPS that are co-located. For this reason, our HwH regulations, including the exemption for grandfathered facilities, only address space used for inpatient services and this would also be true for satellite facilities. As has always been the case, an HwH or satellite facility would be able to discontinue or to initiate noninpatient services, including onsite or offsite outpatient hospital services without compromising its grandfathered status. Such changes in scope of outpatient services or the establishment of provider-based departments would of course have to be done in compliance with other applicable regulations, such as 42 CFR 413.65 governing provider-based status for facilities or organizations.

Comment: Several commenters urged CMS to make an exception for grandfathered children's hospitals and allow them to expand square footage and also bed

numbers without any deleterious impact on their status as hospitals certified by Medicare as exempt from the IPPS. The commenters noted that there are only three grandfathered children's hospitals. One commenter emphasized that, as opposed to other excluded HwHs, children's hospitals do not serve a Medicare population, because very few beneficiaries are children. Therefore, any expansion that CMS allows for the three grandfathered facilities would not lead to increased Medicare costs. Although these HwHs do not treat a significant number of Medicare beneficiaries, however, the commenters emphasize that loss of the Medicare exclusion from the IPPS would have a significant and negative impact on their Medicaid reimbursements as well as on their ability to receive funds to train residents under the Federal CHGME. The commenters believed that, despite the fact that each of the children's hospitals are major Medicaid providers, the number of beds in a facility has no bearing of whether or not a patient is deemed Medicaid eligible. Furthermore, they added, since Federal funding for State Medicaid disproportionate share hospital payments is capped, if these hospitals are allowed to grow, such growth would not cause the Federal portion of Medicaid to exceed the caps. The commenters claimed that there is no benefit to Medicare from applying the prohibition against growth or increase in bed numbers to children's hospitals; rather, they believe that there would be significant harm to these hospitals and to their community if they had to choose one of the three alternatives open to them: not expanding to serve their communities; losing their Medicare IPPS-exempt status; or altering their administrative and medical governance with regard to their co-located hospital, which would pose significant legal, operational, and financial barriers.

This commenter further asserted that the three reasons why CMS has established special regulations for grandfathered HwHs are not germane for children's hospitals, that is, "to prevent proliferation of LTCHs that function as units of host acute care hospitals; to prevent the avoidance of TEFRA target rates; and to avoid two Medicare payments for one episode of care." The commenter also asserted the following points: there is no proliferation of children's hospitals; children are admitted directly to their facilities and do not spend time in the acute care hospital, so there are no issues about two hospital payments for one spell of illness; and the three grandfathered children's HwHs have not reorganized since they were established at least 30 years ago, long before this category was recognized for payment purposes by CMS.

Some commenters stated that CMS has established a precedent of treating children's hospitals differently from other excluded hospital types in establishing our regulations at §412.22(i), which exempted children's hospitals from the general policy that disallowed excluded hospitals with satellite facilities that were in existence prior to October 1, 1997, from expanding their total bed numbers (the sum of the beds in the hospital and the satellite) beyond the number that they had on October 1, 1997. These commenters further maintained that CMS has stated that it believes that the grandfathering regulations for satellite regulations and grandfathering regulations for HwHs should be consistent and that, specifically, the satellite regulations at §412.22(h)(2)(i) exempt children's hospitals from the limitation on bed number expansion to which other excluded hospital satellites are subject. Therefore, the commenter requested that CMS provide the same exception for grandfathered children's

HwH and allow expansion in the number of beds without compromising their grandfathered status.

Response**:** The commenters have urged us to establish a policy that would distinguish grandfathered children's HwHs from the other categories of grandfathered HwHs and allow them to expand both in square footage and in number of beds. We understand the commenters' statements that, although the facilities do not serve a significant Medicare population and hence there would be little or no additional costs to the Medicare program should they be permitted to expand, their continued status as hospitals excluded from the IPPS under Medicare is important to them because it might enhance their ability to obtain higher Medicaid payment or more for CHGME.

As we have noted above, we are finalizing a policy for all grandfathered excluded HwHs that would allow them to increase or decrease their square footage without compromising their status of IPPS-excluded hospitals or their grandfathered status and this policy would also be applicable to the three grandfathered children's HwHs. We are making this change because we believe that the commenters have presented cogent arguments regarding their facility's need to physically expand in order to accommodate new medical equipment and services as well as to meet new administrative needs in order to continue to deliver high quality medical care. However, we have stated that we are not allowing grandfathered HwHs to increase their number of beds without compromising their grandfathered status. The commenters claimed that children's HwHs treat few Medicare beneficiaries, and therefore there would be no significant additional costs to the Medicare system should they be allowed to increase their bed numbers. Because a

change allowing children's HwHs to keep grandfathered status while increasing their number of beds would not significantly increase Medicare spending but would increase Medicaid payments to the hospitals, these hospitals recommend that such a change be made.

We considered this comment carefully but do not find it persuasive. As stated above, a key objective of revising our HwH and satellite grandfathering regulations is to provide a high degree of uniformity and consistency for all grandfathered IPPS-excluded facilities. We do not believe it would be consistent with this objective if we were to single out a particular type of excluded facility for special, more favorable treatment simply because the patient population treated by the hospital typically includes very few Medicare patients. (In addition, even though Medicare payment amounts might not increase in this circumstance, we find it important to maintain a high level of credibility in the Medicare system because it is typically used as a reference for Medicaid payments.) We also do not believe the absence of adverse Medicare cost impact is a sufficient reason for making a change to national Medicare policy solely in order to increase Medicaid payments to a select class of hospitals. In this context, we note under Medicaid, the States are not bound to follow Medicare payment rules for children's hospitals, but instead have considerable flexibility to modify their individual State plans to provide the level of payments for services that will best meet the needs of Medicaid recipients in the particular State. To the extent additional payment under Medicaid is appropriate in a State, we believe provision for it should be made through the State Medicaid plan rather than by a national Medicare change affecting all States. Moreover,

as we have noted, our data reveal that the there presently is no shortage of bed capacity for the three grandfathered children's HwHs, but that, on the contrary, all three are operating below the licensed bed capacity under State law. Thus, it appears that the current number of beds in these hospitals is adequate. Further, we wish to emphasize that grandfathered facilities remain free at any time to increase their number of beds so long as the applicable separateness and control regulations are met.

In regard to the comment that CMS should allow grandfathered children's HwHs to increase their bed size without losing their grandfathered status because CMS has established a precedent for special treatment of children's hospitals through the regulations at §412.22(h)(2)(i), which exempt children's hospitals from the satellite restrictions applicable to certain other types of IPPS-excluded hospitals, we believe this comment reflects a misunderstanding of the scope and purpose of §412.22(h)(2)(i).

To respond fully to this comment, it will be necessary to review the background of §412.22(h)(2)(i). Under the BBA of 1997, certain types of hospitals and hospital units which were first excluded from the IPPS for a cost reporting period beginning on or after October 1, 1997 were paid under lower TEFRA ceilings than hospitals and units that were excluded from the IPPS for a cost reporting period beginning before that date (64 FR 41533). Following enactment of this provision, CMS became aware of some interest by existing hospitals in establishing satellite units in new locations that would function in much the same way as new hospitals, but would qualify for payment under the higher TEFRA ceilings applicable to previously-excluded hospitals. To prevent satellite facilities of this type from being used to circumvent the BBA provision, we added new regulatory requirements, in §412.22(h)(2)(i). Under those requirements, an IPPS-excluded hospital's number of beds, including both beds at

the main campus and beds at any satellite locations, could not exceed the hospital's number of beds on the last day of its last cost reporting period beginning before October 1, 1997.

As noted earlier, the lower TEFRA ceilings imposed by the BBA applied only to certain types of hospitals, specifically long-term care, psychiatric, and rehabilitation hospitals. They did not apply to children's hospitals. In determining the scope of section 412.22(h)(2)(i), therefore, we decided not to impose the satellite restrictions on children's hospitals because those new children's hospitals were not subject to the new, lower TEFRA ceilings and therefore would have no incentive to attempt to evade them.

In other words, the inapplicability of §412.22(h)(2)(i) to children's hospitals does not reflect any decision by CMS to provide special, favorable treatment for children's hospitals by excluding them from a restriction that would otherwise apply to them. On the contrary, it simply reflects a policy decision by CMS that a regulation designed to prevent a particular abusive practice should not be applied to those hospitals that would not have an incentive to engage in that practice.

(Although not raised by any commenter, a question might arise as to why CMS did not exempt cancer hospitals from the bed size restriction since they, like children's hospitals, were not subject to the lower TEFRA ceilings imposed by the BBA. The legislative provision under which cancer hospitals are excluded from the IPPS at section 1886(d)(1)(B)(v)(I), (II) and (III)] limits cancer hospital status to those specified hospitals. These provisions effectively prevent the recognition of new cancer hospitals. We were concerned that this provision might create an incentive for the opening of new satellites in an attempt to circumvent the restriction inherent in the legislative provision, which would be an abusive practice of the same type as using satellites to evade the BBA provisions. To counter the incentive that might exist for such a practice, cancer hospitals have not been excluded from the scope of §412.22(h)(2)(i).)

We also would address the commenter's specific assertions that children's hospitals should not be subject to general restrictions on growth that we have established for grandfathered HwHs and satellite facilities because of the following reasons: there is no proliferation of children's hospitals; children are admitted directly to their facilities and do not spend time in acute care hospitals; the three grandfathered children's HwHs have not reorganized since they were established at least 30 years ago, long before this category was established for payment purposes by CMS. Although these assertions may be accurate, we do not believe that they are germane to the issue of the revisions of the regulations for grandfathered HwHs and satellite.

In this final rule, we are finalizing policies that revise the preclusion on changing "terms and conditions" and will allow grandfathered HwHs and satellite facilities to decrease their square footage or bed numbers and also to increase their square footage. As discussed above, expansion in square footage of the three grandfathered children's HwHs, could result in increased costs to the Medicare program, since children's hospitals are paid for under the TEFRA system. We have determined, however, that the increased costs will be "de minimus" and we believe that such costs to the Medicare program associated with increases in square footage are outweighed by the benefits associated with advancements in technology and other patient care enhancements that may be achieved through changes to hospital facilities that concurrently increase the square footage of the facilities.

Comment: One commenter representing a cancer hospital, which the commenter identifies as the only grandfathered hospital in this provider category, stated that limiting

the growth of this cancer hospital is inequitable and punitive since it is the only cancer hospital being affected. The commenter stated that the regulatory criteria have ensured that there will be no future hospitals in this category developed and, therefore, our concerns about the negative impact of HwH growth on the Medicare system has no policy rationale in this case. The commenter urged CMS to exempt this cancer hospital from the growth restrictions for grandfathered HwHs.

Response: We do not agree that the grandfathering provision for HwHs in existence before September 30, 1995, is "inequitable or punitive." Although we understand that the specific statutory provision at section 1886(d)(1)(B)(v) of the Act and the regulatory criteria at §412.23(f) make it unlikely that there will be additional cancer HwHs established, we reiterate that our grandfathering policy for HwHs was not established in order to limit HwH growth. Our goal, as noted above, was to enable hospitals excluded from the IPPS that were co-located prior to the recognition of HwHs as an entity to continue in their present arrangement with their "host" hospital without having to comply with the regulatory framework that we were establishing for HwHs. Because we were giving these hospitals a significant advantage, we believe that it was reasonable and equitable to put restrictions on their growth unless they elected to comply with the HwH regulations at §412.22(e). As we have indicated previously, grandfathered facilities remain free at any time to increase their beds so long as they comply with separateness and control requirements.

Based on our reconsideration of our proposed policy, at this time we are finalizing regulations at §412.22(f)(3) that allow grandfathered HwHs to increase in square footage

because we believe that there have been significant clinical advances, some of which are detailed elsewhere in these responses, reasonably requiring a hospital to physically expand in order to accommodate new equipment or treatment modalities that would enable it to continue to offer the highest level medical care to its patients. We could also envision that circumstances under which changing administrative or otherwise non-clinical needs could require additional space. However, we emphasize that we do not believe that any of these changes require the establishment of additional beds. Therefore, although the commenter's hospital will be permitted to increase its square footage, we are not establishing an exemption for a grandfathered cancer HwH from the limitation on increasing the number of beds.

After consideration of the public comments received, we are revising §412.22(f)(3) and (h)(5) and §412.25(c) (4) of the regulations to state that grandfathered HwHs and satellites will be permitted to decrease their square footage or number of beds, or both or increase their square footage without compromising their grandfathered status. This policy is effective for cost reporting periods beginning on or after October 1, 2006.

Because grandfathered HwHs or grandfathered satellite facilities may be co-located with an acute care hospital or may be co-located with another excluded hospital (69 FR 49198), we want to emphasize that under our policy revisions described above, where the HwH or satellite facility decreases its number of beds or square footage, there could be an impact on the host hospital if the hospital is also a PPS-exempt hospital and is also exempted because of grandfathering from compliance with the "separateness and control" requirements. (Because excluded hospitals are prohibited from having

excluded hospital units under §412.25(a)(1)(ii), this discussion is limited to HwHs and satellite facilities of hospitals.) For example, if grandfathered HwH "A" is co-located with another hospital excluded from the IPPS, hospital "B" (which is a rehabilitation hospital), a decrease in the number of beds in hospital "A" could impact the grandfathered status of hospital "B" if hospital "B" absorbed the extra beds. In such a case, if the determination were made that hospital "B" would expand, in order to maintain status as an excluded hospital, hospital "B" would then have to meet the applicable "separateness and control" requirements at §412.22(e).

6. Changes to the Methodology for Determining LTCH Cost-to-Charge Ratios (CCRs) and the Reconciliation of High-Cost and Short-Stay Outlier Payments under the LTCH PPS

a. Background

In the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34498), we made revisions to our policies concerning the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. As we stated in that final rule, (68 FR 34507), because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities and, therefore, merited revision.

We revised our regulations to specify that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, because we believe that a hospital has the ability to inappropriately increase its outlier payments during the time lag between the current

charges and the CCR from the settled cost report, through dramatic charge increases. Using either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, in many cases, reduces the time lag for updating CCRs by a year or more.

We also revised the regulations to specify that, in the event more recent charge data indicate that an alternative CCR would be more appropriate, CMS has the authority to direct the fiscal intermediary to change the LTCH's CCR to reflect the change evidenced by the more recent data. We made this change because even the later (that is, most recent) CCRs calculated from the tentatively settled cost reports would overestimate costs for hospitals that have continued to increase charges much faster than costs during the time between the tentatively settled cost report and the time when the claim is processed. In addition, we further revised the regulations to allow a hospital to contact its fiscal intermediary to request that its otherwise applicable CCR be changed if the LTCH presents substantial evidence that its CCR is inaccurate (68 FR 34497 and 34506 through 34508).

Also in the June 9, 2003 final rule (68 FR 34499 through 34500 and 34506 through 34507), we revised the regulations to specify that a fiscal intermediary may use a statewide average CCR if it is unable to determine an accurate CCR in one of three circumstances discussed in greater detail below. We made this revision because we noted that as hospitals raise their charges faster than their costs increase, over time their CCRs will decline. If hospitals continue to increase charges at a faster rate than their costs increase over a long period of time, or if they increase charges at extreme rates, their

CCRs may fall below the range considered reasonable and, under our former policy, fiscal intermediaries would, in most cases, assign a statewide average CCR. These statewide averages are generally considerably higher than the threshold. Therefore, prior to the change in the regulations, these hospitals benefited from an artificially high ratio being applied to their already high charges. Furthermore, hospitals could continue to increase charges faster than costs, without any further downward adjustment to their CCR.

In addition, in the June 9, 2003 final rule (68 FR 34500 through 34502 and 34506 through 34508), we added a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled. We noted that we had become increasingly aware that some hospitals had taken advantage of the former outlier policy by increasing their charges at extremely high rates, knowing that there would be a time lag before their CCRs would be adjusted to reflect the higher charges. We believed that even the revisions to the regulations described above would not completely eliminate all such opportunity. We explained that we believed that a hospital would still be able to dramatically increase its charges by far above the rate-of-increase in costs during any given year.

In the RY 2007 LTCH PPS proposed rule (71 FR 4648, 4674 through 4676, and 4690 through 4692), we discussed our current methodology for determining hospitals' CCRs under the LTCH PPS high-cost and short-stay outlier policies, and we presented proposals to refine our methodology for determining the annual CCR ceiling and statewide average CCRs. In that same proposed rule, we also discussed our existing

policy for the reconciliation of LTCH PPS high-cost and short-stay outlier payments, along with our proposal to codify in Subpart O of 42 CFR Part 412 those policies, including proposed modifications and editorial clarifications to those existing policies.

In that RY 2007 LTCH PPS proposed rule, we proposed that the proposed revisions to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments would be effective October 1, 2006, noting that historically, annual updates to LTCH CCR ceiling and statewide average CCRs have been effective on October 1. In addition, our proposal stated that the LTCH CCR ceiling and statewide average CCRs that would be effective October 1, 2006, would be presented in the annual IPPS proposed and final rules.

As we stated in both the RY 2007 LTCH PPS final rule (71 FR 27832 through 27833 and 27871) and the FY 2007 IPPS proposed rule (71 FR 24127), we received a few specific comments on this portion of the RY 2007 LTCH PPS proposed rule concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. As mentioned below, one commenter in this final rule supported our proposal. Several other commenters referenced one of the specific comments raised by another commenter on the proposed changes to the methodology for determining LTCH CCRs in their own comments on the RY 2007 LTCH PPS proposed rule. In addition, a commenter on the RY 2007 LTCH PPS proposed rule included a synopsis of our proposed changes concerning the determination of LTCH's CCRs. Based on the commenter's synopsis of the proposed changes, we believe that the commenters clearly understood the nature and purpose of the proposed changes. However, the commenter

pointed out that, in the RY 2007 LTCH PPS proposed rule, we did not provide an analysis of the effect of this proposed change, nor did we provide an example of the new CCR values under this proposed methodology. Another commenter did not "object in concept to the proposed combination of [IPPS] operating and capital cost-to-charge ratios" (to compute a "total" CCR for each IPPS hospital by adding together each hospital's operating CCR and its capital CCR) from which to compute the LTCH CCR ceiling and applicable statewide average CCRs. However, the commenter also pointed out that we did not provide any impact data and requested that we defer adoption of that proposed change until such data are provided for comment.

Therefore, in light of the comments referenced above, we proposed in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135) the same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments that we proposed in the RY 2007 LTCH PPS proposed rule. We included in the FY 2007 IPPS proposed rule the values of the proposed LTCH CCR ceiling and the proposed statewide average LTCH CCRs that would be effective October 1, 2006, based on our proposed policy changes, along with the values of the proposed LTCH CCRs that would be determined under our current methodology. We also indicated that we would respond further to any comments received on the proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH PPS high-cost outlier and short-stay payments presented in the FY 2007 IPPS proposed rule in the FY 2007 IPPS final rule that will be published this summer. We received two public comments concerning the proposed changes to the

policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH high-cost outlier and short-stay payments presented in the FY 2007 IPPS proposed rule (71 FR 24125 through 24136). As discussed in greater detail below in this section, in this final rule, we are finalizing the proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH high-cost outlier and short-stay payments as proposed. In the RY 2007 LTCH PPS final rule (71 FR 27871), we revised the short-stay outlier payment formula based on the existing regulatory language at §412.529(c) concerning the determination of LTCH CCRs and the reconciliation of short-stay outlier payments since we did not finalize any changes to our policy regarding the determination of LTCHs' CCRs and the reconciliation of LTCH PPS short-stay outlier payments in that LTCH PPS final rule.

In that same final rule, we noted that, to the extent the policy changes we proposed in the FY 2007 IPPS proposed rule regarding the determination of LTCHs' CCRs and the reconciliation of short-stay outlier payments are implemented, we may need to make conforming changes to the regulatory language in §412.529 in the FY 2007 IPPS final rule to ensure that any such changes are consistent with (and do not contradict) the changes we made to §412.529 in the RY 2007 LTCH PPS final rule. Accordingly, in adopting the proposed changes to the regulations regarding the determination of LTCHs' CCRs and the reconciliation of outlier payments in this final rule, we are making conforming changes to the regulatory language in §412.529 as necessary based on the changes to the short-stay outlier policy at §412.529 established in the RY 2007 LTCH PPS proposed rule (71 FR 27899 through 27900).

Comment: One commenter supported our proposed changes to the methodology for determining LTCH CCRs and LTCH PPS outlier reconciliation. The commenter was particularly appreciative of the impact analysis presented in the FY 2007 IPPS proposed rule.

Response: We appreciate the commenter's support and are pleased that our impact analysis was able to assist in the understanding of our proposal.

b. High-Cost Outliers

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, when we implemented the LTCH PPS, we established an adjustment for additional payments for outlier cases that have extraordinarily high-costs relative to the costs of most discharges at §412.525(a). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient level and hospital level. Specifically, under §412.525(a), we make outlier payments for any discharge if the estimated cost of the case exceeds the adjusted LTCH PPS payment for the LTC-DRG plus a fixed-loss amount. Under the LTCH PPS high-cost outlier policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charge. In accordance with §412.525(a)(3), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount).

c. Short-Stay Outliers

When we implemented the LTCH PPS, under §412.529, we established a special payment policy for short-stay outlier cases, that is, LTCH PPS cases with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for each LTC-DRG. Generally, LTCHs are defined by statute as having an average length of stay of greater than 25 days. We believe that a short-stay outlier payment adjustment results in more appropriate payments, because these cases most likely would not receive a full course of a LTCH-level of treatment in such a short period of time and a full LTC-DRG payment may not always be appropriate. A short-stay outlier is defined at §412.529(a) as a LTCH discharge with a length of stay of up to and including five-sixths the geometric average length of stay for the LTC-DRG. Under the short-stay outlier policy at §412.529(c)(1), for LTCH PPS discharges occurring before July 1, 2006, in general, we adjust the per discharge payment under the LTCH PPS by the least of 120 percent of the estimated cost of the case, 120 percent of the LTC-DRG specific per diem amount, or the full LTC-DRG payment. Under the short-stay outlier policy at §412.529(c)(2), for LTCH PPS discharges occurring on or after July 1, 2006, in general, we adjust the per discharge payment under the LTCH PPS by the least of 100 percent of the estimated cost of the case, 120 percent of the LTC-DRG specific per diem amount, the full LTC-DRG payment, or a blend of an amount comparable to the IPPS per diem amount (capped at the full IPPS comparable amount) and the 120 percent of the LTC-DRG specific amount (71 FR 27899). Consistent with the LTCH PPS high-cost outlier policy, we calculate the

estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charges.

d. CCR Ceiling

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" LTCH-specific CCR based on the sum of LTCH operating and capital-related costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100-4)) as compared to total charges. A LTCH's CCR is calculated by dividing its 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). (Instructions regarding the changes established in the June 9, 2003 IPPS high-cost outlier final rule for both LTCHs and IPPS hospitals can be found in Program Transmittal A-03-058 (Change Request 2785; July 3, 2003).)

Under our current policy, a LTCH is assigned the applicable statewide average CCR instead of using its CCR computed from data in its most recent (settled or tentatively settled) cost report if, among other things, the LTCH's CCR is found to be in excess of the applicable maximum CCR threshold. The applicable maximum CCR threshold is the combined IPPS operating and capital CCR ceiling. For instance, for FY 2006, under the current policy, the IPPS operating CCR ceiling is 1.254 and the IPPS capital CCR ceiling is 0.169 (70 FR 47496). Therefore, under our current policy, the

combined operating and capital CCR ceiling is 1.423 (1.254 + 0.169 = 1.423) as specified in Program Transmittal 692 (Change Request 4046, September 30, 2005).

These ceilings represent 3.0 standard deviations from the mean of the log distribution of operating and capital cost-to-charge ratios for all IPPS hospitals. As we explained in the June 9, 2003 final rule (68 FR 34507), LTCH 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. (There are also other circumstances, discussed below, when we use a statewide CCR instead of a LTCH-specific CCR.)

Under the current methodology, we determine a "combined" statewide average CCR for LTCHs located in rural areas of a State that accounts for operating and capital costs and charges and a "combined" statewide average CCR for LTCHs located in urban areas of a State that accounts for operating and capital-related costs and charges. In order to calculate a combined statewide average CCR under our current methodology, we first calculate separate statewide average operating CCRs and capital CCRs. Under the IPPS, two statewide average operating CCRs are computed for each State: a statewide average CCR for rural areas and a statewide average CCR for urban areas. One statewide average capital CCR is computed for each State (applicable to both urban and rural areas). We use the same capital CCR for urban and rural areas because capital costs are the same regardless of geographic location. (Below we discuss our proposed revisions to this methodology, which we are adopting as final in this final rule.)

As we explained in the RY 2006 LTCH PPS final rule (70 FR 24192), we believe it is appropriate to use the combined IPPS operating and capital CCR ceiling and the applicable combined IPPS statewide average urban and rural CCRs in determining LTCHs' CCRs because LTCHs' cost and charge structures are similar to that of IPPS acute care hospitals. For instance, LTCHs are certified as acute care hospitals, as set forth in section 1861(e) of the Act, to participate as a hospital in the Medicare program, and these hospitals, in general, are paid as LTCHs only because their Medicare average length of stay is greater than 25 days (§412.23(e)). Furthermore, as also explained in that same final rule, prior to qualifying as a LTCH under §412.23(e)(2)(i), a hospital generally is paid as an acute care hospital under the IPPS during the period in which it demonstrates that it has an average length of stay of greater than 25 days. In addition, because there are less than 400 LTCHs, and they are unevenly geographically distributed throughout the United States, there may not be sufficient LTCH CCR data to determine an appropriate LTCH PPS CCR ceiling using LTCH data.

Because LTCHs have a single "total" CCR (rather than separate operating and capital CCRs), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in the FY 2007 IPPS proposed rule (71 FR 24128 through 24129 and 24132 through 24133), we proposed to revise our regulations for high-cost outliers and short-stay outliers (§§412.525(a)(4) and 412.529(c)(5), respectively) to specify that, for discharges occurring on or after October 1, 2006, if a LTCH's CCR is in excess of the LTCH CCR ceiling (which would be calculated as 3 standard deviations above the corresponding national geometric mean total CCR (established and published annually by

CMS)), the fiscal intermediary may use a statewide average CCR (also established annually by CMS and discussed in more detail below). (We also proposed a change in our methodology for calculating the applicable statewide average CCRs under the LTCH PPS, which we are finalizing in this final rule, as discussed in greater detail below.)

Specifically, for purposes of determining a LTCH's CCR under the LTCH PPS high-cost and short-stay outlier policies at §§412.525(a)(4) and 412.529 respectively, for discharges occurring on or after October 1, 2006, we proposed that we would determine the single "total" CCR ceiling, based on IPPS CCR data, by first calculating the total (that is, operating and capital) IPPS CCR for each hospital and then determining the average total CCR for all IPPS hospitals. For example, if an IPPS hospital's operating CCR is 0.432 and its capital CCR is 0.027, its total CCR would be 0.459 (0.432 + 0.027 = 0.459). This calculation would be repeated for all IPPS hospitals in order to determine a total CCR for all IPPS hospitals. Next, the total IPPS CCR would be used to determine the average total IPPS CCR and standard deviation across all IPPS hospitals. The LTCH CCR ceiling would then be established at 3 standard deviations from the national geometric mean total IPPS CCR, rather than determining the LTCH total CCR ceiling as we do under our current policy by adding the separate IPPS operating CCR and capital CCR ceilings, which are each separately determined at 3 standard deviations from the average operating IPPS CCR and average capital IPPS CCR, respectively.

Under this proposed policy, we would use the same IPPS CCR data that we currently use to annually determine the separate IPPS operating CCR and capital CCR ceilings (that we add together under our current policy to determine the annual CCR

ceiling for LTCHs) to compute IPPS hospital-specific total CCRs that would be used to determine the single LTCH total CCR ceiling. We believe that determining a LTCH CCR ceiling based on IPPS total (operating and capital-related) Medicare costs and charges rather than adding the separate IPPS CCR ceilings determined from operating CCRs and capital CCRs, respectively, would be more consistent with the LTCH PPS single payment, which does not differentiate payments between operating and capital-related costs. We noted that we still believe that it is appropriate to continue to use IPPS data to determine the annual LTCH CCR ceiling.

We also explained in both the RY 2007 LTCH PPS proposed rule (71 FR 4675) and the FY 2007 IPPS proposed rule (71 FR 24129), that these proposed revisions to our policy concerning the determination of the annual LTCH CCR ceiling would be effective for discharges occurring on or after October 1, 2006, rather than July 1, 2006. We proposed this approach because we proposed to continue to use the same IPPS data used to determine the individual IPPS operating and capital CCR ceilings established and published annually in the IPPS proposed and final rules. Because both the separate IPPS operating and capital CCRs ceilings and the new LTCH "total" CCR ceiling would be determined using the same data, we believe it would be administratively expedient to continue to establish the LTCH CCR ceiling to be effective for discharges occurring on or after October 1 of each year. (As stated previously, this is consistent with our current policy, where the LTCH CCR ceiling is updated annually on October 1.) Therefore, under this proposal, the public would continue to consult the annual IPPS proposed and final rules for changes to the LTCH CCR ceiling that would be effective for discharges

occurring on or after October 1. Under this proposal, the current LTCH CCR ceiling established for discharges occurring on or after October 1, 2005, in the FY 2006 IPPS final rule would remain in effect for discharges occurring on or before September 30, 2006.

Comment: One commenter questioned why CMS' proposal concerning LTCH CCRs did not utilize a floor for applying the statewide average similar to using a ceiling. The commenter explained that even though a hospital could increase payment by increasing its charges, if a hospital has a historically low CCR, then it should be assigned the statewide average.

Response: As discussed in the June 9, 2003 outlier final rule (68 FR 34494 and 34507), we no longer assign the statewide average when a hospital's CCR falls below a minimum CCR threshold or "floor," as we believe a LTCH could arbitrarily increase its charges in order to maximize outlier payments. Even though this increase in charges should result in a lower CCR in the future (due to the time lag in cost report settlement), a floor would result in a LTCH being assigned the statewide average CCR. This would result in inappropriately higher outlier payments because in order to avoid making excessive outlier payments, under both our current policy and the proposed LTCH CCR policy, we apply the LTCH's actual CCR no matter how low the hospital's CCR falls. This policy for LTCHs is consistent with the policy we have adopted under the IPPS.

Under both our current policy and the proposed LTCH CCR policy, we apply a CCR maximum threshold or "ceiling" for those hospital's beyond three standard deviations of the national mean CCR to address what we believe is questionable data. As

we explained in the FY 2007 IPPS proposed rule (71 FR 24127), 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 likely errors and should not be relied upon, and therefore, we assign the hospital the statewide average CCR. We note that, if a hospital has a historically low CCR, then a consistent pattern of a low CCR suggests that this CCR is reflective of their actual ratio of costs to-charges as opposed to an instance of the data being aberrant. Therefore, we believe application of the statewide average CCR is not necessary. While it is possible that this low CCR may be based on questionable data, under both our current policy and the proposed LTCH CCR policy, a hospital may request its fiscal intermediary to use a different (higher or lower) CCR based on substantial evidence presented by the hospital.

We did not remove the ceiling similar to removing the floor as the vulnerability of a hospital gaming the outlier payment system applies to hospitals raising their charges thus lowering their CCR and then receiving the statewide average (if a floor was in place). Hospitals with high CCRs reflect costs that are high or exceed their charges, which is uncommon. Therefore, as stated above, we believe if a hospital does cross the ceiling, it is likely due to an error and we assign the statewide average. However, as noted above, a hospital may request its fiscal intermediary to use a different (higher or lower) CCR based on substantial evidence presented by the hospital even if a hospital's CCR is above the ceiling. Therefore, consistent with our current CCR policy, the applicable statewide average CCR will only be assigned when a LTCH’s CCR exceeds the maximum CCR threshold (ceiling) determined as three standard deviations of the

national mean total CCR (as described above), and not when it falls below the minimum threshold (floor).

We received no other comments and after consideration of the public comments received, we are adopting as final, without modification, the policy proposed in the proposed rule. Accordingly, in this final rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are establishing under the LTCH PPS high-cost outlier policy at §412.525(a)(4)(iv)(C)(2) and the LTCH PPS short-stay outlier policy at §412.529(c)(3)(iv)(C)(2), that the fiscal intermediary may use a statewide CCR if it is unable to determine an accurate CCR for a LTCH if, amoung other things, a LTCHs' CCR is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. Furthermore, §§412.525(a)(4)(iv)(C)(2) and 412.529(c)(3)(iv)(C)(2) specify that CMS will establish and publish this mean annually. As discussed above, as proposed, for discharges occurring on or after October 1, 2006, the LTCH total CCR ceiling will be calculated as three standard deviations above the corresponding national geometric mean total CCR, which will be determined based on IPPS CCR data, by first calculating the total (that is, operating and capital) IPPS CCR for each hospital and then determining the average total IPPS CCR for all hospitals. As noted in the FY 2007 IPPS proposed rule (71 FR 24129) and reiterated above, consistent with our current policy, the LTCH total CCR ceiling will be updated annually and will be effective for discharges occurring on or after October 1 of each year. Therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to

the LTCH CCR ceiling that would be effective for discharges occurring on or after October 1.

In the FY 2007 IPPS proposed rule, based on IPPS total CCR data from the December 2005 update to the Provider-Specific File, we proposed a total CCR ceiling of 1.313 under the LTCH PPS that would be effective October 1, 2006. Furthermore, in the FY 2007 IPPS proposed rule, we proposed that, if more recent data are available, we would use those data to determine the final total CCR ceiling under the LTCH PPS for FY 2007 using the proposed methodology described above. Based on the latest available data (data from the March 2006 update to the Provider-Specific File), for this final rule, the CCR ceiling under our proposed methodology would be 1.321.

The LTCH CCR ceiling determined under our current "combined" methodology using the most recent data would result in a slightly higher LTCH CCR ceiling (that is, 1.26 + 0.154 = 1.414) for FY 2007 compared to the "total" CCR ceiling of 1.321 for FY 2007 calculated using our new methodology. However, based on CCRs from the March 2006 update of the Provider-Specific File, there are no LTCHs that have a CCR that is greater than the ceiling of 1.321 (the highest LTCH CCR in the current database of 392 LTCHs is 1.27).

e. Statewide Average CCRs

In addition to being authorized to assign the applicable statewide average CCR to a LTCH whose CCR is above the ceiling, the fiscal intermediary may use the applicable statewide average CCR in other circumstances. In the June 9, 2003 IPPS high-cost outlier final rule, we also established our current policy that the fiscal intermediary may

use the applicable statewide average CCR for LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data) or for new LTCHs that have not yet submitted their 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.

We note that, consistent with our current policy, either CMS or the LTCH may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the LTCH's actual costs and charges. This applies to new LTCHs (as defined above) as well. For instance, CMS may determine that the applicable statewide average CCR should not be applied to hospitals that convert from acute care IPPS hospitals to LTCHs and receive new LTCH provider numbers. Rather, the cost and charge data from the IPPS hospitals' cost reports (even if they are for more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.

In addition to proposing to revise our methodology for determining the annual CCR ceiling under the LTCH PPS for discharges occurring on or after October 1, 2006, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in the FY 2007 proposed rule (71 FR 24131 through 24134), we proposed to revise our regulations for high-cost outliers and short-stay outliers (§§412.525(a)(4) and 412.529(c)(5), respectively) for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the remaining LTCH PPS outlier policy changes that were established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513), including proposed modifications and editorial

clarifications to those existing policies established in that final rule, which are discussed in greater detail below in this section. We proposed these additional revisions to §§412.525(a)(4) and 412.529(c)(5) because we believe that making these revisions would more precisely describe the application of those policies as they relate to the determination of LTCH CCRs and because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above in this section.

Specifically, we proposed to specify under the LTCH PPS high-cost outlier policy at §412.525(a)(4) and the LTCH PPS short-stay outlier policy at §412.529 that the fiscal intermediary may use a statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs 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 may consider in determining a LTCH's CCR included 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.)

We did not receive any public comments on our proposal. Therefore, in this final rule, we are adopting as final, without modification, our proposed policy. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, we are establishing §§412.525(a)(4)(iv)(C)(1) through (3) and 412.529(c)(3)(iv)(C)(1) through (3), which specify that the fiscal intermediary may use a statewide average CCR if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18; (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs 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 may consider in determining a LTCH's CCR included 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.) These regulations further specify that the statewide average CCRs used under the LTCH PPS, as described in greater detail below, will be established annually by CMS.

Also, in the FY 2007 IPPS proposed rule (71 FR 24130 through 24131 and 24133 through 24134) we described our existing methodology for calculating the combined statewide average CCR for rural and urban LTCHs. Under the proposed LTCH PPS

high-cost outlier policy at §412.525(a)(4) and the proposed LTCH PPS short-stay outlier policy at §412.529 for discharges occurring on or after October 1, 2006, we proposed to compute statewide average CCRs for use under the LTCH PPS in a manner similar to the way we proposed to compute LTCH PPS CCR ceilings. Specifically, under this proposed policy, we would use the same IPPS CCR data that we currently use to annually establish the separate IPPS operating and capital statewide CCRs to compute statewide average total CCRs. Below we outline our proposed methodology for calculating the total statewide average CCR for a rural LTCH:

Step 1: Calculate the total CCR for each rural IPPS hospital by adding together its operating CCR and its capital CCR.

Step 2: Calculate the weighted average total CCR for all rural IPPS hospitals in the State (as shown in the third column of Table 8C of the Addendum to the FY 2007 IPPS proposed rule). This same proposed methodology would be applied when determining the "total" statewide average CCR for LTCHs located in urban areas, except that we would replace "rural IPPS hospitals" with "urban IPPS hospitals" in Steps 1 and 2. Under this proposal, the underlying data, that is, the IPPS CCRs, would remain the same. (We note that the weighted average total CCR for all urban IPPS hospitals in the State is shown in the second column of Table 8C of the Addendum to this final rule and the weighted average total CCR for all rural IPPS hospitals in the State is shown in the third column of Table 8C of the Addendum to this final rule, based on the policies finalized in this final rule as discussed below.)

We also proposed that these statewide average "total" (operating and capital) CCRs that would be used under the LTCH PPS would continue to be published annually in the IPPS proposed and final rules, and, therefore, the public would continue to consult the annual IPPS proposed and final rules for changes to the applicable statewide average total CCRs that would be effective for discharges occurring on or after October 1. Under this proposal, the current applicable statewide average operating and capital CCRs, established for discharges occurring on or after October 1, 2005, would remain in effect for discharges occurring on or before September 30, 2006. Our rationale for proposing to establish statewide average "total" CCRs (as described above in this section) based on IPPS data under the proposed revisions to the high-cost outlier policy at §412.525(a)(4) and short-stay outlier policy at §412.529 is the same as the one stated above for proposing to use IPPS data to determine a "total" LTCH CCR ceiling.

We did not receive any public comments on our proposed changes. Therefore, we are adopting them as final without modification. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, under §§412.525(a)(4)(iv)(C) and 412.529(c)(3)(iv)(C), as proposed and as described above, for discharges occurring on or after October 1, 2006, the applicable LTCH statewide average total CCRs will be determined based on IPPS CCR data in a manner similar to the way we will be computing the LTCH PPS CCR ceiling, as discussed above. As also noted in the FY 2007 IPPS proposed rule (71 FR 24129 and 24134) and reiterated above, consistent with our policy, the LTCH PPS statewide average total CCRs will be updated annually and will be effective for discharges occurring on or after October 1 of each year.

Therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH PPS statewide average total CCRs that would be effective for discharges occurring on or after October 1.

We also proposed to determine the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS using, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively (71 FR 24130 through 24131 and 24134). As we explained in the FY 2007 IPPS proposed rule, we proposed this proxy because we believe that the CCR data on the Provider-Specific File for Maryland hospitals may not be accurate. This is because acute care hospitals in Maryland are operating under a waiver of Medicare's ratesetting methodologies for inpatient and outpatient services under the authorities of sections 1814(b)(3) and 1833(a)(2) of the Act. The State's Health Services Cost Review Commission (HSCRC) is the regulatory body that establishes hospital-specific rates for all hospital services in Maryland.

Because all Maryland short-term acute care hospitals are paid based on the hospital-specific rates set by the HSCRC rather than under the IPPS, CCRs are not required to determine their Medicare payments (as they are for other acute care hospitals that are not governed under the waiver at sections 1814(b)(3) and 1833(a)(2) of the Act, and who are reimbursed for their treatment of Medicare patients under the IPPS). Therefore, CCRs in the Provider-Specific File for Maryland acute care hospitals, for the most part, are missing (because they are not used for payment). Those CCRs that are inputted into the Provider-Specific File for Maryland acute care hospitals by the fiscal

intermediary are most likely unaudited because they are not used for making payments. For all these reasons, we are concerned that CCRs for Medicare acute care hospitals located in Maryland that are in the Provider-Specific File may not be reliable. Therefore, we believe that they should not be used as proxies for setting the statewide average total CCRs for Maryland LTCHs.

As we discussed in the FY 2007 IPPS proposed rule (71 FR 24130 and 24134), we believe it would be more appropriate to establish statewide average total CCRs for Maryland LTCHs based on national average total CCRs of IPPS hospitals that were audited by fiscal intermediaries. Therefore, we proposed to establish statewide average total CCRs for Maryland LTCHs based on the national average total CCRs of all IPPS hospitals because we believe that the average of the CCRs of all the IPPS hospitals across the country that were audited by fiscal intermediaries would be based on sufficient rigorous complete data that would be a representative proxy for the ratio of costs-to-charges of LTCHs in Maryland that are subject to LTCH PPS. (We note that, under our proposal, the fiscal intermediary may assign the statewide average CCR in one of three circumstances (that is, "new" LTCHs, as defined above; LTCHs with a CCR that is in excess of the LTCH ceiling; and LTCHs with unavailable data, as discussed above).) We solicited comments or suggestions for an alternative proxy statewide average CCR to use for LTCHs that are located in Maryland and are paid under the LTCH PPS in the FY 2007 IPPS proposed rule. We did not receive any public comments on our proposal or any alternative proxy statewide average CCR to use for LTCHs that are located in Maryland and are paid under the LTCH PPS. Therefore, under the broad authority of

section 123 of the BBRA and section 307(b)(1) of BIPA, we are adopting our proposed methodology for determining the statewide average CCR for Maryland under the LTCH PPS as final without modification.

In the FY 2007 IPPS proposed rule (71 FR 24130 and 24134) we stated that, if more recent data are available for the final rule, we would use those data to determine the final LTCH PPS statewide average CCRs for FY 2007 using the proposed methodology describe above that we are adopting as final in this final rule. Therefore, in this final rule, based on the most recent complete IPPS total CCR data from the March 2006 update of the Provider-Specific File, the final LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective October 1, 2006, are presented in Table 8C of the Addendum to this final rule. (As was proposed, we note that for this final rule, 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. As was proposed, we also note that for this final rule, as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2006, and therefore there are no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this final rule.)

Comparing the statewide average "total" CCRs in Table 8C of the Addendum to this final rule to the "combined" statewide average CCRs that would have been calculated using our existing methodology shows that the changes to our methodology for

determining LTCH statewide average CCRs results in only minor changes in the average CCR for each State. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, as discussed above) will be in urban Wyoming (-0.7 percent). However, there is currently only 1 LTCH located in Wyoming. The largest increase in a statewide average CCR will be in urban District of Columbia (0.7 percent), and there are currently only 2 LTCHs located in the District of Columbia.

f. Data Used to Determine a CCR

Similar to our current policy, in the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), we also proposed to specify under our proposed revision to the LTCH PPS high-cost outlier policy at §412.525(a)(4) and the LTCH PPS short-stay outlier policy at §412.529 that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed would be 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. Furthermore, in the same proposed rule, we proposed under the LTCH PPS high-cost outlier policy at §412.525(a)(4) and the LTCH PPS short-stay outlier policy at §412.529 to state that CMS may specify an alternative to the CCR computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later (under proposed §§412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv)(B)), or a hospital may also request that the fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. These proposed revisions to our policy for determining a LTCH's CCR for discharges occurring on or after October 1, 2006, under the proposed revisions to the LTCH PPS high-cost and short-stay outlier policies, described above, are similar to our existing policy established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513). In addition, we proposed a technical correction to existing §412.525(a)(3) to change the plural reference from cost-to-charge "ratios" to the singular reference to a cost-to-charge "ratio" because, under the LTCH PPS, a single (total) CCR is computed for LTCHs.

We did not receive any comment on our proposal. Therefore, we are adopting as final without modification the proposed policy changes. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, we are establishing under §§412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv) that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed will be 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. Under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also establishing at §§412.525(a)(4)(iv)(A) and 412.529(c)(3)(iv)(A) that, for discharges occurring on or after October 1, 2006, CMS may specify an alternative to the CCR computed under new §§412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv)(B) (that is, computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later), or a hospital may also request that the fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. In addition, as proposed, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are revising §412.525(a)(3) to change the plural reference from cost-to-charge "ratios" to the singular reference to a cost-to-charge "ratio" in this final rule.

g. Reconciliation of Outlier Payments Upon Cost Report Settlement

In the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34508 through 34512), we established our policy for LTCHs that effective with LTCH PPS discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based

upon the actual CCR computed from the costs and charges incurred in the period during which the discharge occurs. In that same final rule, we also established our current policy that for discharges occurring on or after August 8, 2003, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. Additional information on the administration of the reconciliation process under the IPPS is provided in Program Transmittal 707 (Change Request 3966, October 12, 2005). We note that, in addition to the changes to the high-cost outlier and short-stay outlier policies presented in this final rule, we are currently developing additional instructions on the administration of the existing reconciliation process under the LTCH PPS that would be similar to the IPPS reconciliation process.

In the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), for discharges occurring on or after October 1, 2006, we proposed to codify into the LTCH PPS section of the regulations (Subpart O of 42 CFR Part 412) the provisions governing the determination of LTCHs' CCRs, including proposed modifications and editorial clarifications to our existing methodology for determining the annual LTCH CCR ceiling and applicable statewide average CCRs under the LTCH PPS. In addition, in that same proposed rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we proposed to revise §§412.525(a)(4), and 412.529(c)(3) for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part

412 the provisions discussed above concerning the reconciliation of LTCH PPS outlier payments, including proposed editorial clarifications discussed in greater detail below in this section, that would more precisely describe the application of those policies. We proposed the additional revisions to §§412.525(a)(4) and 412.529(c)(3) concerning the reconciliation of outlier payments, which are discussed in greater detail below in this section, because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above.

Specifically, we proposed under the LTCH PPS high-cost outlier policy at §412.525(a)(4) and the LTCH PPS short-stay outlier policy at §412.529, similar to our current policy, to specify that, for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments would be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, we proposed under the LTCH PPS high-cost outlier policy at §412.525(a)(4)and the LTCH PPS short-stay outlier policy at §412.529, similar to our current policy, to specify that, for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Consistent with our current policy, we also proposed that such an adjustment would be based upon a widely available index to be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation. As we discussed in the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), we proposed to make these additions to §§412.525(a)(4) and 412.529

because we believe that such proposed changes reinforce the concept that the LTCH PPS has a single payment rate for inpatient operating and capital-related costs (as discussed in greater detail previously), and because we believe it would be more appropriate and administratively simpler to include all of the regulatory provisions concerning the determination of LTCH PPS (high-cost and short-stay) outlier payments applicable under the LTCH PPS regulations in Subpart O of 42 CFR Part 412.

We did not receive any public comments on the proposed changes regarding the reconciliation of LTCH PPS outlier payments upon cost report settlement. Therefore, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are adopting as final, without modification, the proposed changes to the regulations at §412.525(a)(4)(iv)(D) through (E) for LTCH PPS high-cost outliers and §412.529(c)(3)(iv)(D) through (E) for LTCH PPS short-stay outliers regarding the methodology for determining LTCH CCRs and LTCH PPS outlier reconciliation.

7. Technical Corrections Relating to LTCHs

In the FY 2007 IPPS proposed rule (71 FR 24135), we proposed to make the following technical changes to various sections of the regulations relating to LTCHs to update or correct cross-references or to include inadvertently omitted provisions:

a. In the following sections, we proposed to correct several incorrect cross-references in the existing regulations:

- In §412.505(b)(1), we proposed to change the cross-reference "§412.22(e) and (h)(5)" to the phrase "§412.22(e)(3) and (h)(6), if applicable".

- In §412.508(c)(3), we proposed to change the cross-reference "§1001.301" to "§1001.201."

- In §412.541(b)(2)(i), we proposed to change the cross-reference "§412.533(b)" to "§412.533(a)(5) and §412.533(c)" to correctly refer to the provisions on the determination of the LTCH PPS rates.

b. We proposed to revise §412.511 to change the cross-reference "§412.22(e) and (h)(5)" to the phrase "§412.22(e)(3) and (h)(6)" and to clarify the requirement that LTCHs must meet under §§412.22(e)(3) and (h)(6) to report co-location status as part of its overall reporting requirements.

c. We proposed to revise §412.525(d) by adding new paragraphs (d)(3) and (d)(4) to specify two additional payment adjustments to the per discharge payments under the LTCH PPS that were inadvertently omitted; that is, the special payment under the onsite transfer and readmission policy at §412.532 and the special payment provisions for LTCH HwHs and satellites of LTCHs at §412.534.

d. We proposed to revise §412.532(a)(2) to correct the cross-reference to the definition of a satellite facility by changing "§412.22(f)" to "§412.22(h)". In addition, we proposed to revise paragraph (b) of §412.532 to include satellite facilities and SNFs as part of the definition of entities that may be "co-located" or "onsite" with a hospital. In existing §412.532(a)(2) and (a)(3), we include satellite facilities and SNFs, respectively, within the onsite provider payment policy as entities that may be co-located with a LTCH, but omitted to mention them in §412.532(b) as being included when we defined

"co-located or onsite" facilities. We proposed to conform §412.532(b) to include their mention.

We did not receive any public comments on these technical changes and, therefore, are adopting them as final without modification.

8. Cross-Reference Correction in Authority Citations for 42 CFR Parts 412 and 413

As stated earlier, on November 15, 2004, we published in the **Federal Register** the final rule establishing a PPS for IPFs (69 FR 66922). As a part of that rule, we amended the authority citations for 42 CFR Parts 412 and 413 to include references to section 124 of Pub. L. 106-113. Section 124 directed us to take various actions regarding a per diem PPS for IPFs. We included incorrect cross-references to the United States Statutes at Large citation for this provision. We proposed to amend the authority citations for Parts 412 and 413 by removing the incorrect cross-reference to "113 Stat. 1515" and inserting the correct cross-reference "113 Stat. 1501A-332".

We did not receive any public comments on the proposed cross-reference correction and, therefore, are adopting it as final without modification.

9. Report of Adjustment (Exceptions) Payments

Section 4419(b) of Pub. L. 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, an excluded hospital or excluded

unit of a hospital must file its cost report for a fiscal year with its fiscal intermediary within 5 months after the close of its cost reporting period in accordance with §413.24(f)(2). The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) within approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 180 days from the date of the NPR. The fiscal intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. 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 2005.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2005. As indicated above, the adjustments made during FY 2005 only pertain to cost reporting periods ending in years prior to FY 2004. Total adjustment payments awarded to excluded hospitals and units during FY 2005 are $21,362,945. 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
Rehabilitation	12	$ 4,753,618	$1,352,043
Psychiatric	34	27,408,956	18,362,262
Long-Term Care	2	2,147,623	1,485,380
Children's	--	--	--

Class of Hospital	Number	Excess cost over ceiling	Adjustment payments
Cancer	--	--	--
Religious Nonmedical Health Care Institution	3	383,951	163,260

B. Critical Access Hospitals (CAHs)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

2. Sunset of Designation of CAHs as Necessary Providers: Technical Correction

Under section 1820(c)(2)(B)(i) of the Act, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or only secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Section 405(h) of Pub. L. 108-173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that terminated a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. As a result of this amendment, as of January 1, 2006, States are no longer able to designate CAH status based upon a determination that an entity is a necessary provider of health care. However, section 405(h) of Pub. L. 108-173 also included a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this

provision, a CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, is permitted to maintain its necessary provider designation.

The regulations that specify the location requirements for CAHs described above are set forth at 42 CFR 485.610(c). To implement the amendment made by section 405(h) of Pub. L. 108-173, we published a final rule in the **Federal Register** on August 11, 2004 (69 FR 49271) to revise the regulations under paragraph (c) of §485.610. In that revision, we inadvertently included an erroneous date: In the second sentence of paragraph (c), we stated that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after October 1, 2006. Although a correction notice was published in the **Federal Register** on October 7, 2004 (69 FR 60252), the notice corrected only the second citation of the date in that paragraph. As a result, the second sentence of §485.610(c) continues to state, incorrectly, that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation as of January 1, 2006.

To avoid further confusion, and to ensure that the regulations implementing the CAH location requirement under section 1820(c)(2)(B)(i)(II) of the Act specify that requirement accurately, we proposed to revise the second sentence of §485.610(c) to state that a CAH that was designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation as of January 1, 2006. We note that this change would merely correct the previous error and does not reflect any change in our policy as to how the statutory provision is implemented.

Comment: A number of commenters raised issues concerning the interpretative guidelines that we issued relating to implementation of the CAH necessary provider provision.

Response: These interpretative guidelines were developed after the FY 2005 IPPS final rule was published. We consider the comments that we received to be outside the scope of the May 12, 2006 proposed rule and, therefore, are not responding to them in this final rule. However, we are considering these comments as part of our ongoing policy review efforts and will take appropriate action if warranted.

In this final rule, we are adopting as final, without modification, the revision to the second sentence of §412.610(c) described above.

VII. Payment for Services Furnished Outside the United States

A. Background

Section 1862(a)(4) of the Act generally prohibits payment under Medicare for items and services furnished outside the United States. Under sections 1861(x) and 210(i) of the Act, "United States" is defined to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and America Samoa. Furthermore, under Pub. L. 94-241, "those laws which provide Federal services and financial assistance programs" apply to the Northern Mariana Islands to the same extent as they do to Guam. In addition, we have interpreted the term "United States" as including U.S. territorial waters. We consider shipboard services furnished in a port of the United States or within 6 hours before arrival at, or departure from, a port of the United States to be furnished in the United States territorial waters (54 FR 41723). Therefore, in our

regulations at §411.9(a), we define the United States to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services furnished on board ship, the territorial waters adjoining the land areas of the United States. This general prohibition has exceptions, under which payment may be made for inpatient hospital services, emergency inpatient hospital services, and for physician and ambulance services associated with these hospital services that are furnished outside the United States.

Payment may be made for inpatient hospital services if a Medicare beneficiary who is a United States resident received these services at a hospital located outside of the United States that either was closer to, or was substantially more accessible from, the beneficiary's residence than the nearest United States hospital that was adequately equipped and available to treat the beneficiary. Payment may be made for emergency inpatient hospital services if a beneficiary was in the United States (or in Canada while traveling between Alaska and another State without unreasonable delay and by the most direct route) when the emergency arose, and the hospital located outside the United States was closer to, or substantially more accessible from, the place where the emergency arose than the nearest available adequately equipped hospital within the United States. Payment may be made for physician and ambulance services furnished in connection with these inpatient and emergency inpatient hospital services. Our existing regulations that implement these statutory provisions are located at 42 CFR 409.3, 409.5, 410.14, 410.66, 411.9, 413.74 and Subparts G and H of Part 424.

B. Proposed Clarification of Regulations

Services that fall under these exceptions typically are furnished in Canada or Mexico. However, in accordance with section 1814(f) of the Act and the definition of the term "United States" (42 CFR 411.9(a)), it is permissible for Medicare to pay for services furnished in foreign countries other than Canada and Mexico. For example, if a Medicare beneficiary who is in Guam needed emergency inpatient hospital services and the nearest available hospital adequately equipped to treat that beneficiary was located in the Philippines, Medicare payment would be permitted for the services.

Several of our existing regulations (§§409.3, 409.5, 410.66, and 413.74) specifically refer to services furnished in Canada and Mexico and do not indicate that it is permissible for Medicare payment to be made for services furnished in other foreign countries. The references in these sections also are more limited than the provisions of 42 CFR Part 424, Subpart H, the portion of our regulations that addresses treatment furnished in a foreign country. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24136), we proposed to amend those regulations that refer to Canada and Mexico in order to conform them to the Act and to our other regulations addressing these situations.

Comment: Commenters indicated that they believed additional clarification of the proposed revisions on payment for services outside the United States may be necessary to avoid confusion. Specifically, they noted that the example cited in the preamble states: if a Medicare beneficiary who is in Guam needed emergency inpatient hospital services and the nearest available hospital adequately equipped was located in the Philippines, Medicare payment would be permitted for the services. The commenters indicated that

this statement and the proposed accompanying changes to the regulations raise several questions. First, does it matter that the beneficiary happens to be in Guam, or is there an expectation that the beneficiary resides in Guam? Second, does it matter if the beneficiary is in a United States Territory (that is, Guam), or would payment be permitted for services furnished to a beneficiary who was in another foreign country? Finally, what is the applicability of these provisions to a beneficiary who maintains residence outside the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, or American Samoa?

Further, the commenters believed that CMS should evaluate the safety concerns of beneficiaries living outside the United States, but in close proximity to hospitals accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in foreign countries. They stated that these beneficiaries are forced to travel great distances to reach hospitals in the U.S., sometimes at great risk to their health, while adequately equipped, accredited hospitals are immediately available to meet their health care needs.

Response: If a Medicare beneficiary is in Guam (or any other U.S. Territory) and an emergency arises that results in the beneficiary receiving emergency inpatient services from a foreign hospital, Medicare may pay for such services irrespective of whether the beneficiary is a resident of Guam (or any other U.S. Territory). That is, section 1814(f)(2) of the Act and 42 CFR 424.122 do not require that a beneficiary be a resident of Guam (or any other U.S. Territory where an emergency occurs) in order for Medicare to pay for those services. Because section 1814(f)(2) of the Act and our regulations at

§424.122 already directly address when Medicare payment may be made for emergency inpatient services furnished in foreign hospitals, it is unnecessary to outline those provisions again in 42 CFR 409.3, 409.5, 410.66, and 413.74 of the regulations.

With respect to the question concerning Medicare beneficiaries who maintain their residence outside the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands as we noted above, section 1814(f)(2) of the Act and §424.122 of the regulations do not require that a beneficiary be a resident of Guam (or any other U.S. Territory where an emergency occurs) in order for Medicare to pay for emergency inpatient services that a Medicare beneficiary receives from a foreign hospital. However, section 1814(f)(1) of the Act and §424.123 of the regulations require that, in order for payment to be made for nonemergency inpatient hospital services that a Medicare beneficiary receives at a hospital located outside the United States, the beneficiary must be a U.S. resident who received these nonemergency services at a hospital located outside of the United States that either was closer to, or was substantially more accessible from, the beneficiary's residence than the nearest U. S. hospital that was adequately equipped and available to treat the beneficiary.

With respect to beneficiaries who are forced to travel great distances to reach hospitals in the United States, although we are concerned about the health and safety of Medicare beneficiaries, CMS does not have the legal authority to expand upon the foreign services for which Medicare may make payment, because Medicare law prohibits

payment for items and services furnished outside the United States, except for certain limited services (see sections 1814(f) and 1862(a)(4) of the Act).

After consideration of the public comments received, we are adopting as final, without modification, the amendments to our existing regulations regarding services furnished outside the United States described above.

In the FY 2007 IPPS proposed rule, we also proposed to make some related technical changes. In §§409.3(e) and 424.123(c)(2), we proposed to change the references from the Joint Commission on Accreditation of Hospitals (JCAH) to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the current name of that organization. In §424.121(c), we proposed to change the obsolete cross-reference from §405.313 to the correct cross-reference, §411.9.

We did not receive any public comments on these technical changes. Therefore, we are adopting as final, without modification, the technical changes to §§409.3(e), 424.123(c)(2), and 424.121(c) described above.

VIII. Payment for Blood Clotting Factor Administered to Inpatients with Hemophilia

Section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to inpatients with hemophilia from the definition of "operating costs of inpatient hospital services." Section 6011(b) of Pub. L. 101-239 states that the Secretary of Health and Human Services shall determine the payment amount made to hospitals under Medicare Part A for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor by the

number of units provided to the individual. The regulations governing payment for blood clotting factors furnished to hospital inpatients and for payment for the furnishing fee are located in §§412.2(f)(8) and 412.115(b).

In FY 2005, we made payments for blood clotting factors furnished to inpatients at 95 percent of average wholesale price (AWP), consistent with the rates then paid under section 1842(o) of the Act for Medicare Part B drugs (including blood clotting factor furnished to beneficiaries who are not inpatients).

Section 303 of Pub. L. 108-173 added section 1847A to the Act. Effective January 1, 2005, this section requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP), while section 1842(o)(5) of the Act provides for a Medicare Part B payment of a furnishing fee for blood clotting factor. On November 15, 2004, we published regulations in the **Federal Register** (69 FR 66310 through 66319) that implemented the provisions of section 1847A of the Act. These regulations are codified at Subpart K of Part 414 and §410.63, respectively.

The furnishing fee is updated each calendar year as specified by section 1842(o)(5) of the Act. The furnishing fee for clotting factor for years after CY 2005 is equal to the fee for the previous year increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. This requirement is set forth in our regulations at §410.63.

In the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after

October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 42 CFR Part 414 and for the furnishing fee as determined under §410.63.

On November 21, 2005, we issued regulations in the **Federal Register** (70 FR 70225) updating the furnishing fee payment amount for CY 2006. We announced that the increase in the CPI for medical care for the 12 months ending June 30, 2005 was 4.2 percent. Consequently, the furnishing fee for CY 2006, initially established effective January 1, 2005, at $0.14 per unit of clotting factor, for CY 2006 was set at $0.146 per individual unit (I.U.) for blood clotting factor. We indicated in the preamble to that rule that while "the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits."

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factor. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated annually. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer readers to the Medicare Part B drug pricing regulations.

Comment: Two commenters addressed the blood clotting policy in response to the proposed rule. One commenter supported CMS in its quest for a uniform approach for drug payment. Both commenters recommended that CMS continue to provide the

additional payment for blood clotting factor administered to hemophiliac inpatients in the future even if severity-adjusted DRGs are implemented.

Response: We appreciate the commenters' support. The blood clotting factor policy will remain unchanged even if there are changes to the DRG system. CMS will continue to provide the additional payment for blood clotting factor administered to hemophilia inpatients. As we stated in our proposed rule (79 FR 24136) and restated in this final rule, by fiscal intermediaries utilizing the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, readers should refer to the Medicare Part B drug pricing regulations.

IX. Limitation on Payments to Skilled Nursing Facilities for Bad Debt

A. Background

Under section 1861(v)(1) of the Act and §413.89 of our existing regulations, Medicare may pay some or all of the uncollectible deductible and coinsurance amounts to those entities paid under a reasonable cost payment methodology that are eligible to receive payment for bad debt. Under our existing regulations, Medicare generally pays 100 percent of allowable bad debt amounts to most entities eligible to receive bad debt payment, including SNFs, CAHs, rural health clinics, federally qualified health clinics, community mental health clinics, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. To determine if bad debt amounts are allowable, the requirements at §413.89 and the Provider Reimbursement Manual (PRM) (CMS Pub.15 Part 1, Chapter 3) must be met.

However, under section 1861(v)(1)(T)(iv) of the Act and our existing regulations, Medicare payments for allowable bad debt amounts for hospitals are reduced by 30 percent. Moreover, under our existing regulations, Medicare does not pay for bad debt amounts arising from anesthetists' services paid under a fee schedule (§413.89(i)). In addition, although Medicare pays end-stage renal disease (ESRD) facilities 100 percent of allowable bad debt claims, these payments are capped at facilities' unrecovered cost (§413.178 of the regulations).

B. Changes Made by Section 5004 of Pub. L. 109-171

Section 5004 of Pub. L. 109-171 (DRA of 2005) amended section 1861(v)(1) of the Act to mandate that, for cost reporting periods beginning on or after October 1, 2005,

Medicare payments to SNFs for certain allowable bad debt amounts be reduced. Specifically, for Medicare beneficiaries who are not dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act), allowable bad debt amounts attributable to the coinsurance amounts under the Medicare program are reduced by 30 percent (deductibles are not applicable to patients in SNFs). Allowable bad debt amounts for Medicare beneficiaries who are dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act) will continue to be paid at 100 percent.

C. Proposed Regulation Changes

In the FY 2007 IPPS proposed rule (71 FR 24137), we proposed to conform the Medicare regulations under §413.89 to the provisions of section 5004 of Pub. L. 109-171. Specifically, we proposed to revise paragraph (h) by redesignating the existing contents as paragraph (h)(1) and add a new paragraph (h)(2) to reflect this payment limitation. We proposed to include in paragraph (h)(2) a cross-reference to the definition of "full-benefit dual eligible individual" found at §423.772 of our regulations. In addition, we proposed to revise §413.89(a) to add a cross-reference to the existing limitations on payments to hospitals and the proposed new limitations on payments to SNFs found in paragraph (h), and to correct the cross-reference to the exception for payments for bad debts arising from anesthetists' services paid under a fee schedule from "paragraph (h)" to "paragraph (i)."

Comment: One commenter expressed concern that under the proposed definition of a “full benefit dual eligible individual” found at §423.772 of our regulations, SNFs will not only have to document that the patient is eligible for both Medicare and

Medicaid services but also will now have to document that the patient has coverage under a prescription drug plan under Part D of Title XVIII of the Act or under an MA-PD plan under Part C of Title XVIII of the Act. The commenter stated that the additional documentation will increase the burden on SNFs to provide documentation.

Response: After reviewing the legislative background associated with section 5004 of Pub. L. 109-171, we determined that it was not the Congress' intent to reduce bad debt payments to SNFs for individuals who are eligible for both Medicare and Medicaid, also known as dual eligible individuals. Section 5004 defines "dual eligible individuals" as individuals who are entitled to benefits under Part A of Medicare and are described in section 1935(c)(6)(A)(ii) of the Act.

The definition of a "full-benefit dual eligible individual" at section 1935(c)(6)(A) of the Act is codified at §423.772 of the regulations. Specifically, section 1935(c)(6)(A) of the Act defines a "full-benefit dual eligible individual" in terms of both clause (i) and (ii). Section 1935(c)(6)(A)(i) of the Act (and paragraph (1) under the definition of "full-benefit dual eligible individual" at §423.772) states that the individual must have coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVUIII of the Act or under an MA-PD plan under Part C of title XVIII of the Act. Section 1935(c)(6)(A)(ii) of the Act (and paragraph (2) under the definition of "full-benefit dual eligible individual" at §423.772) states the individual must be determined eligible by the State for medical assistance for full benefits under Title XIX of the Act under section 1902(a)(10)(A) or section 1902(a)(10)(C), by reason of section 1902(f) of the Act, or under any other category of eligibility for medical assistance for

full benefits under Title XIX of the Act. Clearly, the Congress did not include the criterion at section 1935(c)(6)(A)(i) of the Act (and, thus, paragraph (1) under the definition of "full-benefit dual eligible individual" at §423.772] for defining dual eligible individuals to determine the applicability of the reduction of bad debt payments under section 5004 of Pub. L. 109-171.

Accordingly, for this final rule, we are revising the proposed regulation text at new §413.89(h)(2) to better conform with the language of the statute by defining a dual eligible individual as an individual who is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under title XIX as described under paragraph (2) of the definition of a full-benefit dual eligible individual at §423.772. We believe that this revision addresses the concerns expressed by the commenter.

Comment: One commenter stated that, in April 2006, CMS issued revisions to the freestanding SNF Medicare cost reporting Form 2540-96 and instructions to implement the provisions of section 5004 of Pub. L. 109-171 but has not issued similar revisions to the hospital-based (distinct part) SNF Medicare cost reporting Form 2552-96. The commenter requested that CMS clarify whether the provisions of section 5004 will or will not apply to both freestanding and hospital-based SNFs.

Response: Section 5004 of Pub. L. 109-171 applies to both freestanding and hospital-based SNFs. We are currently preparing revisions to the hospital-based SNF Medicare cost reporting Form 2552-96 and instructions to implement the provisions of section 5004. We anticipate that the revisions will be issued in a Transmittal to the

Provider Reimbursement Manual - Part 2 (Pub #15-2) prior to the publication of this final rule.

After consideration of the public comments received, we are adopting as final, with one modification, the amendments needed to conform our regulations to the provisions of section 5004 of Pub. L. 109-171, and to add and correct the cross-references, as described above.

X. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 2006 "Report to the Congress: Medicare Payment Policy" and have given it careful consideration in conjunction with the proposed policies set forth in this document. MedPAC's Recommendation 2A states that "The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth." This recommendation is discussed in Appendix B to this final rule.

In section II.C. of the preamble of this final rule, we further address MedPAC's 2005 recommendations included in Recommendation 1 in the March 2005 Report to Congress on Physician-Owned Specialty Hospitals as well as Recommendation 3, which recommended that the Secretary implement MedPAC's recommended policies over a transition period. The recommendations in Recommendation 1 relate to refining the DRGs used under the IPPS to more fully capture differences in severity of illness among patients; basing the DRG relative weights on the estimated cost of providing care rather than on charges; and basing the weights on the national average of hospitals' relative values in each DRG. In section II.E. of the preamble to this final rule, we also further address Recommendation 2 of the March 2005 Report on Physician-Owned Specialty Hospitals, which recommended adjusting the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653-7220, or visit MedPAC's Web site at: www.medpac.gov.

XI. Health Care Infrastructure Improvement Program: Selection Criteria for Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care and Forgiveness of Indebtedness

A. Background

Section 1016 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended the Act to add section 1897, which establishes the Health Care Infrastructure Improvement Program. Section 1897 of the Act authorizes the Secretary to establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of eligible projects. Section 1897(d) of the Act specifies that an eligible project is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements. Section 1897(b) of the Act requires the Secretary to establish the application process, the terms and conditions, and other requirements for the loan program. The statute was subsequently amended by section 6045 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005 (the Tsunami Relief Act of 2005) (Pub. L. 109-13) to also provide that any determination made by the Secretary under section 1897 of the Act is not subject to any administrative or judicial review.

Section 1897(c)(2) of the Act defines a "qualifying hospital" as a hospital or entity that is engaged in research in the causes, prevention, and treatment of cancer; and is designated as a cancer center by the National Cancer Institute (NCI) or is designated by the State legislature as the official cancer institute of the State and such designation by

the State legislature occurred prior to December 8, 2003. Section 1897(c)(3) of the Act, as added by Pub. L. 109-13, specifies that an "entity" has the same meaning as specified in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from tax under section 501(a) of the Code; has at least one existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located; and retains clinical outpatient treatment for cancer on site as well as laboratory research and education and outreach for cancer in the same facility. Section 1897(c)(3) of the Act is effective as if included in the enactment of Pub. L. 108-173.

Section 1897(f) of the Act provides that the Secretary may forgive a loan provided to a qualifying hospital, under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C.1087a et seq.). However, the Secretary must condition such forgiveness on the establishment by the hospital of (1) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of the State or region, including residents of rural areas; (2) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (3) unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

In addition, section 1897(h) of the Act requires the Secretary to submit to Congress within 4 years after enactment of Pub. L. 108-173 a report on the projects for which loans are provided under section 1897 of the Act and a recommendation as to

whether the Congress should authorize the Secretary to continue loans under this section beyond FY 2008.

Prior to the enactment of Pub. L. 109-13, section 1897(g) (1) of the Act provided for the appropriation of $200,000,000 to carry out the loan program. The funds allocated for the loan program are to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008. However, the Congress rescinded $58,000,000, through Pub. L. 109-13, leaving $142,000,000 available for the loan program. Section 1897(g) of the Act also states that, of the $142,000,000, not more than $2,000,000 can be used for the administration of the loan program for each fiscal year from FY 2004 through FY 2008). (We note that no administrative funding was used in FY 2004.)

B. Issuance of an Interim Final Rule with Comment Period and a Proposed Regulation

On September 30, 2005, we published two rules in the **Federal Register** (an interim final rule with comment period (70 FR 57368) and a proposed rule (70 FR 57376)) to establish the loan program to improve certain hospital infrastructure, including capital improvement, as provided for under the Health Care Infrastructure Improvement Program established under section 1897 of the Act. In the September 30, 2005 interim final rule with comment period, we set forth, under a new 42 CFR Chapter IV, Subchapter H, Part 505, the Federal regulations established by the Secretary governing requirements for qualifying hospitals or entities, the application process, and the criteria and conditions for selecting eligible projects under the loan program. In the September 30, 2005 proposed rule, we proposed to establish the loan

forgiveness criteria for qualifying hospitals that receive loans under the Health Care Infrastructure Improvement Program.

C. Provisions of the Interim Final Rule With Comment Period

1. Loan Qualifying Criteria (§§505.3, 505.5(a), and 505.11)

In order to receive a loan under the Health Care Infrastructure Improvement Program, an applicant must meet the statutory definition of a qualifying hospital as defined in sections 1897(c)(2) and (c)(3) of the Act. We incorporated these definitions in the regulations at §505.3.

We specified in the regulations at §505.11 that a qualifying hospital must submit an application to CMS by a specified date to request a loan for the capital costs of an eligible project. We specified the requirements and procedures for submittal of the application.

In §505.5(a), we provided that the capital costs for which a qualifying hospital may obtain a loan are limited to the reasonable costs incurred by the hospital, and capitalized on the Medicare cost report, for any facility or item of equipment that it has acquired the possession or use of at the time the loan funding is awarded.

2. Selection Criteria (§505.5(b) and (c))

We established the criteria under which qualifying hospitals are prioritized for the loan program. We specified that we prioritize applicants that meet the following conditions:

(a) The hospital is located in a State that, based on population density, is defined as a rural State.

(2) The hospital is located in a State with multiple Indian tribes.

We indicated that CMS will send written notice to qualifying hospitals that have been selected to participate in the loan program.

3. Terms of the Loan (§§505.7 and 505.9)

Under the terms of the loan program, we specified that we require an authorized official of each qualifying hospital to execute a promissory note, loan agreement, or any other approved form that we may designate, to ensure compliance with the terms of the loan program. In the interim final rule, we indicated that each loan recipient receives a lump sum distribution for which payment of principal and interest is deferred for 60 months beginning with the day of official notification to the qualifying hospital of loan award. The loan repayment period is 20 years. (However, as discussed in section XI.B. of this preamble, in the September 30, 2005 proposed rule, we further proposed forgiveness criteria for loans, as directed by the statute.)

In accordance with the loan criteria, the loan recipient must agree to make payments every month for 20 years until the loan, including interest, is repaid. A loan recipient may make full prepayment or partial prepayment without paying any prepayment charge. When a prepayment is made, the qualifying hospital must provide CMS with written notice.

Furthermore, the loan recipient must agree that the provisions of a loan under section 1897 of the Act does not--

- Relieve the hospital of any obligation to obtain any required State or local permit or approval with respect to the project;

- Limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or
- Otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

4. Public Comments Received on the Interim Final Rule With Comment Period

We received seven public comments on the September 30, 2005 interim final rule.

Comment: In general, commenters expressed concern that many qualifying hospitals providing cancer care to rural areas and Native populations throughout the country may not qualify to participate in the loan program since the regulatory criteria require that qualifying hospitals be located in one of the ten states listed. Moreover, one commenter was concerned that CMS may have misconstrued Congressional intent in establishing the selection criteria based on the statutory terms for loan forgiveness. The commenter noted that the proposed selection criteria relied on location and population rather than the merits of the application in order to award loans. Some commenters expressed concern that the selection criteria were too restrictive because preference was conferred to the 10 least populated states with the greatest numbers of Indian tribes in the country. Some commenters suggested that CMS expand the selection criteria to allow all qualifying hospitals that serve rural and Indian tribe populations to be considered for loan funds. In addition, one commenter suggested that in order to maximize the benefit to a greater number of applicants, CMS limit the amount of available loan funds to $10 million per State.

Response: The statute instructs the Secretary to establish criteria for selecting among qualifying hospitals that apply for a loan under this section. The criteria are to consider the extent to which the project for which the loan is sought is nationally or regionally significant, in terms of expanding or improving the healthcare infrastructure of the United States or the region or in terms of the medical benefit that the project will have. Section 1897 of the Act also provides for loan forgiveness and, in setting conditions for loan forgiveness, requires that qualifying hospitals establish certain outreach programs that include rural areas and Indian tribe populations. Therefore, we continue to believe it is appropriate to prioritize qualifying hospitals for purposes of making loans to qualifying hospitals based on rural and Indian tribe criteria as previously discussed in the interim final rule. We stated in the interim final rule that, "Since the statute outlines specific criteria in which to forgive loans, we believe that it is consistent with the Congressional intent to give priority to qualifying hospitals that meet at least some of the statutory conditions for loan forgiveness when selecting qualifying hospitals for the loan program" (70 FR 57369). We note that there are many outstanding hospitals providing cancer care in the country and we believe the selection criteria will allow us to select from applicants that both demonstrate merit and meet the priorities that are indicated in the statutory language for this loan program.

In response to the comment regarding State limits on available loan funds, we disagree that a $10 million limit per State would be in the best interests of qualifying hospitals. Section 1897(d) of the Act directs that loan funds are to be used for qualifying projects, defined in statute as “designed to improve the healthcare infrastructure of the

hospital, including construction, renovation, or other capital improvements." We note that construction, renovation, or other capital improvement projects for qualifying hospitals providing cancer care are likely to be costly and require large expenditures. We believe limiting the loan amount to a total of $10 million for all applicants within a State could inadvertently cause some qualifying hospitals to receive insufficient funding for their eligible project. Insufficient funding may also hinder a qualifying hospital's ability to establish the outreach programs and unique research resources that are required for loan forgiveness and intended to benefit the community through the qualifying hospital's participation in this loan program.

Comment: One commenter noted that the statutory language did not limit qualifying hospitals to entities that file cost reports and suggested that the regulations be modified to allow a state university/cancer research center that is not an entity described at section 501(c)(3) of the Internal Revenue Code of 1986, but that meets all other requirements, to be considered a qualifying hospital under this loan program. In addition, the commenter asked why CMS proposed that a qualifying hospital that had not acquired the possession and use of assets which it intends as a qualifying project under this loan program must have entered into a contractual obligation for those projects before December 8, 2003, the date of enactment of Pub. L. 108-173.

Response: We are not requiring that qualifying hospitals be entities that file cost reports. Since CMS is administering the program, we believe that it is appropriate to apply our reasonable cost methodology to determine the capital costs of an eligible project where applicable. We note that it is the statute that defines qualifying hospitals to

include an entity described at section 501(c)(3) of the Internal Revenue Code of 1986 and not a definition established through regulations. Finally, we believe it is appropriate to specify a deadline for which qualifying hospitals must have had a written commitment of assets intended as eligible projects. A deadline allows CMS to make a determination that the requested loan amount is reasonable and appropriate for the eligible project. Without a deadline we would not be able to determine the parameters of the eligible project. We chose December 8, 2003, because that was the date Pub. L. 108-173 was enacted.

5. Provisions of This Final Rule

This final rule finalizes the provisions set forth in the September 30, 2005 interim final rule with comment, without modification.

D. Proposed Rule on Forgiveness of Indebtedness

In the September 30, 2005 proposed rule, we proposed to establish the loan forgiveness criteria for qualifying hospitals that are selected to participate in the loan program under the Health Care Infrastructure Improvement Program.

1. Conditions for Loan Forgiveness (§505.13)

As specified in section 1897(f) of the Act, we proposed to forgive a loan provided to a qualifying hospital under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.). The student loan program specifies that in order to be eligible for loan forgiveness, borrowers are required to satisfy certain conditions, such as completing a service obligation that satisfies certain terms and conditions as determined by the Secretary. Therefore, we proposed that, to fulfill the service

obligation, borrowers must meet the loan forgiveness conditions based on the provisions of section 1897(f) of the Act. Section 1897(f) of the Act provides that the Secretary shall condition such forgiveness on the establishment by the hospital of (1) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas; (2) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (3) unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

In addition, we proposed that the qualifying hospital must submit a written request for loan forgiveness to CMS by the effective date of the final rule (that is, October 1, 2006).

2. Plan Criteria for Meeting the Conditions for Loan Forgiveness (§505.15)

In the September 30, 2005 proposed rule, we proposed to specify the loan forgiveness criteria under three domains, as outlined in section XI.C.1 of this preamble, that are consistent with the sections 1897(f)(A), (f)(B), and (f)(C) of the Act:

(a) Domain 1--Outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas; (b) Domain 2--Outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (c) Domain 3--Unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

Specifically, we proposed to add §§505.13, 505.15, and 505.17 to provide that the qualifying hospital must designate in its plan to CMS--

- The population(s) for which it would target its outreach programs.
- Sufficient detail to clearly describe how it would designate its targeted populations and that the populations designated should be in accordance with the provisions of the statute.
- A detailed description of how it would identify the cancer types that it is targeting.
- A detailed description of the approaches it would be conducting or implementing, including the reasons why the intervention approaches were selected and why they may make a difference in improving cancer care for the targeted population.
- Improvement goals for the prevention, early diagnosis, and treatment, for each cancer type identified in its outreach programs.
- At least one measure (for example, either an outcome measure or a process measure) used to track its progress in achieving the goals it has established for each area of prevention, early diagnosis, and treatment, for each cancer type identified in its plan.
- A description of how it would establish or maintain existing unique research resources or how it would establish or maintain existing unique research resources or an affiliation with another entity that has unique research resources.

We proposed at §505.13(c) that the qualifying hospital must submit to CMS by the timeframe specified by the Secretary the following: (1) a written request for loan forgiveness; (2) a plan describing how the qualifying hospital would establish, implement

or maintain existing outreach programs for its targeted populations; and (3) how it would establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources over the loan deferment period. We proposed to make that timeframe 60 days after the publication of the final rule.

In proposed §505.3, we proposed to define "outreach programs" as formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s). Likewise, we proposed to define "unique research resources" as resources that are used for the purpose of discovering or testing options related to the causes, prevention, and treatment of cancer.

We invited specific public comments on the type of information that must be included in the plan and the timeframe for a qualifying hospital to submit its plan to CMS. We also solicited comments on whether we should provide more specific criteria for the qualifying hospital to use in defining its targeted populations.

We believed that 60 days after the final rule publication date is reasonable time for qualifying hospitals intending to apply for loan forgiveness to prepare and submit their initial plan, since the loan deferment period is up to 60 months after notification of acceptance in the program and the qualifying hospital would be assessed on its performance during the loan deferment period.

Furthermore, we believed that requiring the qualifying hospitals to submit a plan in which they would determine the targeted population, the types of cancers (that is, the cancer types to be considered), goals for improving prevention, diagnosis, and treatment,

and the measures to track their progress in reaching the goals provides flexibility to the qualifying hospitals as they develop, implement, or maintain their outreach programs.

We also believed that it is appropriate to request this level of detail from the qualifying hospitals because section 1897(h) of the Act requires the Secretary to submit a report to the Congress before fiscal year 2008. The report must indicate the projects for which loans are provided under this section and recommend whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008. Receiving this information from the qualifying hospitals is necessary for the Secretary to make a fully informed recommendation to the Congress.

Under §505.17, we proposed that the qualifying hospital must submit annual progress reports to CMS describing its progress in achieving its plan or any changes to the initial plan and a final annual report at least 6 months before the end of the 60-month loan deferment period.

Further, we proposed under §505.19 that, if a qualifying hospital meets the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §505.13, §505.15, and §505.17, the loan would be forgiven. We proposed that if the loan is forgiven, we would send written notification for the loan forgiveness approval to the loan recipient at least 90 days before the end of the loan deferment period. If the loan recipient does not meet the conditions, plan criteria, or reporting requirements for the loan forgiveness specified in §505.13, §505.15, and §505.17, we proposed that we would send written notification for the denial of the loan forgiveness.

3. Public Comments Received on the Proposed Rule and Our Responses

We received one public comment on the September 30, 2005 proposed rule.

Comment: One commenter suggested that the proposed loan deferment period of 60 months, during which the qualifying hospital is to establish outreach programs and unique research resources in accordance with the statutory conditions for loan forgiveness, is unnecessarily and excessively protracted. The commenter noted that the statute does not dictate the duration of the loan deferment period and that the statutory conditions for loan forgiveness can and should be accomplished with appropriate speed. The commenter urged CMS to shorten the deferment period, suggesting that 36 months is sufficient time for qualifying hospitals to satisfy the statutory conditions for loan forgiveness. In fact, the commenter believed that the most meaningful steps toward satisfaction of the conditions for loan forgiveness should be accomplished within the first twelve months of the program. The commenter noted that the shortened time period would spur qualifying hospitals to establish the outreach programs and unique research resources more quickly thereby maximizing the benefit to the community and making the most out of the funding.

Response: The proposed loan deferment period of 60 months was intended to ensure that qualifying hospitals had sufficient time to establish the outreach programs and unique research resources to achieve loan forgiveness. In the proposed rule, we specifically requested comments from the public regarding the timeframe in order to assess whether the proposed period was appropriate. We appreciate the commenter's input that it is possible to establish the outreach programs and unique research resources

as specified in the proposed rule within 36 months and possibly as early as 12 months, the shortest timeframe for which the commenter suggested the most meaningful steps could be accomplished. While the commenter suggested that 36 months is sufficient time for qualifying hospitals to satisfy the statutory conditions for loan forgiveness, we find that the commenter's additional argument that delaying loan forgiveness could inadvertently and unnecessarily delay providing intended benefits to the public to be compelling. Therefore, considering that a qualifying hospital may be well on the way to satisfying the conditions for loan forgiveness within 12 months, and in order to motivate loan recipients intending to strive for loan forgiveness to provide this benefit to the public as soon as feasible, we are changing the time period in which a qualifying hospital may be assessed and approved for loan forgiveness to as early as 12 months from the date that CMS notifies the qualifying hospital of the award of the loan. We note that, while 60 months was likely an overestimate of the time needed to satisfy the terms for loan forgiveness, we are reluctant to limit all qualifying hospitals to 12 months to accomplish the initiatives required for loan forgiveness based on the submission of one comment. Therefore, we believe it is more appropriate to provide for consideration of loan forgiveness as early as 12 months from the date CMS notifies the qualifying hospital of the awarding of the loan and require that all evaluations for loan forgiveness must conclude no later than 60 months from the date CMS notifies the qualifying hospital of the awarding of the loan.

4. Provisions of the Final Rule

We are adopting as final the proposed changes to §505.3 and the addition of §§505.13 and 505.15, with only minor editorial changes. To accommodate the option in which qualifying hospitals may establish the outreach programs and unique research resources to achieve loan forgiveness as early as 12 months after loan notification, we are modifying §505.17(b) as proposed to specify that CMS will use the annual report to assess the qualifying hospital's loan forgiveness status and if the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§505.13, 505.15, and §505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven. We note that at §505.17(c), we specify that the qualifying hospital's final annual report is due to CMS at least 6 months before the end of the loan deferment period specified in §505.7(b). We are also modifying §505.19 to specify that CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of (1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or (2) 90 days before the end of the loan deferment period defined in §505.7(b).

E. Statutory Requirements for Issuance of Regulations

Section 902 of Pub. L. 108-173 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or

interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions set forth in the September 30, 2005 interim final rule with comment (70 FR 57368) and the September 30, 2005 proposed rule (70 FR 57376). In addition, this final rule is being published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

XII. Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)

[If you choose to comment on issues in this section, please include the caption "Exclusion of CAP from the ASP Calculation" at the beginning of your comments.]

A. Background

1. Average Sales Price (ASP)

Section 303(c) of Pub. L. 108-173 (the MMA) revised the drug payment methodology by creating a new pricing system based on the ASP of a drug or biological. Effective January 2005, Medicare pays for the vast majority of Part B covered drugs and biologicals using a drug payment methodology based on the ASP. (Please note that information on covered outpatient drugs and biologicals can be found at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.) In accordance with sections 1847A and 1927(b)(3)(A) of the Act, manufacturers submit the ASP data for their products to us on a quarterly basis, at the 11-digit National Drug Code (NDC) level.

These data include each manufacturer's total sales (in dollars) and number of units of a drug to all purchasers in the United States in a calendar quarter (excluding certain sales exempted by statute), with limited exceptions, and other data elements pertaining to the NDC. The sales price is net of discounts such as volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927 of the Act). The

Medicare payment rate is based on 106 percent of the ASP, less applicable deductible and coinsurance amounts, and is updated quarterly.

2. Competitive Acquisition Program (CAP)

Section 303(d) of Pub. L. 108-173 added a new section 1847B to the Act. This section provides for an alternative payment methodology to the ASP for certain Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis by establishing a CAP for the acquisition of and payment for competitively-biddable Part B covered drugs and biologicals. This program began on July 1, 2006. Physicians now have a choice between--(1) obtaining these drugs from approved CAP vendors; and (2) acquiring and billing for Part B covered drugs under the ASP system. In the March 4, 2005 Federal Register (70 FR 10746), we proposed regulations to establish provisions for acquiring and billing for drugs and biologicals through the CAP . (Please note that information on the CAP can be found at: http://www.cms.hhs.gov/CompetitiveAcquisforBios/.)

3. Regulatory History

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP are taken into account in computing the ASP under section 1847A of the Act. Most commenters recommended that purchases made under the CAP be excluded from the ASP calculation. However, one commenter suggested that, because the CAP was not included in the list of sales that are exempt from the ASP calculation set forth in section 1847A(c)(2) of the Act, prices under the CAP could not be excluded. In our July 6, 2005 interim final rule with

comment period (70 FR 39022), we responded that because the CAP was not included in the section 1847A(c)(2) of the Act list of sales that are exempt from the ASP calculation, we believed that sales to vendors made under the CAP must be included in the ASP.

Commenters on the July 6, 2005 interim final rule with comment period reiterated their objections to including purchases made by vendors under the CAP in the ASP calculations. These commenters requested that we change our interpretation of our statutory authority. Several commenters provided detailed legal arguments supporting the exclusion of purchases by vendors made under the CAP from the calculation of ASP.

Some commenters stated that we could use our demonstration authority to exclude CAP prices from ASP. Other commenters took the position that we could use our authority to establish CAP drug categories to establish a category of drugs and biologicals that would be excluded from the ASP calculation. Several commenters stated that sales to approved CAP vendors should be considered excluded from the determination of "best price" under section 1927(c)(1)(C) of the Act. These commenters maintained that by virtue of this exclusion, prices of CAP drugs and biologicals could be excluded from the calculation of ASP. One commenter contended that sales to CAP vendors are excluded from best price because CAP vendors do not fit squarely into the list of entities contained in the definition of "best price" in section 1927(c)(1)(C)(i) of the Act. Another commenter suggested that approved CAP vendors, as Medicare contractors, should be considered Federal purchasers exempt from the determination of best price under sections 1927(c)(1)(C)(i)(I) through (II) of the Act.

Finally, several commenters stated that the intent of Congress was to create two different and separate structures, with separate pricing, in order to provide physicians with a choice of programs. These commenters referenced the language contained in sections 1847A(a)(2) and 1847B(a)(1)(A) of the Act in support of their contentions. Section 1847A(a)(2) of the Act states that section 1847A "shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1847B for that section to apply instead of this section for the payment for drugs and biologicals." Section 1847B(a)(1)(A) of the Act states that "this section shall not apply in the case of a physician who elects section 1847A to apply." These commenters stated that this language, which is contained in both the ASP and CAP statutory provisions, clearly indicates that Congress intended the two programs to operate independently. These commenters asserted that as independent programs, the pricing methodologies under ASP and the CAP should not be linked. These commenters further believed that including CAP prices in the calculation of ASP would undermine the CAP program by virtually eliminating any incentive that a manufacturer might have to offer discounts to CAP vendors.

In response to the comments that we received on this issue, we revisited our analysis of our statutory authority. In the November 21, 2005 **Federal Register** (70 FR 70477), we published an interim final rule with comment in which we stated that we did not find entirely persuasive the commenters' arguments regarding demonstration authority, best price, or the definition of categories as a legal basis for revising our interpretation. However, we recognized the commenters' concerns about the effect of

including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In addition, we found compelling the commenters' statements about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. We acknowledged the possibility that Congress intended the programs to be completely independent of each other.

Therefore, as a result of our reassessment, and in accordance with our statutory authority, including our authority under section 1847A(b)(2)(B) of the Act to establish methods for counting units, we decided to exclude, for the initial 3-year contract period under the CAP, units of CAP drugs that are administered to beneficiaries by participating CAP physicians. We revised §414.802 (definition of unit) to reflect the exclusion of units of CAP drugs administered to beneficiaries by participating CAP physicians. We further stated that we intend to examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP. We also clarified that manufacturers must exclude rebates and lagged price concessions attributable to units of CAP drugs administered to a beneficiary by a participating CAP physician when using the estimation methodology specified in §414.804.

On April 21, 2006, we announced the selection of the approved CAP vendor for the initial phase of the CAP. The approved CAP vendor is required to provide manufacturers, upon request, with information necessary to determine which sales to the

approved CAP vendor are sales of CAP drugs that are excluded from the ASP calculation.

We did not receive any timely comments on the November 21, 2005 interim final rule with comment period. In a March 3, 2006 **Federal Register** notice (71 FR 10975), we published a PRA notice soliciting comment on our proposed modification of the OMB-approved ASP information collection requirements, regarding the collection of the number of CAP units excluded from the ASP calculation. In response to this notice, a commenter stated that, in certifying the accuracy of the submitted ASP data, manufacturers must rely on approved CAP vendors to provide the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians. The commenter noted that CAP vendors are the only entities with direct information on CAP units sold. Because of this circumstance, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians places the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information. Further, the commenter noted that manufacturers may not have timely access to this information and they cannot independently confirm its accuracy. The commenter suggested that we consider an alternative approach.

B. Regulation Change

Existing §414.802 requires that, during the first 3 years of the CAP, the method for counting units excludes units of CAP drugs (as defined in §414.902) administered to a beneficiary by a participating CAP physician (as defined in §414.902). As a result of

comments received on our March 3, 2006 PRA notice and our ongoing work with manufacturers, we learned that manufacturers were concerned that they would have difficulty obtaining the information necessary to accurately exclude CAP units (as currently defined in §414.802) from the ASP calculation. We have reexamined our current definition of unit based on the manufacturers concerns.

After reexamination of the issues, we have determined that we did not fully consider that the current definition of unit may have unintended results. For example, an unintended result occurs when, as permitted by the statute in certain emergency situations under the CAP, the participating CAP physician administers a drug from his or her stock and orders a replacement from the approved CAP vendor. Our existing regulations specify a unit qualifies as a CAP unit when it is administered to a beneficiary by a participating CAP physician. However, in this instance, the drug that was administered was obtained outside the CAP, and the drug supplied by the approved CAP vendor was not administered to the beneficiary. Therefore, under our current definition of "unit," under the CAP, the manufacturer could not exclude the units of CAP drugs that participating CAP physicians obtain from approved CAP vendors in accordance with the resupply provisions of §414.906(e).

This result would have the effect of inappropriately including the sales of units of CAP drugs in the ASP calculation. Moreover, this result is inconsistent with our intended policy. In addition, requiring manufacturers to track administration of units of CAP drugs that approved CAP vendors supply to participating CAP physicians to resupply the physician's stock (in order to determine whether such drugs are ever administered to a

Medicare beneficiary for purposes of excluding them from the calculation of ASP) would be burdensome for manufacturers and participating CAP physicians. These burdens are caused by the fact that manufacturers would have to rely on data from the participating CAP physicians to identify such units. However, our regulations and CAP participation agreement do not require participating CAP physicians to track the administration of drugs from their private stock.

Our decision to exclude CAP units from the ASP was based on our concerns about the effect of including CAP prices in the calculation of ASP. The decision also was based on our belief that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. To remedy this unintended result and to better effectuate our intent in excluding CAP units, we are revising the definition of "unit" at §414.802 for ASP purposes during the first 3 years of the CAP. We are persuaded by the commenters and by our review of the current regulation that: (1) the current definition of unit does not achieve the policy goal of establishing methods of counting units so that the payment amounts under the ASP methodology are not affected by the CAP; and (2) an alternative definition of unit will be significantly less burdensome on manufacturer, CAP vendors, and participating CAP physicians.

Therefore, as a result of our reexamination, and in accordance with our authority under section 1847A(b)(2)(B) of the Act to establish methods for counting units, we have decided to revise our definition of "unit" in our regulations to exclude, for the initial 3-year contract period under the CAP, units of CAP drugs sold to an approved CAP

vendor for use under the CAP. We note that the revised definition is consistent with suggestions made by commenters in response to the March 4, 2005 proposed rule. Many commenters suggested that "sales to" or "purchases by" approved CAP vendors be excluded from the calculation of ASP. However, we are clarifying, that only those units of CAP drugs sold to an approved CAP vendor for use under the CAP are excluded from the calculation of ASP.

In implementing this revised definition of unit, it is our intent to facilitate the start up of the CAP and reduce complexities and burdens associated with identifying units of CAP drugs excluded from the calculation of ASP. We believe the revised definition of unit establishes a method for counting units so that the payment amounts under the ASP methodology are not affected by the CAP. Further, we believe that manufacturers can more readily verify excluded units of CAP drugs in accordance with the revised definition.

Manufacturers must continue to exclude rebates and lagged price concessions attributable to units of CAP drugs sold to approved CAP vendors for use under the CAP.

We welcome comments on the exclusion of CAP drug units from the calculation of the ASP. We also seek comments on accounting for this exclusion when estimating lagged price concessions. We will address comments received in a subsequent **Federal Register** document.

After the initial 3-year period of the CAP, we will evaluate the impact on approved CAP vendors, manufacturers, and others of excluding units sold to approved CAP vendors for use under the CAP from the calculation of ASP. If there appears to be a

reason not to continue to exclude units of CAP drugs sold to approved CAP vendors for use under the CAP from the calculation of ASP, we will undertake rulemaking to describe our findings and conclusions and to seek public comment.

XIII. 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. In the FY 2007 IPPS proposed rule (71 FR 24137 through 24139), we published a list of data files that are available for purchase from CMS or that may be downloaded from the Internet without charge.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 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 PRA 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.

The following information collection requirements are included in this final rule and their associated burdens are subject to the PRA:

Section 412.64 Federal Rates for Inpatient Operating Costs for Federal Fiscal Year 2005 and Subsequent Fiscal Years (Reporting of Hospital Quality Data for Annual Hospital Payment Update)

In the FY 2007 IPPS proposed rule (71 FR 23996), we outlined the requirements for this section and we are restating those requirements and burden estimates as part of this final rule. Section 412.64(d)(2) requires hospitals, in order to qualify for the full annual market basket update, to submit quality data on a quarterly basis to CMS, as specified by CMS.

As discussed in the section IV.A. of this preamble, section 5001(a) of Pub. L. 109-171 sets forth new requirements for the Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program. New sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act require that we expand the "starter" set of 10 measures that we currently use. In accordance with section 238(b) of Pub. L. 108-173, effective for all payments beginning with FY 2007, the set of measures will expand from 10 to 21 measures, as we adopt the baseline set of performance measures set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences.

The burden estimate has been updated based on increased number of collected measures and the anticipated levels of participation by hospitals. We estimate that there will be approximately 3,700 respondents per year. Of this number, approximately

3,100 hospitals are JCAHO accredited and are currently collected measures and submitting data to the JCAHO on a quarterly basis. Of the JCAHO accredited hospitals, approximately 1,080 are collecting the same measures CMS will be collecting for public reporting and there is no additional burden for these hospitals. Approximately 1,940 of the JCAHO-accredited hospitals will need to collect SCIP in addition to the data already collected for maintaining JCAHO accreditation. Approximately 60 accredited hospitals do not submit for the three starter set topics and must begin collecting and submitting data on all four topics. In addition, there are approximately 600 hospitals that do not participate in the JCAHO accreditation process. These non-JCAHO hospitals will have the additional burden of collecting data on all four topics.

For JCAHO hospitals, we estimate it will take 25 hours per quarter per topic for collection. We expect the burden for hospitals to total 238,560 hours per year, including time allotted for overhead. For non-JCAHO accredited hospitals, we estimate the burden to be 246,000 hours per year including overhead. The total number of burden hours for all hospitals is 485,560 hours. The number of respondents will vary according to the level of voluntary participation. One hundred percent of the data may be collected electronically. There will be no additional burden placed on hospitals that submit this data in response to section 5001(b) of Pub. L. 109-171.

We are revising this collection to include the burden associated with the collection of the additional quality measures. However, the burden associated with the requirements under §412.64(d) are currently approved under OMB Number 0938–0918, with an expiration date of December 31, 2008.

Section 412.92 Special Treatment: Sole Community Hospitals

In the FY 2007 proposed rule (71 FR 23996), we outlined the requirements for §412.92. We are restating those requirements and burden estimates as part of this final rule. Section 412.92(b)(3) requires an approved sole community hospital (SCH) to notify the appropriate fiscal intermediary of any change which would affect its classification as an SCH.

The burden associated with this requirement is the time and effort it would take for the SCH to provide such notification to the fiscal intermediary. We estimate that on an annual basis it would take an SCH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 SCHs.

Section 412.108 Special Treatment: Medicare-Dependent, Small Rural Hospitals

In the FY 2007 IPPS proposed rule (71 FR 23996), we outlined the requirements for this section. We are restating those requirements and burden estimates as part of this final rule. Section 412.108(b)(4) requires an approved MDH to notify the appropriate fiscal intermediary of any change which would affect its status as an MDH.

The burden associated with this requirement is the time and effort it would take for the MDH to provide such notification to the fiscal intermediary. We estimate that on an annual basis it would take an MDH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 MDHs.

Section 412.525 Adjustments to the Federal Prospective Payment

In the RY 2007 LTCH PPS proposed rule (71 FR 4648), we outlined the collection of information requirements associated with §412.525 and we are restating those requirements and burden estimates as part of this final rule. Section 412.525(a)(4)(iv)(A) states that CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. In addition, a hospital may also request that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence provided by the hospital.

The burden associated with this requirement is the time and effort necessary for a hospital to gather, process, and submit the necessary documentation to its fiscal intermediary to substantiate its request for the use of a different CCR by its fiscal intermediary. For example, necessary documentation, as stipulated by CMS and the fiscal intermediary, may include but not be limited to financial records documenting the hospital's cost and charges.

The estimated burden for this requirement is 8 hours per hospital. Therefore, we estimate that it would require 80 annual hours (8 hours x 10 facilities), to comply with this requirement.

We initiated the OMB approval process by publishing a 60-day **Federal Register** notice on July 21, 2006 (71 FR 41448).

Section 412.529 Special Payment Provision for Short-Stay Outliers

In the RY 2007 LTCH PPS proposed rule (71 FR 4648), we also outlined the collection of information requirements associated with §412.529 and we are restating these requirements and burden estimates as part of this final rule. Section

412.529(c)(4)(iv)(A) states that CMS may specify an alternative to the CCR otherwise applicable under paragraph (c)(4)(iv)(B) of this section. In addition, a hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence provided by the hospital.

The burden associated with this requirement is the time and effort necessary for a hospital to gather, process, and submit the necessary documentation to its fiscal intermediary to substantiate its request for the use of a different CCR by its fiscal intermediary. For example, necessary documentation, as stipulated by CMS and the fiscal itnermediary, may include but not be limited to financial records documenting the hospital's cost and charges.

The estimated burden for this requirement is 8 hours per hospital. Therefore, we estimate that it would require 80 annual hours (8 hours x 10 facilities), to comply with this requirement.

We initiated the OMB approval process by publishing a 60-day **Federal Register** notice on July 21, 2006 (71 FR 41448).

Section 505.13 Conditions for Loan Forgiveness

In the September 30, 2005 **Federal Register** (70 FR 57376), we published a proposed rule that outlined the requirements for §505.13 and we are restating those requirements and evaluation of the burden as part of this final rule. Section 505.13(d) requires a hospital seeking loan forgiveness to submit to CMS, within the timeframe specified by the Secretary, a written request for loan forgiveness and a loan forgiveness plan that meets the criteria specified in §505.15.

The burden associated with this requirement is the time and effort needed to draft and submit the written request of forgiveness and the time and effort to develop and submit a loan forgiveness plan. While these requirements are subject to the PRA, we believe they are exempt as defined in 5 CFR 1320.3(c)(4). These requirements will impact less than 10 hospitals.

This final rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this final 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 the Office of Management and Budget's (OMB) approval:

Occupational Mix Adjustment to the FY 2007 Index (Hospital Wage Index Occupational Mix Survey)

As stated in section III.C. and III.G. of this preamble, for FY 2007 in order to comply with the Bellevue decision, CMS will base the occupational mix adjustment on data collected from the 2006 survey. CMS submitted a revised information collection request to the Office of Management and Budget (OMB) that contained the existing burden and the additional burden associated with collecting new occupational mix data from hospitals to determine the occupational mix adjustment by September 30, 2006.

The burden associated with this information collection request is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. While this burden is subject to the PRA, it is already approved under OMB control number 0938-0907, with an expiration date of May 31, 2009.

Revisions to the Wage Index Based on Hospital Redesignations (Medicare Geographic Classification Review Board)

As noted in section III.H of this preamble, section 1886(d)(10) of the Act established the MGCRB, an entity that has the authority to accept IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests. It is important for CMS to ensure the accuracy of the MGCRB decisions and remain apprised of potential payment impacts. Our regulations at §412.256 require a hospital to submit a copy of its MGCRB application to CMS.

The burden associated with this requirement is the time and effort associated with a hospital compiling and submitting a copy of its MGCRB application to CMS. While this requirement is subject to the PRA, it is currently approved under OMB control number 0938-0573, with an expiration date of November 30, 2008.

Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)

Section XII.A.1 of this preamble provides background information pertaining to the use of the average sales price (ASP) as the basis for our drug payment methodology. In accordance with section 1847A of the Act, most Medicare Part B covered drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price of the drug or biological, beginning in CY 2005. The ASP data reporting

requirements are specified in Section 1927 of the Act. The reported ASP data are used to establish the Medicare payment amounts.

Section XII.A.2 and XII.A.3 of this preamble discuss the ASP payment methodology, the CAP for certain Part B covered drugs, and the regulatory history of ASP and CAP. The CAP program began on July 1, 2006. The program provides physicians with a choice between obtaining Part B covered drugs from approved CAP vendors, or acquiring and billing for Part B drugs under the ASP system.

As discussed in a November 21, 2005 (70 FR 70478) interim final rule with comment period and a March 3, 2006 (71 FR 10975) 30-day PRA **Federal Register** notice, the collection of ASP data imposes information collection requirements on the public. The burden associated with ASP information collection requirements is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to prepare and submit the required data to CMS. While these requirements are subject to the PRA, they are currently approved under OMB control number 0938-0921, with an expiration date of May 31, 2009.

As required by section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this document to the Office of Management and Budget (OMB) for its review of these information collection requirements.

C. Waiver of Proposed Rulemaking and Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms

and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find good cause to waive the requirement for publication of a notice of proposed rulemaking and public comment for the provisions of section XII. of this preamble on the grounds that it is necessary to implement this change immediately in order to ensure that a more accurate, and less burdensome, implementation of our policy is in place in time for it to be effective for the next ASP reporting period. We believe that revising the definition of "unit" as described in this rule will best ensure that the payment amounts under the ASP methodology are not affected by the CAP, consistent with our stated policy. Without an immediate revision to the definition of "unit," the regulation requires a level of complexity in determining how to exclude CAP prices that we did not intend and places unintended burdens on participating CAP physicians. Further, unless the revised definition of "unit" is implemented immediately, it would not be effective in time for manufacturers to accurately exclude units of CAP drugs sold to approved CAP vendors for use under the CAP during the third calendar quarter of 2006 and certify their reports.

We also ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act, which normally requires a 30-day delay in the effective date of a final rule, and the Congressional Review Act, which requires a 60-day delay in the effective date of a major rule. However, we can

waive the delay in effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C. 553(d)(3); 5 U.S.C. 808(2)).

We find that good cause exists to waive the 60-day delay in effectiveness for the provisions of section XII. of this preamble and §414.802 so that these portions of this rule take effect immediately upon publication in the **Federal Register**. Unless the revised definition of "unit" is implemented immediately, it would not be effective in time for manufacturers to accurately exclude units of CAP drugs sold to approved CAP vendors for use under the CAP during the third calendar quarter of 2006. As noted above, a delay in implementation of this refinement would impose costs burdens on manufacturers and participating CAP physicians that we did not intend. Further, without this refinement, manufacturers may be unable to certify the accuracy of their ASPs. Because manufactures must certify their ASPs, this refinement must be in place before the beginning of the next ASP reporting period. For these reasons, we find good cause to waive the 60-day delay in the effective date and these regulations will be effective on [OFR--please insert date of publication].

Moreover, in section II.c.iv. of the Addendum to this final rule, we discuss a technical correction that we are making to remove the second sentence from §412.116(e) of our regulations. We find it unnecessary to undertake notice-and-comment rulemaking with respect to removing this sentence because this correction merely removes a sentence that previously was struck from our regulations, but was inadvertently reinstated. We note that this change to the regulations underwent

notice-and-comment rulemaking when it was initially removed from the regulations (68 FR 34515). Thus, because the public already had opportunity to comment on this policy, additional comment would be unnecessary.

D. Response to Comments

Because of the large number of comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments on the CAP ASP provisions we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 409

Health Facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

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 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 505

Administrative practice and procedure, Health facilities, Loan programs, Infrastructure improvement program, Reporting and recordkeeping, and Rural areas.

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 409--HOSPITAL INSURANCE BENEFITS

1. The authority citation for Part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 409.3 is amended by revising paragraph (e) under the definition of "Qualified hospital" to read as follows:

§409.3 Definitions.

* * * * *

Qualified hospital means a facility that--* * *

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate foreign licensing agency, and for purposes of furnishing nonemergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or by a foreign program under standards that CMS finds to be equivalent to those of JCAHO.

3. Section 409.5 is revised to read as follows:

§409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital or inpatient CAH services and posthospital SNF care. It also pays for home health services and hospice care. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met as specified in the pertinent sections of this subpart and in part 418 of this chapter regarding hospice care. Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 410--SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

4. The authority citation for Part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

5. Section 410.66 is revised to read as follows:

§410.66 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in a foreign country.

Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

6. The authority citation for Part 412 is revised 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 Pub. L. 106-113 (113 Stat. 1501A-332).

7. Section 412.8 is amended by--

a. Revising paragraph (b)(2).

b. Adding a new paragraph (c).

The revision and addition read as follows:

§412.8 Publication of schedules for determining prospective payment rates.

* * * * *

(b) * * *

(2) Except as provided in paragraph (c) of this section, CMS publishes a **Federal Register** document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the August 1 before the Federal fiscal year in which the rates would apply.

(c) Publication schedule for FY 2007. For FY 2007, not later than August 1, 2006, CMS publishes a **Federal Register** document setting forth a description of the methodology and data used in computing the inpatient prospective payment rates for that year.

8. Section 412.22 is amended by--

a. Revising the introductory text of paragraph (f).

b. Adding a new paragraph (f)(3).

c. Revising paragraph (h)(1).

d. In paragraph (h)(2), removing the phrase "(h)(3), (h)(6), and (h)(7) of this section" and adding the phrase "(h)(3), (h)(4), (h)(5), (h)(7), and (h)(8) of this section" in its place.

e. Redesignating paragraphs (h)(5), (h)(6), and (h)(7) as paragraphs (h)(6), (h)(7), and (h)(8), respectively.

f. Revising paragraph (h)(3).

g. Revising paragraph (h)(4).

h. Adding a new paragraph (h)(5).

i. In newly redesignated paragraph (h)(6), removing the phrase "(h)(1) through (h)(4) of this section" and adding the phrase "(h)(1) through (h)(5) of this section" in its place.

The revisions and addition read as follows:

§412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(f) Application for certain hospitals. Except as provided in paragraph (f)(3) of this section, if a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital--

* * * * *

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital may increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time without affecting the provisions of paragraph (f)(1) or (f)(2) of this section.

(i) If a hospital to which the provisions of paragraph (f)(1) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 1995.

(ii) If a hospital to which the provisions of paragraph (f)(2) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 2003, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 2003.

* * * * *

(h) Satellite facilities. (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a

building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

* * * * *

(3) Except as provided in paragraphs (h)(4) and (h)(5) of this section, the provisions of paragraph (h)(2) of this section do not apply to--

* * * * *

(4) For cost reporting periods beginning before October 1, 2006, in applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility--

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section--

(i) Any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage or decrease the number of beds considered to be part of the satellite facility at any time without affecting the provisions of paragraph (h)(3) of this section; and

(ii) If the satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

* * * * *

9. Section 412.25 is amended by--

a. In paragraph (e) introductory text, remove the cross-reference "paragraph (e)(2) and (e)(4)" and add the cross-reference "paragraph (e)(2) and (e)(5)" in its place.

b. In paragraph (e)(2) introductory text, remove the cross-reference "paragraph (e)(3) and (e)(5)" and add the cross-reference "paragraph (e)(3) and (e)(6)" in its place.

c. Revising paragraph (e)(3).

d. Revising paragraph (e)(4) introductory text.

e. Redesignating paragraph (e)(5) as (e)(6).

f. Adding a new paragraph (e)(5)

The revisions and addition read as follows:

§412.25 Excluded hospital units: Common requirements.

* * * * *

(e) * * *

(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment

systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.

(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility--

* * * * *

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section--

(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at that the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of this section, without affecting the provisions of paragraph (e)(3) of this section; and

(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

* * * * *

§412.42 [Amended]

10. In paragraph (d) of §412.42, the cross-reference "§405.310(k)" is removed, and the cross-reference "§411.15(k)" is added in its place.

§412.48 [Amended]

11. In paragraph (b) of §412.48, the cross-reference "§§405.330 through 405.332" is removed and the cross-reference "§411.400 and §411.402" is added in its place.

12. Section 412.64 is amended by--

a. Revising paragraph (d)(2).

b. Adding a new paragraph (h)(6).

The revision and addition read as follows:

§412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(d) * * *

(2)(i) In the case of a "subsection (d) hospital," as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the applicable percentage change specified in paragraph (d)(1) of this section is reduced--

(A) For fiscal years 2005 and 2006, by 0.4 percentage points; and

(B) For fiscal year 2007 and subsequent fiscal years, by 2.0 percentage points.

(ii) Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

* * * * *

(h) * * *

(6) If a new rural hospital that is subject to the hospital inpatient prospective payment system opens in a State that has an imputed rural floor and has rural areas, CMS uses the imputed floor as the hospital's wage index until the hospital's first cost report as an inpatient prospective payment system provider is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

* * * * *

13. A new §412.79 is added to Subpart E to read as follows:

§412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.

(a) Base-period costs—(1) General rule. Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in §412.2(c), for the 12-month or longer cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

(2) Exceptions. (i) If the MDH's last cost reporting period beginning before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent

12-month or longer cost reporting period beginning before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period beginning on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(b) Costs on a per discharge basis. The intermediary determines the MDH'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 described in §412.4(b) is considered to be a discharge.

(c) Case-mix adjustment. The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) Updating base period costs. For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in §412.73(c)(14) and (c)(15).

(e) 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.

(f) Notice of hospital-specific rate. The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) Right to administrative and judicial review. An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of Part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) Modification of hospital-specific rate. (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under §405.1821 or §405.1853 of this chapter that resolved a matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under §405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) Maintaining budget neutrality. CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

§412.84 [Amended]

14. In paragraph (m) of §412.84, the cross-reference "paragraph (h)(3)" is removed and the cross-reference "paragraph (i)(4)" is added in its place.

15. Section 412.90 is amended by revising paragraph (j) to read as follows:

§412.90 General rules.

* * * * *

(j) Medicare-dependent, small rural hospitals. For cost reporting periods beginning on or after April 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, and before October 1, 2011, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

* * * * *

16. Section 412.92 is amended by--

a. In paragraph (b)(2)(iv) of §412.92, the word "djustment" is removed and the word "adjustment" is added in its place.

b. Revising paragraph (b)(3) to read as follows:

§412.92 Special treatment: Sole community hospitals.

* * * * *

(b) * * *

(3) Duration of classification.

(i) An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the

classification was approved. An approved sole community hospital must notify the fiscal intermediary if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

(ii) A sole community hospital must report the following to the fiscal intermediary within 30 days of the event:

(A) The opening of a new hospital in its service area.

(B) The opening of a new road between itself and a like provider within 35 miles.

(C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.

(D) Its geographic classification changes.

(E) Any changes to the driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

(iii) A sole community hospital must report to the fiscal intermediary if it becomes aware of any change that would affect its classification as a sole community hospital beyond the events listed in paragraph (b)(3)(ii) of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the

sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

* * * * *

17. Section 412.96 is amended by--

a. Revising paragraph (c)(2)(i) introductory text.

b. Revising paragraph (c)(2)(ii).

c. Revising paragraph (i)(3).

The revisions red as follows:

§412.96 Special Treatment: Referral centers.

* * * * *

(c) * * *

(2) Number of discharges. (i) CMS sets forth the national and regional number of discharges in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (i) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section, its number of discharges (not including discharges from units excluded from the prospective payments system under subpart B of this part or from newborn units) is at least equal to--

* * * * *

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section to meet the number of discharges criterion.

* * * * *

(i) * * *

(3) Annual notice. CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under §412.8(b). These criteria are compared to an applying hospital's number of discharges for the same cost reporting period used to develop the regional criteria in this section in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

18. Section 412.105 is amended by--

a. Revising paragraph (f)(1)(ii)(C).

b. Adding a new paragraph (f)(1)(iii)(C).

The addition reads as follows:

§412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) * * *

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in §413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in §413.78(c), §413.78(d), or §413.78(e) of this subchapter, as applicable, are met.

(iii) * * *

(C) In order to be counted, a resident must be spending time in patient care activities, as defined in §413.75(b) of this subchapter.

* * * * *

19. Section 412.106 is amended by--

a. Revising paragraph (a)(1)(iii).

b. Republishing the introductory text of paragraph (d)(2)(iv).

c. Revising paragraph (d)(2)(iv)(C)(3).

d. Adding a new paragraph (d)(2)(iv)(D).

e. Adding a new paragraph (d)(2)(v).

The revision and additions read as follows:

§412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) * * *

(1) * * *

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in §412.64, except that a reclassification that results from an urban hospital reclassified as rural as set forth in §412.103 is classified as rural.

* * * * *

(d) * * *

(2) * * *

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section--

* * * * *

(C) * * *

(3) Except as provided in paragraph (d)(2)(iv)(D) of this section, the maximum payment adjustment factor is 12 percent.

(D) Effective for discharges occurring on or after October 1, 2006, for a hospital that is classified as a Medicare-dependent, small rural hospital under §412.108, the payment adjustment factor limitation specified in paragraph (d)(2)(iv)(C)(3) does not apply.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990, and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

* * * * *

20. Section 412.108 is amended by--

a. Revising paragraph (a)(1) introductory text.

b. Revising paragraph (b)(4).

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

The revisions and addition read as follows:

§412.108 Special Treatment: Medicare-dependent, small rural hospitals.

(a) Criteria for classification as a Medicare-dependent, small rural hospital.

(1) General considerations. For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before October 1, 2011, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:

* * * * *

(b) * * *

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(i) An approved MDH must notify the fiscal intermediary if any change occurs that is specified in paragraph (b)(4)(ii) of this section occurs. If CMS determines that an MDH failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date that the hospital no longer met the criteria for such status, consistent with the provisions of §405.1885 of this chapter.

(ii) An MDH must report the following to the fiscal intermediary within 30 days of the event:

(A) The number of beds increases to more than 100.

(B) Its geographic classification changes.

(iii) An MDH must report to the fiscal intermediary if it becomes aware of any change that would affect its classification as an MDH beyond the events listed in paragraph (b)(4)(ii) of this section within 30 days of the event. If CMS determines that an MDH has failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date the hospital became aware of the event that resulted in the MDH no longer meeting the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

* * * * *

(c) * * *

(2) * * *

(iii) For discharges occurring during cost reporting periods (or portions thereof) beginning on or after October 1, 2006, and before October 1, 2011, 75 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the highest of the following:

(A) The hospital-specific rate as determined under §412.73.

(B) The hospital-specific rate as determined under §412.75.

(C) The hospital-specific rate as determined under §412.79.

* * * * *

§412.116 [Amended]

21. In §412.116(e), the second sentence is removed.

22. Section 412.234 is amended by--

a. In paragraph (a)(3)(ii), removing the term "fiscal year" and adding the term "Federal fiscal year" in its place.

b. Revising paragraph (a)(3)(iii).

c. Adding a new paragraph (a)(3)(iv).

The revisions and addition read as follows:

§412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) * * *

(3) * * *

(iii) For Federal fiscal year 2007, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(iv) For Federal fiscal year 2008 and thereafter, hospitals located in counties that are in the same Combined Statistical Area (CSA) or Core-Based Statistical Area (CBSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation.

* * * * *

23. Section 412.316 is amended by--

a. Revising paragraph (a).

b. Revising paragraph (b)(2).

c. Adding a new paragraph (b)(3).

d. Revising paragraph (c).

The revisions and addition read as follows:

§412.316 Geographic adjustment factors.

(a) Local cost variation. CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part. The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) * * *

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under §412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under §412.64, except as provided for in paragraph (b)(3) of this section.

(3) For purposes of this section, the geographic classifications specified under §412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in §412.103, the geographic classification is rural.

(c) Cost-of-living adjustment. CMS provides an additional payment to a hospital located in Alaska and Hawaii equal to [0.3152 x (the cost-of-living adjustment factor used to determine payments under subpart D of this part - 1)] percent.

24. Section 412.320 is amended by--

a. Revising paragraph (a)(1)(ii).

b. Adding a new paragraph (a)(1)(iii).

The revision and addition read as follows:

§412.320 Disproportionate share adjustment factor.

(a) * * *

(1) * * *

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under §412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under §412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in §412.103, the geographic classification is rural.

* * * * *

25. Section 412.505 is amended by revising paragraph (b)(1) to read as follows:

§412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

* * * * *

(b) General requirements. (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, §412.22(e)(3) and (h)(6), if applicable, and §412.507 through §412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

* * * * *

§412.508 [Amended]

26. In paragraph (c)(3) of §412.508, the cross-reference "§1001.301" is removed and the cross-reference "1001.201" is added in its place.

27. Section 412.511 is revised to read as follows:

§412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

28. Section 412.525 is amended by--

a. Revising paragraph (a)(3).

b. Revising paragraph (a)(4)(ii).

c. Revising paragraph (a)(4)(iii).

d. Adding a new paragraph (a)(4)(iv).

e. Adding a new paragraph (d)(3).

f. Adding a new paragraph (d)(4).

The revisions and additions read as follows:

§412.525 Adjustments to the Federal prospective payment.

(a) * * *

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

(4) * * *

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of §412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of §412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(1) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18 of this chapter.)

(2) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost to charge ratio. CMS establishes and publishes this mean annually.

(3) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

* * * * *

(d) * * *

(3) Patients who are transferred to onsite providers and readmitted to a long-term care hospital, as provided for in §412.532.

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in §412.534.

29. Section 412.529 is amended by revising paragraph (c)(3) to read as follows:

§412.529 Special payment provision for short-stay outliers.

* * * * *

(c) * * *

(3)(i) For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of §412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of §412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (c)(3)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(1) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18 of this chapter.)

(2) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(3) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (c)(3)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

30. Section 412.532 is amended by--

a. Revising paragraph (a)(2).

b. Revising paragraph (b).

The revisions read as follows:

§412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

(a) * * *

(2) A satellite facility, as defined in §412.22(h), that is co-located with the long-term care hospital.

* * * * *

(b) As used in this section, "co-located" or "onsite" facility means a hospital, satellite facility, unit, or SNF that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in §413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

* * * * *

§412.541 [Amended]

31. In §412.541, paragraph (b)(2)(i), remove the cross-reference "§412.533(b)" and add in its place "§412.533(a)(5) and §412.533(c)".

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

32. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106-133 (113 Stat. 1501A-332).

33. Section 413.74 is amended by revising paragraph (a) to read as follows:

§413.74 Payment to a foreign hospital.

(a) Principle. Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

* * * * *

34. Section 413.75 is amended by--

a. In paragraph (b), revising paragraph (1) under the definition of "Medicare GME affiliated group".

b. In paragraph (b), removing the cross-reference "§413.79(g)(2)" under paragraph (2) of the definition of "Medicare GME affiliated group" and adding the cross-reference "§413.79(f)(2)" in its place.

c. In paragraph (b), removing the cross-reference "§413.79(g)(2)" under paragraph (3) of the definition of "Medicare GME affiliated group" and adding the cross-reference "§413.79(f)(2)" in its place.

d. In paragraph (b), adding in alphabetical order the definition of "Patient care activities".

The addition and revision read as follows:

§413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Medicare GME affiliated group means--

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in subpart D of Part 412 of this subchapter) or in a contiguous area and meet the rotation requirements in §413.79(f)(2).

* * * * *

Patient care activities means the care and treatment of particular patients, including services for which a physician or other practitioner may bill.

* * * * *

35. Section 413.77 is amended by--

a. Revising paragraph (e)(1) introductory text.

b. Revising paragraph (e)(1)(i).

c. Adding a new paragraph (h).

The revisions and addition read as follows:

§413.77 Direct GME payments: Determination of per resident amounts.

* * * * *

(e) Exceptions--(1) Base period for certain hospitals. If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after October 1, 2006, and the residents are not on duty during the first month of that period, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs

incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.

(i) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period as established in paragraph (e)(1) of this section.

* * * * *

(h) Hospital mergers. Effective for cost reporting periods beginning on or after October 1, 2006, when multiple hospitals merge, a primary care and obstetrics and gynecology weighted average per resident amount and a nonprimary care weighted average per resident amount is calculated, if applicable, for the surviving hospital, using FTE resident data and per resident amount data from the most recently settled cost reports of the respective hospitals prior to the merger.

36. Section 413.78 is amended by--

a. Revising paragraph (c)(1).

b. Revising paragraph (d)(1).

c. Revising paragraph (e)(1).

The revisions read as follows:

§413.78 Direct GME payments: Determinations of the total number of FTE residents.

* * * * *

(c) * * *

(1) The resident spends his or her time in patient care activities, as defined in §413.75(b).

* * * * *

(d) * * *

(1) The resident spends his or her time in patient care activities, as defined in §413.75(b).

(e) * * *

(1) The resident spends his or her time in patient care activities, as defined in §413.75(b).

* * * * *

37. Section 413.79 is amended by--

a. Revising paragraph (e)(1)(iv).

b. In the introductory text of paragraph (f), removing the cross-reference "paragraph (e)(3) of this section" and adding the cross-reference "paragraph (d) of this section" in its place.

The revision reads as follows:

§413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(e) * * *

(1) * * *

(iv) Effective for affiliation agreements entered into on or after October 1, 2005, an urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap only if the adjustment that results from the affiliation is an increase to the urban hospital's FTE cap.

* * * * *

38. Section 413.85 is amended by revising paragraph (h)(3) to read as follows:

§413.85 Costs of approved nursing and allied health education activities.

* * * * *

(h) * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

* * * * *

39. Section 413.89 is amended by--

a. Revising paragraph (a).

b. Revising paragraph (h).

The revisions read as follows:

§413.89 Bad debts, charity, and courtesy allowances.

(a) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations

described under paragraph (h) of this section and the exception for anesthetists' services described under paragraph (i) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

* * * * *

(h) Limitations on bad debts. (1) Hospitals. In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced--

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

(2) Skilled nursing facilities. For cost reporting periods beginning during fiscal year 2006 or during a subsequent fiscal year, the amount of skilled nursing facility bad debts for coinsurance otherwise treated as allowable costs (as defined in paragraph (e) of this section) for services furnished to a patient who is not a dual eligible individual is reduced by 30 percent. A dual eligible individual is defined for this section as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a "full-benefit dual eligible individual" at §423.772 of this chapter.

* * * * *

PART 414--PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

40. The authority citation for Part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr (b)(1)).

41. Section 414.802 is amended by revising the definition of "unit" to read as follows:

§414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. During the first 3 years of the CAP (as defined in §414.902), the method of counting units excludes units of CAP drugs (as defined in §414.902) sold to an approved CAP vendor (as defined in §414.902) for use under the CAP (as defined in §414.902).

PART 424--CONDITIONS FOR MEDICARE PAYMENT

42. The authority citation for Part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§424.32 [Amended]

43. In §424.32, in paragraph (b), the phrase "CMS-1490U-Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)" is removed and the phrase "CMS-1491-Request for Medicare Payment-

Ambulance. (For use by an organization requesting payment for ambulance services.)" is removed.

§424.121 [Amended]

44. In §424.121, paragraph (c) is amended by removing the cross-reference "§405.313" and adding the cross-reference "§411.9" in its place.

45. Section 424.123 is amended by revising paragraph (c)(2) to read as follows:

§424.123 Conditions for payment for nonemergency inpatient hospital services furnished by a hospital closer to the individual's residence.

* * * * *

(c) * * *

(2) Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or accredited or approved by a program of the country where it is located under standards the CMS finds to be essentially equivalent to those of the JCAHO.

* * * * *

PART 485--CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

46. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§485.610 [Amended]

47. In paragraph (c) of §485.610, the phrase "as of October 1, 2006" is removed and the phrase "on or before December 31, 2005" is added in its place.

PART 489--PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

48. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, 1869, and 187l of the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

49. Section 489.24 is amended by--

a. Revising the definition of "Labor" under paragraph (b).

b. Revising paragraph (f).

The revisions read as follows:

§489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

* * * * *

(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 care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means 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. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

* * * * *

SUBCHAPTER H--HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

PART 505--ESTABLISHMENT OF THE HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

50. The authority citation for part 505 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C 1302 and 1395hh).

51. In §505.3, the introductory text is republished and definitions of "Outreach programs" and "Unique research resources" are added in alphabetical order to read as follows:

§505.3 Definitions.

For purposes of this subpart, the following definitions apply:

* * * * *

Outreach programs mean formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s).

* * * * *

Unique research resources means resources that are used for the purpose of discovering or testing options related to the causes, prevention, and treatment of cancer.

52. A new Subpart B, containing §§505.13, 505.15, 505.17, and 505.19, is added to Part 505 to read as follows:

Subpart B--Forgiveness of Indebtedness

Secs.

505.13 Conditions for loan forgiveness.

505.15 Plan criteria for meeting the conditions for loan forgiveness.

505.17 Reporting requirements for meeting the conditions for loan forgiveness.

505.19 Approval or denial of loan forgiveness.

Subpart B--Forgiveness of Indebtedness

§505.13 Conditions for loan forgiveness.

The Secretary may forgive a loan provided under this part if the qualifying hospital--

(a) Has been selected to participate in the loan program specified in §505.5(c).

(b) Has established the following in accordance with a plan that meets the criteria specified in §505.15:

(1) An outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

(2) An outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

(3) Unique research resources (such as population databases) or an affiliation with an entity that has unique research resources.

(c) Submits to CMS, within the timeframe specified by the Secretary, a--

(1) Written request for loan forgiveness; and

(2) Loan forgiveness plan that meets the criteria specified in §505.15 of this subpart.

§505.15 Plan criteria for meeting the conditions for loan forgiveness.

The qualifying hospital requesting loan forgiveness must submit to CMS a plan specifying how it will develop, implement, or maintain an existing outreach program for cancer prevention, early diagnosis, and treatment for a substantial majority of the residents of a State or region, including residents of rural areas and for multiple Indian tribes and specifying how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

(a) Outreach programs. The initial plan must specify how the hospital will establish or develop, implement, or maintain existing outreach programs. The plan must--

(1) Address cancer prevention for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for decreasing the targeted cancer rates during the loan deferment program; and

(2) Address early diagnosis of cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving early diagnosis rates for the targeted cancer(s) during the loan deferment period;

(3) Address cancer treatment for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving cancer treatment rates for the targeted cancer(s) during the loan deferment; and

(4) Identify the measures that will be used to determine the qualifying hospital's annual progress in meeting the initial goals specified in paragraphs (a)(1) through (a)(3) of this section.

(b) Unique research resources. The plan must specify how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

§505.17 Reporting requirements for meeting the conditions for loan forgiveness.

(a) Annual reporting requirements. On an annual basis, beginning one year from the date that CMS notified the qualifying hospital of the loan award, the qualifying hospital must submit a report to CMS that updates the plan specified in §505.15 by--

(1) Describing the qualifying hospital's progress in meeting its initial plan goals;

(2) Describing any changes to the qualifying hospital's initial plan goals; and

(3) Including at least one measure used to track the qualifying hospital's progress in meeting its plan goals.

(b) Review of annual reports. CMS will review each qualifying hospital's annual report to provide the hospital with feedback regarding its loan forgiveness status. If CMS determines that the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§505.13, 505.15, and §505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven.

(c) Final annual reporting requirements. A qualifying hospital must submit its final report to CMS at least 6 months before the end of the loan deferment period specified in §505.7(b).

§505.19 Approval or denial of loan forgiveness.

(a) Approval of loan forgiveness. If CMS determines that a qualifying hospital has met the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §505.13, §505.15, and §505.17, CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of--

(1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or

(2) 90 days before the end of the loan deferment period defined in §505.7(b).

(b) Denial of loan forgiveness. If CMS determines that a qualifying hospital has not met the conditions, plan criteria, or reporting requirements for loan forgiveness

specified in §505.13, §505.15, or §505.17 of this part, CMS will send a written notification of denial of loan forgiveness to the qualifying hospital at least 30 days before the end of the loan deferment period defined in §505.7(b).

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

Dated:_____

_____

Mark B. McClellan,

Administrator, Centers for

Medicare & Medicaid Services

Dated:_____

_____

Michael O. Leavitt,

Secretary

BILLING CODE 4120-01-P

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum--Schedule of Tentative Standardized Amounts, Tentative Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2006

I. Summary and Background

Due to the unusual circumstances imposed by the order of the Court of Appeals for the Second Circuit in the decision in Bellevue Hospital Center v. Leavitt, discussed in detail in section III.C. of the preamble of this final rule, we are not able to provide the final FY 2007 occupational mix adjusted 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 the occupational mix adjusted wage index is 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, 2006 for FY 2007. 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 are using 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 final rate-of-increase percentages for updating the target amounts for hospitals

and hospital units excluded from the IPPS. We note that, because hospitals excluded from the IPPS are paid on a cost basis (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 hospitals and hospital units excluded from the IPPS that are effective October 1, 2006.

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, which is based on the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

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 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 is higher. (MDHs did not have the option to use their FY 1996 hospital-specific rate.) Section 5003(a)(1) of Pub. L. 109-171 extended and modified the MDH special payment provision which was previously set to expire on October 1, 2006, to discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Pub. L. 109-171,

if the change results in an increase to its target amount, an MDH must rebase its hospital-specific rates to its FY 2002 cost report. In addition, under section 5003(c) of Pub. L. 109-171, MDHs will now 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 upon section 5003(d) of Pub. L. 109-171, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See 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 2007. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2007. Section IV. of this Addendum sets forth our final changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2007. Section V. of this Addendum sets forth policies on payment for blood clotting factors administered to hemophilia inpatients. The tables to which we refer in the preamble of this final rule are presented in section VI. 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, 2006.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs

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, 1C, and 1D 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 3.4 percent for all areas (that is, the full market basket percentage increase of 3.4 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109-171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 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.

- An adjustment to ensure the DRG recalibration, as provided for under section 1886(d)(4)(C)(iii) of the Act, by applying a final budget neutrality adjustment factor to the standardized amount.

- 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 the special transition measures adopted in relation to the implementation of new labor market areas are budget neutral.

- 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 2006 budget neutrality factor and applying a revised factor.

- An adjustment to remove the FY 2006 outlier offset and apply an offset for FY 2007.

- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108-173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108-173.

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) or, for Puerto Rico, 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) 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 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 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 2007, we are not changing the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2006. Therefore, the labor-related share will continue 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 share of 69.7 percent of the national standardized amount. For a Puerto Rico hospital, we will apply a labor share of 58.7 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For Puerto Rico hospitals whose Puerto Rico-specific wage index values are greater than 1.0000, we will apply a labor share of 62 percent.

The tentative standardized amounts appear in Table 1A, 1B, and 1C of the Addendum to this final rule.

Comment: Several commenters recommended that CMS raise the labor share from 69.7 percent to the previous level of 71.1 percent for hospitals with a wage index greater than one. The commenters explained that a reduced labor share has a negative impact and severe financial strain on their hospitals.

Response: We thank the commenters for their comments. We refer the commenters to the FY 2006 final rule (70 FR 47392-47396) where a full discussion (including comments and responses) on the labor share percentage can be found. As we

indicated, our analysis in last year's rule showed that the labor-related share should equal 69.7 percent nationally based on the latest available data.

2. Computing the Tentative Average Standardized Amount

Section 1886(d)(3)(A)(iv) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount is to 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) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we will calculate FY 2007 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 2007 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 Pub. L. 109-171. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2007 is 3.4 percent. Thus, for FY 2007, the update to the average standardized amount is 3.4 percent for hospitals in all areas.

Section 1886(b)(3)(B) of the Act specifies the mechanism 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 Pub. L. 109-171,

provides for a reduction of 2.0 percentage points to 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 VI. of this Addendum reflect these differential amounts.

Although the update factors for FY 2007 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 2007 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 occupational mix wage index data will have no affect on the market basket increase factor of 3.4 percent. Therefore, the update factors of 3.4 and 1.4 percent are final and not tentative. These update factors (3.4 and 1.4 percent) are one element that will be used to determine the FY 2007 standardized amounts. Other factors, such as the outlier offset and budget neutrality adjustments for wage index and reclassification that are applied to the standardized amounts, are yet to be determined pending the calculation of the occupational mix adjustment. The market basket increase of 3.4 percent is based on the second quarter forecast of the hospital market basket increase by the Office of the Actuary (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 2007 standardized amount to remove the effects of the FY 2006 geographic reclassifications and outlier payments before applying the FY 2007 updates. We then apply budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2007 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 the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include 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 required under section 410A of Pub. L. 108-173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108-173.

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 are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

As noted above, due to the decision of the Bellevue court, we are unable to finalize the wage data used in establishing the FY 2007 IPPS payment factors at this time. We use the wage data to standardize the charges when recalibrating the DRG weights, and therefore, we will recalculate the final DRG weights when the occupational mix adjusted wage data become available. Since the DRG relative weights are not yet final, at this time we are only able to provide the tentative DRG reclassification and recalibration budget neutrality adjustment. Subsequent to this final rule and prior to October 1, 2006, the recalculated DRG weights and the final DRG reclassification and recalibration budget neutrality adjustment will be published in a **Federal Register** notice.

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. For FY 2007, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.C. of the preamble to this final rule. However, the data to compute the 100 percent occupational mix adjustment are not available to us at this time. Although section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we cannot include the effects of the occupational mix adjustment on the wage index in our budget neutrality calculations at this time. Therefore, the budget neutrality adjustment to the standardized amounts that we calculated below is tentative pending the calculation of the occupational mix adjusted wage indices that will be provided on the CMS Web site and in a **Federal Register** notice prior to October 1.

In FY 2005, those urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Because we are in the third year of this 3-year transition, we are adjusting the standardized amounts for FY 2007 to ensure budget neutrality for this policy. We discuss this adjustment in section III.B. of the preamble to this final rule. Again, the adjustment for this factor will be affected by the occupational mix adjusted wage indices that will be recalculated prior to October 1. For this reason, the adjustment for previously urban hospitals that become rural under the new labor market area

definitions is tentative pending final calculation of the occupational mix adjusted wage indices.

Section 4410 of Pub. L. 105-33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Pub. L. 105-33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor. As discussed in the FY 2006 IPPS final rule (70 FR 47493), FY 2007 is the third and final year of the 3-year provision that uses an imputed wage index floor for States that have no rural areas and States that have geographic rural areas, but that have no hospitals actually classified as rural. We are also adjusting for the effects of this provision in our calculation of the wage update budget neutrality factor. This figure will also be updated pending calculation of the occupational mix adjusted wage indices.

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 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

Based on this comparison, we computed a tentative budget neutrality adjustment factor equal to 0.997030. We also are adjusting the Puerto Rico-specific standardized

amount for the effect of DRG reclassification and recalibration. We computed a tentative budget neutrality adjustment factor for the Puerto Rico-specific standardized amount equal to 0.997968. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments. In addition, as discussed in section IV.E. of the preamble to this final rule, we are applying the same tentative DRG reclassification and recalibration budget neutrality factor of 0.997968 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2006.

Using the same data, we calculated a tentative transition budget neutrality adjustment to account for the "hold harmless" policy under which urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market area definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Using the pre-reclassified wage index, we simulated payments under the new labor market area definitions and compared them to simulated payments under the "hold harmless" policy. Based on this comparison, we computed a tentative transition budget neutrality adjustment of 0.999605.

Comment: Several commenters addressed CMS' policy of excluding data from CAHs when computing the wage index. The commenters believed that the artificial increase in the national average hourly wage has lowered the budget neutrality adjustment by an estimated $1.52 billion over 5 years (2003 through 2007). The commenters stated that CMS should apply a one-time positive budget neutrality

adjustment in FY 2007 to compensate for the prior underpayments. They did not believe similar future adjustments would be necessary since very few hospitals are expected "to convert to CAH status now that the necessary provider designation is no longer an option."

Response: We do not believe that the elimination of these data has resulted in an overstated national average hourly wage, nor has the budget neutrality adjustment been inappropriately reduced. Section 1886(d)(3)(E) of the Act requires that wage index adjustments be made in a manner that assures that aggregate payments in a fiscal year are not greater or less than those that would have been made without the wage index adjustment. We calculate the budget neutrality adjustment for the wage index by comparing simulated payments under our current wage index adjustment policies with simulated payments with no wage index adjustment. Our current policy is to exclude CAH data from our calculation of the IPPS wage index, so we believe this policy should be taken into account when we calculate the budget neutrality adjustment for the wage index. Consequently, we will not apply a one-time positive budget neutrality adjustment in FY 2007. We note that a full discussion on the wage index can be found in section III. of the preamble to this final rule.

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 neither the wage index reclassifications provided under section 508 of Pub. L. 108-173 nor the wage index adjustments provided under section 1886(d)(13) of the Act are budget neutral. Section 508(b) of Pub. L. 108-173 provides that the wage index reclassifications approved under section 508(a) of Pub. L. 108-173 "shall not be effected in a budget neutral manner." Section 1886(d)(13)(H) of the Act similarly 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, we used FY 2005 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 0.991850 to ensure that the effects of this reclassification are budget neutral.

The tentative adjustment factor is applied to the standardized amount after removing the effects of the FY 2006 budget neutrality adjustment factor. We note that

the FY 2007 tentative adjustment reflects FY 2007 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2005 and FY 2006 (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, CMS will make a FY 2007 reclassification determination for a hospital based on what we believe will be most advantageous to the hospital using the fully occupational mix adjusted wage index. We will calculate the final budget neutrality adjustments for geographic reclassification subsequent to this final rule, but prior to October 1, and will make this information available with the occupational mix adjusted wage indices and final IPPS rates.

c. 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 costs. Payments for eligible cases are then made based on

a marginal cost factor, which is a percentage of the costs above the fixed-loss cost threshold. The marginal cost factor for FY 2007 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 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 .

i. FY 2007 tentative outlier fixed-loss cost threshold.

As stated above, the wage index tables, rates, and impacts will not be final in this final rule because we are yet to determine occupational mix adjusted wage indices. Therefore, we are only able to provide tentative standardized amounts, relative weights, offsets, and budget neutrality factors in this final rule. Once we have the final occupational mix data, we will recalculate these amounts to reflect the final occupational mix adjusted wage indices. 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, 2006 for FY 2007. 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 2007, we proposed to use the same methodology used for FY 2006 (70 FR 47493) to calculate the outlier threshold. As we have done in the past, to calculate the proposed FY 2007 outlier threshold, we simulated payments by applying FY 2007 rates and policies using cases from the FY 2005 MedPAR files. Therefore, in order to determine the FY 2007 outlier threshold, we inflate the charges on the MedPAR claims by 2 years, from FY 2005 to FY 2007.

In certain years in the past, we have inflated MedPAR claims by calculating a 2-year average annual rate-of-change in charges-per-case using the charge data for the two most recent years for which we had relatively complete MedPAR data. As discussed in the FY 2006 IPPS final rule (70 FR 47494), however, we believe that charge data from FY 2003 may be distorted due to the atypically high rate of hospital charge inflation during FY 2003. Therefore, we are not inflating charges using a 2-year average annual rate-of-change from FY 2003 to FY 2004 and FY 2004 to FY 2005.

Instead, we proposed to continue using a refined methodology that takes into account the lower inflation in hospital charges that is 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 and accurate CCRs. Our refined methodology uses more recent data that reflects the rate-of-change in hospital charges

under the new outlier policy. Specifically, we proposed to establish the FY 2007 outlier threshold as follows: Using the latest data available, we would calculate the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2004 in combination with the first quarter of FY 2005 (July 1, 2004 through December 31, 2004) to the last quarter of FY 2005 in combination with the first quarter of FY 2006 (July 1, 2005 through December 31, 2005). This rate of change was 7.57 percent (1.0757) or 15.15 percent (1.1515) over 2 years.

As we have done in the past, we proposed to establish the FY 2007 outlier threshold using hospital CCRs from the March 2006 update to the Provider-Specific File--the most recent available at the time of this final rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

Using this methodology, we proposed to establish an outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $25,530.

We noted that the case-weighted national average CCR declined by approximately 1 percent from the March 2005 to the March 2006 update of the Provider-Specific File. Hospital charges continue to increase at a steady rate of growth between 7 and 8 percent over each of the last 2 years, resulting in a decline to the CCRs that are used to compute the outlier threshold. Using lower CCRs from the March 2006 Provider-Specific File, in combination with the FY 2005 MedPAR claims and inflated charges, contributes to a higher outlier threshold for FY 2007 compared to FY 2006.

As we did in establishing the FY 2006 outlier threshold (70 FR 47494), in our projection of FY 2007 outlier payments, we proposed not to make an adjustment for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We stated that we continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule, 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 which specific hospitals will have CCRs and outlier payments reconciled in their cost reports 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 and, therefore, are more indicative of post-reconciliation than pre-reconciliation outlier payments. As a result, we proposed to continue to omit any assumptions about the effects of reconciliation from the outlier threshold calculation.

Comment: Many commenters, including two major hospital associations, were concerned that the proposed outlier threshold for FY 2007 remains too high and CMS will have removed over $300 million from the IPPS rates that were not paid back as outliers. The commenters noted that total estimated outlier payments in FY 2004 and FY 2005 were well under the 5.1 percent target. As a result, the commenters recommended further refining the outlier methodology so that, in their view, it will be more likely that CMS projects a threshold that meets the 5.1 target. The commenters explained that aside from inflating the claim charges, CMS should also use an adjustment factor to project

CCRs. The commenters believed that the use of more than one indicator will make the threshold calculation more reliable and accurate.

The commenters used data from the March 31, 2006 HCRIS update to determine hospitals' CCRs (instead of using CCRs from the PSF per CMS's methodology). The commenters accounted for a nine month time lag from the end of a cost reporting period until the fiscal intermediary is able to update the CCR to project the CCRs expected to be used for outlier calculations in FY 2007. The commenters then calculated a cost inflation factor of 5.69 percent by determining the 2002-2004 aggregate annual rate of increase in cost per discharge. The commenters used this cost inflation factor along with CMS' charge inflation factor of 7.57 percent to project CCRs. These projected CCRs were applied to projected FY 2007 charges to simulate the determination of costs for FY 2007 outlier payments. Using this methodology, the commenters determined and recommended an outlier threshold of $24,000 that they assert would result in 5.1 percent outlier payments. The commenters also indicated that CMS would have paid 5.1 percent of total IPPS payments as outliers in FY 2006 using a threshold of $21,275 instead of $23,600. In addition, the commenters asserted that CMS removed a total of $3 billion more from the IPPS rates than it spent on outlier payments over FY 2004, 2005, and 2006. Therefore, the commenters urged CMS to adopt a better methodology of projecting the CCRs, regardless of the DRG refinements being adopted for FY 2007.

One commenter argued that using CMS' previous methodology with costs instead of charges resulted in an outlier threshold of $23,055 for FY 2007 that would be more likely to result in 5.1 percent of total IPPS payments being paid as outliers. Using a

methodology with costs and data from HCRIS (to determine hospital CCRs), the commenter computed a threshold of $22,645. The commenter asserted that projections using a cost threshold for FY 2004-2006 would have been much closer to the ultimate threshold needed to achieve the 5.1 percent target. Because the commenter believed there is now 3 years of data demonstrating that a cost methodology is a better predictor of the threshold, the commenter recommended that CMS adopt a threshold of $22,645.

MedPAC also commented that CMS should adjust the outlier methodology and apply an adjustment to project CCRs. MedPAC explained that using CCRs that are too high will overstate costs resulting in a fixed loss threshold that is too high. Therefore, MedPAC recommended that CMS project the average costs and charge per case to project hospitals' CCRs using the charge inflation factor already determined by CMS and the cost inflation factor using the market basket when projecting the CCRs.

Another commenter stated that it is inappropriate to use a methodology that ignores cost inflation. The commenter argued that the threshold is a “cost outlier threshold” and therefore an adjustment for cost should be incorporated in to the outlier threshold methodology.

One commenter asked CMS to strongly reconsider the increase to the outlier threshold and implement a reduction that is consistent with the trends for FY 2005 and FY 2006 in outlier payments. Another commenter recommended that CMS calculate what the outlier threshold would need to be for the current fiscal year (2006) to enable outlier payments to meet the 5.1 percent target and apply that threshold for FY 2007.

Response: As the commenters noted, the outlier thresholds we have projected in the last several years have resulted in payments below the 5.1 percent target. However, we have been hesitant to change our model because, in the early years of this decade, outlier payments were significantly higher than the 5.1 percent target we projected because the charging practices of some hospitals resulted in overestimation of hospitals' cost-per-case. However, now that data for later years in which charging practices were stabilized are available, after careful consideration, we agree that a refinement to the proposed methodology to account for the rate of change in the relationship between costs and charges would likely increase the precision of our model and we believe this would be an appropriate refinement to adopt in determining the FY 2007 outlier threshold.

For FY 2007, we are using the same methodology we proposed, except that we are using more recent data to determine the charge inflation factor (as explained below). In addition, we are applying an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we proposed, for this final rule, we simulated payments by applying FY 2007 rates and policies using cases from the FY 2005 MedPAR files. Therefore, as stated above, in order to determine the FY 2007 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2005 to FY 2007.

As noted above, the commenters supported our charge inflation methodology. Therefore, using the most recent data available (updated from the proposed rule), we calculated the 1-year average annualized rate-of-change in charges-per-case from the first quarter of FY 2005 in combination with the second quarter of FY 2005 (October 1, 2004

through March 31, 2005) to the first quarter of FY 2006 in combination with the second quarter of FY 2006 (October 1, 2005 through March 31, 2006). This rate of change was 7.9 percent (1.079) or 16.42 percent (1.1642) over 2 years.

As we have done in the past, we are establishing the FY 2007 outlier threshold using hospital CCRs from the March 2006 update to the Provider-Specific File--the most recent data available at the time of this final rule.

However, as noted above, many commenters believe an adjustment to the CCRs would be appropriate in projecting a threshold that meets the 5.1 percent target. The commenters referenced above used cost report data from HCRIS and applied a cost inflation factor based on the annual rate of increase in the cost per discharge from 2002 through 2004. However, we still believe the best source of hospital's operating and capital CCRs are those that come from the Provider-Specific File. As noted in the FY 2006 final rule (70 FR 47495), fiscal intermediaries will determine actual outlier payment amounts using some of the same CCRs that are in the March 2006 PSF. Fiscal intermediaries will begin using an updated CCR to calculate the outlier payments for a hospital only after a more recent cost report of the hospital has been tentatively settled. Nevertheless, we now agree with the commenters that it is appropriate to apply an adjustment factor to the CCRs so that the CCRs we are using in our simulation more closely reflect the CCRs that will be used in FY 2007.

We worked with our actuarial office in deriving the methodology described below to develop the CCR adjustment factor. Specifically, we used the operating cost per discharge increase in combination with the final updated market basket increase

determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. By using the 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 2007, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2003 to FY 2004 (1.0645) from the cost report and dividing it by the final market basket increase from FY 2004 (1.039) 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 2001 to FY 2002 percentage increase of operating costs per discharge of 1.0836 divided by FY 2002 final market basket increase of 1.04, FY 2002 to FY 2003 percentage increase of operating costs per discharge of 1.0698 divided by FY 2003 final market basket increase of 1.04). For FY 2007, we averaged the differentials calculated for FY 2002, FY 2003, and FY 2004 which resulted in a mean ratio of 1.0327. We multiplied the 3-year average of 1.0327 by the 2005 market basket percentage increase of 1.0420, which resulted in an operating cost inflation factor of 7.61 percent or 1.0761. We then divided the operating cost inflation factor by the 1- year average change in charges (1.079) and applied an adjustment factor of 0.9973 to the operating CCRs from the Provider-Specific File.

We believe it is appropriate to apply only a one year adjustment factor to the CCRs. On average, it takes approximately 9 months for fiscal intermediaries 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

inserts the CCR in the PSF until the beginning of FY 2007 is approximately 1 year. Therefore, as stated above, we believe a one year adjustment to the CCRs is appropriate.

We used the same methodology for the capital CCRs and applied an adjustment factor of 0.9574 (cost inflation factor of 1.0303 divided by a charge inflation factor of 1.0761) to the capital CCRs. 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 and therefore we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

We believe this calculation of an adjustment to the CCRs is more accurate and stable than the commenters' methodology because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor.

Using this methodology, we are establishing a tentative outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $24,475. The tentative outlier threshold that we calculated for this final rule is $1,055 lower than the $25,530 threshold from the proposed rule. We anticipate that a threshold based on the methodology above will reach the target of 5.1 percent. We note that, in this final rule, we are adopting this methodology to compute the final outlier fixed-loss cost threshold for FY 2007, although the final dollar amount of the outlier threshold will be published in a subsequent **Federal Register** document.

We also note, that the case-weighted national average CCR declined by approximately an additional 1 percent from the December 2005 to the March 2006 update of the Provider-Specific File. We further reduced the CCRs by applying an adjustment to reflect the differential increase between costs and charges. As noted above, using lower CCRs from the March 2006 Provider-Specific File, in combination with the FY 2005 MedPAR claims and inflated charges, contributes to a lower outlier threshold for FY 2007 in this final rule compared to the proposed rule.

Finally, charges are a key influence over outlier payments. Therefore, we continue to believe it is appropriate to use a methodology based on charges instead of costs. Please refer to our response to a similar comment in the FY 2006 final rule (70 FR 47495) for a more detailed discussion of this issue.

Comment: One commenter suggested that CMS consider making mid-year adjustments to the outlier threshold if it appears that outlier payments are going to be significantly above or below the 5.1 percent target. The commenter believed that a mid-year adjustment would aid CMS in reaching the 5.1 percent target irrespective of the methodology CMS uses to determine the threshold. However, the commenter did note that a mid-year correction will be of less need if CMS were to adopt a methodology based on cost or the CMS model that projects CCRs. Another commenter recommended that CMS evaluate the practicality and effects of a correction error similar to the update forecast error adjustment used in recommending an update for the market basket rate of increase.

One commenter urged CMS to publicly account for the amount of unspent outlier payments over the last 3 years and to establish a policy whereby the unspent money is returned to the base rate for inpatient spending.

Response: We appreciate the commenters suggestions for improving payment accuracy for outliers. However, we have already responded to similar comments in the FY 2006 final rule (70 FR 47495).

Furthermore, we believe that a policy whereby the standardized amounts would be adjusted to reflect differences between the 5.1 percent removed from the rates and the amounts actually paid as outliers would be inconsistent with the purpose of the statute relating to outlier payments and the prospective payment system. Section 1886(d)(3)(B) of the Act requires that we reduce the standardized amounts by a factor equal to the proportion of outlier payments "as estimated by the Secretary." Therefore, we believe that the statute does not contemplate adjustments to the standardized amounts in an upcoming year because actual outlier payments in past years were more or less than we had estimated.

Comment: One commenter was concerned that CMS has not met the 5.1 percent target in previous years and suggested that CMS project the outlier threshold at 5.5 percent of total payments to ensure it meets the 5.1 percent target.

Another commenter was concerned about the impact that the DRG refinement will have on outlier payments. The commenter recommended that CMS maintain the threshold at $23,600 for FY 2007 while hospitals adjust to the other PPS payment changes that will occur.

One commenter supported eliminating outlier payments in its entirety and recommended a more equitable approach by simply increasing the standardized amounts by 5.1 percent. The commenter explained that this method would remove the ability to game the system and would be more desirable to deserving providers that do not abuse the system.

Response: As noted above, 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. Therefore, we cannot eliminate outlier payments as suggested by one commenter or set a threshold that is based on the current fiscal year for the coming fiscal year. Although we are refining the DRGs, the statute requires us to set an outlier threshold so that estimated total outlier payments are between 5 and 6 percent of total IPPS payments. If we failed to project a new outlier threshold for FY 2007, but rather simply continued to use the outlier threshold for FY 2006, we would not meet the mandate of the statute.

We also note that we project outlier payments at 5.1 percent to ensure that we offset the minimum amount necessary from the standardized amounts to meet our statutory obligation. Although CMS could legally project an outlier threshold so that 5.5 percent of total IPPS payments are paid as outliers, the law would also require us to remove 5.5 percent from the standardized amounts to finance the outlier pool, which would reduce funds available for typical cases. As a result, we believe setting the outlier threshold so that 5.1 percent of total IPPS payments are paid as outliers is more equitable to all hospitals, as less money is withdrawn from the standardized amounts due to the

outlier offset and it allows proportionally greater payment for typical cases. Therefore, we are adopting as final our proposal to set the outlier threshold so that 5.1 percent of estimated total IPPS payments are paid as outliers.

ii. Other changes concerning outliers.

As stated in the FY 1994 IPPS final rule (58 FR 46348, September 1, 1993), we establish outlier thresholds that are 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 set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2007 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.87 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 2007 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The tentative outlier adjustment factors that will be applied to the standardized amount for FY 2007 are as follows:

	Operating Standardized Amounts	**Capital Federal Rate**
National	0.948966	0.956763
Puerto Rico	0.967415	0.967670

We are applying the tentative outlier adjustment factors to the tentative FY 2007 rates after removing the effects of the FY 2006 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. 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 whose CCRs fall below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary computes operating CCRs greater than 1.26 or capital CCRs greater than 0.154, or hospitals for whom the fiscal intermediary is unable to calculate a CCR (as described at §412.84(i)(3) of our regulations), we are still using statewide average CCRs to determine whether a hospital qualifies for outlier payments.[31] Table 8A in section VI. of this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2006, these statewide average ratios will replace the ratios published in the IPPS final rule for FY 2006 (70 FR 47672). Table 8B in section VI. of this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B will be used during FY 2007 when hospital-specific CCRs based on the latest

[31] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, please see section VI. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to outliers on October 12, 2005. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. To download and view the manual update, please visit http://www.cms.hhs.gov/transmittals/downloads/R707CP.pdf.

iii. FY 2005 and FY 2006 outlier payments.

In the FY 2006 IPPS final rule (70 FR 47496), we stated that, based on available data, we estimated that actual FY 2005 outlier payments would be approximately 4.1 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2004 MedPAR file (discharge data for FY 2004 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2005 bills, but instead reflected the application of FY 2005 rates and policies to available FY 2004 bills.

Our current estimate, using available FY 2005 bills, is that actual outlier payments for FY 2005 were approximately 3.96 percent of actual total DRG payments. Thus, the data indicate that, for FY 2005, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2005 (and, thus, is less than the percentage by which we reduced the standardized amounts for FY 2005). We note that, for FY 2006, the outlier threshold was lowered to $23,600 compared to $25,800 for FY 2005. The outlier threshold was lower in FY 2006 than FY 2005 as a result of slower growth in hospital charge inflation following implementation of the outlier final rule that went into effect on August 9, 2003. Nevertheless, 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 2005 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2006 will be approximately 4.62 percent of actual total DRG payments, 0.48 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2006. This estimate is based on simulations using the FY 2005 MedPAR file (discharge data for FY 2005 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2006 by applying FY 2006 rates and policies, including an outlier threshold of $23,600 to available FY 2005 bills. Even though we are estimating payments below the 5.1 percent threshold for FY 2006, our simulations using FY 2005 Medicare data show consistent levels of charge inflation and a need to increase the threshold for FY 2007 to ensure that 5.1 percent of total IPPS payments are paid as outliers.

iv. Technical changes

Subpart F of Part 412 of the existing regulations discusses payment for outlier cases and special payment for new technology. We have become aware of an inadvertent mistake in §412.84(m). Currently, §412.84(m) discusses the application of the time value of money when a hospital's outlier payments are reconciled. When referencing reconciliation, the section mistakenly references paragraph (h)(3) instead of paragraph (i)(4). We received no comments on this change and therefore are finalizing our proposal to revise §412.84(m) to reference the current policy under paragraph (i)(4).

In addition, in the June 9, 2003 outlier final rule, we amended §412.116(e) to remove the second sentence, which stated that payments for outliers "are made based on submitted bills and represent final payment." It was necessary to remove this sentence, as we added a provision to the regulations that provides that outlier payments are subject to reconciliation when hospitals' cost reports are settled. In the FY 2004 IPPS final rule (68 FR 45393), we again amended §412.116(e) to provide that new technology add-on payments are made on a case-by-case basis, rather than on an interim basis. However, it has come to our attention that, in the FY 2004 IPPS final rule, we inadvertently reinserted the sentence that we had struck in the June 9, 2003 outlier final rule. We never intended to reinsert this sentence, and our policy since the implementation of the outlier final rule has always been the same (that outlier payments are subject to reconciliation when hospitals' cost reports are settled). Therefore, in order to correct the regulations to reflect our current policy, we are removing the second sentence from §412.116(e). Although we did not propose this technical correction, as further discussed in section XIII.C. of this final rule, we find it unnecessary to undertake notice and comment rulemaking with respect to this technical correction.

d. Tentative Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108-173)

Section 410A of Pub. L. 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 Pub. L. 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.M. 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 that will be made to each participating hospital under the demonstration will be approximately $1,021,985. 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. For 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The required tentative adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

In order to achieve budget neutrality, we are adjusting the tentative national IPPS rates by a tentative amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. 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 2007 Standardized Amount

The tentative adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B in section VI. of this Addendum contain the tentative national standardized amount that we are applying to all hospitals, except hospitals in Puerto Rico. The tentative Puerto Rico-specific amounts are shown in Table 1C. 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 the labor-related share applied to the tentative standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying the labor-related share of 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this application is that the labor-related share of the tentative standardized amount is 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 3.4 percent update for FY 2007, and tentative standardized amounts reflecting the 2.0 percentage point reduction to the update (a 1.4 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

We note that in this final rule we are not supplying a table that illustrates the changes from the FY 2006 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.

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 tentative 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 2007 are set forth in Table 1C of section VI. 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 is more advantageous to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108-173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Tentative Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in section VI. of this Addendum, contain the tentative labor-related and tentative nonlabor-related shares of the standardized amount that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2007. This section addresses two types of adjustments to the tentative standardized amounts that are 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 2007 wage index. We note that because the occupational mix adjusted wage index data will not be finalized until after this final rule, we will not be publishing Tables 4A-1, 4A-2, 4B, 4C-1, 4C-2, and 4F in this final rule. However, we will publish these tables in the **Federal Register** and on the CMS Web site once all the data is finalized and prior to October 1, 2006.

2. Final Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes 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 2007, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the appropriate 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-All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble of this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are using for discharges occurring in FY 2007. 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 Prospective Payment Rates for FY 2007

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 2007 equals the Federal rate.

The prospective payment rate for SCHs for FY 2007 equals the higher of the applicable Federal rate or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2007 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 Puerto Rico for FY 2007 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

As noted above, we are not able to provide the final FY 2007 occupational mix adjusted wage index tables. Although Tables 4A-1, 4A-2, 4B, 4C-1, and 4C-2 will be

published on the CMS Web site and in a subsequent **Federal Register** document to this final rule, any reference to these tables below refers to these future tables.

1. Federal Rate

The Federal rate is determined as follows:

Step 1--Select the appropriate average standardized amount considering the applicable wage index and whether the hospital has 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 appropriate cost-of-living adjustment factor.

Step 4--Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5--Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be 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, the payment in Step 5 would be 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 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 previously, MDHs are required to rebase their 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 will no longer be 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 IV.C. of the preamble to this final rule. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2006.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2007

We are increasing the hospital-specific rates by 3.4 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2007. 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 2007, is the market basket rate-of-increase. 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 under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2007, is the market basket rate-of-increase.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2006, and Before October 1, 2007

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 appropriate average standardized amount considering the applicable wage index (see Table 1C).

Step 2 - Multiply the labor-related portion of the standardized amount by the appropriate 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 appropriate DRG relative weight (see Table 5 of section IV. of the 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 appropriate average standardized amount considering the applicable wage index.

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 appropriate DRG relative weight (see Table 5 of section VI. of the 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 may then be 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 2007

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 regulations at §§412.308 through 412.352. Below we discuss the factors that we are using to determine the tentative capital Federal rate for FY 2007, which will be effective for discharges occurring on or after October 1, 2006. As discussed in section I. of the Addendum of this final rule, we are not able to provide the final FY 2007 capital Federal prospective rates in this rule due to requirements imposed by the Second Circuit Court's order regarding wage index information as collected for the inpatient Federal rates. This affects the Federal capital payment rates, as well, because wage index information is used to determine the GAF/DRG budget neutrality factor, the GAF, and outlier adjustment factor that are used in arriving at the capital Federal rates. We are

providing tentative amounts, where applicable, as proxies for these rates and factors until the occupational mix adjusted wage index is finalized. Subsequent to this final rule, we will publish in a **Federal Register** document a listing the capital Federal rates, offsets and budget neutrality factors that are effective October 1, 2006 for FY 2007.

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 100 percent of 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 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.

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 fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and §412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105-33, which required that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in §412.308(b)(6), a small part of that reduction was restored 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 being made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we no longer use 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 the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, 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 accordance with section 1886(d)(9)(A) of the Act, under the PPS 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 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 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 Pub. L. 105-33, operating payments to hospitals in Puerto Rico were revised to be 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 in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Pub. L. 108-173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals 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 Pub. L. 108-173 provided that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico 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 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 capital rate and 75 percent of the 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 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In the discussion that follows, we explain the factors that we are using to determine the tentative FY 2007 capital Federal rate. In particular, we

explain why the tentative FY 2007 capital Federal rate will increase approximately 1.60 percent compared to the FY 2006 capital Federal rate. However, we estimate aggregate capital payments will decrease by 0.2 percent during this same period. This decrease is due to a decrease in the estimated total number of Medicare fee-for-service discharges for FY 2007 as compared to the estimated total number of Medicare fee-for-service discharges in FY 2006. We are estimating a decrease in Medicare fee-for-service discharges in FY 2007 as compared to FY 2006, in part because we are projecting an increase in beneficiary Medicare managed care enrollment as a result of the implementation of several provisions of Pub. L. 108-173. Therefore, although we are projecting that capital PPS payments per discharge will increase slightly from FY 2006 to FY 2007, we project that aggregate capital PPS payments will decrease for the same period.

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 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are estimated to decrease slightly in FY 2007 compared to FY 2006.

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 2007 under that framework is 1.10 percent based on the best data available at this time. The update factor is based on a projected 1.1 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we 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 2007 CIPI projection in that same section of this Addendum. Below we describe the policy adjustments that have been applied.

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, 2005 IPPS proposed rule for FY 2005 (69 FR 28816)). (We are no longer using an update framework in making 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).)

For FY 2007, 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 in FY 2007. The net adjustment for change in case-mix is the difference between the projected increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2007 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 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 2005 DRG reclassification and recalibration as part of our update for FY 2007. We estimate that FY 2005 DRG reclassification and recalibration will result in a 0.0 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, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2007 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 measurement of the forecast error. A forecast error of 0.1 percentage point was calculated for the FY 2005 update. That is, current historical data indicate that the forecasted FY 2005 CIPI used in calculating the FY 2005 update factor (0.7 percent) slightly understated the actual realized price increases (0.8 percent) by 0.1 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed 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, we are making a 0.0 percent adjustment for forecast error in the update for FY 2007.

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 framework used in the past under the 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 in 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 to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, 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 within-DRG severity increases 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 1.0 to 1.4 percent per year. We use 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, the intensity adjustment for FY 2007 is based on data from the 5-year period FY 2001 through FY 2005. We found a dramatic increase in hospital charges for each of those 5 years without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals' charges, which we found when we were determining the intensity factor in the FY 2004, FY 2005 and FY 2006 update recommendations as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285) and the FY 2006 IPPS final rule (70 FR 47500), respectively. 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 in the FY 2006 IPPS final rule (70 FR 47500), 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 2006.

On June 9, 2003, we published 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 change 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. The increase in charges in FY 2004, for example, is approximately

12 percent, which, while less than the increase in the previous 3 years, is still much higher than increases in years prior to FY 2001. In addition, this approximate 12-percent increase in charges for FY 2004 significantly exceeds the case-mix increase for the same period. Based on the approximate 12-percent increase in charges for FY 2004, 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 hospitals may not have had enough time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2004 and FY 2005 charge data may still be skewed. 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 it still will be several years before all the effects of hospitals attempting to maximize outlier payments are removed from the intensity calculation. Therefore, as proposed, we are making a 0.0 percent adjustment for intensity for FY 2007. 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 2007 until any increase in charges 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 1.1 percent capital update factor for FY 2007 as shown in the table below.

CMS FY 2007 Update Factor to the Capital Federal Rate

Capital Input Price Index	1.1
Intensity:	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	1.0

Projected Case-Mix Change	-1.0
Subtotal	0.0
Effect of FY 2005 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.1

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2006 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2007. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 46). MedPAC reviews inpatient and outpatient services together because they are so closely interrelated. For FY 2007, MedPAC recommended an increase in the payment rate for the operating IPPS by the projected increase in the hospital market basket index, less half of MedPAC's expectation for productivity growth (or 0.45 percent, based on its assessment of beneficiaries' access to care and changes in hospital capacity, volume of services, access to capital, quality of care, and the relationship of Medicare payments and hospitals' costs.) In addition, MedPAC recommended combining the annual rate update with an incentive payment policy for quality. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2006, Section 2A.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier 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 DRG payments.

In the FY 2006 IPPS final rule (70 FR 47501), we estimated that outlier payments for capital would equal 4.85 percent of inpatient capital-related payments based on the capital Federal rate in FY 2006. Based on the tentative thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that tentative outlier payments for capital-related costs would equal 4.32 percent for inpatient capital-related payments based on the tentative Federal rate in FY 2007. Therefore, we are applying a tentative outlier adjustment factor of 0.9568 to the tentative capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2007 will be slightly lower than the percentages for FY 2006.

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 tentative FY 2007 outlier adjustment of 0.9568 is a 0.56 percent change from the FY 2006 outlier adjustment of 0.9515. Therefore, the net change in the tentative outlier adjustment to the tentative capital Federal rate for FY 2007 is 1.0056 (0.9568/0.9915). Thus, the outlier adjustment increases the tentative FY 2007 capital Federal rate by 0.56 percent compared with the FY 2006 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.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using 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 tentative factors for FY 2007, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to

estimated aggregate capital Federal rate payments based on the FY 2007 relative weights and the tentative FY 2007 GAF. As we established in the FY 2006 IPPS final rule (70 FR 47503), the budget neutrality factors were 0.9920 for the national capital rate and 0.9959 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 GAF, based on calculations using updated data, we are applying a tentative incremental budget neutrality adjustment of 1.0003 for FY 2007 to the previous cumulative FY 2006 adjustments of 0.9920, yielding a tentative adjustment of 0.9923, through FY 2007 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are applying a tentative incremental budget neutrality adjustment of 1.0021 for FY 2007 to the previous cumulative FY 2006 adjustment of 0.9959, yielding a tentative cumulative adjustment of 0.9980 through FY 2007.

We then compared estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to estimated aggregate capital Federal rate payments based on the FY 2007 DRG relative weights and the tentative FY 2007 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 0.9992 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the tentative GAF through FY 2007 are 0.9914 nationally and 0.9972 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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	1.00029[15]	0.99915	0.99943[15]	0.99142[15]	1.00213[15]	0.99915	1.00128[15]	0.99719[15]

[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 2007, as discussed above in section III. of this Addendum.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, 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 PPS, 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 serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the FY 2006 IPPS final rule (70 FR 47503), we calculated a GAF/DRG budget neutrality factor of 1.0008 for FY 2006. For FY 2007, we are establishing a tentative GAF/DRG budget neutrality factor of 0.9994. 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 from 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 GAF. The tentative incremental change in the adjustment from FY 2006 to FY 2007 is 0.9994. The tentative cumulative change in the capital Federal rate due to this adjustment is 0.9914 (the product of the incremental factors for FYs 1993 though 2006 and the

tentative incremental factor of 0.9994 for FY 2007). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the tentative cumulative adjustment of 0.9994 for FY 2007.)

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the tentative GAF of FY 2007 geographic reclassification decisions made by the MGCRB compared to FY 2006 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) 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 2007 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 will be 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 2007 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: (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). Because we have cost reports ending in FY 2005 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2005 from the December 2005 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six 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 2005, this ratio is rounded to 0.0003. Because we have not received all cost reports ending in FY 2005, we also divided the

FY 2005 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2004. This ratio also rounds to 0.0003. Because special exceptions are budget neutral, we are offsetting the tentative capital Federal rate by 0.03 percent for special exceptions payments for FY 2007. Therefore, the exceptions adjustment factor is equal to 0.9997 (1 - 0.0003) to account for special exceptions payments in FY 2007.

In the FY 2006 IPPS final rule (70 FR 47503), we estimated that total (special) exceptions payments for FY 2006 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) in determining the FY 2006 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2007 will equal 0.03 percent of aggregate payments based on the tentative FY 2007 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2007. The exceptions adjustment factor for FY 2007 is the same as the factor used in determining the FY 2006 capital Federal rate in the FY 2006 IPPS final rule (70 FR 47503). 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 tentative FY 2007 capital Federal rate is 1.0000 (0.9997/0.9997).

5. Capital Standard Federal Rate for FY 2007

In the FY 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In this final rule, we are establishing a tentative capital

Federal rate of $427.38 for FY 2007. The tentative capital Federal rate for FY 2007 was calculated as follows:

- The FY 2007 update factor is 1.0110; that is, the update is 1.1 percent.
- The tentative FY 2007 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9994.
- The tentative FY 2007 outlier adjustment factor is 0.9568.
- The FY 2007 (special) exceptions payment adjustment factor is 0.9997.

Because the tentative 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 tentative budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2007 affected the computation of the tentative FY 2007 capital Federal rate in comparison to the average FY 2006 capital Federal rate. The FY 2007 update factor has the effect of increasing the tentative capital Federal rate by 1.1 percent compared to the average FY 2006 Federal rate. The tentative GAF/DRG budget neutrality factor has the effect of decreasing the tentative capital Federal rate by 0.06 percent. The tentative FY 2007 outlier adjustment factor has the effect of increasing the tentative capital Federal rate by 0.56 percent compared to the average FY 2006 capital Federal rate. The FY 2007

exceptions payment adjustment factor remains unchanged from the FY 2006 exceptions payment adjustment factor, and therefore, has a 0.0 percent net effect on the tentative FY 2007 capital Federal rate. The combined effect of all the changes is to tentatively increase the capital Federal rate by 1.6 percent compared to the average FY 2006 capital Federal rate.

Comparison of Factors and Adjustments:
FY 2006 Capital Federal Rate and
FY 2007 Capital Federal Rate

	FY 2006	FY 2007	Change	Percent Change
Update Factor[1]	1.0080	1.0110	1.0110	1.10
GAF/DRG Adjustment Factor[1]	1.0008	0.9994[3]	0.9994	-0.06
Outlier Adjustment Factor[2]	0.9515	0.9568[3]	1.0056	0.56
Exceptions Adjustment Factor[2]	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$420.65	$427.38[3]	1.0160	1.60

[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 2006 to FY 2007 resulting from the application of the tentative 0.9994 GAF/DRG budget neutrality factor for FY 2007 is 0.9994

[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 tentative FY 2007 outlier adjustment factor would be 0.9568/0.9515, or 1.0056.

[3] Tentative factors for FY 2007, as discussed above in section III. of this Addendum.

We are also providing a chart that shows how the tentative final FY 2007 capital Federal rate differs from the proposed FY 2007 capital Federal rate presented in the FY 2007 IPPS proposed rule (71 FR 24158 - 24159).

Comparison of Factors and Adjustments:
Proposed FY 2007 Capital Federal Rate and
Tentative Final FY 2007 Capital Federal Rate

	Proposed FY 2007	Final FY 2007	Change	Percent Change
Update factor	1.0080	1.0110	1.0030	0.30
GAF/DRG Adjustment Factor	1.0012	0.9994*	0.9982	–0.18
Outlier Adjustment Factor	0.9513	0.9568*	1.0058	0.58
Exceptions Adjustment Factor	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$424.42	$427.38*	1.0070	0.70

* Tentative factors for FY 2007, as discussed above in section III. of this Addendum.

6. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, 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. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this final rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals 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. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the tentative GAF budget neutrality factor is 1.0021, while the DRG adjustment is0.9992, for a combined tentative cumulative adjustment of 0.9972.

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 Pub. L. 105-33. In FY 2003, a small part of that reduction was restored.

For FY 2006, before application of the GAF, the special capital rate for Puerto Rico hospitals was $201.93 for discharges occurring on or after October 1, 2005 through

September 30, 2006. With the changes we are making to the factors used to determine the capital rate, the tentative FY 2007 special capital rate for Puerto Rico is $203.13.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2007

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 2006. The applicable capital Federal rate was determined by making adjustments as follows:

- 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, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2007, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share 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 tentative outlier thresholds for FY 2007 are in section II.A.4.c. of this Addendum. For FY 2007, 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 DRG plus the tentative fixed-loss amount of $24,475.

An eligible hospital may also qualify for a special exceptions payment under §412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (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 PPS 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 prices 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 2007

Based on the latest forecast by Global Insight, Inc. (second quarter of 2006), we are forecasting the CIPI to increase 1.1 percent in FY 2007. This reflects a projected 1.7 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.1 percent increase in other capital expense prices in FY 2007, partially offset by a 2.1 percent decline in vintage-weighted interest expenses in FY 2007. The weighted average of these three factors produces the 1.1 percent increase for the CIPI as a whole in FY 2007.

The CIPI forecast of 1.1 percent is higher than the CIPI forecast of 0.8 percent that appeared in the proposed rule. This is mainly due to a change in the forecast of vintage-weighted depreciation prices from a 1.4 percent to a 1.7 percent increase and a change in vintage-weighted interest expenses from a 2.3 to a 2.1 percent decline. The change in the forecast for depreciation prices reflects the incorporation of newly available source data for fixed asset prices into the market basket, while the change in the forecast for interest expenses reflects the incorporation of recent increases in interest rates.

IV. Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

A. Payments to Existing Excluded Hospitals and Units

As discussed in section VI. of the preamble of this final rule, the inpatient operating costs of children's hospitals and cancer hospitals that are excluded from the IPPS are paid on the basis of reasonable cost subject to the rate-of-increase ceiling established under the authority of sections 1886(b)(3)(A)(i) and (ii) of the Act and §413.40 of the regulations. The ceiling is based on a target amount per discharge under TEFRA. In addition, in accordance with §403.752(a) of the regulations, RNHCIs also are paid under §413.40 which uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate of increase limits. The most recent projected forecast of the market basket percentage increase for FY 2007 for children's hospitals, cancer hospitals, and RNHCIs using the IPPS market basket (70 FR 47396 through 47405) is 3.4 percent (the same as we proposed).

LTCHs, rehabilitation hospitals and units, and psychiatric hospitals and units, historically, were excluded from the IPPS and subject to the rate-of-increase limits under §413.40, as well. However, prospective payment systems have been developed for each of the three types of hospitals, and each kind of hospital is currently paid under its own PPS, either at 100 percent of the Federal rate or according to a transition period methodology, if applicable. (For more detailed discussion of these payment methodologies, see 69 FR 49190; 69 FR 66922; 68 FR 45674; and 67 FR 55954.)

For cost reporting periods beginning on or after October 1, 2002, to the extent a LTCH or a psychiatric hospital or unit has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the blended payment are determined in accordance with sections 1886(b)(3)(A)(i) and 1886(b)(3)(B)(ii) of the Act and the regulations at §413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, "Subject to the provisions of [§413.40], paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of [§413.40] paragraph (c)(5)(ii) of this section apply." Thus, because §413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of §413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, the target amount for FY 2003 is determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount for FY 2002 (§413.40(c)(4)(iii)), the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor).

Effective for cost reporting periods beginning on or after October 1, 2002, IRFs are paid 100 percent of the adjusted Federal prospective payment rate under the IRP PPS.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. In implementing the LTCH PPS, an existing LTCH (that is, not defined as new

under §412.23(e)(4)) could have elected to be paid based on 100 percent of the standard Federal prospective payment rate during the transition period. However, we also established a 5-year transition period from reasonable cost-based payments (subject to the TEFRA limit) to fully Federal prospective payment amounts during which an existing LTCH could receive a PPS-blended payment consisting of two payment components--one based on reasonable cost under the TEFRA payment system, and the other based on the standard Federal prospective payment rate.

Effective for cost reporting periods that will begin on or after October 1, 2006, the LTCHs that receive payment based on a blended payment amount will no longer receive a portion of their payment that is based, in part, on reasonable cost subject to the rate-of-increase ceiling under §413.40. This is because, in accordance with §412.533, LTCHs are paid 100 percent of the adjusted Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles for cost reporting periods beginning on or after October 1, 2006.

As part of the PPS for existing IPFs, we have established a 3-year transition period during which existing IPFs will be paid based on a blend of reasonable cost-based payment (subject to the TEFRA limit) and the prospective per diem payment rate. IPFs that are paid under a blended methodology will have the reasonable cost-based portion of their payment subject to a hospital target amount. The most recent projected forecast of the market basket percentage increase for FY 2007 for the reasonable cost-based portion of an IPF's payment using the excluded hospital market basket (70 FR 47396 through

47405) is 3.4 percent. For cost reporting periods beginning on or after January l, 2008, IPFs will be paid 100 percent of the Federal prospective per diem amount.

The market basket percentage increases for FY 2007 are made by CMS' Office of the Actuary and reflect the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital care. They are based on the best available data. As discussed in section III.L. of the preamble of this FY 2006 IPPS final rule, we use the IPPS market basket for children's hospitals, cancer hospitals, and RNHCIs, and the excluded hospital market basket for LTCHs, and IPFs for the reasonable cost portion of its payment to the extent a portion of its PPS payment is based on reasonable costs. We did not propose any changes to our method of calculating the hospital market basket for IPPS or for excluded hospitals for FY 2007. Consistent with our current methodology of calculating the hospital market basket for IPPS and excluded hospitals, we use updated data for our final rule to the extent it is available. As we indicated above, based on updated data, the projected IPPS market basket increase is 3.4 percent (the same as we proposed) and the projected excluded hospital market basket increase is 3.4 percent (as opposed to 3.6 percent in the proposed rule) for FY 2007.

B. New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established a payment methodology for new (cost reporting periods beginning on or after October 1, 1997) rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs. For the first two 12-month cost reporting periods, payment was based on the lower of the hospital's net inpatient operating costs or 110 percent of the national median of target amounts for the particular

class of hospital for FY 1996, updated to the applicable cost reporting period, and adjusted for differences in area wage levels. Consequently, beginning with the FY 1998 IPPS final rule, we published annually in the Federal Register, the updated 110 percent median of the wage-neutral national target amounts, divided into the labor and nonlabor-related share, for each of the three classes of providers affected by the payment limitation. As explained in the FY 2006 IPPS final rule (70 FR 47466 through 47467), the charts containing the updated 110 percent median payment amount information are no longer needed and are discontinued.

V. Payment for Blood Clotting Factor Administered to Inpatient with Hemophilia

As discussed in section VIII. of the preamble to this final rule, in the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 48 CFR Part 414 and for the furnished fee as determined under §410.63.

In accordance with §410.63(c)(2) and our November 21, 2005 regulations (70 FR 70225), the furnishing fee for blood clotting factor for CY 2006 was determined to be $0.146 per individual unit (I.U.). Although the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits. In section VIII of the preamble to this final rule, we are providing that fiscal intermediaries continue to make payment amounts for blood clotting factor administered to hemophilia inpatients using the Medicare Part B payment amounts determined under

Subpart K of 42 CFR Part 414 and that payment amounts for the furnishing fee for the blood clotting factor be calculated at 3 digits, currently at $0.146 per I.U. of blood clotting factor.

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factors. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated quarterly. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer reader to the Medicare Part B drug pricing regulations.

VI. Tables

This section includes 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 2007 wage indices and the hospital reclassifications and payment amounts for operating and capital-related costs that are affected by the new occupational mix survey data discussed in section III.C. of this final rule, will be published on the CMS Web site and in a subsequent **Federal Register** notice between August 1 and October 1, 2006.

Table 2--Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2005; Hospital Wage Indexes for Federal Fiscal Year 2007; Hospital Average Hourly Wage for Federal Fiscal Years 2005 (2001 Wage Data), 2006 (2002 Wage Data), and 2007 (2003 Wage Data); Wage Indexes and 3-Year Average of Hospital Average Hourly Wages

Table 3A--FY 2007 and 3-Year Average Hourly Wage for Urban Areas by CBSA

Table 3B--FY 2007 and 3-Year Average Hourly Wage for Rural Areas by CBSA

Table 4A-1--Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA--FY 2007

Table 4A-2--Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Urban Areas by CBSA for the Period April 1 through September 30, 2007

Table 4B--Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA--FY 2007

Table 4C-1--Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA--FY 2007

Table 4C-2--Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Hospitals That Are Reclassified by CBSA for the Period April 1 through September 30, 2007

Table 4F--Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA--FY 2007

The following tables are included in this final rule as tentative tables and do not reflect decisions that are yet to be made by CMS pending the final calculation of the occupational mix adjusted wage index. Additional information appears with each table. Revised tables reflecting CMS' decisions on behalf of hospitals using occupational mix adjusted wage indices will be published on the CMS Web site, as well as in a subsequent **Federal Register** notice between August 1 and October 1, 2006.

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 4J--Out-Migration Adjustment--FY 2007

Table 5--List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS)

Table 9A--Hospital Reclassifications and Redesignations by Individual Hospitals and CBSA for FY 2007

Table 9B--Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108-173 for FY 2007

Table 9C--Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act for FY 2007

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 Diagnosis-Related Group (DRG)--July 2006

The following tables are final and not subject to revision based on the final calculation of the occupational mix adjusted wage index.

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 6G--Additions to the CC Exclusions List

Table 6H--Deletions from the CC Exclusions List

Table 7A--Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V23.0

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V24.0

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--July2006

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--July 2006

Table 8C--Statewide Average Total Cost-to-Charge Ratios for LTCHs--July 2006

Table 11--FY 2007 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

TABLE 1A.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, 69.7 PERCENT LABOR SHARE/30.3 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1

Full Update (3.4 percent) **Tentative** Labor Related Share: $3,400.13* **Tentative** Nonlabor Related Share: $1,478.10*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Reduced Update (1.4 percent) **Tentative** Labor Related Share: $3,334.36* **Tentative** Nonlabor Related Share: $1,449.51*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.

TABLE 1B.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1

Full Update (3.4 percent)
Tentative Labor Related Share: $3,024.51*
Tentative Nonlabor Related Share: $1,853.72*

*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.

Reduced Update (1.4 percent)
Tentative Labor Related Share: $2,966.00*
Tentative Nonlabor Related Share: $1,817.87*

*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.

TABLE 1C.--ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

Rates if wage index greater than one (National) **Tentative** Labor Related Share: $3,400.13* **Tentative** Nonlabor Related Share: $1,478.10*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Rates if wage index greater than one (Puerto Rico) **Tentative** Labor Related Share: $1,436.25* **Tentative** Nonlabor Related Share: $880.28*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Rates if wage index less than one (National) **Tentative** Labor Related Share: $3,024.51* **Tentative** Nonlabor Related Share: $1,853.72*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Rates if wage index less than one (Puerto Rico) **Tentative** Labor Related Share: $1,359.80* **Tentative** Nonlabor Related Share: $956.72*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

National **Tentative** Capital Payment Rate: $427.38*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Puerto Rico **Tentative** Capital Payment Rate: $203.13*	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.

TABLE 4J.--OUT-MIGRATION ADJUSTMENT --FY 2007

The following list represents all hospitals located in counties that became newly eligible in FY 2005 or FY 2006 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, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act for any portion of the fiscal year are designated with an asterisk. It is important to note that Table 4J is a tentative table and the asterisked information reflects the latest information available to CMS regarding MGCRB and Administrator reclassification decisions for FY 2007. It does not reflect any potential withdrawal decisions yet to be made by CMS or the hospitals. This table also does not reflect any additional hospitals located in counties that may newly qualify for the adjustment in FY 2007. We must reevaluate which counties are newly eligible for the out-migration adjustment in FY 2007 using the 100 percent occupational mix adjusted wage index data. A revised Table 4J reflecting CMS decisions on behalf of hospitals using occupational mix adjusted wage indices will be published in a subsequent **Federal Register** notice between August 1 and October 1, 2006. The subsequent **Federal Register** notice will also contain tables listing all interim reclassification/redesignations. Hospitals will then have 30 days from the date data appears on the CMS Web site to determine whether to submit a request to withdraw the reclassification/redesignation shown in such tables and receive the out-migration adjustment instead. Unless we are notified within 30 days of the data appearing on the CMS Web site, we will automatically assume that hospitals reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Hospitals are not required to provide CMS with any type of formal notification that they wish to remain reclassified/redesignated.

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
010005	*	*	0.0259	MARSHALL
010008	*	*	0.0212	CRENSHAW
010009	*	*	0.0092	MORGAN
010010			0.0259	MARSHALL
010012	*	*	0.0205	DE KALB
010022	*	*	0.0714	CHEROKEE
010025	*	*	0.0235	CHAMBERS
010029	*	*	0.0107	LEE
010035	*	*	0.0375	CULLMAN
010038			0.0062	CALHOUN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
010045	*	*	0.016	FAYETTE
010047			0.0155	BUTLER
010054	*	*	0.0092	MORGAN
010061			0.0506	JACKSON
010078			0.0062	CALHOUN
010083	*	*	0.0121	BALDWIN
010085	*	*	0.0092	MORGAN
010100	*	*	0.0121	BALDWIN
010101	*	*	0.031	TALLADEGA
010109			0.0451	PICKENS
010129			0.0121	BALDWIN
010143	*	*	0.0375	CULLMAN
010146			0.0062	CALHOUN
010150	*	*	0.0155	BUTLER
010158	*	*	0.0093	FRANKLIN
010164	*	*	0.031	TALLADEGA
040014	*	*	0.0159	WHITE
040019	*	*	0.0697	ST. FRANCIS
040047	*	*	0.009	RANDOLPH
040069	*	*	0.014	MISSISSIPPI
040071	*	*	0.0026	JEFFERSON
040076	*	*	0.1075	HOT SPRING
040100	*	*	0.0159	WHITE
050008			0.0026	SAN FRANCISCO
050009	*	*	0.0478	NAPA
050013	*	*	0.0478	NAPA
050014	*	*	0.0131	AMADOR
050016			0.0103	SAN LUIS OBISPO
050042	*	*	0.0219	TEHAMA
050046		*	0.0156	VENTURA
050047			0.0026	SAN FRANCISCO
050055			0.0026	SAN FRANCISCO
050065	*	*	0.0029	ORANGE
050069	*	*	0.0029	ORANGE
050073	*	*	0.0269	SOLANO
050076	*	*	0.0026	SAN FRANCISCO
050082		*	0.0156	VENTURA
050084			0.0555	SAN JOAQUIN
050089	*	*	0.0152	SAN BERNARDINO
050090	*	*	0.0308	SONOMA
050099	*	*	0.0152	SAN BERNARDINO
050101	*	*	0.0269	SOLANO
050117			0.0463	MERCED
050118	*	*	0.0555	SAN JOAQUIN
050122			0.0555	SAN JOAQUIN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
050129	*	*	0.0152	SAN BERNARDINO
050133			0.017	YUBA
050136	*	*	0.0308	SONOMA
050140	*	*	0.0152	SAN BERNARDINO
050150	*	*	0.0316	NEVADA
050152			0.0026	SAN FRANCISCO
050159		*	0.0156	VENTURA
050167			0.0555	SAN JOAQUIN
050168	*	*	0.0029	ORANGE
050173	*	*	0.0029	ORANGE
050174	*	*	0.0308	SONOMA
050193	*	*	0.0029	ORANGE
050224	*	*	0.0029	ORANGE
050226	*	*	0.0029	ORANGE
050228	*	*	0.0026	SAN FRANCISCO
050230	*	*	0.0029	ORANGE
050232			0.0103	SAN LUIS OBISPO
050236		*	0.0156	VENTURA
050245	*	*	0.0152	SAN BERNARDINO
050272	*	*	0.0152	SAN BERNARDINO
050279	*	*	0.0152	SAN BERNARDINO
050291	*	*	0.0308	SONOMA
050298	*	*	0.0152	SAN BERNARDINO
050300	*	*	0.0152	SAN BERNARDINO
050313			0.0555	SAN JOAQUIN
050325			0.0176	TUOLUMNE
050327	*	*	0.0152	SAN BERNARDINO
050335			0.0176	TUOLUMNE
050336			0.0555	SAN JOAQUIN
050348	*	*	0.0029	ORANGE
050367	*	*	0.0269	SOLANO
050385	*	*	0.0308	SONOMA
050394		*	0.0156	VENTURA
050407			0.0026	SAN FRANCISCO
050426	*	*	0.0029	ORANGE
050444			0.0463	MERCED
050454			0.0026	SAN FRANCISCO
050457			0.0026	SAN FRANCISCO
050469	*	*	0.0152	SAN BERNARDINO
050476			0.0257	LAKE
050494	*		0.0316	NEVADA
050506			0.0103	SAN LUIS OBISPO
050517	*	*	0.0152	SAN BERNARDINO
050526	*	*	0.0029	ORANGE
050528	*	*	0.0463	MERCED

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
050535	*	*	0.0029	ORANGE
050543	*	*	0.0029	ORANGE
050547	*	*	0.0308	SONOMA
050548	*	*	0.0029	ORANGE
050549		*	0.0156	VENTURA
050550	*	*	0.0029	ORANGE
050551	*	*	0.0029	ORANGE
050567	*	*	0.0029	ORANGE
050568			0.0062	MADERA
050570	*	*	0.0029	ORANGE
050580	*	*	0.0029	ORANGE
050584	*	*	0.0152	SAN BERNARDINO
050585	*	*	0.0029	ORANGE
050586	*	*	0.0152	SAN BERNARDINO
050589	*	*	0.0029	ORANGE
050592	*	*	0.0029	ORANGE
050594	*	*	0.0029	ORANGE
050603	*	*	0.0029	ORANGE
050609	*	*	0.0029	ORANGE
050616		*	0.0156	VENTURA
050618	*	*	0.0152	SAN BERNARDINO
050633			0.0103	SAN LUIS OBISPO
050667	*	*	0.0478	NAPA
050668			0.0026	SAN FRANCISCO
050678	*	*	0.0029	ORANGE
050680	*	*	0.0269	SOLANO
050690	*	*	0.0308	SONOMA
050693	*	*	0.0029	ORANGE
050695			0.0555	SAN JOAQUIN
050720	*	*	0.0029	ORANGE
050728	*	*	0.0308	SONOMA
050744			0.0029	ORANGE
050745			0.0029	ORANGE
050746			0.0029	ORANGE
050747			0.0029	ORANGE
050749		*	0.0156	VENTURA
060001	*	*	0.0294	WELD
060003	*	*	0.0203	BOULDER
060027	*	*	0.0203	BOULDER
060103	*	*	0.0203	BOULDER
060116			0.0203	BOULDER
070003	*	*	0.0009	WINDHAM
070006	*	*	0.0047	FAIRFIELD
070010	*	*	0.0047	FAIRFIELD
070018	*	*	0.0047	FAIRFIELD

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
070020			0.0073	MIDDLESEX
070021	*	*	0.0009	WINDHAM
070028	*	*	0.0047	FAIRFIELD
070033	*	*	0.0047	FAIRFIELD
070034	*	*	0.0047	FAIRFIELD
080001			0.0063	NEW CASTLE
080003			0.0063	NEW CASTLE
100014			0.0118	VOLUSIA
100017			0.0118	VOLUSIA
100045	*	*	0.0118	VOLUSIA
100047			0.0021	CHARLOTTE
100062			0.006	MARION
100068			0.0118	VOLUSIA
100072			0.0118	VOLUSIA
100077			0.0021	CHARLOTTE
100102			0.0125	COLUMBIA
100118	*	*	0.0398	FLAGLER
100156			0.0125	COLUMBIA
100175			0.0231	DE SOTO
100212			0.006	MARION
100232	*	*	0.0347	PUTNAM
100236			0.0021	CHARLOTTE
100252	*	*	0.0233	OKEECHOBEE
100290			0.0582	SUMTER
110023	*	*	0.05	GORDON
110027			0.0387	FRANKLIN
110029	*	*	0.0063	HALL
110041	*	*	0.0777	HABERSHAM
110069	*	*	0.0474	HOUSTON
110124			0.0428	WAYNE
110150	*	*	0.0261	BALDWIN
110153	*	*	0.0474	HOUSTON
110187	*	*	0.1172	LUMPKIN
110189	*	*	0.0031	FANNIN
110190			0.0182	MACON
110205	*	*	0.0779	GILMER
130003	*	*	0.0095	NEZ PERCE
130024			0.0275	BONNER
130049	*	*	0.0349	KOOTENAI
130066			0.0349	KOOTENAI
140012	*	*	0.022	LEE
140026			0.0346	LA SALLE
140033	*	*	0.0147	LAKE
140043	*	*	0.0046	WHITESIDE
140058	*	*	0.0081	MORGAN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
140084	*	*	0.0147	LAKE
140100	*	*	0.0147	LAKE
140110	*	*	0.0346	LA SALLE
140130	*	*	0.0147	LAKE
140155	*	*	0.0027	KANKAKEE
140160	*	*	0.0286	STEPHENSON
140161	*	*	0.0138	LIVINGSTON
140186	*	*	0.0027	KANKAKEE
140202	*	*	0.0147	LAKE
140205			0.0163	BOONE
140234	*	*	0.0346	LA SALLE
140291	*	*	0.0147	LAKE
150022			0.0249	MONTGOMERY
150030	*	*	0.0201	HENRY
150035			0.0083	PORTER
150045			0.0416	DE KALB
150065	*	*	0.0139	JACKSON
150076	*	*	0.0189	MARSHALL
150088	*	*	0.0196	MADISON
150091			0.0573	HUNTINGTON
150102	*	*	0.016	STARKE
150113	*	*	0.0196	MADISON
150122	*	*	0.0199	RIPLEY
160013			0.0218	MUSCATINE
160030			0.004	STORY
160032			0.0272	JASPER
160080	*	*	0.0049	CLINTON
170137	*	*	0.0336	DOUGLAS
180012	*	*	0.0083	HARDIN
180066	*	*	0.0567	LOGAN
180127	*	*	0.0352	FRANKLIN
180128			0.0282	LAWRENCE
190001	*	*	0.0645	WASHINGTON
190003	*	*	0.0107	IBERIA
190015	*	*	0.0401	TANGIPAHOA
190017			0.0235	ST. LANDRY
190054			0.0107	IBERIA
190078			0.0235	ST. LANDRY
190088			0.0705	WEBSTER
190099	*	*	0.039	AVOYELLES
190106	*	*	0.0238	ALLEN
190133			0.0238	ALLEN
190144			0.0705	WEBSTER
190184			0.0161	CALDWELL
190190			0.0161	CALDWELL

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
190191	*	*	0.0235	ST. LANDRY
190246			0.0161	CALDWELL
200002			0.0129	LINCOLN
200024	*	*	0.0071	ANDROSCOGGIN
200032			0.0466	OXFORD
200034	*	*	0.0071	ANDROSCOGGIN
200050	*	*	0.014	HANCOCK
210001			0.0129	WASHINGTON
210004			0.004	MONTGOMERY
210016			0.004	MONTGOMERY
210018			0.004	MONTGOMERY
210022			0.004	MONTGOMERY
210023			0.0209	ANNE ARUNDEL
210028			0.0512	ST. MARYS
210043			0.0209	ANNE ARUNDEL
210048			0.0287	HOWARD
210057			0.004	MONTGOMERY
220001	*	*	0.0056	WORCESTER
220002	*	*	0.0249	MIDDLESEX
220010	*	*	0.0306	ESSEX
220011	*	*	0.0249	MIDDLESEX
220019	*	*	0.0056	WORCESTER
220025	*	*	0.0056	WORCESTER
220028	*	*	0.0056	WORCESTER
220029	*	*	0.0306	ESSEX
220033	*	*	0.0306	ESSEX
220035	*	*	0.0306	ESSEX
220049	*	*	0.0249	MIDDLESEX
220058	*	*	0.0056	WORCESTER
220062	*	*	0.0056	WORCESTER
220063	*	*	0.0249	MIDDLESEX
220070	*	*	0.0249	MIDDLESEX
220080	*	*	0.0306	ESSEX
220082	*	*	0.0249	MIDDLESEX
220084	*	*	0.0249	MIDDLESEX
220089			0.0249	MIDDLESEX
220090	*	*	0.0056	WORCESTER
220095	*	*	0.0056	WORCESTER
220098	*	*	0.0249	MIDDLESEX
220101	*	*	0.0249	MIDDLESEX
220105	*	*	0.0249	MIDDLESEX
220163	*	*	0.0056	WORCESTER
220171	*	*	0.0249	MIDDLESEX
220174	*	*	0.0306	ESSEX
220176			0.0056	WORCESTER

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
230003	*	*	0.0035	OTTAWA
230013	*	*	0.0091	OAKLAND
230015			0.0359	ST. JOSEPH
230019	*	*	0.0091	OAKLAND
230021			0.0136	BERRIEN
230022	*	*	0.0113	BRANCH
230029	*	*	0.0091	OAKLAND
230037	*	*	0.0178	HILLSDALE
230041			0.0099	BAY
230047	*	*	0.0082	MACOMB
230069	*	*	0.0487	LIVINGSTON
230071	*	*	0.0091	OAKLAND
230072	*	*	0.0035	OTTAWA
230075			0.0145	CALHOUN
230078	*	*	0.0136	BERRIEN
230092	*	*	0.0389	JACKSON
230093	*	*	0.0079	MECOSTA
230096	*	*	0.0359	ST. JOSEPH
230099	*	*	0.0339	MONROE
230106	*		0.003	NEWAYGO
230121	*	*	0.0691	SHIAWASSEE
230130	*	*	0.0091	OAKLAND
230151	*	*	0.0091	OAKLAND
230174	*	*	0.0035	OTTAWA
230195	*	*	0.0082	MACOMB
230204	*	*	0.0082	MACOMB
230207	*	*	0.0091	OAKLAND
230217	*	*	0.0145	CALHOUN
230222			0.0228	MIDLAND
230223	*	*	0.0091	OAKLAND
230227	*	*	0.0082	MACOMB
230254	*	*	0.0091	OAKLAND
230257	*	*	0.0082	MACOMB
230264	*	*	0.0082	MACOMB
230269	*	*	0.0091	OAKLAND
230277	*	*	0.0091	OAKLAND
230279	*	*	0.0487	LIVINGSTON
240018	*	*	0.1196	GOODHUE
240044			0.0868	WINONA
240064	*	*	0.0138	ITASCA
240069	*	*	0.0419	STEELE
240071	*	*	0.0454	RICE
240187	*	*	0.0506	MC LEOD
240211	*	*	0.0705	PINE
250040	*	*	0.0294	JACKSON

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
260011	*	*	0.0007	COLE
260047	*	*	0.0007	COLE
260074	*	*	0.0158	RANDOLPH
260097			0.0425	JOHNSON
280077	*	*	0.0089	DODGE
280123			0.0137	GAGE
290019	*	*	0.0026	CARSON CITY
290049			0.0026	CARSON CITY
290051			0.0026	CARSON CITY
300011	*	*	0.0069	HILLSBOROUGH
300012	*	*	0.0069	HILLSBOROUGH
300017	*	*	0.0361	ROCKINGHAM
300020	*	*	0.0069	HILLSBOROUGH
300023	*	*	0.0361	ROCKINGHAM
300029	*	*	0.0361	ROCKINGHAM
300034	*	*	0.0069	HILLSBOROUGH
310002	*	*	0.0351	ESSEX
310009	*	*	0.0351	ESSEX
310010			0.0092	MERCER
310011			0.0115	CAPE MAY
310013	*	*	0.0351	ESSEX
310018	*	*	0.0351	ESSEX
310021	*	*	0.0092	MERCER
310038	*	*	0.035	MIDDLESEX
310039	*	*	0.035	MIDDLESEX
310044			0.0092	MERCER
310054	*	*	0.0351	ESSEX
310070	*	*	0.035	MIDDLESEX
310076	*	*	0.0351	ESSEX
310083	*	*	0.0351	ESSEX
310092			0.0092	MERCER
310093	*	*	0.0351	ESSEX
310096	*	*	0.0351	ESSEX
310108	*	*	0.035	MIDDLESEX
310110			0.0092	MERCER
310119	*	*	0.0351	ESSEX
310123			0.0351	ESSEX
310124			0.035	MIDDLESEX
320003			0.0629	SAN MIGUEL
320011			0.0442	RIO ARRIBA
320018			0.0063	DONA ANA
320085			0.0063	DONA ANA
330004	*	*	0.0959	ULSTER
330008	*	*	0.047	WYOMING
330027	*	*	0.0137	NASSAU

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
330094	*	*	0.0778	COLUMBIA
330106	*	*	0.0137	NASSAU
330126	*		0.056	ORANGE
330135	*		0.056	ORANGE
330167		*	0.0137	NASSAU
330181		*	0.0137	NASSAU
330182	*	*	0.0137	NASSAU
330191	*	*	0.0026	WARREN
330198		*	0.0137	NASSAU
330205	*		0.056	ORANGE
330224	*	*	0.0959	ULSTER
330225		*	0.0137	NASSAU
330235	*	*	0.027	CAYUGA
330259		*	0.0137	NASSAU
330264	*		0.056	ORANGE
330276			0.0063	FULTON
330331		*	0.0137	NASSAU
330332		*	0.0137	NASSAU
330372		*	0.0137	NASSAU
330386	*	*	0.1139	SULLIVAN
340015			0.0267	ROWAN
340020			0.0207	LEE
340021	*	*	0.0216	CLEVELAND
340037			0.0216	CLEVELAND
340039	*	*	0.0144	IREDELL
340069	*	*	0.0053	WAKE
340070	*	*	0.0448	ALAMANCE
340073	*	*	0.0053	WAKE
340085			0.0377	DAVIDSON
340096			0.0377	DAVIDSON
340104			0.0216	CLEVELAND
340114	*	*	0.0053	WAKE
340126	*	*	0.0161	WILSON
340127	*	*	0.0961	GRANVILLE
340129	*	*	0.0144	IREDELL
340133			0.0308	MARTIN
340138	*	*	0.0053	WAKE
340144	*	*	0.0144	IREDELL
340145	*	*	0.0563	LINCOLN
340173	*	*	0.0053	WAKE
360013	*	*	0.0166	SHELBY
360025	*	*	0.0087	ERIE
360036	*	*	0.0263	WAYNE
360065	*	*	0.0141	HURON
360070			0.0028	STARK

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
360078	*	*	0.0159	PORTAGE
360084	*	*	0.0028	STARK
360086	*	*	0.0168	CLARK
360095	*	*	0.0087	HANCOCK
360100			0.0028	STARK
360107	*	*	0.0213	SANDUSKY
360131			0.0028	STARK
360151			0.0028	STARK
360156			0.0213	SANDUSKY
360175	*	*	0.0159	CLINTON
360187	*	*	0.0168	CLARK
360197	*	*	0.0092	LOGAN
360270			0.012	DEFIANCE
370004	*	*	0.0193	OTTAWA
370014	*	*	0.0831	BRYAN
370015	*	*	0.0463	MAYES
370023			0.0084	STEPHENS
370065			0.0121	CRAIG
370113	*	*	0.0205	DELAWARE
370149			0.0356	POTTAWATOMIE
370219			0.0356	POTTAWATOMIE
380002			0.013	JOSEPHINE
380022	*	*	0.0201	LINN
380029			0.0075	MARION
380051			0.0075	MARION
380056			0.0075	MARION
390011			0.0012	CAMBRIA
390044	*	*	0.02	BERKS
390046	*	*	0.0098	YORK
390056			0.0042	HUNTINGDON
390065	*	*	0.0501	ADAMS
390066	*	*	0.0259	LEBANON
390096	*	*	0.02	BERKS
390101			0.0098	YORK
390110	*	*	0.0012	CAMBRIA
390130			0.0012	CAMBRIA
390138	*	*	0.0325	FRANKLIN
390146			0.0053	WARREN
390150	*	*	0.0206	GREENE
390151	*	*	0.0325	FRANKLIN
390162			0.02	NORTHAMPTON
390201	*	*	0.1127	MONROE
390233			0.0098	YORK
420007	*	*	0.0001	SPARTANBURG
420020	*	*	0.0035	GEORGETOWN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
420027	*	*	0.021	ANDERSON
420030	*	*	0.0103	COLLETON
420039	*	*	0.0153	UNION
420043			0.0177	CHEROKEE
420068	*	*	0.0097	ORANGEBURG
420070	*	*	0.0101	SUMTER
420083	*	*	0.0001	SPARTANBURG
420098			0.0035	GEORGETOWN
440008	*	*	0.0663	HENDERSON
440024	*	*	0.0387	BRADLEY
440030			0.0056	HAMBLEN
440035	*	*	0.0441	MONTGOMERY
440047			0.0499	GIBSON
440056	*	*	0.0321	JEFFERSON
440060	*	*	0.0499	GIBSON
440063			0.0011	WASHINGTON
440067	*	*	0.0056	HAMBLEN
440073	*	*	0.0513	MAURY
440105			0.0011	WASHINGTON
440115			0.0499	GIBSON
440148	*	*	0.0568	DE KALB
440153			0.0007	COCKE
440174			0.0372	HAYWOOD
440181			0.0407	HARDEMAN
440184			0.0011	WASHINGTON
440185	*	*	0.0387	BRADLEY
450032	*	*	0.0416	HARRISON
450039	*	*	0.0097	TARRANT
450059	*	*	0.0073	COMAL
450064	*	*	0.0097	TARRANT
450087	*	*	0.0097	TARRANT
450099	*	*	0.018	GRAY
450121	*	*	0.0097	TARRANT
450135	*	*	0.0097	TARRANT
450137	*	*	0.0097	TARRANT
450144	*	*	0.0573	ANDREWS
450163			0.0134	KLEBERG
450187	*	*	0.0264	WASHINGTON
450194	*	*	0.0328	CHEROKEE
450214	*	*	0.0368	WHARTON
450224	*	*	0.0411	WOOD
450347	*	*	0.0427	WALKER
450370			0.0258	COLORADO
450389	*	*	0.0881	HENDERSON
450395	*	*	0.0484	POLK

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
450419	*	*	0.0097	TARRANT
450438	*	*	0.0258	COLORADO
450447	*	*	0.0358	NAVARRO
450451	*	*	0.0551	SOMERVELL
450465			0.0435	MATAGORDA
450547	*	*	0.0411	WOOD
450563	*	*	0.0097	TARRANT
450565			0.0486	PALO PINTO
450596			0.0808	HOOD
450597			0.0077	DE WITT
450639	*	*	0.0097	TARRANT
450672	*	*	0.0097	TARRANT
450675	*	*	0.0097	TARRANT
450677	*	*	0.0097	TARRANT
450694	*	*	0.0368	WHARTON
450747	*	*	0.0195	ANDERSON
450755	*	*	0.0484	HOCKLEY
450779	*	*	0.0097	TARRANT
450813	*	*	0.0195	ANDERSON
450872	*	*	0.0097	TARRANT
450880	*	*	0.0097	TARRANT
450886			0.0097	TARRANT
450888			0.0097	TARRANT
460017			0.0392	BOX ELDER
460039	*	*	0.0392	BOX ELDER
490019			0.124	CULPEPER
490038			0.0022	SMYTH
490084			0.0167	ESSEX
490105	*	*	0.0022	SMYTH
490110			0.0082	MONTGOMERY
500003	*	*	0.0208	SKAGIT
500007			0.0208	SKAGIT
500019			0.0213	LEWIS
500021	*	*	0.0055	PIERCE
500024	*	*	0.0023	THURSTON
500039	*	*	0.0174	KITSAP
500041	*	*	0.0118	COWLITZ
500079	*	*	0.0055	PIERCE
500108	*	*	0.0055	PIERCE
500129	*	*	0.0055	PIERCE
500139	*	*	0.0023	THURSTON
500143	*	*	0.0023	THURSTON
510018	*	*	0.0209	JACKSON
510039			0.0112	OHIO
510047	*	*	0.0275	MARION

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
510050			0.0112	OHIO
510077	*	*	0.0021	MINGO
520028	*	*	0.0157	GREEN
520035			0.0077	SHEBOYGAN
520044			0.0077	SHEBOYGAN
520057			0.0118	SAUK
520059	*	*	0.02	RACINE
520071	*	*	0.0239	JEFFERSON
520095	*	*	0.0118	SAUK
520096	*	*	0.02	RACINE
520102	*	*	0.0298	WALWORTH
520116	*	*	0.0239	JEFFERSON
520132			0.0077	SHEBOYGAN

NOTE: The following Table 5 is a tentative table. The final Table 5 will be published in a subsequent Federal Register notice.

TABLE 5.-- LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
1	Yes	No	01	SURG	CRANIOTOMY AGE >17 W CC	3.4574	7.3	9.8
2	Yes	No	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9490	3.4	4.4
3	No	No	01	SURG *	CRANIOTOMY AGE 0-17	2.0113	8.8	11.0
4	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
5	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
6	No	No	01	SURG	CARPAL TUNNEL RELEASE	0.7915	2.1	3.1
7	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6576	6.5	9.4
8	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5943	2.0	2.8
9	No	No	01	MED	SPINAL DISORDERS & INJURIES	1.3619	4.4	6.2
10	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2544	4.6	6.0
11	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8577	2.7	3.6
12	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9324	4.3	5.5
13	Yes	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8543	4.0	4.9
14	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	1.2110	4.3	5.5
15	Yes	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9446	3.1	4.1
16	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.3552	5.0	6.4
17	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.7140	2.4	3.1
18	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0043	4.1	5.2
19	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7198	2.7	3.4
20	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0
21	No	No	01	MED	VIRAL MENINGITIS	1.4131	4.7	6.2
22	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.1638	3.9	5.0
23	No	No	01	MED	NONTRAUMATIC STUPOR & COMA	0.7970	3.0	3.9
24	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0
25	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
26	No	No	01	MED	SEIZURE & HEADACHE AGE 0-17	1.0022	2.7	3.8
27	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3491	3.1	4.8
28	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3343	4.2	5.7
29	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7395	2.6	3.2
30	No	No	01	MED *	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3402	*	*
31	No	No	01	MED	CONCUSSION AGE >17 W CC	0.9792	3.0	3.9
32	No	No	01	MED	CONCUSSION AGE >17 W/O CC	0.6386	1.9	2.3
33	No	No	01	MED *	CONCUSSION AGE 0-17	0.2136	*	*
34	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0165	3.6	4.8
35	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6584	2.5	3.1
36	No	No	02	SURG	RETINAL PROCEDURES	0.8042	1.4	1.8
37	No	No	02	SURG	ORBITAL PROCEDURES	1.2028	2.7	4.1
38	No	No	02	SURG	PRIMARY IRIS PROCEDURES	0.6191	2.2	2.8
39	No	No	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6422	1.5	2.0
40	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.0277	3.0	4.1
41	No	No	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3462	*	*
42	No	No	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7670	1.7	2.4
43	No	No	02	MED	HYPHEMA	0.6168	2.4	3.0
44	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS	0.7164	3.8	4.8
45	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7438	2.5	3.0
46	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7903	3.2	4.2
47	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5515	2.4	3.0
48	No	No	02	MED *	OTHER DISORDERS OF THE EYE AGE 0-17	0.3050	*	*
49	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.6654	3.2	4.5
50	No	No	03	SURG	SIALOADENECTOMY	0.8801	1.5	1.9
51	No	No	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8789	1.9	2.7
52	No	No	03	SURG	CLEFT LIP & PALATE REPAIR	0.6502	1.3	1.5
53	No	No	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.3532	2.5	4.0
54	No	No	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17	0.4944	*	*

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
55	No	No	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9649	1.9	2.9
56	No	No	03	SURG	RHINOPLASTY	0.8933	1.9	2.7
57	No	No	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9965	2.1	3.2
58	No	No	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2807	*	*
59	No	No	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6831	1.8	2.4
60	No	No	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2137	1.4	1.7
61	No	No	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.5991	3.7	6.1
62	No	No	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.3027	1.3	1.5
63	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3933	3.0	4.6
64	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2496	4.2	6.2
65	No	No	03	MED	DYSEQUILIBRIUM	0.6155	2.3	2.8
66	No	No	03	MED	EPISTAXIS	0.6279	2.4	3.1
67	No	No	03	MED	EPIGLOTTITIS	0.8244	2.8	3.7
68	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6614	3.1	3.8
69	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4920	2.5	3.0
70	No	No	03	MED	OTITIS MEDIA & URI AGE 0-17	0.3556	2.1	2.4
71	No	No	03	MED	LARYNGOTRACHEITIS	0.7755	3.4	4.4
72	No	No	03	MED	NASAL TRAUMA & DEFORMITY	0.7749	2.6	3.3
73	Yes	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8502	3.3	4.3
74	No	No	03	MED *	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3441	3.3	3.3
75	Yes	No	04	SURG	MAJOR CHEST PROCEDURES	3.0340	7.4	9.7
76	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8356	8.2	10.7
77	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1894	3.3	4.5
78	Yes	No	04	MED	PULMONARY EMBOLISM	1.2364	5.3	6.2
79	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6262	6.7	8.3
80	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8949	4.3	5.3
81	No	No	04	MED *	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5579	5.2	6.2
82	Yes	No	04	MED	RESPIRATORY NEOPLASMS	1.4114	5.1	6.8

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
83	Yes	No	04	MED	MAJOR CHEST TRAUMA W CC	1.0306	4.2	5.3
84	Yes	No	04	MED	MAJOR CHEST TRAUMA W/O CC	0.6028	2.6	3.1
85	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.2457	4.7	6.2
86	Yes	No	04	MED	PLEURAL EFFUSION W/O CC	0.7124	2.7	3.5
87	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3835	4.9	6.4
88	No	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.8884	3.9	4.9
89	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0376	4.6	5.6
90	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6155	3.2	3.7
91	No	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.5608	2.5	3.4
92	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1977	4.8	6.0
93	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7445	3.0	3.8
94	No	No	04	MED	PNEUMOTHORAX W CC	1.1474	4.5	5.9
95	No	No	04	MED	PNEUMOTHORAX W/O CC	0.5880	2.7	3.4
96	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7355	3.5	4.3
97	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5431	2.8	3.4
98	No	No	04	MED	BRONCHITIS & ASTHMA AGE 0-17	0.5837	2.8	3.1
99	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7155	2.4	3.1
100	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5409	1.7	2.1
101	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8614	3.2	4.2
102	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5625	2.0	2.5
103	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	18.8897	22.2	35.4
104	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	8.2784	12.8	15.1
105	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	6.0509	8.4	10.2
106	No	No	05	SURG	CORONARY BYPASS W PTCA	6.7434	9.3	10.9
107	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
108	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7539	8.8	10.9
109	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
110	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	3.8050	5.4	8.1

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
111	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4890	2.3	3.1
112	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	Yes	No	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.2627	10.8	13.7
114	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.7522	6.6	8.7
115	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
116	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
117	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3693	2.7	4.3
118	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6689	2.0	3.0
119	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.4512	3.3	5.4
120	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.4145	6.0	9.2
121	Yes	No	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.6161	5.2	6.5
122	No	No	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.9626	2.7	3.4
123	No	No	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4884	2.9	4.7
124	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4098	3.3	4.4
125	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.0537	2.1	2.7
126	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6622	9.0	11.3
127	Yes	No	05	MED	HEART FAILURE & SHOCK	1.0485	4.1	5.1
128	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.7499	4.3	5.2
129	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0103	1.6	2.5
130	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9709	4.3	5.5
131	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5755	3.1	3.7
132	No	No	05	MED	ATHEROSCLEROSIS W CC	0.6318	2.2	2.8
133	No	No	05	MED	ATHEROSCLEROSIS W/O CC	0.5482	1.8	2.1
134	No	No	05	MED	HYPERTENSION	0.6193	2.5	3.1
135	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9404	3.3	4.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
136	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.6572	2.1	2.7
137	No	No	05	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8393	*	*
138	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8363	3.0	3.9
139	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5297	2.0	2.4
140	No	No	05	MED	ANGINA PECTORIS	0.5044	1.9	2.4
141	No	No	05	MED	SYNCOPE & COLLAPSE W CC	0.7627	2.7	3.4
142	No	No	05	MED	SYNCOPE & COLLAPSE W/O CC	0.6003	2.1	2.5
143	No	No	05	MED	CHEST PAIN	0.5635	1.7	2.1
144	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.3365	4.2	5.9
145	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5838	2.0	2.6
146	Yes	No	06	SURG	RECTAL RESECTION W CC	2.7392	8.4	9.9
147	Yes	No	06	SURG	RECTAL RESECTION W/O CC	1.5121	4.9	5.6
148	No	No	06	SURG	NO LONGER VALID	0.0000	0.0	0.0
149	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4364	5.1	5.7
150	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7852	8.7	10.8
151	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2867	4.0	5.0
152	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8876	6.5	7.9
153	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0973	4.4	4.9
154	No	No	06	SURG	NO LONGER VALID	0.0000	0.0	0.0
155	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.2959	3.0	4.0
156	No	No	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8644	8.9	9.3
157	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3421	4.1	5.7
158	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6588	2.1	2.7
159	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.4316	3.7	5.1
160	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8676	2.2	2.7
161	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.2405	3.2	4.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
162	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6918	1.7	2.1
163	No	No	06	SURG *	HERNIA PROCEDURES AGE 0-17	0.6809	2.0	2.4
164	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.1484	6.4	7.7
165	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.1853	3.4	4.0
166	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4020	3.2	4.3
167	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.9001	1.8	2.1
168	No	No	03	SURG	MOUTH PROCEDURES W CC	1.2829	3.3	4.8
169	No	No	03	SURG	MOUTH PROCEDURES W/O CC	0.7682	1.8	2.3
170	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.9902	7.8	10.9
171	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2243	3.1	4.2
172	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.4280	5.1	6.9
173	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7645	2.7	3.6
174	No	No	06	MED	G.I. HEMORRHAGE W CC	1.0295	3.8	4.7
175	No	No	06	MED	G.I. HEMORRHAGE W/O CC	0.5806	2.4	2.9
176	Yes	No	06	MED	COMPLICATED PEPTIC ULCER	1.1269	4.0	5.1
177	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9347	3.6	4.4
178	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6911	2.6	3.1
179	No	No	06	MED	INFLAMMATORY BOWEL DISEASE	1.0814	4.5	5.8
180	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9925	4.1	5.3
181	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC	0.5784	2.8	3.3
182	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7855	3.2	4.1
183	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5847	2.3	2.8
184	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6196	2.5	3.7
185	No	No	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8883	3.3	4.5
186	No	No	03	MED *	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3294	2.6	3.1
187	No	No	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.8425	3.1	4.2

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
188	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0922	4.0	5.4
189	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5913	2.4	3.0
190	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.6336	2.3	3.0
191	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	3.9330	8.8	12.5
192	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6747	4.2	5.5
193	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.3813	10.1	12.6
194	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.5875	5.4	6.4
195	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0519	8.8	10.6
196	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5458	4.6	5.4
197	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.5503	7.4	9.1
198	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1793	3.7	4.3
199	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.2333	6.4	9.0
200	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.8319	6.5	10.3
201	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7826	10.0	13.6
202	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3383	4.6	6.2
203	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3632	4.8	6.5
204	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0989	4.1	5.4
205	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2005	4.4	5.9
206	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7288	3.0	3.8
207	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1824	4.1	5.3
208	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6875	2.4	3.0
209	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
210	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.9021	5.9	6.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
211	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2936	4.3	4.6
212	No	No	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.9192	2.2	2.5
213	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	2.1167	7.1	9.6
214	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	Yes	No	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.8776	3.1	5.4
217	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0479	9.0	12.9
218	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.7057	4.4	5.5
219	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.1034	2.7	3.2
220	No	No	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.5988	2.6	4.0
221	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	No	No	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1727	2.4	3.3
224	No	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.8582	1.6	1.9
225	Yes	No	08	SURG	FOOT PROCEDURES	1.2775	3.8	5.4
226	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6305	4.6	6.5
227	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8615	2.1	2.6
228	No	No	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1538	2.9	4.2
229	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7217	2.0	2.5
230	No	No	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3375	3.6	5.4
231	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
232	No	No	08	SURG	ARTHROSCOPY	0.9721	1.9	2.7
233	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9028	4.3	6.4
234	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.2580	1.9	2.7
235	Yes	No	08	MED	FRACTURES OF FEMUR	0.8214	3.8	4.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
236	Yes	No	08	MED	FRACTURES OF HIP & PELVIS	0.7685	3.8	4.6
237	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6569	3.0	3.8
238	Yes	No	08	MED	OSTEOMYELITIS	1.4081	6.5	8.4
239	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.1194	4.9	6.2
240	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3782	4.9	6.5
241	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6637	3.0	3.7
242	No	No	08	MED	SEPTIC ARTHRITIS	1.1006	5.1	6.6
243	No	No	08	MED	MEDICAL BACK PROBLEMS	0.7967	3.6	4.5
244	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7390	3.6	4.5
245	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4941	2.5	3.1
246	No	No	08	MED	NON-SPECIFIC ARTHROPATHIES	0.6312	2.8	3.6
247	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5932	2.6	3.3
248	No	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8873	3.8	4.8
249	No	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7501	2.8	4.0
250	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.7223	3.2	3.9
251	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.5119	2.3	2.8
252	No	No	08	MED *	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2600	*	*
253	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8175	3.8	4.6
254	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4974	2.6	3.1
255	No	No	08	MED *	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.3028	*	*
256	Yes	No	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8715	3.9	5.0
257	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9123	2.0	2.6

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
258	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7137	1.5	1.7
259	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	1.0057	1.8	2.8
260	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6812	1.2	1.4
261	No	No	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.9527	1.6	2.2
262	No	No	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9647	3.2	4.6
263	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.1206	8.3	11.1
264	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0990	4.9	6.5
265	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.6950	4.2	6.7
266	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.9141	2.2	3.1
267	No	No	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9444	2.9	4.2
268	No	No	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2209	2.4	3.6
269	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7923	6.0	8.3
270	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8211	2.7	3.6
271	Yes	No	09	MED	SKIN ULCERS	1.0752	5.6	7.1
272	Yes	No	09	MED	MAJOR SKIN DISORDERS W CC	1.0312	4.5	5.9
273	Yes	No	09	MED	MAJOR SKIN DISORDERS W/O CC	0.5861	3.0	3.7
274	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1327	4.5	6.2
275	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5925	2.4	3.3
276	No	No	09	MED	NON-MALIGANT BREAST DISORDERS	0.7422	3.6	4.6
277	Yes	No	09	MED	CELLULITIS AGE >17 W CC	0.8950	4.5	5.5
278	Yes	No	09	MED	CELLULITIS AGE >17 W/O CC	0.5644	3.4	4.0
279	No	No	09	MED *	CELLULITIS AGE 0-17	0.7922	3.2	3.7
280	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7716	3.2	4.0
281	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5206	2.3	2.8
282	No	No	09	MED *	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2633	*	*

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
283	Yes	No	09	MED	MINOR SKIN DISORDERS W CC	0.7603	3.4	4.6
284	Yes	No	09	MED	MINOR SKIN DISORDERS W/O CC	0.4585	2.3	2.9
285	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.1773	8.1	10.3
286	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES	1.9074	3.8	5.2
287	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.9509	7.6	9.9
288	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY	1.9136	2.9	3.7
289	No	No	10	SURG	PARATHYROID PROCEDURES	0.9232	1.6	2.4
290	No	No	10	SURG	THYROID PROCEDURES	0.8811	1.5	2.0
291	No	No	10	SURG	THYROGLOSSAL PROCEDURES	0.5837	1.3	1.5
292	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.6914	7.3	10.2
293	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3891	3.5	4.8
294	Yes	No	10	MED	DIABETES AGE >35	0.7861	3.3	4.3
295	No	No	10	MED	DIABETES AGE 0-35	0.7652	2.8	3.7
296	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8334	3.6	4.7
297	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5090	2.5	3.0
298	No	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5753	2.5	3.5
299	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0480	3.8	5.1
300	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.1175	4.6	5.9
301	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC	0.6208	2.7	3.4
302	No	No	11	SURG	KIDNEY TRANSPLANT	3.1125	6.7	7.9
303	No	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.9755	5.0	6.3
304	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3454	5.8	8.3
305	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1521	2.5	3.0
306	No	No	11	SURG	PROSTATECTOMY W CC	1.3360	3.6	5.6
307	No	No	11	SURG	PROSTATECTOMY W/O CC	0.6414	1.7	2.0
308	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4570	3.3	5.3
309	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.9018	1.4	1.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
310	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2129	3.1	4.5
311	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6543	1.5	1.9
312	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.1767	3.3	4.9
313	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.7454	1.8	2.4
314	No	No	11	SURG *	URETHRAL PROCEDURES, AGE 0-17	0.5076	29.4	89.0
315	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.1139	3.7	6.8
316	Yes	No	11	MED	RENAL FAILURE	1.2596	4.8	6.3
317	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8067	2.4	3.5
318	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.2348	4.4	6.0
319	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6066	1.9	2.6
320	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8766	4.1	5.1
321	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5793	3.0	3.6
322	No	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.6171	3.1	3.6
323	No	No	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8266	2.3	3.1
324	No	No	11	MED	URINARY STONES W/O CC	0.5059	1.6	1.8
325	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6901	2.9	3.7
326	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4540	2.1	2.6
327	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.2115	1.8	2.0
328	No	No	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7276	2.6	3.4
329	No	No	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.5212	1.4	1.7
330	No	No	11	MED *	URETHRAL STRICTURE AGE 0-17	0.3268	*	*
331	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0958	4.2	5.5
332	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6256	2.4	3.1
333	No	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	1.0207	3.7	5.4
334	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4176	3.3	4.0
335	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1139	2.2	2.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
336	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8570	2.4	3.2
337	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5869	1.6	1.8
338	No	No	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.3786	3.8	5.8
339	No	No	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.2550	3.3	5.2
340	No	No	12	SURG *	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2904	*	*
341	No	No	12	SURG	PENIS PROCEDURES	1.3394	1.9	3.2
342	No	No	12	SURG	CIRCUMCISION AGE >17	0.8117	2.3	3.0
343	No	No	12	SURG *	CIRCUMCISION AGE 0-17	0.1579	*	*
344	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2119	1.7	2.7
345	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.3011	3.4	5.4
346	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0720	4.5	5.9
347	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5399	2.0	2.7
348	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7434	3.1	4.0
349	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4607	2.1	2.6
350	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7762	3.6	4.5
351	No	No	12	MED *	STERILIZATION, MALE	0.2422	*	*
352	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7822	3.0	4.2
353	No	No	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8132	4.5	6.0
354	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4947	4.5	5.6
355	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.9058	2.8	3.0
356	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7571	1.6	1.9
357	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.2244	6.4	8.0
358	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1414	3.1	3.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
359	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8052	2.1	2.3
360	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8808	2.0	2.5
361	No	No	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0637	2.1	3.0
362	No	No	13	SURG *	ENDOSCOPIC TUBAL INTERRUPTION	0.3096	1.0	1.0
363	No	No	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	1.0996	2.9	4.2
364	No	No	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.8911	2.7	3.8
365	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0516	5.3	7.9
366	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2461	4.6	6.3
367	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5876	2.3	3.1
368	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1640	5.0	6.4
369	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.6577	2.5	3.3
370	No	No	14	SURG	CESAREAN SECTION W CC	0.9008	4.1	5.0
371	No	No	14	SURG	CESAREAN SECTION W/O CC	0.6568	3.1	3.4
372	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5654	2.7	3.4
373	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3912	2.1	2.3
374	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6517	2.4	3.0
375	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1244	4.0	6.2
376	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6173	2.5	3.3
377	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.2520	3.2	4.5
378	No	No	14	MED	ECTOPIC PREGNANCY	0.7182	1.8	2.2
379	No	No	14	MED	THREATENED ABORTION	0.4135	2.2	3.3
380	No	No	14	MED	ABORTION W/O D&C	0.4408	1.5	2.0
381	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7091	1.7	2.4
382	No	No	14	MED	FALSE LABOR	0.1814	1.3	1.5
383	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5102	2.6	3.6
384	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3792	1.7	2.6

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
385	No	No	15	MED *	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4107	*	*
386	No	No	15	MED *	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.6519	*	*
387	No	No	15	MED *	PREMATURITY W MAJOR PROBLEMS	3.1771	*	*
388	No	No	15	MED *	PREMATURITY W/O MAJOR PROBLEMS	1.9170	*	*
389	No	No	15	MED *	FULL TERM NEONATE W MAJOR PROBLEMS	3.2636	3.4	6.8
390	No	No	15	MED *	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1551	*	*
391	No	No	15	MED *	NORMAL NEWBORN	0.1564	*	*
392	No	No	16	SURG	SPLENECTOMY AGE >17	3.0233	6.3	8.9
393	No	No	16	SURG *	SPLENECTOMY AGE 0-17	1.3819	*	*
394	No	No	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.9302	4.5	7.3
395	Yes	No	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.7988	3.1	4.1
396	No	No	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.6647	2.6	3.1
397	No	No	16	MED	COAGULATION DISORDERS	1.3280	3.7	5.1
398	Yes	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.1253	4.1	5.5
399	Yes	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6720	2.6	3.2
400	No	No	17	SURG	NO LONGER VALID	0.0000	0.0	0.0
401	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.9657	8.1	11.3
402	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.1614	2.8	3.9
403	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8609	5.7	8.0
404	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.9229	3.0	4.1
405	No	No	17	MED *	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9592	*	*
406	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7165	6.7	9.4
407	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1529	2.8	3.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
408	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.1595	5.1	8.2
409	No	No	17	MED	RADIOTHERAPY	1.2841	4.5	6.0
410	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.0901	2.9	3.8
411	No	No	17	MED *	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3681	1.6	2.0
412	No	No	17	MED *	HISTORY OF MALIGNANCY W ENDOSCOPY	0.8559	1.5	1.6
413	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3352	5.0	6.8
414	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7666	3.0	4.1
415	No	No	18	SURG	NO LONGER VALID	0.0000	0.0	0.0
416	No	No	18	MED	NO LONGER VALID	0.0000	0.0	0.0
417	No	No	18	MED	SEPTICEMIA AGE 0-17	1.8734	5.2	6.5
418	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0997	4.7	6.1
419	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8616	3.4	4.4
420	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5963	2.6	3.2
421	No	No	18	MED	VIRAL ILLNESS AGE >17	0.7748	3.1	4.0
422	No	No	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6150	2.6	3.7
423	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8370	5.9	8.2
424	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.2452	7.4	11.5
425	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6304	2.6	3.5
426	No	No	19	MED	DEPRESSIVE NEUROSES	0.5125	3.1	4.3
427	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5578	3.2	4.7
428	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7791	4.5	7.3
429	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8390	4.3	5.7
430	Yes	No	19	MED	PSYCHOSES	0.7266	5.8	8.0
431	No	No	19	MED	CHILDHOOD MENTAL DISORDERS	0.6736	4.2	6.8
432	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6601	2.7	4.0
433	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3277	2.1	2.9
434	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
437	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
439	No	No	21	SURG	SKIN GRAFTS FOR INJURIES	1.9078	5.4	8.5
440	Yes	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9293	5.6	8.5
441	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	0.9954	2.3	3.5
442	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5515	6.0	8.9
443	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0498	2.7	3.5
444	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7776	3.2	4.1
445	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5296	2.3	2.8
446	No	No	21	MED *	TRAUMATIC INJURY AGE 0-17	0.3037	*	*
447	No	No	21	MED	ALLERGIC REACTIONS AGE >17	0.5730	1.9	2.6
448	No	No	21	MED *	ALLERGIC REACTIONS AGE 0-17	0.1000	*	*
449	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8730	2.7	3.7
450	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4419	1.6	2.0
451	No	No	21	MED *	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2697	10.2	10.5
452	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0680	3.5	5.0
453	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5300	2.2	2.8
454	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8615	3.0	4.1
455	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4840	1.8	2.3
456	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
457	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.5643	3.3	5.6
462	Yes	No	23	MED	REHABILITATION	0.9442	8.3	9.8
463	Yes	No	23	MED	SIGNS & SYMPTOMS W CC	0.7158	3.1	3.9
464	Yes	No	23	MED	SIGNS & SYMPTOMS W/O CC	0.5269	2.4	2.9
465	No	No	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5944	2.5	3.7
466	No	No	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7636	2.8	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
467	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.4754	1.9	2.7
468	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.9880	9.6	13.0
469	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	No	No		**	UNGROUPABLE	0.0000	0.0	0.0
471	Yes	Yes	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.0376	4.1	4.6
472	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.3599	7.3	12.7
474	No	No	04	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	No	No	04	MED	NO LONGER VALID	0.0000	0.0	0.0
476	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1586	6.9	9.9
477	Yes	No		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0895	5.9	8.7
478	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
479	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4403	1.9	2.6
480	No	No	PRE	SURG	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	9.3990	14.0	19.1
481	No	No	PRE	SURG	BONE MARROW TRANSPLANT	6.3832	18.7	22.0
482	Yes	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.3413	9.4	11.8
483	No	No	PRE	SURG	NO LONGER VALID	0.0000	0.0	0.0
484	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.0950	8.5	12.8
485	Yes	No	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.5053	8.2	10.1
486	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8313	8.5	12.3
487	Yes	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.8927	5.2	7.1
488	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	5.1250	12.2	17.7
489	No	No	25	MED	HIV W MAJOR RELATED CONDITION	1.7871	5.8	8.2
490	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0389	3.8	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
491	No	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7205	2.5	3.0
492	No	No	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	3.4869	8.9	13.8
493	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8291	4.6	6.0
494	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0328	2.1	2.7
495	No	No	PRE	SURG	LUNG TRANSPLANT	8.4190	14.2	17.3
496	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	6.3677	6.4	8.8
497	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.8171	4.8	5.7
498	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.9880	3.3	3.7
499	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.3863	3.0	4.2
500	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9210	1.8	2.2
501	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6398	8.4	10.4
502	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4281	5.0	5.8
503	No	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2440	3.0	3.9
504	No	No	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	11.2212	20.8	28.0
505	No	No	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	2.6339	2.8	6.9
506	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	3.7919	10.8	15.2
507	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.9318	5.4	7.8
508	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	1.4169	5.3	7.5
509	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.8347	3.7	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
510	No	No	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2468	4.2	6.1
511	No	No	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6833	2.6	3.7
512	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.2610	11.1	13.6
513	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.9658	8.9	10.6
514	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
515	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.2306	2.2	3.8
516	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
517	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
518	No	No	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.6367	1.8	2.5
519	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.5421	2.9	4.7
520	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.7568	1.6	1.9
521	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7339	4.2	5.5
522	Yes	No	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.6008	7.5	9.4
523	No	No	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.4182	3.2	3.9
524	No	No	01	MED	TRANSIENT ISCHEMIA	0.7371	2.6	3.1
525	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.1909	7.7	14.3
526	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
527	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
528	No	No	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.0543	13.3	16.4
529	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.1665	4.7	7.4
530	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2175	2.3	2.9
531	Yes	No	01	SURG	SPINAL PROCEDURES W CC	3.1057	6.4	9.3
532	Yes	No	01	SURG	SPINAL PROCEDURES W/O CC	1.4551	2.8	3.7
533	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5468	2.4	3.7
534	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	0.9932	1.4	1.7
535	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	7.3768	6.9	9.3
536	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.6073	5.5	7.3
537	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.8351	4.7	6.6
538	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	1.0284	2.2	2.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
539	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.1863	6.8	10.6
540	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.1759	2.6	3.5
541	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	19.2267	37.1	44.5
542	Yes	No	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.6047	27.3	32.7
543	Yes	No	01	SURG	CRANIOTOMY W MOJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS	4.3496	7.9	11.6
544	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.9873	4.0	4.4
545	Yes	Yes	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT	2.5306	4.4	5.2
546	No	No	08	SURG	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	5.3820	7.0	8.8
547	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	6.1357	10.9	12.4
548	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	4.6440	8.1	8.9
549	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	5.0241	8.6	10.2
550	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	3.5928	6.2	6.8
551	No	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	3.0368	4.2	6.1
552	No	No	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	2.0871	2.5	3.5
553	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	3.0091	6.3	9.3
554	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	2.0771	3.7	5.6
555	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	2.3062	3.4	4.8
556	No	No	05	SURG	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	1.7782	1.6	2.0
557	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	2.7610	3.0	4.1

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
558	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	2.0814	1.5	1.8
559	No	No	01	MED	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	2.2513	5.4	6.9
560	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	2.9031	8.2	10.6
561	No	No	01	MED	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	2.2176	7.4	9.6
562	Yes	No	01	MED	SEIZURE AGE > 17 W CC	1.0582	3.7	4.9
563	Yes	No	01	MED	SEIZURE AGE > 17 W/O CC	0.6432	2.6	3.2
564	No	No	01	MED	HEADACHES AGE >17	0.6933	2.6	3.4
565	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	5.2294	13.4	15.8
566	Yes	No	06	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS	2.3335	5.6	7.8
567	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE > 17 W CC W MAJOR GI DX	5.2173	12.7	16.0
568	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES PROC AGE > 17 W CC W/O MAJOR GI DX	3.3635	8.3	11.5
569	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	4.3425	11.9	14.6
570	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	2.6978	8.4	10.1
571	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS	1.1126	3.8	4.8
572	Yes	No	08	MED	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	1.3378	5.6	7.1
573	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES	3.3457	9.1	11.1
574	No	No	16	MED	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	1.2698	4.3	5.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
575	Yes	No	18	MED	SEPTICEMIA W MV96+ HOURS AGE >17	5.9388	13.2	16.1
576	Yes	No	18	MED	SEPTICEMIA W/O MV96+ HOURS AGE >17	1.5953	5.5	7.3
577	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE	1.7844	1.6	2.3
578	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W OR PROCEDURE	4.8492	12.8	16.7
579	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W OR PROCEDURE	2.8386	8.4	11.5

DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: AN ASTERISK IN THE GMLOS OR AMLOS COLUMN INDICATES THERE IS NO DATA TO COMPUTE.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
052.2	Postvaricella myelitis	Y	1	543, 561
053.14	Herpes zoster myelitis	Y	1	543, 561
054.74	Herpes simplex myelitis	Y	1	543, 561
238.71	Essential thrombocythemia	N	16	398, 399
238.72	Low grade myelodysplastic syndrome lesions	N	16	395, 396
238.73	High grade myelodysplastic syndrome lesions	N	16	395, 396
238.74	Myelodysplastic syndrome with 5q deletion	N	16	395, 396
238.75	Myelodysplastic syndrome, unspecified	N	16	395, 396
238.76	Myelofibrosis with myeloid metaplasia	N	17	401, 402, 403, 404, 539, 540
238.79	Other lymphatic and hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.30	Amyloidosis, unspecified	N	8	240, 241
277.31	Familial Mediterranean fever	N	8	240, 241
277.39	Other amyloidosis	N	8	240, 241
284.01	Constitutional red blood cell aplasia	N	16	574
284.09	Other constitutional aplastic anemia	N	16	574
284.1	Pancytopenia	N	16	395, 396
284.2	Myelophthisis	N	17	401, 402, 403, 404, 539, 540
288.00	Neutropenia, unspecified	N	16 25	574 490
288.01	Congenital neutropenia	N	16 25	574 490
288.02	Cyclic neutropenia	N	16 25	574 490
288.03	Drug induced neutropenia	N	16 25	574 490
288.04	Neutropenia due to infection	N	16 25	574 490
288.09	Other neutropenia	N	16 25	574 490

Diagnosis Code	Description	CC	MDC	DRG
288.4	Hemophagocytic syndromes	N	16	398, 399
288.50	Leukocytopenia, unspecified	N	16	398, 399
288.51	Lymphocytopenia	N	16	398, 399
288.59	Other decreased white blood cell count	N	16	398, 399
288.60	Leukocytosis, unspecified	N	16	398, 399
288.61	Lymphocytosis (symptomatic)	N	16	398, 399
288.62	Leukemoid reaction	N	16	398, 399
288.63	Monocytosis (symptomatic)	N	16	398, 399
288.64	Plasmacytosis	N	16	398, 399
288.65	Basophilia	N	16	398, 399
288.69	Other elevated white blood cell count	N	16	398, 399
289.53	Neutropenic splenomegaly	N	16	398, 399
289.83	Myelofibrosis	N	17	401, 402, 403, 404, 539, 540
323.01	Encephalitis and encephalomyelitis in viral diseases classified elsewhere	N	1	543, 561
323.02	Myelitis in viral diseases classified elsewhere	N	1	543, 561
323.41	Other encephalitis and encephalomyelitis due to infection classified elsewhere	N	1	543, 561
323.42	Other myelitis due to infection classified elsewhere	N	1	543, 561
323.51	Encephalitis and encephalomyelitis following immunization procedures	N	1	543, 561
323.52	Myelitis following immunization procedures	N	1	543, 561
323.61	Infectious acute disseminated encephalomyelitis (ADEM)	N	1	543, 561
323.62	Other postinfectious encephalitis and encephalomyelitis	N	1	543, 561
323.63	Postinfectious myelitis	N	1	543, 561
323.71	Toxic encephalitis and encephalomyelitis	N	1	34, 35, 543
323.72	Toxic myelitis	N	1	34, 35, 543
323.81	Other causes of encephalitis and encephalomyelitis	N	1 25	543, 561 489
323.82	Other causes of myelitis	N	1 25	543, 561 489
331.83	Mild cognitive impairment, so stated	N	1	12

Diagnosis Code	Description	CC	MDC	DRG
333.71	Athetoid cerebral palsy	N	1	12
333.72	Acute dystonia due to drugs	N	1	34, 35
333.79	Other acquired torsion dystonia	N	1	34, 35
333.85	Subacute dyskinesia due to drugs	N	1	34, 35
333.94*	Restless Legs Syndrome	N	1	12
338.0	Central pain syndrome	N	23	463, 464
338.11	Acute pain due to trauma	N	23	463, 464
338.12	Acute post-thoracotomy pain	N	23	463, 464
338.18	Other acute postoperative pain	N	23	463, 464
338.19	Other acute pain	N	23	463, 464
338.21	Chronic pain due to trauma	N	23	463, 464
338.22	Chronic post-thoracotomy pain	N	23	463, 464
338.28	Other chronic postoperative pain	N	23	463, 464
338.29	Other chronic pain	N	23	463, 464
338.3	Neoplasm related pain (acute) (chronic)	N	23	463, 464
338.4	Chronic pain syndrome	N	23	463, 464
341.20	Acute (transverse) myelitis NOS	N	1	543, 561
341.21	Acute (transverse) myelitis in conditions classified elsewhere	N	1	543, 561
341.22	Idiopathic transverse myelitis	N	1	543, 561
377.43	Optic nerve hypoplasia	N	2	45
379.60	Inflammation (infection) of postprocedural bleb, unspecified	N	2	46, 47, 48
379.61	Inflammation (infection) of postprocedural bleb, stage 1	N	2	46, 47, 48
379.62	Inflammation (infection) of postprocedural bleb, stage 2	N	2	46, 47, 48
379.63	Inflammation (infection) of postprocedural bleb, stage 3	N	2	46, 47, 48
389.15	Sensorineural hearing loss, unilateral	N	3	73, 74
389.16	Sensorineural hearing loss, asymmetrical	N	3	73, 74
429.83	Takotsubo syndrome	N	5	144, 145
478.11	Nasal mucositis (ulcerative)	N	3 15	73, 74 391[1]

Diagnosis Code	Description	CC	MDC	DRG
478.19	Other disease of nasal cavity and sinuses	N	3 15	73, 74 391[1]
518.7	Transfusion related acute lung injury (TRALI)	Y	4	101, 102
519.11	Acute bronchospasm	N	PRE 4	482 96, 97, 98
519.19	Other diseases of trachea and bronchus	N	PRE 4	482 96, 97, 98
521.81	Cracked tooth	N	PRE 3	482 185, 186, 187
521.89	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.00	Acute gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.01	Acute gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.10	Chronic gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.11	Chronic gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.30	Aggressive periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.31	Aggressive periodontitis, localized	N	PRE 3	482 185, 186, 187
523.32	Aggressive periodontitis, generalized	N	PRE 3	482 185, 186, 187
523.33	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.40	Chronic periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.41	Chronic periodontitis, localized	N	PRE 3	482 185, 186, 187
523.42	Chronic periodontitis,generalized	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
525.60	Unspecified unsatisfactory restoration of tooth	N	PRE 3	482 185, 186, 187
525.61	Open restoration margins	N	PRE 3	482 185, 186, 187
525.62	Unrepairable overhanging of dental restorative materials	N	PRE 3	482 185, 186, 187
525.63	Fractured dental restorative material without loss of material	N	PRE 3	482 185, 186, 187
525.64	Fractured dental restorative material with loss of material	N	PRE 3	482 185, 186, 187
525.65	Contour of existing restoration of tooth biologically incompatible with oral health	N	PRE 3	482 185, 186, 187
525.66	Allergy to existing dental restorative material	N	PRE 3	482 185, 186, 187
525.67	Poor aesthetics of existing restoration	N	PRE 3	482 185, 186, 187
525.69	Other unsatisfactory restoration of existing tooth	N	PRE 3	482 185, 186, 187
526.61	Perforation of root canal space	N	PRE 3	482 185, 186, 187
526.62	Endodontic overfill	N	PRE 3	482 185, 186, 187
526.63	Endodontic underfill	N	PRE 3	482 185, 186, 187
526.69	Other periradicular pathology associated with previous endodontic treatment	N	PRE 3	482 185, 186, 187
528.00	Stomatitis and mucositis, unspecified	N	PRE 3	482 185, 186, 187
528.01	Mucositis (ulcerative) due to antineoplastic therapy	N	PRE 3	482 185, 186, 187
528.02	Mucositis (ulcerative) due to other drugs	N	PRE 3	482 185, 186, 187
528.09	Other stomatitis and mucositis (ulcerative)	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
538	Gastrointestinal mucositis (ulcerative)	N	6	182, 183, 184
608.20	Torsion of testis, unspecified	N	12	352
608.21	Extravaginal torsion of spermatic cord	N	12	352
608.22	Intravaginal torsion of spermatic cord	N	12	352
608.23	Torsion of appendix testis	N	12	352
608.24	Torsion of appendix epididymis	N	12	352
616.81	Mucositis (ulcerative) of cervix, vagina, and vulva	N	13	358, 359, 368
616.89	Other inflammatory disease of cervix, vagina and vulva	N	13	358, 359, 368
618.84	Cervical stump prolapse	N	13	358, 359, 369
629.29	Other female genital mutilation status	N	13	358, 359, 369
629.81	Habitual aborter without current pregnancy	N	13	358, 359, 369
629.89	Other specified disorders of female genital organs	N	13	358, 359, 369
649.00	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.01	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.02	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.03	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.04	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.10	Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.11	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375

Diagnosis Code	Description	CC	MDC	DRG
649.12	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.13	Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.14	Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.20	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.21	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.22	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.23	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.24	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.31	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384

Diagnosis Code	Description	CC	MDC	DRG
649.34	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.40	Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.41	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.42	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.43	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.44	Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.50	Spotting complicating pregnancy, unspecified as to episode of care or not applicable	N	14	469
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.53	Spotting complicating pregnancy, antepartum condition or complication	N	14	383, 384
649.60	Uterine size date discrepancy, unspecified as to episode of care or not applicable	N	14	469
649.61	Uterine size date discrepancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.62	Uterine size date discrepancy, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.63	Uterine size date discrepancy, antepartum condition or complication	N	14	383, 384
649.64	Uterine size date discrepancy, postpartum condition or complication	N	14	376, 377
729.71	Nontraumatic compartment syndrome of upper extremity	N	8	248
729.72	Nontraumatic compartment syndrome of lower extremity	N	8	248
729.73	Nontraumatic compartment syndrome of abdomen	N	8	248

Diagnosis Code	Description	CC	MDC	DRG
729.79	Nontraumatic compartment syndrome of other sites	N	8	248
731.3	Major osseous defects	N	8	244, 245
768.7*	Hypoxic-ischemic encephalopathy (HIE)	N	15	390
770.87*	Respiratory arrest of newborn	N	15	390
770.88*	Hypoxemia of newborn	N	15	390
775.81*	Other acidosis of newborn	N	15	390
775.89*	Other neonatal endocrine and metabolic disturbances	N	15	390
779.85*	Cardiac arrest of newborn	Y	15	387[2], 389[2]
780.32	Complex febrile convulsions	Y	1	26, 562, 563
780.96	Generalized pain	N	23	463, 464
780.97	Altered mental status	N	23	463, 464
784.91	Postnasal drip	N	3	73, 74
784.99	Other symptoms involving head and neck	N	3	73, 74
788.64	Urinary hesitancy	N	11	325, 326, 327
788.65	Straining on urination	N	11	325, 326, 327
793.91	Image test inconclusive due to excess body fat	N	23	463, 464
793.99	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy	N	13	358, 359, 369
795.81	Elevated carcinoembryonic antigen [CEA]	N	23	463, 464
795.82	Elevated cancer antigen 125 [CA 125]	N	23	463, 464
795.89	Other abnormal tumor markers	N	23	463, 464
958.90	Compartment syndrome, unspecified	N	21	454, 455
958.91	Traumatic compartment syndrome of upper extremity	N	21	454, 455
958.92	Traumatic compartment syndrome of lower extremity	N	21	454, 455
958.93	Traumatic compartment syndrome of abdomen	N	21	454, 455
958.99	Traumatic compartment syndrome of other sites	N	21	454, 455

Diagnosis Code	Description	CC	MDC	DRG
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance	N	15 21	387[3], 389[3] 449, 450, 451
995.21	Arthus phenomenon	N	15 21	387[3], 389[3] 449, 450, 451
995.22	Unspecified adverse effect of anesthesia	N	15 21	387[3], 389[3] 449, 450, 451
995.23	Unspecified adverse effect of insulin	N	15 21	387[3], 389[3] 449, 450, 451
995.27	Other drug allergy	N	15 21	387[3], 389[3] 449, 450, 451
995.29	Unspecified adverse effect of other drug, medicinal and biological substance	N	15 21	387[3], 389[3] 449, 450, 451
V18.51	Family history, Colonic polyps	N	23	467
V18.59	Family history, Other digestive disorders	N	23	467
V26.34	Testing of male for genetic disease carrier status	N	23	467
V26.35	Encounter for testing of male partner of habitual aborter	N	23	467
V26.39	Other genetic testing of male	N	23	467
V45.86	Bariatric surgery status	N	23	467
V58.30	Encounter for change or removal of nonsurgical wound dressing	N	23	467
V58.31	Encounter for change or removal of surgical wound dressing	N	23	467
V58.32	Encounter for removal of sutures	N	23	467
V72.11	Encounter for hearing examination following failed hearing screening	N	23 15	467 391[1]
V72.19	Other examination of ears and hearing	N	23 15	467 391[1]
V82.71	Screening for genetic disease carrier status	N	23	467
V82.79	Other genetic screening	N	23	467
V85.51	Body Mass Index, pediatric, less than 5th percentile for age	N	23	467
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age	N	23	467

Diagnosis Code	Description	CC	MDC	DRG
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age	N	23	467
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age	N	23	467
V86.0	Estrogen receptor positive status [ER+]	N	23	467
V86.1	Estrogen receptor negative status [ER-]	N	23	467

[1]On "Only secondary diagnosis" list.
[2]Principal or secondary diagnosis of major problem.
[3]Secondary diagnosis of major problem
*These diagnosis codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

TABLE 6B.--NEW PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
00.44	Procedure on vessel bifurcation	N	--	--
00.56	Insertion or replacement of implantable pressure sensor (lead) for intracardiac hemodynamic monitoring	Y	5	117, 120[1]
00.57	Implantation or replacement of subcutaneous device for intracardiac hemodynamic monitoring	Y	5	118, 120[1]
00.77*	Hip replacement bearing surface, ceramic-on-polyethylene	N	--	--
00.85*	Resurfacing hip, total, acetabulum and femoral head	Y	8 21 24	471, 544 442, 443 485
00.86*	Resurfacing hip, partial, femoral head	Y	8 10 21 24	471, 544 292, 293 442, 443 485
00.87*	Resurfacing hip, partial, acetabulum	Y	8 10 21 24	471, 544 292, 293 442, 443 485
01.28*	Placement of intracerebral catheter(s) via burr hole(s)	Y	1 17 21 24	1, 2, 3, 543 406, 407, 539, 540 442, 443 484
13.90*	Operation on lens, Not Elsewhere Classified	Y	2 21 24 --	39 442, 443 486 476, 477
13.91*	Implantation of intraocular telescope prosthesis	Y	2 21 24 --	39 442, 443 486 476, 477
32.23*	Open ablation of lung lesion or tissue	Y	4 17	75 406, 407, 539, 540
32.24*	Percutaneous ablation of lung lesion or tis	Y	4	76, 77

Procedure Code	Description	OR	MDC	DRG
32.25*	Thoracoscopic ablation of lung lesion or tissue	Y	4 17	75 406, 407, 539, 540
32.26*	Other and unspecified ablation of lung lesion or tissue	Y	4	75
33.71*	Endoscopic insertion or replacement of bronchial valve(s)	N[2]	17	412
33.78*	Endoscopic removal of bronchial device(s) or substances	N[2]	17	412
33.79*	Endoscopic insertion of other bronchial device or substances	N[2]	17	412
35.55*	Repair of ventricular septal defect with prosthesis, closed technique	Y	5	108
36.33*	Endoscopic transmyocardial revascularization	Y	5	108
36.34*	Percutaneous transmyocardial revascularization	Y	5	108
37.20	Noninvasive programmed electrical stimulation [NIPS]	N		
39.74	Endovascular removal of obstruction from head and neck vessel(s)	Y	1 21 24	1, 2, 3, 543 442, 443 486
50.23*	Open ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.24*	Percutaneous ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.25*	Laparoscopic ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.26*	Other and unspecified ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
55.32*	Open ablation of renal lesion or tissue	Y	11	303, 304, 305
55.33*	Percutaneous ablation of renal lesion or tissue	Y	11	303, 304, 305
55.34*	Laparoscopic ablation of renal lesion or tissue	Y	11	303, 304, 305
55.35*	Other and unspecified ablation of renal lesion or tissue	Y	11	303, 304, 305
68.41	Laparoscopic total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375

Procedure Code	Description	OR	MDC	DRG
68.49	Other and unspecified total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.61	Laparoscopic radical abdominal hysterectomy	Y	13 14	353 375
68.69	Other and unspecified radical abdominal hysterectomy	Y	13 14	353 375
68.71	Laparoscopic radical vaginal hysterectomy [LRVH]	Y	13 14	353 375
68.79	Other and unspecified radical vaginal hysterectomy	Y	13 14	353 375

[1] Assigned to DRG 120 when both 00.56 and 00.57 are reported.
[2]Non-operating room procedure that affects DRG assignment.
*These procedure codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
238.7	Other lymphatic and hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.3	Amyloidosis	N	8	240, 241
284.0	Constitutional aplastic anemia	Y	16	395, 396
288.0	Agranulocytosis	Y	16 25	398, 399 490
323.0	Encephalitis in viral diseases classified elsewhere	N	1	20, 543
323.4	Other encephalitis due to infection classified elsewhere	N	1	20, 543
323.5	Encephalitis following immunization procedures	N	1	20, 543
323.6	Postinfectious encephalitis	N	1	20, 543
323.7	Toxic encephalitis	N	1	34, 35, 543
323.8	Other causes of encephalitis	N	1 25	20, 543 489
333.7	Symptomatic torsion dystonia	N	1	12
478.1	Other diseases of nasal cavity and sinuses	N	3 15	73, 74 391[1]
519.1	Other diseases of trachea and bronchus, not elsewhere classified	N	PRE 4	482 96, 97, 98
521.8	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.0	Acute gingivitis	N	PRE 3	482 185, 186, 187
523.1	Chronic gingivitis	N	PRE 3	482 185, 186, 187
523.3	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.4	Chronic periodontitis	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
528.0	Stomatitis	N	PRE 3	482 185, 186, 187
608.2	Torsion of testis	N	12	352
616.8	Other specified inflammatory diseases of cervix, vagina, and vulva	N	13	358, 359, 368
629.8	Other specified disorders of female genital organs	N	13	358, 359, 369
775.8*	Other transitory neonatal endocrine and metabolic disturbances	N	15	390
784.9	Other symptoms involving head and neck	N	3	73, 74
793.9	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
995.2	Unspecified adverse effect of drug, medicinal and biological substance	N	15 21	387[2], 389[2] 449, 450, 451
V18.5	Family history, Digestive disorders	N	23	467
V58.3	Attention to surgical dressings and sutures	N	23	467
V72.1	Examination of ears and hearing	N	15 23	391[1] 467

[1]On "Only secondary diagnosis" list.
[2]Principal or secondary diagnosis of major problem.
*This diagnosis code was discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. It will be deleted on October 1, 2006.

TABLE 6D.--INVALID PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
13.9*	Other operations on lens	Y	2 21 24	39 442-443 486
68.4	Total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.6	Radical abdominal hysterectomy	Y	13 14	353 375
68.7	Radical vaginal hysterectomy	Y	13 14	353 375

*This procedure code was discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. The change will be implemented on October 1, 2006.

TABLE 6E.--REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	DRG
255.10	Hyperaldosteronism, unspecified	N	10	300, 301
285.29	Anemia of other chronic disease	N	16	395, 396
323.1	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere	N	1	543, 561
323.2	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere	N	1	543, 561
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis	N	1 25	543, 561 489
333.6	Genetic torsion dystonia	N	1	12
345.40	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.41	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy	Y	1	26, 562, 563
345.50	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.51	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy	Y	1	26, 562, 563
345.80	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.81	Other forms of epilepsy and recurrent seizures, with intractable epilepsy	Y	1	26, 562, 563
389.11	Sensory hearing loss, bilateral	N	3	73, 74

Diagnosis Code	Description	CC	MDC	DRG
389.12	Neural hearing loss, bilateral	N	3	73, 74
389.14	Central hearing loss, bilateral	N	3	73, 74
389.18	Sensorineural hearing loss of combined types, bilateral	N	3	73, 74
403.00	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified	Y	11	315, 316
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
403.10	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified	N	11	315, 316
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified	N	11	315, 316
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.00	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5	134
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]

Diagnosis Code	Description	CC	MDC	DRG
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.10	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	N	5	134
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.90	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	N	5	134

Diagnosis Code	Description	CC	MDC	DRG
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
524.21	Malocclusion, Angle's class I	N	PRE 3	482 185, 186, 187
524.22	Malocclusion, Angle's class II	N	PRE 3	482 185, 186, 187
524.23	Malocclusion, Angle's class III	N	PRE 3	482 185, 186, 187
524.35	Rotation of tooth/teeth	N	PRE 3	482 185, 186, 187
600.00	Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptom(LUTS)	N	12	348, 349
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349
600.20	Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349

Diagnosis Code	Description	CC	MDC	DRG
600.21	Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction and other lower urinary symptoms (LUTS)	N	12	348, 349
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary symptoms (LUTS)	N	12	348, 349
768.3	Fetal distress first noted during labor and delivery, in liveborn infant	N	15	390
780.31	Febrile convulsions (simple), unspecified	Y	1 15	26, 562, 563 387[5], 389[5]
780.95	Excessive crying of child, adolescent, or adult	N	23	463, 464
790.93	Elevated prostate specific antigen [PSA]	N	23	463, 464
873.63	Tooth (broken) (fractured) (due to trauma), without mention of complication	N	3 24	185, 186, 187 487
873.73	Tooth (broken) (fractured) (due to trauma), complicated	N	3 24	185, 186, 187 487
995.91	Sepsis	Y	18	417, 575, 576
995.92	Severe sepsis	Y	18	417, 575, 576
995.93	Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction	Y	18	417, 575, 576
995.94	Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction	Y	18	417, 575, 576
V26.31	Testing of female for genetic disease carrier status	N	23	467
V26.32	Other genetic testing of female	N	23	467

[1]Principal or secondary diagnosis

[2] Principal or secondary diagnosis of major complication
[3] Principal or secondary diagnosis of complex diagnosis
[4] Principal or secondary diagnosis of major cardiovascular condition
[5]Principal or secondary diagnosis of major problem

TABLE 6F.--REVISED PROCEDURE CODE TITLES

Procedure Code	Description	OR	MDC	DRG
01.26*	Insertion of catheter(s) into cranial cavity or tissue	N		
01.27*	Removal of catheter(s) from cranial cavity or tissue	N		
35.53*	Repair of ventricular septal defect with prosthesis, open technique	Y	5	108
37.26	Catheter based invasive electrophysiologic testing	N[1]	5	104, 518, 555, 556, 557, 558
68.39*	Other and unspecified subtotal abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.59*	Other and unspecified vaginal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375

[1]Non- OR code that affects DRG assignment.
*These procedure codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

TABLE 6G.--ADDITIONS TO THE CC EXCLUSIONS LIST

CCs that are added to the list are in this Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

```
*0519
  0522
*0522
  0520
  0521
  0522
  0527
  0528
  0529
  05314
  05474
*0527
  0522
*0528
  0522
*0529
  0522
*0530
  05314
*05310
  05314
*05311
  05314
*05312
  05314
*05313
  05314
*05314
  0522
  0530
  05310
  05311
  05312
  05313
  05314
  05319
  05379
  0538
  05474
*05319
  05314
*05379
  05314
*0538
  05314
*0539
  05314
*05472
  05314
*05474
  0522
  0530
  05310
  05311
  05312
  05313
  05314
  05319
  05379
  0538
  05474
*05479
  05314
  05474
*0548
  05314
  05474
*0549
  05314
  05474
*07888
  0522
  05314
  05474
*07889
  0522
  05314
  05474
*07981
  0522
  05314
  05474
*07988
  0522
  05314
  05474
*07989
  0522
  05314
  05474
*07998
  0522
  05314
  05474
*07999
  0522
  05314
  05474
*1398
  0522
  05314
  05474
*28401
  2800
  2814
  2818
  28241
  28242
  28249
  28260
  28261
  28262
  28263
  28264
  28268
  28269
  2830
  28310
  28311
  28319
  2832
  2839
  2848
  2849
  2850
  2851
*28409
  2800
  2814
  2818
  28241
  28242
  28249
  28260
  28261
  28262
  28263
  28264
  28268
  28269
  2830
  28310
  28311
  28319
  2832
  2839
  2848
  2849
  2850
  2851
*2842
  2800
  2814
  2818
```

28241
28242
28249
28260
28261
28262
28263
28264
28268
28269
2830
28310
28311
28319
2832
2839
2848
2849
2850
2851
*28800
2881
28981
28982
*28801
2881
28981
28982
*28802
2881
28981
28982
*28803
2881
28981
28982
*28804
2881
28981
28982
*28809
2881
28981
28982
*2884
2881
28981
28982
*28850
2881
28981
28982
*28851
2881
28981
28982
*28859
2881
28981
28982
*28860
2881
28981
28982
*28861
2881
28981
28982
*28862
2881
28981
28982
*28863
2881
28981
28982
*28864
2881
28981
28982
*28865
2881
28981
28982
*28869
2881
28981
28982
*28953
2881
28981
28982
*28983
2800
2814
2818
28241
28242
28249
28260
28261
28262
28263
28264
28268
28269
2830
28310
28311
28319
2832
2839
2848
2849
2850
2851
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872
28730
28731
28732
28733
28739
2874
2875
2878
2879
2881
28981
28982
*32301
0522
05314
05474
34982
*32302
0522
05314
05474
34982
*32341
0522
05314
05474
34982
*32342
0522
05314
05474
34982
*32351
0522
05314
05474
34982
*32352
0522
05314
05474
34982
*32361
0522
05314
05474
34982
*32362
0522
05314
05474
34982
*32363
0522
05314
05474
34982
*32371
0522
05314
05474
34982
*32372
0522
05314
05474
34982
*32381
0522
05314
05474
34982
*32382
0522
05314
05474
34982
*33183
3314
*33371
7817
*33372
7817
*33379
7817
*33385
7817
*3380

04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33811
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33812
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33818
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33819
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33821
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33822
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33828
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*33829
04082
44024
78001
78003
7801
78031
78032
78039

7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*3383
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*3384
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*34120
0522
05314
05474
34982
*34121
0522
05314
05474
34982
*34122
0522
05314
05474
34982
*34500
78032
*34501
78032
*34510
78032
*34511
78032
*3452
78032
*3453
78032
*34540
78032
*34541
78032
*34550
78032
*34551
78032
*34560
78032
*34561
78032
*34570
78032
*34571
78032
*34580
78032
*34581
78032
*34590
78032
*34591
78032
*3488
78032
*3489
78032
*34989
78032
*3499
78032
*37960
37700
37701
37702
*37961
37700
37701
37702
*37962
37700
37701
37702
*37963
37700
37701
37702
*5187
5187
9973
*51911
51900
51901
51902
51909
*51919
51900
51901
51902
51909
*52800
5283
*52801
5283
*52802
5283
*52809
5283
*538
5273
5274
53021
53100
53101
53110
53111
53120
53121
53131
53140
53141
53150
53151
53160
53161
53171
53191
53200
53201
53210
53211
53220
53221
53231
53240
53241
53250
53251
53260
53261
53271
53291
53300
53301
53310
53311
53320
53321
53331
53340
53341
53350
53351
53360
53361
53371
53391
53400
53401

53410
53411
53420
53421
53431
53440
53441
53450
53451
53460
53461
53471
53491
5400
5401
5409
55000
55001
55002
55003
55010
55011
55012
55013
55100
55101
55102
55103
5511
55120
55121
55129
5518
5519
55200
55201
55202
55203
*61681
6140
6143
6145
6150
6163
6164
*61689
6140
6143
6145
6150
6163
6164
*62929
6140
6143
6145
6150
6163
6164
6207
*62981
6140
6143
6145
6150
6163
6164
6207
*62989
6140
6143
6145
6150
6163
6164
6207
*64900
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632

66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800
67004	67512	64111	64801
67120	*64901	64113	64802
67121	63400	64130	64803
67122	63401	64131	64804
67123	63402	64133	64820
67124	63410	64180	64821
67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824
67140	63421	64191	64830
67142	63422	64193	64831
67144	63430	64240	64832
67300	63431	64241	64833
67301	63432	64242	64834
67302	63440	64243	64850
67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853

64854	67122	63401	64131
64860	67123	63402	64133
64861	67124	63410	64180
64862	67130	63411	64181
64863	67131	63412	64183
64864	67133	63420	64190
65930	67140	63421	64191
65931	67142	63422	64193
65933	67144	63430	64240
66500	67300	63431	64241
66501	67301	63432	64242
66503	67302	63440	64243
66510	67303	63441	64244
66511	67304	63442	64250
66632	67310	63450	64251
66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800
67004	67512	64111	64801
67120	*64902	64113	64802
67121	63400	64130	64803

64804	66893	67410	64001
64820	66894	67412	64003
64821	66910	67420	64080
64822	66911	67422	64081
64823	66912	67424	64083
64824	66913	67450	64090
64830	66914	67451	64091
64831	66930	67452	64093
64832	66932	67453	64100
64833	66934	67454	64101
64834	67000	67510	64103
64850	67002	67511	64110
64851	67004	67512	64111
64852	67120	*64903	64113
64853	67121	63400	64130
64854	67122	63401	64131
64860	67123	63402	64133
64861	67124	63410	64180
64862	67130	63411	64181
64863	67131	63412	64183
64864	67133	63420	64190
65930	67140	63421	64191
65931	67142	63422	64193
65933	67144	63430	64240
66500	67300	63431	64241
66501	67301	63432	64242
66503	67302	63440	64243
66510	67303	63441	64244
66511	67304	63442	64250
66632	67310	63450	64251
66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671

64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64904
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270

64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64910
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240

64241	64833	66934	67454
64242	64834	67000	67510
64243	64850	67002	67511
64244	64851	67004	67512
64250	64852	67120	*64911
64251	64853	67121	63400
64252	64854	67122	63401
64253	64860	67123	63402
64254	64861	67124	63410
64260	64862	67130	63411
64261	64863	67131	63412
64262	64864	67133	63420
64263	65930	67140	63421
64264	65931	67142	63422
64270	65933	67144	63430
64271	66500	67300	63431
64272	66501	67301	63432
64273	66503	67302	63440
64274	66510	67303	63441
64400	66511	67304	63442
64403	66632	67310	63450
64410	66634	67311	63451
64413	66800	67312	63452
64660	66801	67313	63460
64661	66802	67314	63461
64662	66803	67320	63462
64663	66804	67321	63470
64664	66810	67322	63471
64670	66811	67323	63472
64671	66812	67324	63480
64673	66813	67330	63481
64730	66814	67331	63482
64731	66820	67332	63490
64732	66821	67333	63491
64733	66822	67334	63492
64734	66823	67380	6390
64740	66824	67381	6391
64741	66880	67382	6392
64742	66881	67383	6393
64743	66882	67384	6394
64744	66883	67400	6395
64800	66884	67401	6396
64801	66890	67402	6398
64802	66891	67403	6399
64803	66892	67404	64000
64804	66893	67410	64001
64820	66894	67412	64003
64821	66910	67420	64080
64822	66911	67422	64081
64823	66912	67424	64083
64824	66913	67450	64090
64830	66914	67451	64091
64831	66930	67452	64093
64832	66932	67453	64100

64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64912
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393

6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64913
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460

63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64914
63400
63401
63402
63410

63411	64181	64822	66911
63412	64183	64823	66912
63420	64190	64824	66913
63421	64191	64830	66914
63422	64193	64831	66930
63430	64240	64832	66932
63431	64241	64833	66934
63432	64242	64834	67000
63440	64243	64850	67002
63441	64244	64851	67004
63442	64250	64852	67120
63450	64251	64853	67121
63451	64252	64854	67122
63452	64253	64860	67123
63460	64254	64861	67124
63461	64260	64862	67130
63462	64261	64863	67131
63470	64262	64864	67133
63471	64263	65930	67140
63472	64264	65931	67142
63480	64270	65933	67144
63481	64271	66500	67300
63482	64272	66501	67301
63490	64273	66503	67302
63491	64274	66510	67303
63492	64400	66511	67304
6390	64403	66632	67310
6391	64410	66634	67311
6392	64413	66800	67312
6393	64660	66801	67313
6394	64661	66802	67314
6395	64662	66803	67320
6396	64663	66804	67321
6398	64664	66810	67322
6399	64670	66811	67323
64000	64671	66812	67324
64001	64673	66813	67330
64003	64730	66814	67331
64080	64731	66820	67332
64081	64732	66821	67333
64083	64733	66822	67334
64090	64734	66823	67380
64091	64740	66824	67381
64093	64741	66880	67382
64100	64742	66881	67383
64101	64743	66882	67384
64103	64744	66883	67400
64110	64800	66884	67401
64111	64801	66890	67402
64113	64802	66891	67403
64130	64803	66892	67404
64131	64804	66893	67410
64133	64820	66894	67412
64180	64821	66910	67420

67422	64081	64732	66821
67424	64083	64733	66822
67450	64090	64734	66823
67451	64091	64740	66824
67452	64093	64741	66880
67453	64100	64742	66881
67454	64101	64743	66882
67510	64103	64744	66883
67511	64110	64800	66884
67512	64111	64801	66890
*64920	64113	64802	66891
63400	64130	64803	66892
63401	64131	64804	66893
63402	64133	64820	66894
63410	64180	64821	66910
63411	64181	64822	66911
63412	64183	64823	66912
63420	64190	64824	66913
63421	64191	64830	66914
63422	64193	64831	66930
63430	64240	64832	66932
63431	64241	64833	66934
63432	64242	64834	67000
63440	64243	64850	67002
63441	64244	64851	67004
63442	64250	64852	67120
63450	64251	64853	67121
63451	64252	64854	67122
63452	64253	64860	67123
63460	64254	64861	67124
63461	64260	64862	67130
63462	64261	64863	67131
63470	64262	64864	67133
63471	64263	65930	67140
63472	64264	65931	67142
63480	64270	65933	67144
63481	64271	66500	67300
63482	64272	66501	67301
63490	64273	66503	67302
63491	64274	66510	67303
63492	64400	66511	67304
6390	64403	66632	67310
6391	64410	66634	67311
6392	64413	66800	67312
6393	64660	66801	67313
6394	64661	66802	67314
6395	64662	66803	67320
6396	64663	66804	67321
6398	64664	66810	67322
6399	64670	66811	67323
64000	64671	66812	67324
64001	64673	66813	67330
64003	64730	66814	67331
64080	64731	66820	67332

67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64921
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302

67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853
67311	63451	64252	64854
67312	63452	64253	64860
67313	63460	64254	64861
67314	63461	64260	64862
67320	63462	64261	64863
67321	63470	64262	64864
67322	63471	64263	65930
67323	63472	64264	65931
67324	63480	64270	65933
67330	63481	64271	66500
67331	63482	64272	66501
67332	63490	64273	66503
67333	63491	64274	66510
67334	63492	64400	66511
67380	6390	64403	66632
67381	6391	64410	66634
67382	6392	64413	66800
67383	6393	64660	66801
67384	6394	64661	66802
67400	6395	64662	66803
67401	6396	64663	66804
67402	6398	64664	66810
67403	6399	64670	66811
67404	64000	64671	66812
67410	64001	64673	66813
67412	64003	64730	66814
67420	64080	64731	66820
67422	64081	64732	66821
67424	64083	64733	66822
67450	64090	64734	66823
67451	64091	64740	66824
67452	64093	64741	66880
67453	64100	64742	66881
67454	64101	64743	66882
67510	64103	64744	66883
67511	64110	64800	66884
67512	64111	64801	66890
*64922	64113	64802	66891
63400	64130	64803	66892
63401	64131	64804	66893
63402	64133	64820	66894
63410	64180	64821	66910
63411	64181	64822	66911
63412	64183	64823	66912
63420	64190	64824	66913
63421	64191	64830	66914
63422	64193	64831	66930
63430	64240	64832	66932
63431	64241	64833	66934
63432	64242	64834	67000
63440	64243	64850	67002

67004	67512	64111	64801
67120	*64923	64113	64802
67121	63400	64130	64803
67122	63401	64131	64804
67123	63402	64133	64820
67124	63410	64180	64821
67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824
67140	63421	64191	64830
67142	63422	64193	64831
67144	63430	64240	64832
67300	63431	64241	64833
67301	63432	64242	64834
67302	63440	64243	64850
67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853
67311	63451	64252	64854
67312	63452	64253	64860
67313	63460	64254	64861
67314	63461	64260	64862
67320	63462	64261	64863
67321	63470	64262	64864
67322	63471	64263	65930
67323	63472	64264	65931
67324	63480	64270	65933
67330	63481	64271	66500
67331	63482	64272	66501
67332	63490	64273	66503
67333	63491	64274	66510
67334	63492	64400	66511
67380	6390	64403	66632
67381	6391	64410	66634
67382	6392	64413	66800
67383	6393	64660	66801
67384	6394	64661	66802
67400	6395	64662	66803
67401	6396	64663	66804
67402	6398	64664	66810
67403	6399	64670	66811
67404	64000	64671	66812
67410	64001	64673	66813
67412	64003	64730	66814
67420	64080	64731	66820
67422	64081	64732	66821
67424	64083	64733	66822
67450	64090	64734	66823
67451	64091	64740	66824
67452	64093	64741	66880
67453	64100	64742	66881
67454	64101	64743	66882
67510	64103	64744	66883
67511	64110	64800	66884

66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64924
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804

66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800
67004	67512	64111	64801
67120	*64930	64113	64802
67121	63400	64130	64803
67122	63401	64131	64804
67123	63402	64133	64820
67124	63410	64180	64821
67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824
67140	63421	64191	64830
67142	63422	64193	64831
67144	63430	64240	64832
67300	63431	64241	64833
67301	63432	64242	64834
67302	63440	64243	64850
67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853
67311	63451	64252	64854
67312	63452	64253	64860
67313	63460	64254	64861
67314	63461	64260	64862
67320	63462	64261	64863
67321	63470	64262	64864

65930	67140	63421	64191
65931	67142	63422	64193
65933	67144	63430	64240
66500	67300	63431	64241
66501	67301	63432	64242
66503	67302	63440	64243
66510	67303	63441	64244
66511	67304	63442	64250
66632	67310	63450	64251
66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800
67004	67512	64111	64801
67120	*64931	64113	64802
67121	63400	64130	64803
67122	63401	64131	64804
67123	63402	64133	64820
67124	63410	64180	64821
67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824

64830	66914	67451	64091
64831	66930	67452	64093
64832	66932	67453	64100
64833	66934	67454	64101
64834	67000	67510	64103
64850	67002	67511	64110
64851	67004	67512	64111
64852	67120	*64932	64113
64853	67121	63400	64130
64854	67122	63401	64131
64860	67123	63402	64133
64861	67124	63410	64180
64862	67130	63411	64181
64863	67131	63412	64183
64864	67133	63420	64190
65930	67140	63421	64191
65931	67142	63422	64193
65933	67144	63430	64240
66500	67300	63431	64241
66501	67301	63432	64242
66503	67302	63440	64243
66510	67303	63441	64244
66511	67304	63442	64250
66632	67310	63450	64251
66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734

64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64933
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403

64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64934
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251

64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64940
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130

64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64941
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000

64001	64673	66813	67330
64003	64730	66814	67331
64080	64731	66820	67332
64081	64732	66821	67333
64083	64733	66822	67334
64090	64734	66823	67380
64091	64740	66824	67381
64093	64741	66880	67382
64100	64742	66881	67383
64101	64743	66882	67384
64103	64744	66883	67400
64110	64800	66884	67401
64111	64801	66890	67402
64113	64802	66891	67403
64130	64803	66892	67404
64131	64804	66893	67410
64133	64820	66894	67412
64180	64821	66910	67420
64181	64822	66911	67422
64183	64823	66912	67424
64190	64824	66913	67450
64191	64830	66914	67451
64193	64831	66930	67452
64240	64832	66932	67453
64241	64833	66934	67454
64242	64834	67000	67510
64243	64850	67002	67511
64244	64851	67004	67512
64250	64852	67120	*64942
64251	64853	67121	63400
64252	64854	67122	63401
64253	64860	67123	63402
64254	64861	67124	63410
64260	64862	67130	63411
64261	64863	67131	63412
64262	64864	67133	63420
64263	65930	67140	63421
64264	65931	67142	63422
64270	65933	67144	63430
64271	66500	67300	63431
64272	66501	67301	63432
64273	66503	67302	63440
64274	66510	67303	63441
64400	66511	67304	63442
64403	66632	67310	63450
64410	66634	67311	63451
64413	66800	67312	63452
64660	66801	67313	63460
64661	66802	67314	63461
64662	66803	67320	63462
64663	66804	67321	63470
64664	66810	67322	63471
64670	66811	67323	63472
64671	66812	67324	63480

63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64943
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430

63431	64241	64833	66934
63432	64242	64834	67000
63440	64243	64850	67002
63441	64244	64851	67004
63442	64250	64852	67120
63450	64251	64853	67121
63451	64252	64854	67122
63452	64253	64860	67123
63460	64254	64861	67124
63461	64260	64862	67130
63462	64261	64863	67131
63470	64262	64864	67133
63471	64263	65930	67140
63472	64264	65931	67142
63480	64270	65933	67144
63481	64271	66500	67300
63482	64272	66501	67301
63490	64273	66503	67302
63491	64274	66510	67303
63492	64400	66511	67304
6390	64403	66632	67310
6391	64410	66634	67311
6392	64413	66800	67312
6393	64660	66801	67313
6394	64661	66802	67314
6395	64662	66803	67320
6396	64663	66804	67321
6398	64664	66810	67322
6399	64670	66811	67323
64000	64671	66812	67324
64001	64673	66813	67330
64003	64730	66814	67331
64080	64731	66820	67332
64081	64732	66821	67333
64083	64733	66822	67334
64090	64734	66823	67380
64091	64740	66824	67381
64093	64741	66880	67382
64100	64742	66881	67383
64101	64743	66882	67384
64103	64744	66883	67400
64110	64800	66884	67401
64111	64801	66890	67402
64113	64802	66891	67403
64130	64803	66892	67404
64131	64804	66893	67410
64133	64820	66894	67412
64180	64821	66910	67420
64181	64822	66911	67422
64183	64823	66912	67424
64190	64824	66913	67450
64191	64830	66914	67451
64193	64831	66930	67452
64240	64832	66932	67453

67454	64101	64743	66882
67510	64103	64744	66883
67511	64110	64800	66884
67512	64111	64801	66890
*64944	64113	64802	66891
63400	64130	64803	66892
63401	64131	64804	66893
63402	64133	64820	66894
63410	64180	64821	66910
63411	64181	64822	66911
63412	64183	64823	66912
63420	64190	64824	66913
63421	64191	64830	66914
63422	64193	64831	66930
63430	64240	64832	66932
63431	64241	64833	66934
63432	64242	64834	67000
63440	64243	64850	67002
63441	64244	64851	67004
63442	64250	64852	67120
63450	64251	64853	67121
63451	64252	64854	67122
63452	64253	64860	67123
63460	64254	64861	67124
63461	64260	64862	67130
63462	64261	64863	67131
63470	64262	64864	67133
63471	64263	65930	67140
63472	64264	65931	67142
63480	64270	65933	67144
63481	64271	66500	67300
63482	64272	66501	67301
63490	64273	66503	67302
63491	64274	66510	67303
63492	64400	66511	67304
6390	64403	66632	67310
6391	64410	66634	67311
6392	64413	66800	67312
6393	64660	66801	67313
6394	64661	66802	67314
6395	64662	66803	67320
6396	64663	66804	67321
6398	64664	66810	67322
6399	64670	66811	67323
64000	64671	66812	67324
64001	64673	66813	67330
64003	64730	66814	67331
64080	64731	66820	67332
64081	64732	66821	67333
64083	64733	66822	67334
64090	64734	66823	67380
64091	64740	66824	67381
64093	64741	66880	67382
64100	64742	66881	67383

67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64950
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313

67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64951
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124

67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824
67140	63421	64191	64830
67142	63422	64193	64831
67144	63430	64240	64832
67300	63431	64241	64833
67301	63432	64242	64834
67302	63440	64243	64850
67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853
67311	63451	64252	64854
67312	63452	64253	64860
67313	63460	64254	64861
67314	63461	64260	64862
67320	63462	64261	64863
67321	63470	64262	64864
67322	63471	64263	65930
67323	63472	64264	65931
67324	63480	64270	65933
67330	63481	64271	66500
67331	63482	64272	66501
67332	63490	64273	66503
67333	63491	64274	66510
67334	63492	64400	66511
67380	6390	64403	66632
67381	6391	64410	66634
67382	6392	64413	66800
67383	6393	64660	66801
67384	6394	64661	66802
67400	6395	64662	66803
67401	6396	64663	66804
67402	6398	64664	66810
67403	6399	64670	66811
67404	64000	64671	66812
67410	64001	64673	66813
67412	64003	64730	66814
67420	64080	64731	66820
67422	64081	64732	66821
67424	64083	64733	66822
67450	64090	64734	66823
67451	64091	64740	66824
67452	64093	64741	66880
67453	64100	64742	66881
67454	64101	64743	66882
67510	64103	64744	66883
67511	64110	64800	66884
67512	64111	64801	66890
*64953	64113	64802	66891
63400	64130	64803	66892
63401	64131	64804	66893
63402	64133	64820	66894
63410	64180	64821	66910

66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800
67004	67512	64111	64801
67120	*64960	64113	64802
67121	63400	64130	64803
67122	63401	64131	64804
67123	63402	64133	64820
67124	63410	64180	64821
67130	63411	64181	64822
67131	63412	64183	64823
67133	63420	64190	64824
67140	63421	64191	64830
67142	63422	64193	64831
67144	63430	64240	64832
67300	63431	64241	64833
67301	63432	64242	64834
67302	63440	64243	64850
67303	63441	64244	64851
67304	63442	64250	64852
67310	63450	64251	64853
67311	63451	64252	64854
67312	63452	64253	64860
67313	63460	64254	64861
67314	63461	64260	64862
67320	63462	64261	64863
67321	63470	64262	64864
67322	63471	64263	65930
67323	63472	64264	65931
67324	63480	64270	65933
67330	63481	64271	66500
67331	63482	64272	66501
67332	63490	64273	66503
67333	63491	64274	66510
67334	63492	64400	66511
67380	6390	64403	66632
67381	6391	64410	66634
67382	6392	64413	66800
67383	6393	64660	66801
67384	6394	64661	66802
67400	6395	64662	66803
67401	6396	64663	66804
67402	6398	64664	66810
67403	6399	64670	66811
67404	64000	64671	66812
67410	64001	64673	66813
67412	64003	64730	66814
67420	64080	64731	66820

66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64961
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503

66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64962
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663
64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850

64851	67004	67512	64111
64852	67120	*64963	64113
64853	67121	63400	64130
64854	67122	63401	64131
64860	67123	63402	64133
64861	67124	63410	64180
64862	67130	63411	64181
64863	67131	63412	64183
64864	67133	63420	64190
65930	67140	63421	64191
65931	67142	63422	64193
65933	67144	63430	64240
66500	67300	63431	64241
66501	67301	63432	64242
66503	67302	63440	64243
66510	67303	63441	64244
66511	67304	63442	64250
66632	67310	63450	64251
66634	67311	63451	64252
66800	67312	63452	64253
66801	67313	63460	64254
66802	67314	63461	64260
66803	67320	63462	64261
66804	67321	63470	64262
66810	67322	63471	64263
66811	67323	63472	64264
66812	67324	63480	64270
66813	67330	63481	64271
66814	67331	63482	64272
66820	67332	63490	64273
66821	67333	63491	64274
66822	67334	63492	64400
66823	67380	6390	64403
66824	67381	6391	64410
66880	67382	6392	64413
66881	67383	6393	64660
66882	67384	6394	64661
66883	67400	6395	64662
66884	67401	6396	64663
66890	67402	6398	64664
66891	67403	6399	64670
66892	67404	64000	64671
66893	67410	64001	64673
66894	67412	64003	64730
66910	67420	64080	64731
66911	67422	64081	64732
66912	67424	64083	64733
66913	67450	64090	64734
66914	67451	64091	64740
66930	67452	64093	64741
66932	67453	64100	64742
66934	67454	64101	64743
67000	67510	64103	64744
67002	67511	64110	64800

64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*64964
63400
63401
63402
63410
63411
63412
63420
63421
63422
63430
63431
63432
63440
63441
63442
63450
63451
63452
63460
63461
63462
63470
63471
63472
63480
63481
63482
63490
63491
63492
6390
6391
6392
6393
6394
6395
6396
6398
6399
64000
64001
64003
64080
64081
64083
64090
64091
64093
64100
64101
64103
64110
64111
64113
64130
64131
64133
64180
64181
64183
64190
64191
64193
64240
64241
64242
64243
64244
64250
64251
64252
64253
64254
64260
64261
64262
64263
64264
64270
64271
64272
64273
64274
64400
64403
64410
64413
64660
64661
64662
64663

64664
64670
64671
64673
64730
64731
64732
64733
64734
64740
64741
64742
64743
64744
64800
64801
64802
64803
64804
64820
64821
64822
64823
64824
64830
64831
64832
64833
64834
64850
64851
64852
64853
64854
64860
64861
64862
64863
64864
65930
65931
65933
66500
66501
66503
66510
66511
66632
66634
66800
66801
66802
66803
66804
66810
66811
66812
66813
66814
66820
66821
66822
66823
66824
66880
66881
66882
66883
66884
66890
66891
66892
66893
66894
66910
66911
66912
66913
66914
66930
66932
66934
67000
67002
67004
67120
67121
67122
67123
67124
67130
67131
67133
67140
67142
67144
67300
67301
67302
67303
67304
67310
67311
67312
67313
67314
67320
67321
67322
67323
67324
67330
67331
67332
67333
67334
67380
67381
67382
67383
67384
67400
67401
67402
67403
67404
67410
67412
67420
67422
67424
67450
67451
67452
67453
67454
67510
67511
67512
*7790
78032
*7791
78032
*77985
77985
*78031
78032
*78032
78031
78032
78039
*78039
78032
*78091
78032
*78092
78032
*78093
78032
*78094
78032
*78095
78032
*78096
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*78097
04082
44024
78001
78003
7801
78031
78032
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*78099

78032	80052	80120	80186
*78864	80053	80121	80189
78820	80054	80122	80190
78829	80055	80123	80191
*78865	80056	80124	80192
78820	80059	80125	80193
78829	80060	80126	80194
*79981	80061	80129	80195
78032	80062	80130	80196
*79989	80063	80131	80199
78032	80064	80132	8021
*95890	80065	80133	80220
80000	80066	80134	80221
80001	80069	80135	80222
80002	80070	80136	80223
80003	80071	80139	80224
80004	80072	80140	80225
80005	80073	80141	80226
80006	80074	80142	80227
80009	80075	80143	80228
80010	80076	80144	80229
80011	80079	80145	80230
80012	80080	80146	80231
80013	80081	80149	80232
80014	80082	80150	80233
80015	80083	80151	80234
80016	80084	80152	80235
80019	80085	80153	80236
80020	80086	80154	80237
80021	80089	80155	80238
80022	80090	80156	80239
80023	80091	80159	8024
80024	80092	80160	8025
80025	80093	80161	8026
80026	80094	80162	8027
80029	80095	80163	8028
80030	80096	80164	8029
80031	80099	80165	80300
80032	80100	80166	80301
80033	80101	80169	80302
80034	80102	80170	80303
80035	80103	80171	80304
80036	80104	80172	80305
80039	80105	80173	80306
80040	80106	80174	80309
80041	80109	80175	80310
80042	80110	80176	80311
80043	80111	80179	80312
80044	80112	80180	80313
80045	80113	80181	80314
80046	80114	80182	80315
80049	80115	80183	80316
80050	80116	80184	80319
80051	80119	80185	80320

80321	80389	80455	8053
80322	80390	80456	8054
80323	80391	80459	8055
80324	80392	80460	8056
80325	80393	80461	8057
80326	80394	80462	8058
80329	80395	80463	8059
80330	80396	80464	80600
80331	80399	80465	80601
80332	80400	80466	80602
80333	80401	80469	80603
80334	80402	80470	80604
80335	80403	80471	80605
80336	80404	80472	80606
80339	80405	80473	80607
80340	80406	80474	80608
80341	80409	80475	80609
80342	80410	80476	80610
80343	80411	80479	80611
80344	80412	80480	80612
80345	80413	80481	80613
80346	80414	80482	80614
80349	80415	80483	80615
80350	80416	80484	80616
80351	80419	80485	80617
80352	80420	80486	80618
80353	80421	80489	80619
80354	80422	80490	80620
80355	80423	80491	80621
80356	80424	80492	80622
80359	80425	80493	80623
80360	80426	80494	80624
80361	80429	80495	80625
80362	80430	80496	80626
80363	80431	80499	80627
80364	80432	80500	80628
80365	80433	80501	80629
80366	80434	80502	80630
80369	80435	80503	80631
80370	80436	80504	80632
80371	80439	80505	80633
80372	80440	80506	80634
80373	80441	80507	80635
80374	80442	80508	80636
80375	80443	80510	80637
80376	80444	80511	80638
80379	80445	80512	80639
80380	80446	80513	8064
80381	80449	80514	8065
80382	80450	80515	80660
80383	80451	80516	80661
80384	80452	80517	80662
80385	80453	80518	80669
80386	80454	8052	80670

80671	8208	85126	85194
80672	8209	85129	85195
80679	82100	85130	85196
8068	82101	85131	85199
8069	82110	85132	85200
80704	82111	85133	85201
80705	83900	85134	85202
80706	83901	85135	85203
80707	83902	85136	85204
80708	83903	85139	85205
80709	83904	85140	85206
80710	83905	85141	85209
80711	83906	85142	85210
80712	83907	85143	85211
80713	83908	85144	85212
80714	83910	85145	85213
80715	83911	85146	85214
80716	83912	85149	85215
80717	83913	85150	85216
80718	83914	85151	85219
80719	83915	85152	85220
8072	83916	85153	85221
8073	83917	85154	85222
8074	83918	85155	85223
8075	8500	85156	85224
8076	85011	85159	85225
8080	85012	85160	85226
8081	8502	85161	85229
8082	8503	85162	85230
8083	8504	85163	85231
80843	8505	85164	85232
80849	8509	85165	85233
80851	85100	85166	85234
80852	85101	85169	85235
80853	85102	85170	85236
80859	85103	85171	85239
8088	85104	85172	85240
8089	85105	85173	85241
82000	85106	85174	85242
82001	85109	85175	85243
82002	85110	85176	85244
82003	85111	85179	85245
82009	85112	85180	85246
82010	85113	85181	85249
82011	85114	85182	85250
82012	85115	85183	85251
82013	85116	85184	85252
82019	85119	85185	85253
82020	85120	85186	85254
82021	85121	85189	85255
82022	85122	85190	85256
82030	85123	85191	85259
82031	85124	85192	85300
82032	85125	85193	85301

85302	8629	8670	8875
85303	8631	8671	8876
85304	86330	8672	8877
85305	86331	8673	8960
85306	86339	8674	8961
85309	86350	8675	8962
85310	86351	8676	8963
85311	86352	8677	8970
85312	86353	8678	8971
85313	86354	8679	8972
85314	86355	86800	8973
85315	86356	86801	8974
85316	86359	86802	8975
85319	86390	86803	8976
85400	86391	86804	8977
85401	86392	86809	90000
85402	86393	86810	90001
85403	86394	86811	90002
85404	86395	86812	90003
85405	86399	86813	9001
85406	86400	86814	90081
85409	86401	86819	90082
85410	86402	8690	90089
85411	86403	8691	9009
85412	86404	8703	9010
85413	86405	8704	9011
85414	86409	8708	9012
85415	86410	8709	9013
85416	86411	8710	90141
85419	86412	8711	90142
8600	86413	8712	90183
8601	86414	8713	9020
8602	86415	8714	90210
8603	86419	8719	90211
8604	86500	87272	90219
8605	86501	87273	90220
86101	86502	87274	90222
86102	86503	87333	90223
86103	86504	8739	90224
86110	86509	87400	90225
86111	86510	87401	90226
86112	86511	87402	90227
86113	86512	87410	90229
86122	86513	87411	90231
86130	86514	87412	90232
86131	86519	8743	90233
86132	86600	8745	90234
8621	86601	8750	90239
86221	86602	8751	90240
86222	86603	8870	90241
86229	86610	8871	90242
86231	86611	8872	90249
86232	86612	8873	90250
86239	86613	8874	90251

90252	80005	80073	80141
90253	80006	80074	80142
90254	80009	80075	80143
90259	80010	80076	80144
90287	80011	80079	80145
9251	80012	80080	80146
9252	80013	80081	80149
9290	80014	80082	80150
95200	80015	80083	80151
95201	80016	80084	80152
95202	80019	80085	80153
95203	80020	80086	80154
95204	80021	80089	80155
95205	80022	80090	80156
95206	80023	80091	80159
95207	80024	80092	80160
95208	80025	80093	80161
95209	80026	80094	80162
95210	80029	80095	80163
95211	80030	80096	80164
95212	80031	80099	80165
95213	80032	80100	80166
95214	80033	80101	80169
95215	80034	80102	80170
95216	80035	80103	80171
95217	80036	80104	80172
95218	80039	80105	80173
95219	80040	80106	80174
9522	80041	80109	80175
9523	80042	80110	80176
9524	80043	80111	80179
9528	80044	80112	80180
9529	80045	80113	80181
9530	80046	80114	80182
9531	80049	80115	80183
9532	80050	80116	80184
9533	80051	80119	80185
9534	80052	80120	80186
9535	80053	80121	80189
9538	80054	80122	80190
9539	80055	80123	80191
9580	80056	80124	80192
9581	80059	80125	80193
9582	80060	80126	80194
9583	80061	80129	80195
9584	80062	80130	80196
9585	80063	80131	80199
9587	80064	80132	8021
*95891	80065	80133	80220
80000	80066	80134	80221
80001	80069	80135	80222
80002	80070	80136	80223
80003	80071	80139	80224
80004	80072	80140	80225

80226	80342	80410	80476
80227	80343	80411	80479
80228	80344	80412	80480
80229	80345	80413	80481
80230	80346	80414	80482
80231	80349	80415	80483
80232	80350	80416	80484
80233	80351	80419	80485
80234	80352	80420	80486
80235	80353	80421	80489
80236	80354	80422	80490
80237	80355	80423	80491
80238	80356	80424	80492
80239	80359	80425	80493
8024	80360	80426	80494
8025	80361	80429	80495
8026	80362	80430	80496
8027	80363	80431	80499
8028	80364	80432	80500
8029	80365	80433	80501
80300	80366	80434	80502
80301	80369	80435	80503
80302	80370	80436	80504
80303	80371	80439	80505
80304	80372	80440	80506
80305	80373	80441	80507
80306	80374	80442	80508
80309	80375	80443	80510
80310	80376	80444	80511
80311	80379	80445	80512
80312	80380	80446	80513
80313	80381	80449	80514
80314	80382	80450	80515
80315	80383	80451	80516
80316	80384	80452	80517
80319	80385	80453	80518
80320	80386	80454	8052
80321	80389	80455	8053
80322	80390	80456	8054
80323	80391	80459	8055
80324	80392	80460	8056
80325	80393	80461	8057
80326	80394	80462	8058
80329	80395	80463	8059
80330	80396	80464	80600
80331	80399	80465	80601
80332	80400	80466	80602
80333	80401	80469	80603
80334	80402	80470	80604
80335	80403	80471	80605
80336	80404	80472	80606
80339	80405	80473	80607
80340	80406	80474	80608
80341	80409	80475	80609

80610	80716	83912	85149
80611	80717	83913	85150
80612	80718	83914	85151
80613	80719	83915	85152
80614	8072	83916	85153
80615	8073	83917	85154
80616	8074	83918	85155
80617	8075	8500	85156
80618	8076	85011	85159
80619	8080	85012	85160
80620	8081	8502	85161
80621	8082	8503	85162
80622	8083	8504	85163
80623	80843	8505	85164
80624	80849	8509	85165
80625	80851	85100	85166
80626	80852	85101	85169
80627	80853	85102	85170
80628	80859	85103	85171
80629	8088	85104	85172
80630	8089	85105	85173
80631	82000	85106	85174
80632	82001	85109	85175
80633	82002	85110	85176
80634	82003	85111	85179
80635	82009	85112	85180
80636	82010	85113	85181
80637	82011	85114	85182
80638	82012	85115	85183
80639	82013	85116	85184
8064	82019	85119	85185
8065	82020	85120	85186
80660	82021	85121	85189
80661	82022	85122	85190
80662	82030	85123	85191
80669	82031	85124	85192
80670	82032	85125	85193
80671	8208	85126	85194
80672	8209	85129	85195
80679	82100	85130	85196
8068	82101	85131	85199
8069	82110	85132	85200
80704	82111	85133	85201
80705	83900	85134	85202
80706	83901	85135	85203
80707	83902	85136	85204
80708	83903	85139	85205
80709	83904	85140	85206
80710	83905	85141	85209
80711	83906	85142	85210
80712	83907	85143	85211
80713	83908	85144	85212
80714	83910	85145	85213
80715	83911	85146	85214

85215	85403	86394	86811
85216	85404	86395	86812
85219	85405	86399	86813
85220	85406	86400	86814
85221	85409	86401	86819
85222	85410	86402	8690
85223	85411	86403	8691
85224	85412	86404	8703
85225	85413	86405	8704
85226	85414	86409	8708
85229	85415	86410	8709
85230	85416	86411	8710
85231	85419	86412	8711
85232	8600	86413	8712
85233	8601	86414	8713
85234	8602	86415	8714
85235	8603	86419	8719
85236	8604	86500	87272
85239	8605	86501	87273
85240	86101	86502	87274
85241	86102	86503	87333
85242	86103	86504	8739
85243	86110	86509	87400
85244	86111	86510	87401
85245	86112	86511	87402
85246	86113	86512	87410
85249	86122	86513	87411
85250	86130	86514	87412
85251	86131	86519	8743
85252	86132	86600	8745
85253	8621	86601	8750
85254	86221	86602	8751
85255	86222	86603	8870
85256	86229	86610	8871
85259	86231	86611	8872
85300	86232	86612	8873
85301	86239	86613	8874
85302	8629	8670	8875
85303	8631	8671	8876
85304	86330	8672	8877
85305	86331	8673	8960
85306	86339	8674	8961
85309	86350	8675	8962
85310	86351	8676	8963
85311	86352	8677	8970
85312	86353	8678	8971
85313	86354	8679	8972
85314	86355	86800	8973
85315	86356	86801	8974
85316	86359	86802	8975
85319	86390	86803	8976
85400	86391	86804	8977
85401	86392	86809	90000
85402	86393	86810	90001

90002	95209	80026	80094
90003	95210	80029	80095
9001	95211	80030	80096
90081	95212	80031	80099
90082	95213	80032	80100
90089	95214	80033	80101
9009	95215	80034	80102
9010	95216	80035	80103
9011	95217	80036	80104
9012	95218	80039	80105
9013	95219	80040	80106
90141	9522	80041	80109
90142	9523	80042	80110
90183	9524	80043	80111
9020	9528	80044	80112
90210	9529	80045	80113
90211	9530	80046	80114
90219	9531	80049	80115
90220	9532	80050	80116
90222	9533	80051	80119
90223	9534	80052	80120
90224	9535	80053	80121
90225	9538	80054	80122
90226	9539	80055	80123
90227	9580	80056	80124
90229	9581	80059	80125
90231	9582	80060	80126
90232	9583	80061	80129
90233	9584	80062	80130
90234	9585	80063	80131
90239	9587	80064	80132
90240	*95892	80065	80133
90241	80000	80066	80134
90242	80001	80069	80135
90249	80002	80070	80136
90250	80003	80071	80139
90251	80004	80072	80140
90252	80005	80073	80141
90253	80006	80074	80142
90254	80009	80075	80143
90259	80010	80076	80144
90287	80011	80079	80145
9251	80012	80080	80146
9252	80013	80081	80149
9290	80014	80082	80150
95200	80015	80083	80151
95201	80016	80084	80152
95202	80019	80085	80153
95203	80020	80086	80154
95204	80021	80089	80155
95205	80022	80090	80156
95206	80023	80091	80159
95207	80024	80092	80160
95208	80025	80093	80161

80162	8027	80363	80431
80163	8028	80364	80432
80164	8029	80365	80433
80165	80300	80366	80434
80166	80301	80369	80435
80169	80302	80370	80436
80170	80303	80371	80439
80171	80304	80372	80440
80172	80305	80373	80441
80173	80306	80374	80442
80174	80309	80375	80443
80175	80310	80376	80444
80176	80311	80379	80445
80179	80312	80380	80446
80180	80313	80381	80449
80181	80314	80382	80450
80182	80315	80383	80451
80183	80316	80384	80452
80184	80319	80385	80453
80185	80320	80386	80454
80186	80321	80389	80455
80189	80322	80390	80456
80190	80323	80391	80459
80191	80324	80392	80460
80192	80325	80393	80461
80193	80326	80394	80462
80194	80329	80395	80463
80195	80330	80396	80464
80196	80331	80399	80465
80199	80332	80400	80466
8021	80333	80401	80469
80220	80334	80402	80470
80221	80335	80403	80471
80222	80336	80404	80472
80223	80339	80405	80473
80224	80340	80406	80474
80225	80341	80409	80475
80226	80342	80410	80476
80227	80343	80411	80479
80228	80344	80412	80480
80229	80345	80413	80481
80230	80346	80414	80482
80231	80349	80415	80483
80232	80350	80416	80484
80233	80351	80419	80485
80234	80352	80420	80486
80235	80353	80421	80489
80236	80354	80422	80490
80237	80355	80423	80491
80238	80356	80424	80492
80239	80359	80425	80493
8024	80360	80426	80494
8025	80361	80429	80495
8026	80362	80430	80496

80499	80627	80853	85102
80500	80628	80859	85103
80501	80629	8088	85104
80502	80630	8089	85105
80503	80631	82000	85106
80504	80632	82001	85109
80505	80633	82002	85110
80506	80634	82003	85111
80507	80635	82009	85112
80508	80636	82010	85113
80510	80637	82011	85114
80511	80638	82012	85115
80512	80639	82013	85116
80513	8064	82019	85119
80514	8065	82020	85120
80515	80660	82021	85121
80516	80661	82022	85122
80517	80662	82030	85123
80518	80669	82031	85124
8052	80670	82032	85125
8053	80671	8208	85126
8054	80672	8209	85129
8055	80679	82100	85130
8056	8068	82101	85131
8057	8069	82110	85132
8058	80704	82111	85133
8059	80705	83900	85134
80600	80706	83901	85135
80601	80707	83902	85136
80602	80708	83903	85139
80603	80709	83904	85140
80604	80710	83905	85141
80605	80711	83906	85142
80606	80712	83907	85143
80607	80713	83908	85144
80608	80714	83910	85145
80609	80715	83911	85146
80610	80716	83912	85149
80611	80717	83913	85150
80612	80718	83914	85151
80613	80719	83915	85152
80614	8072	83916	85153
80615	8073	83917	85154
80616	8074	83918	85155
80617	8075	8500	85156
80618	8076	85011	85159
80619	8080	85012	85160
80620	8081	8502	85161
80621	8082	8503	85162
80622	8083	8504	85163
80623	80843	8505	85164
80624	80849	8509	85165
80625	80851	85100	85166
80626	80852	85101	85169

85170	85236	8604	86500
85171	85239	8605	86501
85172	85240	86101	86502
85173	85241	86102	86503
85174	85242	86103	86504
85175	85243	86110	86509
85176	85244	86111	86510
85179	85245	86112	86511
85180	85246	86113	86512
85181	85249	86122	86513
85182	85250	86130	86514
85183	85251	86131	86519
85184	85252	86132	86600
85185	85253	8621	86601
85186	85254	86221	86602
85189	85255	86222	86603
85190	85256	86229	86610
85191	85259	86231	86611
85192	85300	86232	86612
85193	85301	86239	86613
85194	85302	8629	8670
85195	85303	8631	8671
85196	85304	86330	8672
85199	85305	86331	8673
85200	85306	86339	8674
85201	85309	86350	8675
85202	85310	86351	8676
85203	85311	86352	8677
85204	85312	86353	8678
85205	85313	86354	8679
85206	85314	86355	86800
85209	85315	86356	86801
85210	85316	86359	86802
85211	85319	86390	86803
85212	85400	86391	86804
85213	85401	86392	86809
85214	85402	86393	86810
85215	85403	86394	86811
85216	85404	86395	86812
85219	85405	86399	86813
85220	85406	86400	86814
85221	85409	86401	86819
85222	85410	86402	8690
85223	85411	86403	8691
85224	85412	86404	8703
85225	85413	86405	8704
85226	85414	86409	8708
85229	85415	86410	8709
85230	85416	86411	8710
85231	85419	86412	8711
85232	8600	86413	8712
85233	8601	86414	8713
85234	8602	86415	8714
85235	8603	86419	8719

87272	90219	9531	80049
87273	90220	9532	80050
87274	90222	9533	80051
87333	90223	9534	80052
8739	90224	9535	80053
87400	90225	9538	80054
87401	90226	9539	80055
87402	90227	9580	80056
87410	90229	9581	80059
87411	90231	9582	80060
87412	90232	9583	80061
8743	90233	9584	80062
8745	90234	9585	80063
8750	90239	9587	80064
8751	90240	*95893	80065
8870	90241	80000	80066
8871	90242	80001	80069
8872	90249	80002	80070
8873	90250	80003	80071
8874	90251	80004	80072
8875	90252	80005	80073
8876	90253	80006	80074
8877	90254	80009	80075
8960	90259	80010	80076
8961	90287	80011	80079
8962	9251	80012	80080
8963	9252	80013	80081
8970	9290	80014	80082
8971	95200	80015	80083
8972	95201	80016	80084
8973	95202	80019	80085
8974	95203	80020	80086
8975	95204	80021	80089
8976	95205	80022	80090
8977	95206	80023	80091
90000	95207	80024	80092
90001	95208	80025	80093
90002	95209	80026	80094
90003	95210	80029	80095
9001	95211	80030	80096
90081	95212	80031	80099
90082	95213	80032	80100
90089	95214	80033	80101
9009	95215	80034	80102
9010	95216	80035	80103
9011	95217	80036	80104
9012	95218	80039	80105
9013	95219	80040	80106
90141	9522	80041	80109
90142	9523	80042	80110
90183	9524	80043	80111
9020	9528	80044	80112
90210	9529	80045	80113
90211	9530	80046	80114

80115	80183	80316	80384
80116	80184	80319	80385
80119	80185	80320	80386
80120	80186	80321	80389
80121	80189	80322	80390
80122	80190	80323	80391
80123	80191	80324	80392
80124	80192	80325	80393
80125	80193	80326	80394
80126	80194	80329	80395
80129	80195	80330	80396
80130	80196	80331	80399
80131	80199	80332	80400
80132	8021	80333	80401
80133	80220	80334	80402
80134	80221	80335	80403
80135	80222	80336	80404
80136	80223	80339	80405
80139	80224	80340	80406
80140	80225	80341	80409
80141	80226	80342	80410
80142	80227	80343	80411
80143	80228	80344	80412
80144	80229	80345	80413
80145	80230	80346	80414
80146	80231	80349	80415
80149	80232	80350	80416
80150	80233	80351	80419
80151	80234	80352	80420
80152	80235	80353	80421
80153	80236	80354	80422
80154	80237	80355	80423
80155	80238	80356	80424
80156	80239	80359	80425
80159	8024	80360	80426
80160	8025	80361	80429
80161	8026	80362	80430
80162	8027	80363	80431
80163	8028	80364	80432
80164	8029	80365	80433
80165	80300	80366	80434
80166	80301	80369	80435
80169	80302	80370	80436
80170	80303	80371	80439
80171	80304	80372	80440
80172	80305	80373	80441
80173	80306	80374	80442
80174	80309	80375	80443
80175	80310	80376	80444
80176	80311	80379	80445
80179	80312	80380	80446
80180	80313	80381	80449
80181	80314	80382	80450
80182	80315	80383	80451

80452	80517	80662	82030
80453	80518	80669	82031
80454	8052	80670	82032
80455	8053	80671	8208
80456	8054	80672	8209
80459	8055	80679	82100
80460	8056	8068	82101
80461	8057	8069	82110
80462	8058	80704	82111
80463	8059	80705	83900
80464	80600	80706	83901
80465	80601	80707	83902
80466	80602	80708	83903
80469	80603	80709	83904
80470	80604	80710	83905
80471	80605	80711	83906
80472	80606	80712	83907
80473	80607	80713	83908
80474	80608	80714	83910
80475	80609	80715	83911
80476	80610	80716	83912
80479	80611	80717	83913
80480	80612	80718	83914
80481	80613	80719	83915
80482	80614	8072	83916
80483	80615	8073	83917
80484	80616	8074	83918
80485	80617	8075	8500
80486	80618	8076	85011
80489	80619	8080	85012
80490	80620	8081	8502
80491	80621	8082	8503
80492	80622	8083	8504
80493	80623	80843	8505
80494	80624	80849	8509
80495	80625	80851	85100
80496	80626	80852	85101
80499	80627	80853	85102
80500	80628	80859	85103
80501	80629	8088	85104
80502	80630	8089	85105
80503	80631	82000	85106
80504	80632	82001	85109
80505	80633	82002	85110
80506	80634	82003	85111
80507	80635	82009	85112
80508	80636	82010	85113
80510	80637	82011	85114
80511	80638	82012	85115
80512	80639	82013	85116
80513	8064	82019	85119
80514	8065	82020	85120
80515	80660	82021	85121
80516	80661	82022	85122

85123	85191	85259	86231
85124	85192	85300	86232
85125	85193	85301	86239
85126	85194	85302	8629
85129	85195	85303	8631
85130	85196	85304	86330
85131	85199	85305	86331
85132	85200	85306	86339
85133	85201	85309	86350
85134	85202	85310	86351
85135	85203	85311	86352
85136	85204	85312	86353
85139	85205	85313	86354
85140	85206	85314	86355
85141	85209	85315	86356
85142	85210	85316	86359
85143	85211	85319	86390
85144	85212	85400	86391
85145	85213	85401	86392
85146	85214	85402	86393
85149	85215	85403	86394
85150	85216	85404	86395
85151	85219	85405	86399
85152	85220	85406	86400
85153	85221	85409	86401
85154	85222	85410	86402
85155	85223	85411	86403
85156	85224	85412	86404
85159	85225	85413	86405
85160	85226	85414	86409
85161	85229	85415	86410
85162	85230	85416	86411
85163	85231	85419	86412
85164	85232	8600	86413
85165	85233	8601	86414
85166	85234	8602	86415
85169	85235	8603	86419
85170	85236	8604	86500
85171	85239	8605	86501
85172	85240	86101	86502
85173	85241	86102	86503
85174	85242	86103	86504
85175	85243	86110	86509
85176	85244	86111	86510
85179	85245	86112	86511
85180	85246	86113	86512
85181	85249	86122	86513
85182	85250	86130	86514
85183	85251	86131	86519
85184	85252	86132	86600
85185	85253	8621	86601
85186	85254	86221	86602
85189	85255	86222	86603
85190	85256	86229	86610

86611	8872	90249	80002
86612	8873	90250	80003
86613	8874	90251	80004
8670	8875	90252	80005
8671	8876	90253	80006
8672	8877	90254	80009
8673	8960	90259	80010
8674	8961	90287	80011
8675	8962	9251	80012
8676	8963	9252	80013
8677	8970	9290	80014
8678	8971	95200	80015
8679	8972	95201	80016
86800	8973	95202	80019
86801	8974	95203	80020
86802	8975	95204	80021
86803	8976	95205	80022
86804	8977	95206	80023
86809	90000	95207	80024
86810	90001	95208	80025
86811	90002	95209	80026
86812	90003	95210	80029
86813	9001	95211	80030
86814	90081	95212	80031
86819	90082	95213	80032
8690	90089	95214	80033
8691	9009	95215	80034
8703	9010	95216	80035
8704	9011	95217	80036
8708	9012	95218	80039
8709	9013	95219	80040
8710	90141	9522	80041
8711	90142	9523	80042
8712	90183	9524	80043
8713	9020	9528	80044
8714	90210	9529	80045
8719	90211	9530	80046
87272	90219	9531	80049
87273	90220	9532	80050
87274	90222	9533	80051
87333	90223	9534	80052
8739	90224	9535	80053
87400	90225	9538	80054
87401	90226	9539	80055
87402	90227	9580	80056
87410	90229	9581	80059
87411	90231	9582	80060
87412	90232	9583	80061
8743	90233	9584	80062
8745	90234	9585	80063
8750	90239	9587	80064
8751	90240	*95899	80065
8870	90241	80000	80066
8871	90242	80001	80069

80070	80136	80223	80339
80071	80139	80224	80340
80072	80140	80225	80341
80073	80141	80226	80342
80074	80142	80227	80343
80075	80143	80228	80344
80076	80144	80229	80345
80079	80145	80230	80346
80080	80146	80231	80349
80081	80149	80232	80350
80082	80150	80233	80351
80083	80151	80234	80352
80084	80152	80235	80353
80085	80153	80236	80354
80086	80154	80237	80355
80089	80155	80238	80356
80090	80156	80239	80359
80091	80159	8024	80360
80092	80160	8025	80361
80093	80161	8026	80362
80094	80162	8027	80363
80095	80163	8028	80364
80096	80164	8029	80365
80099	80165	80300	80366
80100	80166	80301	80369
80101	80169	80302	80370
80102	80170	80303	80371
80103	80171	80304	80372
80104	80172	80305	80373
80105	80173	80306	80374
80106	80174	80309	80375
80109	80175	80310	80376
80110	80176	80311	80379
80111	80179	80312	80380
80112	80180	80313	80381
80113	80181	80314	80382
80114	80182	80315	80383
80115	80183	80316	80384
80116	80184	80319	80385
80119	80185	80320	80386
80120	80186	80321	80389
80121	80189	80322	80390
80122	80190	80323	80391
80123	80191	80324	80392
80124	80192	80325	80393
80125	80193	80326	80394
80126	80194	80329	80395
80129	80195	80330	80396
80130	80196	80331	80399
80131	80199	80332	80400
80132	8021	80333	80401
80133	80220	80334	80402
80134	80221	80335	80403
80135	80222	80336	80404

80405	80473	80607	80713
80406	80474	80608	80714
80409	80475	80609	80715
80410	80476	80610	80716
80411	80479	80611	80717
80412	80480	80612	80718
80413	80481	80613	80719
80414	80482	80614	8072
80415	80483	80615	8073
80416	80484	80616	8074
80419	80485	80617	8075
80420	80486	80618	8076
80421	80489	80619	8080
80422	80490	80620	8081
80423	80491	80621	8082
80424	80492	80622	8083
80425	80493	80623	80843
80426	80494	80624	80849
80429	80495	80625	80851
80430	80496	80626	80852
80431	80499	80627	80853
80432	80500	80628	80859
80433	80501	80629	8088
80434	80502	80630	8089
80435	80503	80631	82000
80436	80504	80632	82001
80439	80505	80633	82002
80440	80506	80634	82003
80441	80507	80635	82009
80442	80508	80636	82010
80443	80510	80637	82011
80444	80511	80638	82012
80445	80512	80639	82013
80446	80513	8064	82019
80449	80514	8065	82020
80450	80515	80660	82021
80451	80516	80661	82022
80452	80517	80662	82030
80453	80518	80669	82031
80454	8052	80670	82032
80455	8053	80671	8208
80456	8054	80672	8209
80459	8055	80679	82100
80460	8056	8068	82101
80461	8057	8069	82110
80462	8058	80704	82111
80463	8059	80705	83900
80464	80600	80706	83901
80465	80601	80707	83902
80466	80602	80708	83903
80469	80603	80709	83904
80470	80604	80710	83905
80471	80605	80711	83906
80472	80606	80712	83907

83908	85144	85212	85400
83910	85145	85213	85401
83911	85146	85214	85402
83912	85149	85215	85403
83913	85150	85216	85404
83914	85151	85219	85405
83915	85152	85220	85406
83916	85153	85221	85409
83917	85154	85222	85410
83918	85155	85223	85411
8500	85156	85224	85412
85011	85159	85225	85413
85012	85160	85226	85414
8502	85161	85229	85415
8503	85162	85230	85416
8504	85163	85231	85419
8505	85164	85232	8600
8509	85165	85233	8601
85100	85166	85234	8602
85101	85169	85235	8603
85102	85170	85236	8604
85103	85171	85239	8605
85104	85172	85240	86101
85105	85173	85241	86102
85106	85174	85242	86103
85109	85175	85243	86110
85110	85176	85244	86111
85111	85179	85245	86112
85112	85180	85246	86113
85113	85181	85249	86122
85114	85182	85250	86130
85115	85183	85251	86131
85116	85184	85252	86132
85119	85185	85253	8621
85120	85186	85254	86221
85121	85189	85255	86222
85122	85190	85256	86229
85123	85191	85259	86231
85124	85192	85300	86232
85125	85193	85301	86239
85126	85194	85302	8629
85129	85195	85303	8631
85130	85196	85304	86330
85131	85199	85305	86331
85132	85200	85306	86339
85133	85201	85309	86350
85134	85202	85310	86351
85135	85203	85311	86352
85136	85204	85312	86353
85139	85205	85313	86354
85140	85206	85314	86355
85141	85209	85315	86356
85142	85210	85316	86359
85143	85211	85319	86390

86391
86392
86393
86394
86395
86399
86400
86401
86402
86403
86404
86405
86409
86410
86411
86412
86413
86414
86415
86419
86500
86501
86502
86503
86504
86509
86510
86511
86512
86513
86514
86519
86600
86601
86602
86603
86610
86611
86612
86613
8670
8671
8672
8673
8674
8675
8676
8677
8678
8679
86800
86801
86802
86803
86804
86809
86810
86811
86812
86813
86814
86819
8690
8691
8703
8704
8708
8709
8710
8711
8712
8713
8714
8719
87272
87273
87274
87333
8739
87400
87401
87402
87410
87411
87412
8743
8745
8750
8751
8870
8871
8872
8873
8874
8875
8876
8877
8960
8961
8962
8963
8970
8971
8972
8973
8974
8975
8976
8977
90000
90001
90002
90003
9001
90081
90082
90089
9009
9010
9011
9012
9013
90141
90142
90183
9020
90210
90211
90219
90220
90222
90223
90224
90225
90226
90227
90229
90231
90232
90233
90234
90239
90240
90241
90242
90249
90250
90251
90252
90253
90254
90259
90287
9251
9252
9290
95200
95201
95202
95203
95204
95205
95206
95207
95208
95209
95210
95211
95212
95213
95214
95215
95216
95217
95218
95219
9522
9523
9524
9528
9529
9530
9531
9532
9533
9534
9535
9538
9539
9580
9581
9582
9583
9584
9585
9587
*9973
5187
*99791
5187
*99799
5187
*99881
5187
*99883
5187
*99889
5187
*9989
5187

TABLE 6H.--DELETIONS FROM THE CC EXCLUSIONS LIST

CCs that are deleted from the list are in this Table 6H-Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*2800	2840	2840	2840	00842
2840	*28264	2848	2880	00843
*2801	2840	2849	*2899	00844
2840	*28268	2850	2840	00845
*2808	2840	2851	2880	00846
2840	*28269	*2848	*3230	00847
*2809	2840	2840	34982	00849
2840	*2827	*2849	*3234	7751
*2810	2840	2840	34982	7752
2840	*2828	*2850	*3235	7753
*2811	2840	2840	34982	7754
2840	*2829	*2851	*3236	7755
*2812	2840	2840	34982	7756
2840	*2830	*28521	*3237	7757
*2813	2840	2840	34982	
2840	*28310	*28522	*3238	
*2814	2840	2840	34982	
2840	*28311	*28529	*3337	
*2818	2840	2840	7817	
2840	*28319	*2858	*5173	
*2819	2840	2840	2840	
2840	*2832	*2859	*5191	
*2820	2840	2840	51900	
2840	*2839	*2880	51901	
*2821	2840	2880	51902	
2840	*2840	2881	51909	
*2822	2800	28981	*5280	
2840	2814	28982	5283	
*2823	2818	*2881	*6168	
2840	28241	2880	6140	
*28241	28242	*2882	6143	
2840	28249	2880	6145	
*28242	28260	*2883	6150	
2840	28261	2880	6163	
*28249	28262	*2888	6164	
2840	28263	2880	*6298	
*2825	28264	*2889	6140	
2840	28268	2880	6143	
*28260	28269	*28981	6145	
2840	2830	2840	6150	
*28261	28310	2880	6163	
2840	28311	*28982	6164	
*28262	28319	2840	6207	
2840	2832	2880	*7758	
*28263	2839	*28989	00841	

TABLE 7A.-- MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	24,464	9.6076	2	4	7	12	19
2	10,338	4.3927	1	2	3	6	8
3	3	11.0000	4	4	8	21	21
6	288	3.0833	1	1	2	3	7
7	15,034	9.2559	2	4	7	12	19
8	3,441	2.7629	1	1	2	3	6
9	1,775	6.0248	1	3	4	7	11
10	19,639	5.9172	2	3	4	7	11
11	3,074	3.5501	1	2	3	5	7
12	56,196	5.3631	2	3	4	6	10
13	7,529	4.8515	2	3	4	6	8
14	278,864	5.3705	2	3	4	7	10
15	20,004	4.0156	1	2	3	5	7
16	17,310	6.3008	2	3	5	8	12
17	2,967	3.0334	1	1	2	4	6
18	33,512	5.1525	2	3	4	6	9
19	8,422	3.3749	1	2	3	4	6
20	6,409	9.8313	3	5	8	12	18
21	2,220	6.1752	2	3	5	8	12
22	3,169	5.0104	2	2	4	6	10
23	10,671	3.8995	1	2	3	5	7
24	63,246	4.6433	1	2	3	6	9
25	27,218	3.1280	1	2	2	4	6
26	25	3.8000	1	1	2	5	9
27	5,974	4.7370	1	1	3	6	10
28	19,919	5.5701	1	2	4	7	11
29	6,517	3.2118	1	1	3	4	6
31	5,043	3.9038	1	2	3	5	7
32	1,900	2.2716	1	1	2	3	4
34	27,478	4.7063	1	2	4	6	9
35	7,843	3.0360	1	1	3	4	5
36	1,045	1.7962	1	1	1	1	1
37	1,219	4.1132	1	1	3	5	8
38	50	2.8000	1	1	2	3	6
39	328	2.1220	1	1	1	2	3
40	1,188	4.2315	1	1	3	4	6
42	901	3.0844	1	1	2	3	5
43	125	2.9600	1	1	2	4	5
44	1,291	4.7506	2	3	4	6	8
45	2,771	3.0278	1	2	2	4	6

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
46	3,930	4.1913	1	2	3	5	8
47	1,308	3.0145	1	1	2	4	6
49	2,416	4.5219	1	2	3	5	9
50	2,026	1.8638	1	1	1	2	3
51	193	2.6684	1	1	1	3	5
52	316	1.6962	1	1	1	2	3
53	2,147	4.0051	1	1	2	5	9
55	1,370	2.8832	1	1	1	3	6
56	451	2.6785	1	1	2	3	5
57	888	3.1543	1	1	2	3	7
59	126	2.3730	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,827	4.5313	1	1	3	6	10
64	3,234	6.2004	1	2	4	8	13
65	40,495	2.7634	1	1	2	3	5
66	8,197	3.1080	1	1	2	4	6
67	379	3.6834	1	2	3	5	8
68	18,963	3.8500	1	2	3	5	7
69	5,104	2.9414	1	2	2	4	5
70	25	2.4000	1	1	2	3	4
71	70	4.3429	1	2	3	5	7
72	1,326	3.3205	1	2	3	4	6
73	9,961	4.2979	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,867	9.5747	3	5	7	12	19
76	48,182	10.4832	3	5	8	13	20
77	2,096	4.4938	1	2	4	6	9
78	49,708	6.0925	2	4	5	7	10
79	160,452	8.0513	3	4	7	10	15
80	7,128	5.2173	2	3	4	6	9
81	6	6.1667	2	3	5	8	8
82	63,222	6.6658	2	3	5	9	13
83	7,154	5.1918	2	3	4	6	10
84	1,402	3.1284	1	2	3	4	5
85	22,231	6.1082	2	3	5	8	12
86	1,714	3.4568	1	2	3	4	7
87	96,725	6.3706	2	3	5	8	12
88	427,153	4.8563	2	3	4	6	9
89	554,440	5.5245	2	3	5	7	10
90	43,208	3.7030	1	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,523	5.9402	2	3	5	7	11
93	1,436	3.7632	1	2	3	5	7

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
94	13,657	5.9022	2	3	5	8	12
95	1,576	3.3839	1	2	3	4	6
96	59,742	4.2995	2	2	4	5	7
97	26,592	3.3652	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,402	3.0982	1	1	2	4	6
100	6,406	2.1071	1	1	2	3	4
101	23,399	4.1820	1	2	3	5	8
102	4,907	2.5345	1	1	2	3	5
103	884	35.1640	8	11	22	46	78
104	20,125	14.6458	6	8	12	18	26
105	32,635	9.9310	4	6	8	11	18
106	3,440	10.9392	5	7	9	13	18
108	8,759	10.7132	4	6	9	13	19
110	57,721	8.0026	1	3	6	10	16
111	10,783	3.1055	1	1	2	4	6
113	34,750	12.5640	4	6	10	15	24
114	7,960	8.3485	2	4	7	11	16
117	5,350	4.2781	1	1	2	5	9
118	7,634	3.0183	1	1	2	4	7
119	963	5.3998	1	1	3	7	13
120	33,561	8.9647	1	3	6	12	19
121	150,085	6.1981	2	3	5	8	11
122	54,555	3.2992	1	1	3	4	6
123	29,576	4.7318	1	1	3	6	11
124	120,562	4.3876	1	2	3	6	9
125	92,475	2.7008	1	1	2	3	5
126	5,424	10.6875	3	6	9	13	19
127	667,522	5.0851	2	3	4	6	9
128	4,213	5.1899	2	3	5	6	9
129	3,527	2.5373	1	1	1	2	5
130	87,554	5.3511	1	3	4	7	10
131	22,885	3.6965	1	2	3	5	6
132	101,433	2.8006	1	1	2	3	5
133	5,845	2.1384	1	1	2	3	4
134	39,838	3.1001	1	2	2	4	6
135	7,171	4.2924	1	2	3	5	8
136	939	2.6944	1	1	2	3	5
138	206,296	3.8764	1	2	3	5	7
139	73,965	2.4267	1	1	2	3	4
140	31,123	2.4049	1	1	2	3	4
141	123,214	3.4307	1	2	3	4	6
142	49,069	2.4897	1	1	2	3	4
143	237,871	2.0978	1	1	2	3	4
144	104,970	5.8254	1	2	4	7	11

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
145	5,698	2.5470	1	1	2	3	5
146	10,278	9.7685	4	6	8	11	17
147	2,613	5.5427	2	4	5	7	8
148	133,146	11.9344	5	6	9	15	22
149	19,525	5.6364	3	4	5	7	8
150	22,987	10.7225	4	6	9	13	19
151	5,401	5.0224	1	2	4	7	9
152	5,016	7.9314	3	5	7	9	14
153	1,953	4.8669	2	3	5	6	7
154	27,071	12.9678	3	6	10	16	25
155	6,015	3.9583	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,329	5.6899	1	2	4	7	11
158	3,716	2.6453	1	1	2	3	5
159	19,241	5.0838	1	2	4	6	10
160	11,945	2.6548	1	1	2	3	5
161	10,158	4.5026	1	2	3	6	9
162	4,952	2.0889	1	1	1	3	4
163	5	2.4000	1	1	2	3	5
164	6,003	7.6838	3	4	7	9	13
165	2,457	3.9935	2	2	4	5	7
166	5,157	4.3198	1	2	3	5	8
167	4,922	2.1260	1	1	2	3	4
168	1,538	4.8563	1	2	3	6	10
169	774	2.7661	1	1	2	3	5
170	17,939	10.6904	2	5	8	13	21
171	1,404	4.1660	1	2	3	5	8
172	33,099	6.7836	2	3	5	8	13
173	2,192	3.4995	1	1	3	4	7
174	261,557	4.6848	2	3	4	6	8
175	29,879	2.8529	1	2	2	4	5
176	14,653	5.0912	2	3	4	6	9
177	7,659	4.4332	2	2	4	5	8
178	2,559	3.0770	1	2	3	4	5
179	14,734	5.7800	2	3	4	7	11
180	91,464	5.2570	2	3	4	6	10
181	25,262	3.3086	1	2	3	4	6
182	297,116	4.4864	1	2	3	5	8
183	81,577	2.8984	1	1	2	4	5
184	79	4.2911	1	2	3	4	8
185	6,254	4.4915	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	647	4.1468	1	2	3	6	8
188	93,711	5.4548	1	2	4	7	10
189	13,047	3.0530	1	1	2	4	6

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
190	65	4.8000	1	2	3	6	8
191	10,595	12.3655	3	6	9	15	25
192	1,380	5.5087	1	3	5	7	9
193	4,044	12.5321	5	7	10	15	23
194	461	6.2603	2	4	6	8	11
195	2,846	10.5569	4	6	9	13	19
196	595	5.3345	2	3	5	7	9
197	16,435	9.0254	3	5	7	11	16
198	4,114	4.2859	2	3	4	5	7
199	1,484	8.9892	2	4	7	12	19
200	1,017	10.3520	1	3	7	13	21
201	2,717	13.5628	3	6	10	17	27
202	27,516	6.1264	2	3	5	7	12
203	32,434	6.4368	2	3	5	8	12
204	69,460	5.3914	2	3	4	6	10
205	32,822	5.8530	2	3	4	7	11
206	2,051	3.8035	1	2	3	5	7
207	38,329	5.2350	1	2	4	7	10
208	9,427	2.9434	1	1	2	4	5
210	126,884	6.6228	3	4	5	8	11
211	25,813	4.5833	3	3	4	5	7
212	10	2.5000	1	2	2	4	4
213	9,511	8.9931	2	4	7	11	18
216	19,925	5.3298	1	1	3	7	12
217	15,693	12.1157	3	5	8	15	24
218	30,213	5.3787	2	3	4	7	10
219	21,194	3.1641	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,689	3.2720	1	1	2	4	6
224	9,927	1.9411	1	1	1	2	3
225	6,275	5.2709	1	2	4	7	11
226	6,776	6.3719	1	3	4	8	13
227	4,855	2.6360	1	1	2	3	5
228	2,683	4.2046	1	1	3	5	9
229	1,117	2.5004	1	1	2	3	5
230	2,474	5.4321	1	2	4	7	11
232	572	2.7395	1	1	2	3	6
233	18,500	6.3363	1	2	5	8	13
234	9,052	2.6740	1	1	1	3	6
235	4,763	4.6431	1	2	4	6	8
236	41,789	4.4010	1	3	4	5	8
237	1,925	3.7844	1	2	3	5	7
238	9,693	7.9706	2	4	6	9	14
239	40,343	6.0356	2	3	5	7	11
240	12,933	6.4411	2	3	5	8	12

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
241	2,818	3.6427	1	2	3	4	6
242	2,725	6.4499	2	3	5	8	12
243	100,998	4.4968	1	2	4	6	8
244	16,946	4.4343	1	2	4	5	8
245	5,798	3.0942	1	1	3	4	5
246	1,393	3.5635	1	2	3	4	6
247	21,356	3.2905	1	2	3	4	6
248	16,406	4.8154	2	3	4	6	8
249	13,490	3.9493	1	1	3	5	8
250	4,165	3.8363	1	2	3	5	7
251	2,059	2.7936	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,816	4.5259	2	3	4	5	8
254	10,019	3.0639	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,606	4.9471	1	2	4	6	9
257	13,128	2.5517	1	1	2	3	5
258	11,400	1.6964	1	1	1	2	3
259	2,660	2.8173	1	1	1	3	7
260	2,431	1.4048	1	1	1	1	2
261	1,571	2.2037	1	1	1	2	4
262	602	4.6561	1	2	3	6	9
263	22,544	10.4724	3	5	7	13	20
264	3,912	6.2150	2	3	5	7	11
265	4,036	6.5347	1	2	4	8	14
266	2,230	3.0296	1	1	2	4	6
267	276	4.2428	1	1	3	5	8
268	1,007	3.6495	1	1	2	4	7
269	11,070	7.9865	2	3	6	10	15
270	2,573	3.5876	1	1	3	5	7
271	21,579	6.7917	2	3	5	8	12
272	6,079	5.8195	2	3	4	7	11
273	1,256	3.7070	1	2	3	5	7
274	2,222	6.1787	1	3	5	7	11
275	173	3.2081	1	1	2	4	6
276	1,611	4.6096	1	2	4	6	8
277	119,184	5.4238	2	3	4	7	9
278	33,737	3.9926	2	2	3	5	7
279	6	4.1667	1	2	3	5	5
280	19,335	3.9854	1	2	3	5	7
281	6,583	2.7961	1	1	2	3	5
283	6,770	4.5786	1	2	3	6	8
284	1,845	2.9176	1	1	2	4	5
285	8,079	9.8267	3	5	8	12	18
286	2,869	5.1921	2	2	4	6	10

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
287	5,462	9.5002	3	5	7	11	18
288	11,463	3.7000	1	2	3	4	6
289	6,352	2.3909	1	1	1	2	5
290	11,894	2.0268	1	1	1	2	3
291	60	1.4833	1	1	1	1	2
292	7,592	9.9870	2	4	8	12	19
293	317	4.7192	1	2	3	6	8
294	96,836	4.2502	1	2	3	5	8
295	4,384	3.7003	1	2	3	4	7
296	247,467	4.6444	1	2	4	6	9
297	42,523	3.0312	1	2	3	4	5
298	111	3.5405	1	1	2	4	6
299	1,529	5.0680	1	2	4	6	9
300	21,700	5.8032	2	3	5	7	11
301	3,909	3.3592	1	2	3	4	6
302	10,499	7.9355	4	5	6	9	13
303	24,646	7.2778	3	4	6	8	14
304	14,090	8.3271	2	3	6	10	17
305	3,012	3.1016	1	2	3	4	6
306	5,818	5.5734	1	2	3	8	13
307	1,950	2.0292	1	1	2	2	3
308	6,684	6.1339	1	2	4	8	14
309	3,266	1.9801	1	1	1	2	4
310	25,386	4.4935	1	2	3	6	10
311	5,890	1.8514	1	1	1	2	3
312	1,328	4.9315	1	2	3	6	10
313	505	2.3921	1	1	2	3	5
314	2	89.0000	5	5	173	173	173
315	34,911	6.7495	1	1	4	9	16
316	204,550	6.1591	2	3	5	8	12
317	2,716	3.5044	1	1	2	4	7
318	5,914	5.9731	1	3	4	7	12
319	384	2.5651	1	1	2	3	5
320	225,069	4.9879	2	3	4	6	9
321	31,860	3.5371	1	2	3	4	6
322	67	3.5821	2	2	3	4	6
323	20,427	3.1029	1	1	2	4	6
324	4,637	1.8462	1	1	1	2	3
325	9,930	3.7407	1	2	3	5	7
326	2,586	2.5607	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	574	3.4146	1	1	3	4	6
329	54	1.6852	1	1	1	2	3
331	57,039	5.4034	1	2	4	7	10
332	4,145	3.0625	1	1	2	4	6

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
333	247	5.3320	1	2	4	6	9
334	9,532	4.0415	1	2	3	5	7
335	12,203	2.4946	1	2	2	3	4
336	28,202	3.2201	1	1	2	4	7
337	21,501	1.8442	1	1	2	2	3
338	674	5.7953	1	2	4	8	13
339	1,237	5.1924	1	2	3	7	12
340	1	2.0000	2	2	2	2	2
341	3,131	3.2031	1	1	1	3	7
342	457	3.0394	1	1	2	3	6
344	2,343	2.7222	1	1	1	3	7
345	1,390	5.4324	1	2	3	7	12
346	3,963	5.9066	2	3	4	7	11
347	234	2.7094	1	1	2	3	5
348	4,262	4.0082	1	2	3	5	7
349	554	2.6408	1	1	2	3	5
350	7,281	4.5187	2	2	4	5	8
352	1,177	4.1623	1	2	3	5	9
353	3,092	6.0155	2	3	4	7	11
354	7,572	5.5539	2	3	4	6	10
355	5,006	3.0224	2	2	3	3	4
356	22,278	1.8696	1	1	2	2	3
357	5,543	8.0319	3	4	6	10	15
358	20,961	3.8545	2	2	3	4	7
359	28,665	2.3497	1	2	2	3	3
360	14,282	2.5518	1	1	2	3	4
361	287	2.9303	1	1	2	3	6
362	2	1.0000	1	1	1	1	1
363	1,981	4.0848	1	2	2	4	9
364	1,380	4.1754	1	2	3	5	8
365	1,617	7.8411	2	3	5	10	16
366	4,654	6.2426	1	3	5	8	12
367	438	2.9612	1	1	2	3	5
368	4,145	6.4068	2	3	5	8	12
369	3,727	3.2659	1	1	2	4	6
370	2,251	4.9964	2	3	4	5	7
371	2,715	3.3908	2	3	3	4	4
372	1,377	3.4415	2	2	2	3	5
373	5,284	2.2470	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	12	6.5000	1	2	3	6	8
376	476	3.2815	1	2	2	4	7
377	109	4.4954	1	2	3	6	8
378	202	2.1782	1	1	2	3	4
379	500	3.2960	1	1	2	3	6

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
380	111	2.0180	1	1	1	2	4
381	170	2.4647	1	1	1	2	4
382	48	1.4792	1	1	1	1	2
383	2,806	3.6433	1	1	2	4	7
384	151	2.5960	1	1	1	3	4
387	1	9.0000	9	9	9	9	9
389	3	8.6667	1	1	2	3	3
392	2,140	8.8757	2	4	6	11	19
394	2,761	7.3032	1	2	5	9	16
395	115,607	4.2768	1	2	3	5	8
396	20	2.9500	1	2	3	3	4
397	16,443	5.1098	1	2	4	6	10
398	18,696	5.7191	2	3	4	7	11
399	1,643	3.3603	1	2	3	4	6
401	6,462	11.0371	2	5	8	14	22
402	1,348	3.8858	1	1	3	5	9
403	31,551	7.8595	2	3	6	10	16
404	3,624	3.9914	1	2	3	5	8
406	2,304	9.3859	2	4	7	12	20
407	616	3.4935	1	2	3	5	7
408	1,949	8.2104	1	2	5	10	19
409	1,750	6.0383	2	3	4	6	12
410	29,067	3.7654	1	2	3	4	6
411	5	2.0000	1	1	1	3	4
412	9	1.5556	1	1	2	2	2
413	5,748	6.7189	2	3	5	9	13
414	481	4.0146	1	2	3	5	7
415	55,992	14.0950	4	6	11	17	27
416	288,502	7.4508	2	3	6	9	14
417	33	6.5455	2	3	5	8	12
418	29,991	6.0675	2	3	5	7	11
419	17,719	4.3438	1	2	3	5	8
420	3,023	3.1667	1	2	3	4	5
421	13,262	4.0156	1	2	3	5	7
422	79	3.6456	1	2	2	4	7
423	8,970	8.0750	2	3	6	10	15
424	1,041	11.5053	2	4	8	14	23
425	13,101	3.4571	1	1	3	4	6
426	4,237	4.3099	1	2	3	5	8
427	1,579	4.6390	1	2	3	5	9
428	845	7.2769	1	2	4	8	14
429	23,941	5.4509	2	3	4	6	10
430	75,545	7.7573	2	3	6	9	15
431	333	6.6667	1	2	4	7	11
432	402	4.0199	1	1	3	4	8

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
433	4,472	2.8233	1	1	2	3	4
439	1,759	8.3337	1	3	5	9	17
440	5,216	8.1532	2	3	5	9	16
441	686	3.4125	1	1	2	4	6
442	18,608	8.6730	2	3	6	10	17
443	3,590	3.5279	1	1	3	5	7
444	6,014	4.0328	1	2	3	5	7
445	2,243	2.8270	1	1	2	3	5
447	6,324	2.5745	1	1	2	3	5
449	40,869	3.6910	1	1	3	4	7
450	7,453	1.9804	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,831	4.9369	1	2	3	6	10
453	5,388	2.7572	1	1	2	3	5
454	4,741	4.1080	1	2	3	5	8
455	885	2.2802	1	1	2	3	4
461	2,290	5.5782	1	1	3	7	12
462	7,891	9.5516	4	5	7	10	13
463	32,925	3.8763	1	2	3	5	7
464	7,635	2.8998	1	1	2	4	5
465	163	3.4724	1	1	2	4	6
466	1,204	4.9086	1	1	2	4	7
467	1,028	2.6722	1	1	2	3	5
468	52,062	12.5395	3	6	10	16	24
471	16,780	4.8545	3	3	4	5	8
473	8,582	12.4204	2	3	7	17	32
475	119,965	10.6382	2	5	9	14	20
476	2,851	9.9056	1	4	8	14	20
477	28,211	8.5081	1	3	7	11	17
479	27,660	2.5490	1	1	2	3	5
480	908	19.1013	6	8	13	23	39
481	1,199	22.0025	12	16	20	24	33
482	5,084	11.1810	4	6	9	13	20
484	472	12.7564	2	5	10	17	26
485	3,714	9.4715	4	5	7	11	18
486	2,712	12.1962	2	5	10	16	24
487	5,017	6.8405	1	3	5	9	14
488	828	17.6437	4	7	12	21	33
489	13,555	8.1669	2	3	6	10	15
490	5,255	5.3115	1	2	4	6	9
491	22,688	3.0224	1	2	2	3	5
492	3,924	13.8081	3	5	6	23	32
493	61,129	6.0304	2	3	5	8	11
494	24,558	2.6900	1	1	2	4	5
495	342	17.3421	8	10	13	20	33

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
496	3,727	8.7631	3	4	6	10	17
497	31,236	5.6849	3	3	5	6	9
498	21,296	3.6794	2	3	3	4	5
499	35,261	4.1633	1	2	3	5	8
500	46,497	2.1981	1	1	2	3	4
501	3,203	9.8392	4	5	8	12	18
502	762	5.6995	2	3	5	7	10
503	5,916	3.9238	1	2	3	5	7
504	192	28.0260	8	13	24	36	51
505	180	6.8889	1	1	2	6	13
506	964	15.1432	3	7	12	20	30
507	322	7.7112	1	3	6	10	14
508	655	7.3542	1	3	5	9	14
509	155	5.2323	1	2	3	6	11
510	1,783	6.0432	1	2	4	7	12
511	627	3.6364	1	1	2	4	7
512	550	13.6200	6	8	10	14	25
513	216	10.7407	5	7	8	11	17
515	58,668	3.8406	1	1	1	5	9
518	23,803	2.4598	1	1	1	3	5
519	12,597	4.6702	1	1	3	6	11
520	16,544	1.9403	1	1	1	2	3
521	29,404	5.2599	1	2	4	6	8
522	3,423	10.2875	3	4	5	7	8
523	14,428	3.7573	1	2	3	4	5
524	109,116	3.1429	1	2	3	4	6
525	206	14.2718	1	3	7	17	35
528	1,845	16.3252	6	9	14	21	29
529	5,115	7.2502	1	2	4	9	16
530	3,391	2.9451	1	1	2	3	6
531	4,910	8.9709	2	4	7	11	18
532	2,849	3.6413	1	1	3	5	7
533	46,773	3.6548	1	1	2	4	8
534	42,812	1.7223	1	1	1	2	3
535	8,822	9.2409	2	4	8	12	18
536	8,260	7.2738	2	3	6	9	14
537	8,986	6.5032	1	3	5	8	13
538	5,461	2.9145	1	1	2	4	6
539	4,978	10.5552	2	4	7	14	23
540	1,501	3.5097	1	1	3	4	7
541	25,114	41.6431	16	23	34	50	72
542	23,126	30.3529	11	17	25	37	52
543	5,507	11.7066	2	5	9	16	23
544	446,467	4.3995	3	3	4	5	7
545	43,772	5.0362	3	3	4	6	8

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
546	2,364	8.7657	3	4	7	10	16
547	32,723	12.1254	6	8	10	14	20
548	32,268	8.7755	5	6	8	10	13
549	13,145	10.0860	5	6	8	12	18
550	34,583	6.7752	4	5	6	8	10
551	53,960	6.0685	1	2	5	8	12
552	82,137	3.4766	1	1	2	5	7
553	39,301	9.0530	1	3	7	12	19
554	77,365	5.5722	1	2	4	7	12
555	37,404	4.8144	1	2	3	6	10
556	19,008	2.0085	1	1	1	2	4
557	124,278	4.1023	1	2	3	5	8
558	193,170	1.8108	1	1	1	2	4
559	2,895	6.8370	2	3	5	8	13
	12,150,466						

TABLE 7B.-- MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	24,403	9.6172	2	4	7	12	19
2	10,188	4.4271	1	2	4	6	8
3	3	11.0000	4	4	8	21	21
6	288	3.0833	1	1	2	3	7
7	15,033	9.2561	2	4	7	12	19
8	3,442	2.7638	1	1	2	3	6
9	1,775	6.0248	1	3	4	7	11
10	19,628	5.9178	2	3	4	7	11
11	3,085	3.5546	1	2	3	5	7
12	55,972	5.3686	2	3	4	6	10
13	7,529	4.8515	2	3	4	6	8
14	278,864	5.3705	2	3	4	7	10
15	20,004	4.0156	1	2	3	5	7
16	17,302	6.3015	2	3	5	8	12
17	2,975	3.0376	1	1	2	4	6
18	33,467	5.1537	2	3	4	6	9
19	8,467	3.3795	1	2	3	4	6
21	2,220	6.1752	2	3	5	8	12
22	3,169	5.0104	2	2	4	6	10
23	10,671	3.8995	1	2	3	5	7
26	25	3.8000	1	1	2	5	9
27	5,974	4.7370	1	1	3	6	10
28	19,912	5.5699	1	2	4	7	11
29	6,524	3.2149	1	1	3	4	6
31	5,039	3.9036	1	2	3	5	7
32	1,904	2.2757	1	1	2	3	4
34	27,632	4.7034	1	2	4	6	9
35	7,913	3.0404	1	1	3	4	5
36	308	1.9156	1	1	1	1	2
37	1,219	4.1132	1	1	3	5	8
38	50	2.8000	1	1	2	3	6
39	328	2.1220	1	1	1	2	3
40	1,188	4.2315	1	1	3	4	6
42	1,638	2.4823	1	1	1	2	3
43	125	2.9600	1	1	2	4	5
44	1,291	4.7506	2	3	4	6	8
45	2,771	3.0278	1	2	2	4	6
46	3,929	4.1917	1	2	3	5	8
47	1,309	3.0145	1	1	2	4	6
49	2,416	4.5219	1	2	3	5	9

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
50	2,026	1.8638	1	1	1	2	3
51	193	2.6684	1	1	1	3	5
52	235	1.5149	1	1	1	2	2
53	2,147	4.0051	1	1	2	5	9
55	1,370	2.8832	1	1	1	3	6
56	451	2.6785	1	1	2	3	5
57	742	3.2520	1	1	2	3	7
59	126	2.3730	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,827	4.5313	1	1	3	6	10
64	3,234	6.2004	1	2	4	8	13
65	40,495	2.7634	1	1	2	3	5
66	8,197	3.1080	1	1	2	4	6
67	379	3.6834	1	2	3	5	8
68	18,918	3.8500	1	2	3	5	7
69	5,149	2.9493	1	2	2	4	5
70	25	2.4000	1	1	2	3	4
71	70	4.3429	1	2	3	5	7
72	1,326	3.3205	1	2	3	4	6
73	9,961	4.2979	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,867	9.5747	3	5	7	12	19
76	48,166	10.4844	3	5	8	13	20
77	2,112	4.5123	1	2	4	6	9
78	49,708	6.0925	2	4	5	7	10
79	160,420	8.0517	3	4	7	10	15
80	7,160	5.2197	2	3	4	6	9
81	6	6.1667	2	3	5	8	8
82	63,222	6.6658	2	3	5	9	13
83	7,153	5.1922	2	3	4	6	10
84	1,403	3.1276	1	2	3	4	5
85	22,228	6.1087	2	3	5	8	12
86	1,717	3.4549	1	2	3	4	6
87	96,725	6.3706	2	3	5	8	12
88	427,153	4.8563	2	3	4	6	9
89	554,136	5.5251	2	3	5	7	10
90	43,512	3.7080	2	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,519	5.9408	2	3	5	7	11
93	1,440	3.7625	1	2	3	5	7
94	13,656	5.9023	2	3	5	8	12
95	1,577	3.3843	1	2	3	4	6
96	59,631	4.3002	2	2	4	5	7

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
97	26,703	3.3674	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,392	3.0989	1	1	2	4	6
100	6,416	2.1061	1	1	2	3	4
101	23,370	4.1822	1	2	3	5	8
102	4,936	2.5432	1	1	2	3	5
103	886	35.2641	8	11	22	46	78
104	20,125	14.6458	6	8	12	18	26
105	32,635	9.9310	4	6	8	11	18
106	3,440	10.9392	5	7	9	13	18
108	8,758	10.7099	4	6	9	13	19
110	57,710	8.0024	1	3	6	10	16
111	10,785	3.1058	1	1	2	4	6
113	34,750	12.5640	4	6	10	15	24
114	7,959	8.3465	2	4	7	11	16
117	5,350	4.2781	1	1	2	5	9
118	7,634	3.0183	1	1	2	4	7
119	963	5.3998	1	1	3	7	13
120	33,561	8.9647	1	3	6	12	19
121	150,085	6.1981	2	3	5	8	11
122	54,555	3.2992	1	1	3	4	6
123	29,576	4.7318	1	1	3	6	11
124	120,562	4.3876	1	2	3	6	9
125	92,475	2.7008	1	1	2	3	5
126	5,424	10.6875	3	6	9	13	19
127	667,522	5.0851	2	3	4	6	9
128	4,213	5.1899	2	3	5	6	9
129	3,527	2.5373	1	1	1	2	5
130	87,480	5.3514	1	3	4	7	10
131	22,959	3.7009	1	2	3	5	6
132	101,418	2.8006	1	1	2	3	5
133	5,860	2.1410	1	1	2	3	4
134	39,838	3.1001	1	2	2	4	6
135	7,167	4.2931	1	2	3	5	8
136	943	2.6957	1	1	2	3	5
138	206,188	3.8769	1	2	3	5	7
139	74,073	2.4274	1	1	2	3	4
140	31,123	2.4049	1	1	2	3	4
141	123,116	3.4312	1	2	3	4	6
142	49,167	2.4904	1	1	2	3	4
143	237,871	2.0978	1	1	2	3	4
144	104,925	5.8262	1	2	4	7	11
145	5,743	2.5581	1	1	2	3	5
146	10,276	9.7688	4	6	8	11	17
147	2,615	5.5449	2	4	5	7	8

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
149	19,545	5.6387	3	4	5	7	8
150	22,981	10.7232	4	6	9	13	19
151	5,407	5.0255	1	2	4	7	9
152	5,016	7.9314	3	5	7	9	14
153	1,953	4.8669	2	3	5	6	7
155	6,019	3.9621	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,321	5.6913	1	2	4	7	11
158	3,724	2.6488	1	1	2	3	5
159	19,233	5.0843	1	2	4	6	10
160	11,953	2.6555	1	1	2	3	5
161	10,152	4.5036	1	2	3	6	9
162	4,958	2.0896	1	1	1	3	4
163	5	2.4000	1	1	2	3	5
164	5,999	7.6861	3	4	7	9	13
165	2,461	3.9939	2	2	4	5	7
166	5,156	4.3200	1	2	3	5	8
167	4,923	2.1261	1	1	2	3	4
168	1,640	4.7726	1	2	3	6	10
169	899	2.6151	1	1	2	3	4
170	17,935	10.6919	2	5	8	13	21
171	1,408	4.1648	1	2	3	5	8
172	33,065	6.7846	2	3	5	8	13
173	2,226	3.5341	1	1	3	4	7
174	253,265	4.6853	2	3	4	6	8
175	29,252	2.8605	1	2	2	4	5
176	14,653	5.0912	2	3	4	6	9
177	7,656	4.4327	2	2	4	5	8
178	2,562	3.0800	1	2	3	4	5
179	14,734	5.7800	2	3	4	7	11
180	91,370	5.2580	2	3	4	6	10
181	25,356	3.3125	1	2	3	4	6
182	255,772	4.0692	1	2	3	5	7
183	79,046	2.8475	1	1	2	4	5
184	72	3.7361	1	1	2	4	7
185	6,254	4.4915	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	647	4.1468	1	2	3	6	8
188	87,040	5.3291	1	2	4	6	10
189	12,406	2.9703	1	1	2	4	5
190	10	3.0000	1	1	2	6	6
191	10,592	12.3671	3	6	9	15	25
192	1,380	5.5087	1	3	5	7	9
193	4,042	12.5339	5	7	10	15	23
194	463	6.2721	2	4	6	8	11

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
195	2,846	10.5569	4	6	9	13	19
196	595	5.3345	2	3	5	7	9
197	16,432	9.0256	3	5	7	11	16
198	4,117	4.2888	2	3	4	5	7
199	1,484	8.9892	2	4	7	12	19
200	1,017	10.3520	1	3	7	13	21
201	2,717	13.5628	3	6	10	17	27
202	27,516	6.1264	2	3	5	7	12
203	32,434	6.4368	2	3	5	8	12
204	69,460	5.3914	2	3	4	6	10
205	32,803	5.8542	2	3	4	7	11
206	2,070	3.8024	1	2	3	5	7
207	38,305	5.2356	1	2	4	7	10
208	9,451	2.9471	1	1	2	4	5
210	126,867	6.6230	3	4	5	8	11
211	25,830	4.5839	3	3	4	5	7
212	10	2.5000	1	2	2	4	4
213	9,553	9.0206	2	4	7	11	18
216	19,883	5.3088	1	1	3	7	12
217	15,724	12.1410	3	5	8	15	24
218	30,210	5.3789	2	3	4	7	10
219	21,197	3.1642	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,688	3.2719	1	1	2	4	6
224	9,928	1.9413	1	1	1	2	3
225	6,275	5.2709	1	2	4	7	11
226	6,771	6.3738	1	3	4	8	13
227	4,860	2.6372	1	1	2	3	5
228	2,679	4.2027	1	1	3	5	9
229	1,121	2.5112	1	1	2	3	5
230	2,474	5.4321	1	2	4	7	11
232	572	2.7395	1	1	2	3	6
233	18,493	6.3374	1	2	5	8	13
234	9,059	2.6746	1	1	1	3	6
235	4,763	4.6431	1	2	4	6	8
236	41,789	4.4010	1	3	4	5	8
237	1,925	3.7844	1	2	3	5	7
238	9,693	7.9706	2	4	6	9	14
239	40,343	6.0356	2	3	5	7	11
240	12,896	6.4472	2	3	5	8	12
241	2,855	3.6515	1	2	3	4	6
242	2,725	6.4499	2	3	5	8	12
243	100,998	4.4968	1	2	4	6	8
244	16,933	4.4351	1	2	4	5	8
245	5,811	3.0950	1	1	3	4	5

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
246	1,393	3.5635	1	2	3	4	6
247	21,356	3.2905	1	2	3	4	6
248	16,406	4.8154	2	3	4	6	8
249	13,490	3.9493	1	1	3	5	8
250	4,164	3.8365	1	2	3	5	7
251	2,060	2.7937	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,805	4.5258	2	3	4	5	8
254	10,030	3.0656	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,606	4.9471	1	2	4	6	9
257	13,126	2.5519	1	1	2	3	5
258	11,402	1.6964	1	1	1	2	3
259	2,660	2.8173	1	1	1	3	7
260	2,431	1.4048	1	1	1	1	2
261	1,571	2.2037	1	1	1	2	4
262	602	4.6561	1	2	3	6	9
263	22,532	10.4725	3	5	7	13	20
264	3,924	6.2273	2	3	5	7	11
265	4,036	6.5347	1	2	4	8	14
266	2,230	3.0296	1	1	2	4	6
267	276	4.2428	1	1	3	5	8
268	1,007	3.6495	1	1	2	4	7
269	11,061	7.9889	2	3	6	10	15
270	2,582	3.5930	1	1	3	5	7
271	21,579	6.7917	2	3	5	8	12
272	6,067	5.8218	2	3	4	7	11
273	1,268	3.7161	1	2	3	5	7
274	2,214	6.1847	1	3	5	7	11
275	181	3.2652	1	1	2	4	6
276	1,611	4.6096	1	2	4	6	8
277	119,041	5.4248	2	3	4	7	9
278	33,880	3.9954	2	2	3	5	7
279	6	4.1667	1	2	3	5	5
280	19,329	3.9844	1	2	3	5	7
281	6,589	2.8001	1	1	2	3	5
283	6,755	4.5760	1	2	3	6	8
284	1,860	2.9403	1	1	2	4	5
285	8,082	9.8285	3	5	8	12	18
286	2,869	5.1921	2	2	4	6	10
287	5,462	9.5002	3	5	7	11	18
288	11,460	3.6971	1	2	3	4	6
289	6,352	2.3909	1	1	1	2	5
290	11,894	2.0268	1	1	1	2	3
291	60	1.4833	1	1	1	1	2

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
292	7,590	9.9858	2	4	8	12	19
293	318	4.7673	1	2	3	6	8
294	96,836	4.2502	1	2	3	5	8
295	4,384	3.7003	1	2	3	4	7
296	247,119	4.6457	1	2	4	6	9
297	42,871	3.0365	1	2	3	4	5
298	111	3.5405	1	1	2	4	6
299	1,529	5.0680	1	2	4	6	9
300	21,678	5.8044	2	3	5	7	11
301	3,931	3.3666	1	2	3	4	6
302	10,496	7.9354	4	5	6	9	13
303	19,984	6.3149	2	3	5	7	12
304	13,649	8.1660	2	3	6	10	17
305	2,960	3.0331	1	2	2	4	5
306	5,818	5.5734	1	2	3	8	13
307	1,950	2.0292	1	1	2	2	3
308	5,454	5.2913	1	2	3	7	12
309	2,964	1.7190	1	1	1	2	3
310	25,380	4.4933	1	2	3	6	10
311	5,896	1.8552	1	1	1	2	3
312	1,328	4.9315	1	2	3	6	10
313	505	2.3921	1	1	2	3	5
314	2	89.0000	5	5	173	173	173
315	34,913	6.7494	1	1	4	9	16
316	205,633	6.1505	2	3	5	8	12
317	2,716	3.5044	1	1	2	4	7
318	5,912	5.9738	1	3	4	7	12
319	386	2.5725	1	1	2	3	5
320	224,944	4.9886	2	3	4	6	9
321	31,985	3.5383	1	2	3	4	6
322	67	3.5821	2	2	3	4	6
323	20,425	3.1030	1	1	2	4	6
324	4,639	1.8463	1	1	1	2	3
325	9,924	3.7401	1	2	3	5	7
326	2,592	2.5656	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	574	3.4146	1	1	3	4	6
329	54	1.6852	1	1	1	2	3
331	56,139	5.4124	1	2	4	7	10
332	3,963	3.0636	1	1	2	4	6
333	244	5.3648	1	2	4	6	10
334	9,529	4.0421	1	2	3	5	7
335	12,206	2.4946	1	2	2	3	4
336	28,193	3.2206	1	1	2	4	7
337	21,510	1.8441	1	1	2	2	3

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
338	674	5.7953	1	2	4	8	13
339	1,237	5.1924	1	2	3	7	12
340	1	2.0000	2	2	2	2	2
341	3,131	3.2031	1	1	1	3	7
342	457	3.0394	1	1	2	3	6
344	2,343	2.7222	1	1	1	3	7
345	1,390	5.4324	1	2	3	7	12
346	3,962	5.9079	2	3	4	7	11
347	235	2.7021	1	1	2	3	5
348	4,262	4.0082	1	2	3	5	7
349	554	2.6408	1	1	2	3	5
350	7,281	4.5187	2	2	4	5	8
352	1,177	4.1623	1	2	3	5	9
353	3,092	6.0155	2	3	4	7	11
354	7,572	5.5539	2	3	4	6	10
355	5,006	3.0224	2	2	3	3	4
356	22,085	1.8693	1	1	2	2	3
357	5,543	8.0319	3	4	6	10	15
358	20,947	3.8543	2	2	3	4	7
359	28,679	2.3506	1	2	2	3	3
360	13,879	2.5012	1	1	2	3	4
361	287	2.9303	1	1	2	3	6
362	2	1.0000	1	1	1	1	1
363	2,157	4.2165	1	2	3	5	9
364	1,800	3.8100	1	1	3	5	8
365	1,617	7.8411	2	3	5	10	16
366	4,645	6.2474	1	3	5	8	12
367	447	2.9776	1	1	2	4	5
368	4,145	6.4068	2	3	5	8	12
369	3,727	3.2659	1	1	2	4	6
370	2,251	4.9964	2	3	4	5	7
371	2,715	3.3908	2	3	3	4	4
372	1,377	3.4415	2	2	2	3	5
373	5,284	2.2470	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	12	6.5000	1	2	3	6	8
376	476	3.2815	1	2	2	4	7
377	109	4.4954	1	2	3	6	8
378	202	2.1782	1	1	2	3	4
379	500	3.2960	1	1	2	3	6
380	111	2.0180	1	1	1	2	4
381	170	2.4647	1	1	1	2	4
382	48	1.4792	1	1	1	1	2
383	2,806	3.6433	1	1	2	4	7
384	151	2.5960	1	1	1	3	4

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
387	1	9.0000	9	9	9	9	9
389	3	8.6667	1	1	2	3	3
392	2,140	8.8757	2	4	6	11	19
394	2,761	7.3032	1	2	5	9	16
395	101,519	4.0933	1	2	3	5	8
396	18	3.0556	1	2	3	3	4
397	16,443	5.1098	1	2	4	6	10
398	6,708	5.4499	1	2	4	7	10
399	1,084	3.2260	1	1	3	4	6
401	6,451	11.0460	2	5	8	14	22
402	1,359	3.9014	1	1	3	5	9
403	31,351	7.8732	2	3	6	10	16
404	3,824	4.0811	1	2	3	5	8
406	2,304	9.3859	2	4	7	12	20
407	616	3.4935	1	2	3	5	7
408	1,949	8.2104	1	2	5	10	19
409	1,750	6.0383	2	3	4	6	12
410	29,067	3.7654	1	2	3	4	6
411	5	2.0000	1	1	1	3	4
412	9	1.5556	1	1	2	2	2
413	5,742	6.7180	2	3	5	9	13
414	487	4.0575	1	2	3	5	7
417	33	6.5455	2	3	5	8	12
418	29,991	6.0675	2	3	5	7	11
419	17,640	4.3459	1	2	3	5	8
420	3,102	3.1847	1	2	3	4	6
421	13,262	4.0156	1	2	3	5	7
422	79	3.6456	1	2	2	4	7
423	8,970	8.0750	2	3	6	10	15
424	1,041	11.5053	2	4	8	14	23
425	13,101	3.4571	1	1	3	4	6
426	4,237	4.3099	1	2	3	5	8
427	1,579	4.6390	1	2	3	5	9
428	845	7.2769	1	2	4	8	14
429	23,941	5.4509	2	3	4	6	10
430	75,545	7.7573	2	3	6	9	15
431	333	6.6667	1	2	4	7	11
432	402	4.0199	1	1	3	4	8
433	4,472	2.8233	1	1	2	3	4
439	1,759	8.3337	1	3	5	9	17
440	5,216	8.1532	2	3	5	9	16
441	686	3.4125	1	1	2	4	6
442	18,606	8.6736	2	3	6	10	17
443	3,592	3.5276	1	1	3	5	7
444	6,013	4.0331	1	2	3	5	7

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
445	2,244	2.8266	1	1	2	3	5
447	6,324	2.5745	1	1	2	3	5
449	40,859	3.6912	1	1	3	4	7
450	7,463	1.9812	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,822	4.9372	1	2	3	6	10
453	5,397	2.7589	1	1	2	3	5
454	4,739	4.1087	1	2	3	5	8
455	887	2.2807	1	1	2	3	4
461	2,290	5.5782	1	1	3	7	12
462	7,891	9.5516	4	5	7	10	13
463	32,894	3.8764	1	2	3	5	7
464	7,666	2.9032	1	1	2	4	5
465	163	3.4724	1	1	2	4	6
466	1,204	4.9086	1	1	2	4	7
467	1,028	2.6722	1	1	2	3	5
468	52,050	12.5411	3	6	10	16	24
471	15,677	4.5470	3	3	4	5	7
473	8,582	12.4204	2	3	7	17	32
476	2,851	9.9056	1	4	8	14	20
477	28,205	8.5083	1	3	7	11	17
479	27,673	2.5493	1	1	2	3	5
480	908	19.1013	6	8	13	23	39
481	1,199	22.0025	12	16	20	24	33
482	5,084	11.1810	4	6	9	13	20
484	472	12.7564	2	5	10	17	26
485	3,714	9.4715	4	5	7	11	18
486	2,712	12.1962	2	5	10	16	24
487	5,017	6.8405	1	3	5	9	14
488	828	17.6437	4	7	12	21	33
489	13,555	8.1669	2	3	6	10	15
490	5,255	5.3115	1	2	4	6	9
491	22,688	3.0224	1	2	2	3	5
492	3,924	13.8081	3	5	6	23	32
493	61,105	6.0306	2	3	5	8	11
494	24,582	2.6927	1	1	2	4	5
495	342	17.3421	8	10	13	20	33
496	3,727	8.7631	3	4	6	10	17
497	31,227	5.6855	3	3	5	6	9
498	21,305	3.6795	2	3	3	4	5
499	35,251	4.1635	1	2	3	5	8
500	46,507	2.1984	1	1	2	3	4
501	3,201	9.8416	4	5	8	12	18
502	764	5.7003	2	3	5	7	10
503	5,916	3.9238	1	2	3	5	7

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
504	192	28.0260	8	13	24	36	51
505	180	6.8889	1	1	2	6	13
506	963	15.1547	3	7	12	20	30
507	323	7.6997	1	3	6	10	14
508	655	7.3542	1	3	5	9	14
509	155	5.2323	1	2	3	6	11
510	1,783	6.0432	1	2	4	7	12
511	627	3.6364	1	1	2	4	7
512	550	13.6200	6	8	10	14	25
513	226	10.6327	5	7	8	11	17
515	58,749	3.8459	1	1	2	5	9
518	23,803	2.4598	1	1	1	3	5
519	12,589	4.6711	1	1	3	6	11
520	16,552	1.9409	1	1	1	2	3
521	29,368	5.2609	1	2	4	6	8
522	3,425	10.2908	3	4	5	7	8
523	14,462	3.7574	1	2	3	4	5
524	109,116	3.1429	1	2	3	4	6
525	205	13.7366	1	3	7	17	35
528	1,845	16.3252	6	9	14	21	29
529	5,027	7.1317	1	2	4	9	16
530	3,362	2.9140	1	1	2	3	5
531	4,994	9.0631	2	4	7	12	18
532	2,882	3.6724	1	1	3	5	7
533	43,722	3.6996	1	1	2	4	9
534	40,255	1.7365	1	1	1	2	3
535	8,831	9.2481	2	4	8	12	18
536	8,262	7.2781	2	3	6	9	14
537	8,985	6.5037	1	3	5	8	13
538	5,462	2.9143	1	1	2	4	6
539	4,974	10.5589	2	4	7	14	23
540	1,505	3.5163	1	1	3	4	7
541	25,113	41.6433	16	23	34	50	72
542	23,126	30.3529	11	17	25	37	52
543	5,718	11.3902	2	4	9	16	23
544	446,467	4.3995	3	3	4	5	7
545	44,844	5.1255	3	3	4	6	9
546	2,364	8.7657	3	4	7	10	16
547	32,721	12.1244	6	8	10	14	20
548	32,268	8.7755	5	6	8	10	13
549	13,144	10.0859	5	6	8	12	18
550	34,583	6.7752	4	5	6	8	10
551	53,881	6.0660	1	2	5	8	12
552	82,137	3.4766	1	1	2	5	7
553	39,303	9.0525	1	3	7	12	19

DRG	Number Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
554	77,366	5.5730	1	2	4	7	12
555	37,404	4.8144	1	2	3	6	10
556	19,008	2.0085	1	1	1	2	4
557	124,278	4.1023	1	2	3	5	8
558	193,170	1.8108	1	1	1	2	4
559	2,895	6.8370	2	3	5	8	13
560	3,457	10.2242	3	5	8	13	19
561	2,952	9.3713	2	5	8	12	18
562	52,973	4.8176	1	2	4	6	9
563	21,161	3.1806	1	2	3	4	6
564	16,330	3.4475	1	2	3	4	6
565	46,864	15.3640	6	9	13	19	26
566	73,101	7.6086	1	3	6	10	15
567	10,369	15.6256	6	8	12	19	29
568	16,698	11.3181	2	5	9	14	22
569	60,835	14.2697	6	8	12	17	26
570	72,291	9.9702	4	6	8	12	18
571	11,162	4.7775	2	2	4	6	9
572	49,006	6.9624	2	3	5	8	13
573	6,687	10.9047	5	6	8	12	19
574	26,637	5.6791	2	3	4	7	11
575	10,982	15.6028	6	8	13	19	27
576	277,520	7.1282	2	3	6	9	14
577	5,608	2.3229	1	1	1	2	5
578	35,320	15.9644	5	8	13	20	30
579	20,672	10.9008	3	5	8	13	22
	12,150,466						

TABLE 8A.--STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS--July 2006

State	Urban	Rural
Alabama	0.263	0.336
Alaska	0.407	0.7
Arizona	0.284	0.36
Arkansas	0.336	0.356
California	0.238	0.342
Colorado	0.308	0.508
Connecticut	0.427	0.501
Delaware	0.496	0.462
District of Columbia	0.357	--
Florida	0.251	0.295
Georgia	0.351	0.403
Hawaii	0.366	0.447
Idaho	0.474	0.541
Illinois	0.327	0.417
Indiana	0.417	0.453
Iowa	0.376	0.458
Kansas	0.299	0.443
Kentucky	0.381	0.386
Louisiana	0.301	0.361
Maine	0.496	0.457
Maryland	0.763	0.882
Massachusetts	0.476	--
Michigan	0.373	0.47
Minnesota	0.39	0.523
Mississippi	0.327	0.376
Missouri	0.329	0.381
Montana	0.427	0.497
Nebraska	0.365	0.477
Nevada	0.229	0.455
New Hampshire	0.455	0.448
New Jersey	0.181	--
New Mexico	0.382	0.384
New York	0.362	0.526
North Carolina	0.441	0.43
North Dakota	0.438	0.456
Ohio	0.372	0.543
Oklahoma	0.317	0.402

State	Urban	Rural
Oregon	0.472	0.43
Pennsylvania	0.277	0.436
Puerto Rico	0.457	--
Rhode Island	0.409	--
South Carolina	0.291	0.298
South Dakota	0.354	0.447
Tennessee	0.317	0.383
Texas	0.278	0.353
Utah	0.423	0.588
Vermont	0.556	0.627
Virginia	0.363	0.377
Washington	0.424	0.469
West Virginia	0.484	0.466
Wisconsin	0.431	0.48
Wyoming	0.4	0.562

TABLE 8B.--STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS--July 2006

State	Ratio
Alabama	0.025
Alaska	0.04
Arizona	0.025
Arkansas	0.026
California	0.016
Colorado	0.029
Connecticut	0.031
Delaware	0.037
District of Columbia	0.024
Florida	0.023
Georgia	0.03
Hawaii	0.032
Idaho	0.036
Illinois	0.026
Indiana	0.037
Iowa	0.028
Kansas	0.032
Kentucky	0.03
Louisiana	0.029
Maine	0.035
Maryland	0.013
Massachusetts	0.034
Michigan	0.031
Minnesota	0.029
Mississippi	0.029
Missouri	0.028
Montana	0.036
Nebraska	0.039
Nevada	0.022
New Hampshire	0.036
New Jersey	0.013
New Mexico	0.033
New York	0.03
North Carolina	0.037
North Dakota	0.041
Ohio	0.03
Oklahoma	0.03

State	Ratio
Oregon	0.032
Pennsylvania	0.023
Puerto Rico	0.034
Rhode Island	0.023
South Carolina	0.026
South Dakota	0.033
Tennessee	0.032
Texas	0.027
Utah	0.038
Vermont	0.043
Virginia	0.037
Washington	0.034
West Virginia	0.034
Wisconsin	0.039
Wyoming	0.047

TABLE 8C.--STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS--JULY 2006

State	Urban	Rural
Alabama	0.287	0.366
Alaska	0.441	0.764
Arizona	0.308	0.394
Arkansas	0.367	0.389
California	0.252	0.363
Colorado	0.332	0.573
Connecticut	0.458	0.540
Delaware	0.532	0.505
District of Columbia*	0.388	--
Florida	0.272	0.336
Georgia	0.380	0.437
Hawaii	0.397	0.484
Idaho	0.510	0.582
Illinois	0.351	0.456
Indiana	0.454	0.499
Iowa	0.397	0.497
Kansas	0.326	0.486
Kentucky	0.411	0.418
Louisiana	0.331	0.392
Maine	0.533	0.473
Maryland**	0.450	0.360
Massachusetts*	0.505	--
Michigan	0.406	0.506
Minnesota	0.418	0.552
Mississippi	0.356	0.400
Missouri	0.355	0.415
Montana	0.459	0.543
Nebraska	0.400	0.526
Nevada	0.250	0.525
New Hampshire	0.492	0.481
New Jersey*	0.194	--
New Mexico	0.415	0.417
New York	0.390	0.561
North Carolina	0.482	0.471
North Dakota	0.476	0.503
Ohio	0.398	0.587
Oklahoma	0.345	0.439

State	Urban	Rural
Oregon	0.504	0.454
Pennsylvania	0.296	0.469
Puerto Rico*	0.489	--
Rhode Island*	0.432	--
South Carolina	0.315	0.326
South Dakota	0.384	0.487
Tennessee	0.348	0.417
Texas	0.303	0.384
Utah	0.459	0.650
Vermont	0.601	0.667
Virginia	0.398	0.415
Washington	0.459	0.516
West Virginia	0.517	0.499
Wisconsin	0.473	0.519
Wyoming	0.440	0.615

*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 2006.

**National average IPPS total cost-to-charge ratios, as discussed in section II.E. of this final rule.

NOTE: The following Table 9A is a tentative table and does not reflect decisions that are yet to be made by CMS pending the final calculation of the occupational mix adjusted wage index. The information about reclassified CBSAs reflects the latest information available to CMS regarding MGCRB and Administrator reclassification decisions for FY 2007. A revised Table 9A reflecting CMS' decisions on behalf of hospitals using occupational mix adjusted wage indices will be published in a subsequent Federal Register notice between August 1 and October 1, 2006, as well as on CMS' Web site. Hospitals will then have 30 days from the date the data appears on the CMS Web site to revise a decision made by CMS on their behalf. (See section III.H. of the preamble (Revisions to the Wage Index Based on Hospital Redesignations).)

TABLE 9A.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA--FY 2007

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
010005	01	13820	13820	
010008	01	33860	33860	
010009	19460	26620	26620	
010012	01	16860	16860	
010022	01	40660	40660	LUGAR
010025	01	17980	17980	
010029	12220	17980	17980	
010035	01	13820	13820	
010044	01	13820	13820	
010045	01	13820	13820	
010054	19460	26620	26620	
010059	19460	26620	26620	
010065	01	33860	33860	
010072	01	11500	11500	LUGAR
010083	01	37860	37860	
010085	19460	26620	26620	
010100	01	37860	37860	
010101	01	11500	11500	LUGAR
010118	01	46220	46220	
010126	01	33860	33860	
010143	01	13820	13820	
010150	01	33860	33860	
010158	01	19460	19460	
010164	01	11500	11500	LUGAR
020008	02	11260	11260	
030007	03	22380	22380	
030033	03	22380	22380	
040014	04	30780	30780	
040017	04	22220	22220	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
040019	04	32820	32820	
040020	27860	32820	32820	
040027	04	44180	44180	
040039	04	26	26	
040041	04	30780	30780	
040047	04	26	26	
040069	04	32820	32820	
040071	38220	30780	30780	
040076	04	30780	30780	
040078	26300	30780	30780	
040080	04	27860	27860	
040088	04	43340	43340	
040091	04	45500	45500	
040100	04	30780	30780	
040119	04	30780	30780	
050006	05	39820	39820	
050009	34900	46700	46700	
050013	34900	46700	46700	
050014	05	40900	40900	
050022	40140	42044	42044	
050042	05	39820	39820	
050046	37100		31084	
050054	40140	42044	42044	
050065	42044	31084	31084	
050069	42044	31084	31084	
050071	41940	36084	36084	
050073	46700	36084	36084	
050076	41884	36084	36084	
050082	37100		31084	
050089	40140	31084	31084	
050090	42220	41884	41884	
050099	40140	31084	31084	
050101	46700	36084	36084	
050102	40140	42044	42044	
050118	44700	33700	33700	
050129	40140	31084	31084	
050136	42220	41884	41884	
050140	40140	31084	31084	
050150	05	40900	40900	
050159	37100		31084	
050168	42044	31084	31084	
050173	42044	31084	31084	
050174	42220	41884	41884	
050193	42044	31084	31084	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
050197	41884	36084	36084	
050224	42044	31084	31084	
050226	42044	31084	31084	
050228	41884	36084	36084	
050230	42044	31084	31084	
050236	37100		31084	
050243	40140	42044	42044	
050245	40140	31084	31084	
050251	05	39900	39900	
050272	40140	31084	31084	
050279	40140	31084	31084	
050291	42220	41884	41884	
050292	40140	42044	42044	
050298	40140	31084	31084	
050300	40140	31084	31084	
050327	40140	31084	31084	
050329	40140	42044	42044	
050348	42044	31084	31084	
050367	46700	36084	36084	
050385	42220	41884	41884	
050390	40140	42044	42044	
050394	37100		31084	
050423	40140	42044	42044	
050426	42044	31084	31084	
050430	05	39900	39900	
050510	41884	36084	36084	
050517	40140	31084	31084	
050526	42044	31084	31084	
050534	40140	42044	42044	
050535	42044	31084	31084	
050541	41884	36084	36084	
050543	42044	31084	31084	
050547	42220	41884	41884	
050548	42044	31084	31084	
050549	37100		31084	
050550	42044	31084	31084	
050551	42044	31084	31084	
050567	42044	31084	31084	
050569	05	42220	42220	
050570	42044	31084	31084	
050573	40140	42044	42044	
050580	42044	31084	31084	
050584	40140	31084	31084	
050585	42044	31084	31084	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
050586	40140	31084	31084	
050589	42044	31084	31084	
050592	42044	31084	31084	
050594	42044	31084	31084	
050603	42044	31084	31084	
050609	42044	31084	31084	
050616	37100		31084	
050667	34900	46700	46700	
050678	42044	31084	31084	
050680	46700	36084	36084	
050684	40140	42044	42044	
050686	40140	42044	42044	
050690	42220	41884	41884	
050693	42044	31084	31084	
050694	40140	42044	42044	
050701	40140	42044	42044	
050709	40140	31084	31084	
050718	40140	42044	42044	
050720	42044	31084	31084	
050728	42220	41884	41884	
050749	37100		31084	
060001	24540	19740	19740	
060003	14500	19740	19740	
060023	24300	19740	19740	
060027	14500	19740	19740	
060044	06	19740	19740	
060049	06	22660	22660	
060075	06	24300	24300	
060096	06	19740	19740	
060103	14500	19740	19740	
070001	35300		35004	
070003	07	25540	25540	LUGAR
070005	35300		35004	
070006	14860		35644	
070010	14860		35644	
070016	35300		35004	
070017	35300		35004	
070018	14860		35644	
070019	35300		35004	
070021	07	25540	25540	LUGAR
070022	35300		35004	
070028	14860		35644	
070031	35300		35004	
070033	14860	35644	35644	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
070034	14860		35644	
070036	25540	35300	35300	
070038	35300		35004	
070039	35300		35004	
080004	20100	48864	48864	
080006	08	20100	20100	
080007	08	36140	36140	
090001	47894	13644	13644	
100022	33124	22744	22744	
100023	10	36740	36740	
100024	10	33124	33124	
100045	19660	36740	36740	
100049	10	29460	29460	
100081	10	23020	23020	LUGAR
100109	10	36740	36740	
100118	10	27260	27260	
100139	10	23540	23540	LUGAR
100150	10	33124	33124	
100157	29460	45300	45300	
100176	48424	38940	38940	
100217	42680	38940	38940	
100232	10	27260	27260	
100239	45300	42260	42260	
100249	10	45300	45300	
100252	10	38940	38940	
100258	48424	22744	22744	
100292	10	23020	23020	LUGAR
110001	19140	12060	12060	
110002	11	12060	12060	
110003	11	27260	27260	
110023	11	12060	12060	
110025	15260	27260	27260	
110029	23580	12060	12060	
110038	11	46660	46660	
110040	11	12060	12060	LUGAR
110041	11	12020	12020	
110052	11	16860	16860	LUGAR
110054	40660	12060	12060	
110069	47580	31420	31420	
110075	11	42340	42340	
110088	11	12060	12060	LUGAR
110095	11	46660	46660	
110117	11	12060	12060	LUGAR
110122	46660	45220	45220	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
110125	11	31420	31420	
110128	11	42340	42340	
110150	11	12060	12060	
110153	47580	31420	31420	
110168	40660	12060	12060	
110187	11	12060	12060	LUGAR
110189	11	12060	12060	
110205	11	12060	12060	
120028	12	26180	26180	
130002	13	29	29	
130003	30300	28420	28420	
130018	13	38540	38540	
130049	17660	44060	44060	
130067	13	26820	26820	LUGAR
140012	14	16974	16974	
140015	14	41180	41180	
140032	14	41180	41180	
140033	29404	16974	16974	
140034	14	41180	41180	
140040	14	37900	37900	
140043	14	40420	40420	
140046	14	41180	41180	
140058	14	41180	41180	
140064	14	37900	37900	
140084	29404	16974	16974	
140093	19180	16580	16580	
140100	29404	16974	16974	
140110	14	16974	16974	
140130	29404	16974	16974	
140143	14	37900	37900	
140160	14	40420	40420	
140161	14	16974	16974	
140164	14	41180	41180	
140189	14	16580	16580	
140202	29404	16974	16974	
140233	40420	16974	16974	
140234	14	37900	37900	
140236	14	28100	28100	LUGAR
140291	29404	16974	16974	
150002	23844	16974	16974	
150004	23844	16974	16974	
150006	33140	43780	43780	
150008	23844	16974	16974	
150011	15	26900	26900	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
150015	33140	16974	16974	
150030	15	26900	26900	LUGAR
150034	23844	16974	16974	
150048	15	17140	17140	
150051	14020	26900	26900	
150065	15	26900	26900	
150069	15	17140	17140	
150076	15	43780	43780	
150088	11300	26900	26900	
150090	23844	16974	16974	
150102	15	23844	23844	LUGAR
150112	18020	26900	26900	
150113	11300	26900	26900	
150122	15	26900	26900	
150125	23844	16974	16974	
150126	23844	16974	16974	
150133	15	23060	23060	
150146	15	23060	23060	
150147	23844	16974	16974	
160001	16	19780	19780	
160016	16	19780	19780	
160057	16	26980	26980	
160064	16	24	24	
160080	16	19340	19340	
160089	16	19780	19780	
160147	16	19780	19780	
170006	17	27900	27900	
170010	17	46140	46140	
170012	17	48620	48620	
170013	17	48620	48620	
170020	17	48620	48620	
170023	17	48620	48620	
170033	17	48620	48620	
170058	17	28140	28140	
170068	17	11100	11100	
170120	17	27900	27900	
170142	17	45820	45820	
170175	17	48620	48620	
170190	17	45820	45820	
170193	17	48620	48620	
180005	18	26580	26580	
180011	18	30460	30460	
180012	21060	31140	31140	
180013	14540	34980	34980	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
180017	18	21060	21060	
180018	18	30460	30460	
180019	18	17140	17140	
180024	18	31140	31140	
180027	18	17300	17300	
180029	18	28700	28700	
180044	18	26580	26580	
180048	18	31140	31140	
180066	18	34980	34980	
180069	18	26580	26580	
180075	18	14540	14540	LUGAR
180078	18	26580	26580	
180080	18	28940	28940	
180093	18	21780	21780	
180102	18	17300	17300	
180104	18	17300	17300	
180116	18	14	14	
180124	14540	34980	34980	
180127	18	31140	31140	
180132	18	30460	30460	
180139	18	30460	30460	
190001	19	35380	35380	
190003	19	29180	29180	
190015	19	35380	35380	
190086	19	33740	33740	
190099	19	12940	12940	
190106	19	10780	10780	
190131	12940	35380	35380	
190155	19	12940	12940	LUGAR
190164	19	10780	10780	
190191	19	12940	12940	
190208	19	4	4	
190218	19	43340	43340	
190223	19	12940	12940	LUGAR
200020	38860	40484	40484	
200024	30340	38860	38860	
200034	30340	38860	38860	
200039	20	38860	38860	
200050	20	12620	12620	
200063	20	38860	38860	
220001	49340	14484	14484	
220002	15764	14484	14484	
220008	39300	14484	14484	
220010	21604	14484	14484	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
220011	15764	14484	14484	
220019	49340	14484	14484	
220020	39300	14484	14484	
220025	49340	14484	14484	
220028	49340	14484	14484	
220029	21604	14484	14484	
220033	21604	14484	14484	
220035	21604	14484	14484	
220049	15764	14484	14484	
220058	49340	14484	14484	
220060	14484	12700	12700	
220062	49340	14484	14484	
220063	15764	14484	14484	
220070	15764	14484	14484	
220073	39300	14484	14484	
220077	44140	25540	25540	
220080	21604	14484	14484	
220082	15764	14484	14484	
220084	15764	14484	14484	
220090	49340	14484	14484	
220095	49340	14484	14484	
220098	15764	14484	14484	
220101	15764	14484	14484	
220105	15764	14484	14484	
220133	15764	14484	14484	
220163	49340	14484	14484	
220171	15764	14484	14484	
220174	21604	14484	14484	
230002	19804		11460	
230003	26100		34740	
230013	47644		19804	
230019	47644		19804	
230020	19804		11460	
230022	23	29620	29620	
230024	19804		11460	
230029	47644		19804	
230030	23	40980	40980	
230035	23	24340	24340	LUGAR
230036	23	13020	13020	
230037	23	11460	11460	
230047	47644	19804	19804	
230053	19804		11460	
230054	23	24580	24580	
230065	19804		11460	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
230069	47644	11460	11460	
230071	47644		19804	
230072	26100		34740	
230077	40980	22420	22420	
230080	23	40980	40980	
230089	19804		11460	
230092	27100	29620	29620	
230093	23	24340	24340	
230096	23	28020	28020	
230097	23	24340	24340	
230099	33780	11460	11460	
230104	19804		11460	
230105	23	13020	13020	
230119	19804		11460	
230121	23	29620	29620	LUGAR
230130	47644		19804	
230134	23	26100	26100	LUGAR
230135	19804		11460	
230142	19804		11460	
230146	19804		11460	
230151	47644		19804	
230165	19804		11460	
230174	26100		34740	
230176	19804		11460	
230195	47644	19804	19804	
230204	47644	19804	19804	
230207	47644		19804	
230208	23	24340	24340	LUGAR
230217	12980	29620	29620	
230223	47644		19804	
230227	47644	19804	19804	
230244	19804		11460	
230254	47644		19804	
230257	47644	19804	19804	
230264	47644	19804	19804	
230269	47644		19804	
230270	19804		11460	
230273	19804		11460	
230277	47644		19804	
230279	47644	11460	11460	
230293	19804		11460	
230295	23	26100	26100	LUGAR
240018	24	33460	33460	
240030	24	41060	41060	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
240036	41060	33460	33460	
240064	24	20260	20260	
240069	24	40340	40340	
240071	24	40340	40340	
240075	24	41060	41060	
240088	24	41060	41060	
240093	24	33460	33460	
240105	24	40340	40340	LUGAR
240150	24	40340	40340	LUGAR
240187	24	33460	33460	
240211	24	33460	33460	
250002	25	22520	22520	
250004	25	32820	32820	
250006	25	32820	32820	
250009	25	27180	27180	
250023	25	25060	25060	LUGAR
250031	25	27140	27140	
250034	25	32820	32820	
250040	37700	25060	25060	
250042	25	32820	32820	
250044	25	22520	22520	
250069	25	46220	46220	
250079	25	27140	27140	
250081	25	46220	46220	
250082	25	38220	38220	
250094	25620	25060	25060	
250097	25	12940	12940	
250099	25	27140	27140	
250100	25	46220	46220	
250104	25	27140	27140	
250117	25	25060	25060	LUGAR
260009	26	28140	28140	
260011	27620	17860	17860	
260015	26	27860	27860	
260017	26	41180	41180	
260022	26	16	16	
260025	26	41180	41180	
260049	26	44180	44180	LUGAR
260050	26	41140	41140	
260064	26	17860	17860	
260074	26	17860	17860	
260094	26	44180	44180	
260110	26	41180	41180	
260113	26	14	14	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
260116	26	14	14	
260119	26	27860	27860	
260175	26	28140	28140	
260183	26	41180	41180	
260186	26	17860	17860	
270003	27	24500	24500	
270011	27	24500	24500	
270017	27	33540	33540	
270051	27	33540	33540	
280009	28	30700	30700	
280023	28	30700	30700	
280032	28	30700	30700	
280061	28	53	53	
280065	28	24540	24540	
280077	28	36540	36540	
280125	28	43580	43580	
290002	29	16180	16180	LUGAR
290006	29	39900	39900	
290008	29	41620	41620	
290019	16180	39900	39900	
300005	30	31700	31700	
300011	31700	15764	15764	
300012	31700	15764	15764	
300014	40484	31700	31700	
300017	40484	21604	21604	
300018	40484	31700	31700	
300019	30	49340	49340	
300020	31700	15764	15764	
300023	40484	21604	21604	
300029	40484	21604	21604	
300034	31700	15764	15764	
310002	35084	35644	35644	
310009	35084	35644	35644	
310013	35084	35644	35644	
310014	15804	37964	37964	
310015	35084	35644	35644	
310017	35084	35644	35644	
310018	35084	35644	35644	
310021	45940	35084	35084	
310031	15804	20764	20764	
310038	20764	35644	35644	
310039	20764	35644	35644	
310048	20764	35084	35084	
310050	35084	35644	35644	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
310054	35084	35644	35644	
310070	20764	35644	35644	
310076	35084	35644	35644	
310078	35084	35644	35644	
310081	15804	37964	37964	
310083	35084	35644	35644	
310093	35084	35644	35644	
310096	35084	35644	35644	
310108	20764	35644	35644	
310119	35084	35644	35644	
320005	22140	10740	10740	
320006	32	42140	42140	
320013	32	42140	42140	
320014	32	29740	29740	
320033	32	42140	42140	LUGAR
320063	32	36220	36220	
320065	32	36220	36220	
330004	28740	39100	39100	
330008	33	15380	15380	LUGAR
330027	35004	35644	35644	
330038	33	40380	40380	LUGAR
330073	33	40380	40380	LUGAR
330079	33	47	47	
330085	33	45060	45060	
330094	33	28740	28740	
330103	33	39	39	
330106	35004		35644	
330136	33	45060	45060	
330157	33	45060	45060	
330167	35004		35644	
330181	35004		35644	
330182	35004	35644	35644	
330191	24020	10580	10580	
330198	35004		35644	
330224	28740	39100	39100	
330225	35004		35644	
330229	27460	21500	21500	
330235	33	45060	45060	LUGAR
330239	27460	21500	21500	
330250	33	15540	15540	
330259	35004		35644	
330277	33	27060	27060	
330331	35004		35644	
330332	35004		35644	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
330359	33	39100	39100	LUGAR
330372	35004		35644	
330386	33	39100	39100	
340004	24660	49180	49180	
340008	34	16740	16740	
340010	24140	39580	39580	
340013	34	24860	24860	
340014	49180	24660	24660	
340021	34	16740	16740	
340023	11700	24860	24860	
340027	34	24780	24780	
340039	34	16740	16740	
340047	49180	24660	24660	
340050	34	22180	22180	
340051	34	25860	25860	
340068	34	48900	48900	
340069	39580	20500	20500	
340070	15500	24660	24660	
340071	34	39580	39580	LUGAR
340073	39580	20500	20500	
340091	24660	49180	49180	
340109	34	47260	47260	
340114	39580	20500	20500	
340115	34	20500	20500	
340124	34	39580	39580	LUGAR
340126	34	39580	39580	
340127	34	20500	20500	
340129	34	16740	16740	
340131	34	24780	24780	
340136	34	20500	20500	LUGAR
340138	39580	20500	20500	
340144	34	16740	16740	
340145	34	16740	16740	LUGAR
340147	40580	39580	39580	
340148	49180	24660	24660	
340173	39580	20500	20500	
350003	35	13900	13900	
350006	35	13900	13900	
350009	35	22020	22020	
360008	36	26580	26580	
360010	36	10420	10420	
360011	36	18140	18140	
360013	36	30620	30620	
360014	36	18140	18140	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
360019	10420	17460	17460	
360020	10420	17460	17460	
360025	41780	17460	17460	
360027	10420	17460	17460	
360036	36	17460	17460	
360039	36	18140	18140	
360054	36	26580	26580	
360065	36	17460	17460	
360078	10420	17460	17460	
360079	19380	17140	17140	
360084	15940	10420	10420	
360086	44220	19380	19380	
360095	36	45780	45780	
360096	36	49660	49660	LUGAR
360107	36	45780	45780	
360121	36	11460	11460	
360150	10420	17460	17460	
360159	36	18140	18140	
360175	36	18140	18140	
360185	36	49660	49660	LUGAR
360187	44220	19380	19380	
360197	36	18140	18140	
360211	48260	38300	38300	
360238	36	49660	49660	LUGAR
360241	10420	17460	17460	
360245	36	17460	17460	LUGAR
360253	19380	17140	17140	
370004	37	27900	27900	
370006	37	17	17	
370014	37	43300	43300	
370015	37	46140	46140	
370016	37	36420	36420	
370018	37	46140	46140	
370022	37	30020	30020	
370025	37	46140	46140	
370026	37	36420	36420	
370034	37	22900	22900	
370047	37	43300	43300	
370049	37	36420	36420	
370099	37	46140	46140	
370103	37	45	45	
370113	37	22220	22220	
380001	38	38900	38900	
380022	38	18700	18700	LUGAR

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
380027	38	21660	21660	
380050	38	32780	32780	
380090	38	21660	21660	
390006	39	25420	25420	
390013	39	25420	25420	
390030	39	10900	10900	
390031	39	39740	39740	LUGAR
390046	49620	29540	29540	
390048	39	25420	25420	
390052	39	11020	11020	
390065	39	47894	47894	
390066	30140	25420	25420	
390071	39	48700	48700	LUGAR
390079	39	13780	13780	
390081	37964	48864	48864	
390086	39	44300	44300	
390091	39	38300	38300	
390093	39	38300	38300	
390110	27780	38300	38300	
390113	39	36	36	
390133	10900	37964	37964	
390138	39	47894	47894	
390150	39	38300	38300	LUGAR
390151	39	13644	13644	
390156	37964	48864	48864	
390180	37964	48864	48864	
390222	37964	48864	48864	
390246	39	48700	48700	
400048	25020	41980	41980	
410010	39300	14484	14484	
410012	39300	14484	14484	
410013	39300	35980	35980	
420007	43900	24860	24860	
420009	42	24860	24860	LUGAR
420020	42	16700	16700	
420027	11340	24860	24860	
420028	42	44940	44940	LUGAR
420030	42	16700	16700	
420036	42	16740	16740	
420039	42	43900	43900	LUGAR
420067	42	42340	42340	
420068	42	12260	12260	
420069	42	44940	44940	LUGAR
420070	44940	17900	17900	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
420071	42	24860	24860	
420080	42	42340	42340	
420083	43900	24860	24860	
420085	34820	48900	48900	
430012	43	43620	43620	
430014	43	22020	22020	
430094	43	53	53	
440002	27180	32820	32820	
440008	44	27180	27180	
440020	44	26620	26620	
440024	17420	16860	16860	
440025	44	34	34	
440035	17300	34980	34980	
440050	44	11700	11700	
440056	34100	28940	28940	
440058	44	16860	16860	
440059	44	34980	34980	
440060	44	27180	27180	
440067	34100	28940	28940	
440068	44	16860	16860	
440072	44	32820	32820	
440073	44	34980	34980	
440148	44	34980	34980	
440151	44	34980	34980	
440175	44	34980	34980	
440180	44	28940	28940	
440185	17420	16860	16860	
440192	44	34980	34980	
450007	45	41700	41700	
450032	45	43340	43340	
450039	23104	19124	19124	
450059	41700	12420	12420	
450064	23104	19124	19124	
450073	45	10180	10180	
450080	45	30980	30980	
450087	23104	19124	19124	
450099	45	11100	11100	
450121	23104	19124	19124	
450135	23104	19124	19124	
450137	23104	19124	19124	
450144	45	36220	36220	
450148	23104	19124	19124	
450187	45	26420	26420	
450192	45	19124	19124	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
450194	45	19124	19124	
450196	45	19124	19124	
450211	45	26420	26420	
450214	45	26420	26420	
450224	45	46340	46340	
450283	45	19124	19124	LUGAR
450286	45	17780	17780	LUGAR
450324	43300	19124	19124	
450347	45	26420	26420	
450351	45	23104	23104	
450389	45	19124	19124	LUGAR
450393	43300	19124	19124	
450395	45	26420	26420	
450400	45	47380	47380	
450419	23104	19124	19124	
450438	45	26420	26420	
450447	45	19124	19124	
450451	45	23104	23104	
450469	43300	19124	19124	
450484	45	30980	30980	
450508	45	46340	46340	
450547	45	19124	19124	
450563	23104	19124	19124	
450639	23104	19124	19124	
450653	45	33260	33260	
450656	45	46340	46340	
450672	23104	19124	19124	
450675	23104	19124	19124	
450677	23104	19124	19124	
450694	45	26420	26420	
450747	45	19124	19124	
450755	45	31180	31180	
450770	45	12420	12420	LUGAR
450779	23104	19124	19124	
450813	45	41700	41700	
450830	45	36220	36220	
450839	45	43340	43340	
450858	23104	19124	19124	
450872	23104	19124	19124	
450880	23104	19124	19124	
460004	36260	41620	41620	
460005	36260	41620	41620	
460007	46	41100	41100	
460011	46	39340	39340	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
460021	41100	29820	29820	
460039	46	36260	36260	
460041	36260	41620	41620	
460042	36260	41620	41620	
470001	47	30	30	
470011	47	15764	15764	
470012	47	38340	38340	
490004	25500	16820	16820	
490005	49020	47894	47894	
490013	49	31340	31340	
490018	49	16820	16820	
490042	13980	40220	40220	
490048	40220	31340	31340	
490079	49	24660	24660	
490092	49	40060	40060	
490105	49	28700	28700	
490106	49	16820	16820	
490109	47260	40060	40060	
500002	50	28420	28420	
500003	34580	42644	42644	
500016	48300	42644	42644	
500021	45104	42644	42644	
500024	36500	45104	45104	
500039	14740	42644	42644	
500041	31020	38900	38900	
500072	50	42644	42644	
500079	45104	42644	42644	
500108	45104	42644	42644	
500129	45104	42644	42644	
500139	36500	45104	45104	
500143	36500	45104	45104	
510001	34060	38300	38300	
510002	51	40220	40220	
510006	51	38300	38300	
510018	51	16620	16620	LUGAR
510024	34060	38300	38300	
510030	51	34060	34060	
510046	51	16620	16620	
510047	51	38300	38300	
510062	51	16620	16620	
510070	51	16620	16620	
510071	51	16620	16620	
510077	51	26580	26580	
520002	52	48140	48140	

Provider Number	Geographic CBSA	Reclassified CBSA 10/1/2006-3/31/2007	Reclassified CBSA 4/1/2007-9/30/2007	LUGAR
520021	29404	16974	16974	
520028	52	31540	31540	
520037	52	48140	48140	
520059	39540	29404	29404	
520060	52	22540	22540	LUGAR
520066	27500	31540	31540	
520071	52	33340	33340	LUGAR
520076	52	31540	31540	
520088	22540	33340	33340	
520094	39540	33340	33340	
520095	52	31540	31540	
520096	39540	33340	33340	
520102	52	33340	33340	LUGAR
520107	52	24580	24580	
520113	52	24580	24580	
520116	52	33340	33340	LUGAR
520173	52	20260	20260	
520189	29404	16974	16974	
530015	53	26820	26820	
530025	53	22660	22660	

NOTE: The following Table 9B is a tentative table and does not reflect decisions that are yet to be made by CMS pending the final calculation of the occupational mix adjusted wage index. The information about reclassified CBSAs reflects the latest information available to CMS regarding MGCRB and Administrator reclassification decisions for FY 2007. A revised Table 9B reflecting CMS' decisions on behalf of hospitals using occupational mix adjusted wage indices will be published in a subsequent Federal Register notice between August 1 and October 1, 2006, as well as on CMS' Web site. Hospitals will then have 30 days from the date the data appears on the CMS Web site to revise a decision made by CMS on their behalf. (See section III.H. of the preamble (Revisions to the Wage Index Based on Hospital Redesignations).).

TABLE 9B.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173--FY 2007

Provider Number	Note	Geographic CBSA	Wage Index CBSA- 10/1/06-3/31/07	Wage Index CBSA- 4/1/07-9/30/07*	Own Wage Index- 10/1/06-3/31/07
050494		05	42220		
050549		37100	42220		
070001		35300	35004		
070005		35300	35004		
070006	*	14860	35644		
070010		14860	35644		
070016		35300	35004		
070017		35300	35004		
070018	*	14860	35644		
070019		35300	35004		
070022		35300	35004		
070028		14860	35644		
070031		35300	35004		
070034	*	14860	35644		
070039		35300	35004		
140155	*	28100	16974	16974	
140186	*	28100	16974	16974	
160040		47940	16300		
160067		47940	16300		
160110		47940	16300		
220046		38340	14484		
230003		26100	28020		
230004		34740	28020		
230013		47644	22420		
230019		47644	22420		
230020		19804	11460		

Provider Number	Note	Geographic CBSA	Wage Index CBSA- 10/1/06-3/31/07	Wage Index CBSA- 4/1/07-9/30/07*	Own Wage Index- 10/1/06-3/31/07
230024		19804	11460		
230029		47644	22420		
230038		24340	28020		
230053		19804	11460		
230059		24340	28020		
230066		34740	28020		
230071		47644	22420		
230072		26100	28020		
230089		19804	11460		
230104		19804	11460		
230106		24340	28020		
230119		19804	11460		
230130		47644	22420		
230135		19804	11460		
230146		19804	11460		
230151		47644	22420		
230165		19804	11460		
230174		26100	28020		
230176		19804	11460		
230207		47644	22420		
230223		47644	22420		
230236		24340	28020		
230254		47644	22420		
230269		47644	22420		
230270		19804	11460		
230273		19804	11460		
230277		47644	22420		
250078	*	25620	25060	25060	
250122		25	25060		
270002	*	27	33540	33540	
270012	*	24500	33540	33540	
270023		33540	13740		
270032		27	13740		
270057		27	13740		
310028		35084	35644		
310051		35084	35644		
310060		10900	35644		
310115		10900	35644		
310120		35084	35644		
330023	*	39100	35644	35644	
330049		39100	35644		

Provider Number	Note	Geographic CBSA	Wage Index CBSA- 10/1/06-3/31/07	Wage Index CBSA- 4/1/07-9/30/07*	Own Wage Index- 10/1/06-3/31/07
330067	*	39100	35644	35644	
330106		35004	-- -- --		To be determined
330126		39100	35644		
330135		39100	35644		
330205		39100	35644		
330209		39100	35004		
330264		39100	35004		
340002		11700	16740		
350002		13900	22020		
350010		35	22020		
350014		35	22020		
350015		13900	22020		
350017		35	22020		
350019	*	24220	22020	22020	
350030		35	22020		
390001		42540	10900		
390003		39	10900		
390044	***	39	37964	37964	
390045	**	39	10900		
390096	***	39	37964	37964	
390054		42540	29540		
390072		39	10900		
390095		42540	10900		
390119		42540	10900		
390137		42540	10900		
390169		42540	10900		
390185		42540	29540		
390192		42540	10900		
390237		42540	10900		
390270		42540	29540		
430005		43	39660		
430008	*	43	43620	43620	
430013	*	43	43620	43620	
430015		43	43620		
430048		43	43620		
430060		43	43620		
430064		43	43620		
430077		39660	43620		
430091		39660	43620		
450010		48660	32580		
450072		26420	26420		

Provider Number	Note	Geographic CBSA	Wage Index CBSA- 10/1/06-3/31/07	Wage Index CBSA- 4/1/07-9/30/07*	Own Wage Index- 10/1/06-3/31/07
450591		26420	26420		
470003		15540	14484		
490001		49	31340		
490024		40220	19260		
530008	*	53	16220	16220	
530010	*	53	16220	16220	

*These hospitals are assigned a wage index value under a special exceptions policy (see the FY 2005 IPPS final rule, 69 FR 49105).
**This hospital has been assigned a wage index for the 1st half of FY 2007 under a special exceptions policy. (See section IV.G.6. of the preamble).
***These hospitals are receiving the same wage index for FY 2007 as hospitals reclassified to the wage index CBSA under a special exceptions policy. (See section IV.G.7. of the preamble).

NOTE: The following Table 9C is a tentative table. The final Table 9C will be published in a subsequent Federal Register notice.

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(e) OF THE ACT--FY 2007

Provider Number	Geographic CBSA	Redesignated Rural Area
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
140167	14	14
170137	29940	17
230078	35660	23
250126	32820	25
260006	41140	26
260047	27620	26
260195	44180	26
330044	46540	33
330245	46540	33
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390181	39	39
390183	39	39
390201	39	39
440135	34980	44
440144	44	44
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
500148	48300	50
520060	52	52

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 DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]

DRG	Number of Cases	Threshold
1	24,393	$53,859
2	10,183	$37,071
3	3	$58,210
6	288	$16,764
7	15,032	$41,272
8	3,441	$31,202
9	1,775	$25,427
10	19,625	$25,060
11	3,083	$18,954
12	55,941	$18,864
13	7,525	$17,686
14	278,664	$24,952
15	19,988	$20,852
16	17,297	$26,470
17	2,973	$15,671
18	33,442	$21,265
19	8,461	$15,788
21	2,220	$26,884
22	3,168	$23,889
23	10,670	$17,034
26	25	$20,742
27	5,971	$25,126
28	19,909	$25,472
29	6,522	$15,804
31	5,039	$21,114
32	1,903	$14,176
34	27,626	$21,155
35	7,908	$14,353
36	307	$17,756
37	1,219	$24,755
38	50	$12,318
39	328	$14,729
40	1,187	$22,468
42	1,636	$17,058
43	125	$12,886

DRG	Number of Cases	Threshold
44	1,290	$14,781
45	2,770	$16,499
46	3,929	$16,766
47	1,309	$12,103
49	2,415	$31,272
50	2,024	$19,196
51	193	$19,075
52	234	$14,080
53	2,145	$26,675
55	1,368	$20,084
56	451	$19,390
57	742	$20,308
59	126	$14,929
60	3	$18,786
61	222	$28,823
62	4	$7,163
63	2,827	$26,792
64	3,234	$23,219
65	40,485	$13,493
66	8,195	$12,916
67	379	$17,186
68	18,914	$14,138
69	5,147	$10,697
70	25	$7,437
71	70	$15,616
72	1,326	$16,659
73	9,957	$18,043
74	3	$8,024
75	46,851	$48,022
76	48,157	$43,553
77	2,111	$25,956
78	49,690	$26,233
79	160,369	$29,354
80	7,158	$18,880
81	6	$25,916
82	63,189	$26,608
83	7,153	$21,595
84	1,403	$12,778
85	22,221	$25,180
86	1,717	$15,470
87	96,689	$26,951

DRG	Number of Cases	Threshold
88	427,043	$19,077
89	553,984	$21,998
90	43,488	$13,140
91	53	$11,541
92	16,513	$24,878
93	1,440	$16,320
94	13,655	$23,750
95	1,577	$12,584
96	59,616	$15,882
97	26,688	$11,788
98	13	$12,310
99	21,386	$15,711
100	6,410	$12,191
101	23,368	$18,513
102	4,930	$12,459
103	886	$234,602
104	20,120	$123,729
105	32,625	$93,408
106	3,440	$110,994
108	8,757	$89,200
110	57,708	$59,122
111	10,783	$45,058
113	34,727	$45,309
114	7,959	$30,170
117	5,349	$25,612
118	7,618	$33,293
119	963	$25,956
120	33,555	$36,437
121	150,046	$29,682
122	54,522	$20,932
123	29,562	$25,715
124	120,510	$29,669
125	92,404	$23,736
126	5,422	$40,901
127	667,290	$21,942
128	4,210	$15,608
129	3,521	$21,829
130	87,465	$20,048
131	22,952	$12,056
132	101,372	$13,633
133	5,853	$12,293

DRG	Number of Cases	Threshold
134	39,815	$13,564
135	7,164	$19,603
136	943	$14,059
138	206,126	$17,760
139	74,038	$11,503
140	31,103	$11,146
141	123,082	$16,534
142	49,143	$13,230
143	237,807	$12,604
144	104,877	$24,605
145	5,742	$12,881
146	10,269	$45,041
147	2,614	$31,225
149	19,523	$30,188
150	22,971	$44,974
151	5,403	$27,702
152	5,011	$33,350
153	1,951	$23,250
155	6,015	$27,694
156	4	$42,508
157	8,316	$25,981
158	3,718	$14,389
159	19,221	$28,296
160	11,939	$18,822
161	10,145	$25,544
162	4,950	$15,299
163	5	$14,048
164	5,996	$38,818
165	2,457	$25,554
166	5,154	$29,280
167	4,909	$19,591
168	1,640	$25,296
169	895	$16,736
170	17,929	$44,476
171	1,408	$26,705
172	33,047	$26,380
173	2,225	$17,045
174	253,126	$21,911
175	29,235	$12,602
176	14,648	$23,944
177	7,654	$20,572

DRG	Number of Cases	Threshold
178	2,557	$15,461
179	14,727	$22,980
180	91,335	$20,871
181	25,350	$12,528
182	255,693	$17,100
183	79,005	$13,059
184	72	$12,775
185	6,251	$18,862
186	7	$5,729
187	646	$18,324
188	87,004	$22,789
189	12,389	$12,993
190	10	$13,793
191	10,586	$54,694
192	1,379	$32,567
193	4,040	$51,607
194	461	$32,138
195	2,846	$50,174
196	594	$32,425
197	16,420	$41,918
198	4,109	$26,021
199	1,481	$37,144
200	1,017	$39,787
201	2,717	$52,741
202	27,495	$25,140
203	32,423	$26,174
204	69,425	$23,010
205	32,781	$23,351
206	2,069	$16,166
207	38,288	$24,720
208	9,444	$15,527
210	126,728	$36,053
211	25,766	$26,659
212	10	$18,683
213	9,549	$33,765
216	19,882	$35,362
217	15,719	$41,753
218	30,181	$32,729
219	21,168	$23,440
220	2	$23,903
223	12,681	$25,312

DRG	Number of Cases	Threshold
224	9,900	$18,601
225	6,275	$26,110
226	6,770	$29,333
227	4,857	$18,593
228	2,678	$24,524
229	1,121	$15,634
230	2,473	$26,447
232	570	$20,883
233	18,488	$34,629
234	9,054	$27,553
235	4,763	$16,190
236	41,769	$15,355
237	1,924	$13,823
238	9,693	$26,230
239	40,335	$23,007
240	12,890	$24,447
241	2,848	$14,324
242	2,722	$22,524
243	100,967	$16,980
244	16,921	$15,376
245	5,808	$10,439
246	1,393	$13,417
247	21,347	$12,715
248	16,397	$18,868
249	13,487	$15,452
250	4,164	$15,019
251	2,060	$10,708
253	24,800	$16,458
254	10,027	$10,209
256	7,605	$17,958
257	13,112	$19,571
258	11,381	$15,394
259	2,660	$21,525
260	2,419	$15,097
261	1,569	$20,644
262	602	$20,936
263	22,523	$32,381
264	3,924	$22,357
265	4,035	$28,309
266	2,229	$19,597
267	276	$20,106

DRG	Number of Cases	Threshold
268	1,007	$25,612
269	11,061	$30,462
270	2,581	$17,761
271	21,573	$21,481
272	6,062	$20,880
273	1,268	$12,695
274	2,214	$22,743
275	181	$13,374
276	1,611	$15,518
277	118,989	$18,380
278	33,858	$11,743
279	6	$9,028
280	19,325	$16,053
281	6,587	$11,088
283	6,751	$15,599
284	1,860	$9,705
285	8,075	$35,308
286	2,868	$34,849
287	5,460	$31,315
288	11,449	$36,434
289	6,342	$19,683
290	11,870	$18,835
291	60	$12,847
292	7,589	$41,562
293	318	$27,393
294	96,811	$16,300
295	4,383	$16,230
296	247,069	$17,299
297	42,864	$10,800
298	111	$11,190
299	1,529	$21,390
300	21,669	$23,232
301	3,928	$13,530
302	10,492	$53,266
303	19,976	$35,819
304	13,647	$37,422
305	2,957	$25,305
306	5,818	$25,921
307	1,947	$13,760
308	5,453	$27,129
309	2,964	$19,731

DRG	Number of Cases	Threshold
310	25,376	$25,322
311	5,889	$14,252
312	1,328	$24,325
313	505	$16,679
314	2	$63,693
315	34,913	$34,732
316	205,567	$24,393
317	2,713	$17,231
318	5,910	$24,031
319	386	$13,806
320	224,861	$18,200
321	31,967	$12,268
322	67	$13,265
323	20,412	$18,194
324	4,635	$11,389
325	9,919	$14,495
326	2,592	$9,794
327	11	$4,294
328	574	$15,404
329	54	$11,795
331	56,121	$22,457
332	3,962	$13,793
333	244	$18,788
334	9,525	$29,865
335	12,194	$23,947
336	28,187	$18,026
337	21,481	$12,476
338	674	$26,938
339	1,237	$24,409
341	3,131	$26,307
342	457	$16,760
344	2,341	$26,248
345	1,390	$24,261
346	3,961	$22,447
347	235	$12,285
348	4,262	$15,649
349	554	$10,003
350	7,277	$16,400
352	1,177	$16,558
353	3,089	$31,178
354	7,566	$29,684

DRG	Number of Cases	Threshold
355	4,987	$19,221
356	22,033	$16,309
357	5,537	$37,740
358	20,928	$24,238
359	28,580	$17,269
360	13,854	$18,919
361	287	$23,680
362	2	$6,876
363	2,155	$23,016
364	1,799	$19,187
365	1,617	$32,690
366	4,645	$23,871
367	446	$12,997
368	4,145	$23,493
369	3,723	$14,329
370	2,249	$17,536
371	2,705	$12,708
372	1,376	$10,820
373	5,273	$7,551
374	153	$13,095
375	12	$22,605
376	476	$12,906
377	109	$24,239
378	201	$16,324
379	499	$8,220
380	111	$9,315
381	169	$15,169
382	48	$3,953
383	2,806	$10,556
384	151	$7,391
389	3	$46,615
392	2,139	$45,751
394	2,759	$31,094
395	101,471	$16,872
396	18	$13,668
397	16,393	$23,048
398	6,706	$23,192
399	1,080	$14,880
401	6,450	$43,894
402	1,356	$25,221
403	31,326	$29,940

DRG	Number of Cases	Threshold
404	3,820	$20,305
406	2,303	$42,371
407	615	$24,760
408	1,948	$33,871
409	1,748	$25,028
410	29,054	$23,858
411	5	$9,758
412	9	$9,301
413	5,741	$25,510
414	487	$16,429
417	33	$28,208
418	29,977	$22,175
419	17,634	$18,485
420	3,099	$12,971
421	13,255	$16,146
422	79	$11,674
423	8,963	$28,718
424	1,041	$36,310
425	13,096	$13,576
426	4,235	$10,358
427	1,579	$11,150
428	845	$13,754
429	23,937	$16,826
430	75,524	$13,556
431	333	$12,627
432	402	$13,998
433	4,471	$6,847
439	1,759	$29,659
440	5,216	$29,541
441	686	$20,435
442	18,596	$37,577
443	3,589	$22,629
444	6,012	$16,302
445	2,242	$11,469
447	6,323	$11,513
449	40,846	$18,238
450	7,446	$9,442
451	2	$19,193
452	28,815	$21,741
453	5,394	$11,421
454	4,738	$17,849

DRG	Number of Cases	Threshold
455	887	$10,666
461	2,290	$27,945
462	7,872	$17,133
463	32,884	$15,084
464	7,661	$11,312
465	163	$12,726
466	1,204	$14,603
467	1,026	$10,034
468	52,034	$57,083
470	128	$25,336
471	15,629	$55,462
473	8,578	$38,317
476	2,850	$35,279
477	28,196	$34,210
479	27,646	$30,664
480	908	$128,168
481	1,198	$88,802
482	5,081	$49,179
484	472	$75,098
485	3,713	$51,983
486	2,712	$69,277
487	5,016	$32,011
488	828	$63,276
489	13,547	$28,578
490	5,252	$21,783
491	22,663	$35,757
492	3,924	$44,444
493	61,082	$34,552
494	24,547	$22,715
495	342	$121,068
496	3,726	$96,376
497	31,199	$62,663
498	21,280	$52,014
499	35,237	$28,340
500	46,422	$19,794
501	3,200	$42,436
502	764	$29,393
503	5,910	$26,641
504	192	$146,326
505	180	$28,322
506	963	$50,293

DRG	Number of Cases	Threshold
507	323	$31,953
508	654	$23,720
509	155	$16,128
510	1,782	$21,239
511	627	$13,459
512	550	$90,167
513	226	$67,279
515	58,660	$86,655
518	23,763	$34,494
519	12,586	$44,219
520	16,525	$35,867
521	29,364	$15,459
522	3,423	$12,513
523	14,462	$8,492
524	109,013	$16,146
525	205	$156,053
528	1,845	$107,773
529	5,026	$36,123
530	3,360	$25,556
531	4,993	$45,570
532	2,882	$28,122
533	43,711	$29,882
534	40,198	$21,414
535	8,826	$119,398
536	8,259	$108,963
537	8,983	$32,586
538	5,459	$22,310
539	4,973	$44,568
540	1,504	$25,469
541	25,104	$250,678
542	23,115	$151,096
543	5,718	$64,315
544	445,785	$39,430
545	44,802	$44,809
546	2,360	$83,370
547	32,709	$97,710
548	32,245	$79,387
549	13,141	$80,448
550	34,565	$63,344
551	53,869	$51,334
552	82,060	$40,475

DRG	Number of Cases	Threshold
553	39,292	$46,776
554	77,351	$36,869
555	37,378	$42,650
556	18,974	$37,645
557	124,154	$51,129
558	192,632	$42,278
559	2,894	$40,715
560	3,457	$44,371
561	2,952	$35,689
562	52,955	$22,123
563	21,145	$13,990
564	16,327	$15,294
565	46,822	$78,211
566	73,082	$39,116
567	10,363	$72,688
568	16,695	$48,792
569	60,815	$63,221
570	72,246	$44,142
571	11,153	$23,679
572	48,982	$25,169
573	6,682	$51,652
574	26,619	$24,475
575	10,977	$85,769
576	277,472	$28,296
577	5,596	$35,303
578	35,311	$64,885
579	20,665	$39,571

* As noted in section II.G.5 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** notice between August 1 and October 1, 2006.

[1] Cases taken from the FY 2005 MedPAR file; DRGs are from GROUPER Version 24.0.

TABLE 11.--FY 2007 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
1	[5]CRANIOTOMY AGE >17 W CC	1.6835	37.1	30.9
2	[6]CRANIOTOMY AGE >17 W/O CC	1.6835	37.1	30.9
3	[6]CRANIOTOMY AGE 0-17	1.6835	37.1	30.9
6	[6]CARPAL TUNNEL RELEASE	0.4175	17.0	14.2
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.2052	36.1	30.1
8	[2]PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.5594	21.0	17.5
9	SPINAL DISORDERS & INJURIES	1.0424	34.0	28.3
10	NERVOUS SYSTEM NEOPLASMS W CC	0.6971	22.1	18.4
11	[2]NERVOUS SYSTEM NEOPLASMS W/O CC	0.5594	21.0	17.5
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6788	25.1	20.9
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6003	23.1	19.3
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	0.6772	24.9	20.8
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.7705	26.1	21.8
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.6978	23.1	19.3
17	[2]NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5594	21.0	17.5
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7503	25.4	21.2
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4512	19.5	16.3
21	[3]VIRAL MENINGITIS	0.7819	23.9	19.9
22	[3]HYPERTENSIVE ENCEPHALOPATHY	0.7819	23.9	19.9
23	NONTRAUMATIC STUPOR & COMA	1.0118	29.4	24.5
26	[6]SEIZURE & HEADACHE AGE 0-17	0.5594	21.0	17.5
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9978	30.6	25.5
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.7983	25.8	21.5
29	[1]TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.4175	17.0	14.2
30	[6]TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.4175	17.0	14.2
31	[1]CONCUSSION AGE >17 W CC	0.4175	17.0	14.2
32	[6]CONCUSSION AGE >17 W/O CC	0.4175	17.0	14.2
33	[6]CONCUSSION AGE 0-17	0.4175	17.0	14.2
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.7029	23.4	19.5
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5080	21.1	17.6
36	[6]RETINAL PROCEDURES	0.5594	21.0	17.5
37	[6]ORBITAL PROCEDURES	0.5594	21.0	17.5
38	[6]PRIMARY IRIS PROCEDURES	0.5594	21.0	17.5

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
39	[6]LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5594	21.0	17.5
40	[6]EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5594	21.0	17.5
41	[6]EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.5594	21.0	17.5
42	[6]INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5594	21.0	17.5
43	[6]HYPHEMA	0.4175	17.0	14.2
44	[3]ACUTE MAJOR EYE INFECTIONS	0.7819	23.9	19.9
45	[1]NEUROLOGICAL EYE DISORDERS	0.4175	17.0	14.2
46	[2]OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5594	21.0	17.5
47	[6]OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4175	17.0	14.2
48	[6]OTHER DISORDERS OF THE EYE AGE 0-17	0.4175	17.0	14.2
49	[6]MAJOR HEAD & NECK PROCEDURES	1.1625	29.5	24.6
50	[6]SIALOADENECTOMY	1.1625	29.5	24.6
51	[6]SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1625	29.5	24.6
52	[6]CLEFT LIP & PALATE REPAIR	1.1625	29.5	24.6
53	[6]SINUS & MASTOID PROCEDURES AGE >17	1.1625	29.5	24.6
54	~~6~~SINUS & MASTOID PROCEDURES AGE 0-17	1.1625	29.5	24.6
55	[4]MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1625	29.5	24.6
56	[6]RHINOPLASTY	1.1625	29.5	24.6
57	[6]T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4175	17.0	14.2
58	[6]T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.4175	17.0	14.2
59	[6]TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4175	17.0	14.2
60	[6]TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.4175	17.0	14.2
61	[6]MYRINGOTOMY W TUBE INSERTION AGE >17	0.4175	17.0	14.2
62	[6]MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.4175	17.0	14.2
63	[4]OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1625	29.5	24.6
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1797	26.2	21.8
65	[1]DYSEQUILIBRIUM	0.4175	17.0	14.2
66	[6]EPISTAXIS	0.4175	17.0	14.2
67	[3]EPIGLOTTITIS	0.7819	23.9	19.9
68	OTITIS MEDIA & URI AGE >17 W CC	0.6211	20.3	16.9
69	[1]OTITIS MEDIA & URI AGE >17 W/O CC	0.4175	17.0	14.2
70	[6]OTITIS MEDIA & URI AGE 0-17	0.4175	17.0	14.2
71	[6]LARYNGOTRACHEITIS	0.5594	21.0	17.5
72	[3]NASAL TRAUMA & DEFORMITY	0.7819	23.9	19.9
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7745	22.9	19.1

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
74	[6]OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.4175	17.0	14.2
75	MAJOR CHEST PROCEDURES	1.9944	33.5	27.9
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3982	42.5	35.4
77	[2]OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	0.5594	21.0	17.5
78	PULMONARY EMBOLISM	0.6746	22.6	18.8
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8182	22.8	19.0
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.6485	20.9	17.4
81	[6]RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.4175	17.0	14.2
82	RESPIRATORY NEOPLASMS	0.8242	21.4	17.8
83	[1]MAJOR CHEST TRAUMA W CC	0.4175	17.0	14.2
84	[6]MAJOR CHEST TRAUMA W/O CC	0.4175	17.0	14.2
85	PLEURAL EFFUSION W CC	0.6956	21.4	17.8
86	[6]PLEURAL EFFUSION W/O CC	0.4175	17.0	14.2
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0295	24.8	20.7
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6411	19.3	16.1
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6802	20.6	17.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4958	17.8	14.8
91	[6]SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.5594	21.0	17.5
92	INTERSTITIAL LUNG DISEASE W CC	0.6638	19.6	16.3
93	[1]INTERSTITIAL LUNG DISEASE W/O CC	0.4175	17.0	14.2
94	PNEUMOTHORAX W CC	0.6785	21.3	17.8
95	[8]PNEUMOTHORAX W/O CC	0.6785	21.3	17.8
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6230	18.9	15.8
97	[8]BRONCHITIS & ASTHMA AGE >17 W/O CC	0.6230	18.9	15.8
98	[6]BRONCHITIS & ASTHMA AGE 0-17	0.5594	21.0	17.5
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9381	24.6	20.5
100	[3]RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7819	23.9	19.9
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	22.2	18.5
102	[1]OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4175	17.0	14.2
103	[7]HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[6]CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	1.1625	29.5	24.6
105	[6]CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	1.1625	29.5	24.6
106	[6]CORONARY BYPASS W PTCA	1.1625	29.5	24.6
108	[6]OTHER CARDIOTHORACIC PROCEDURES	1.1625	29.5	24.6
110	[4]MAJOR CARDIOVASCULAR PROCEDURES W CC	1.1625	29.5	24.6
111	[6]MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.1625	29.5	24.6
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3942	36.1	30.1
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2425	33.0	27.5

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
117	[2]CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.5594	21.0	17.5
118	[3]CARDIAC PACEMAKER DEVICE REPLACEMENT	0.7819	23.9	19.9
119	[3]VEIN LIGATION & STRIPPING	0.7819	23.9	19.9
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0893	31.4	26.2
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7451	22.4	18.7
122	[2]CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5594	21.0	17.5
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.7858	17.0	14.2
124	[4]CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1625	29.5	24.6
125	[1]CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.4175	17.0	14.2
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8867	26.3	21.9
127	HEART FAILURE & SHOCK	0.6832	21.2	17.7
128	[2]DEEP VEIN THROMBOPHLEBITIS	0.5594	21.0	17.5
129	[1]CARDIAC ARREST, UNEXPLAINED	0.4175	17.0	14.2
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6484	22.8	19.0
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5267	21.0	17.5
132	ATHEROSCLEROSIS W CC	0.6621	20.7	17.3
133	[2]ATHEROSCLEROSIS W/O CC	0.5594	21.0	17.5
134	HYPERTENSION	0.4909	21.7	18.1
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8014	23.8	19.8
136	[1]CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.4175	17.0	14.2
137	[6]CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.4175	17.0	14.2
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6618	21.9	18.3
139	[2]CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5594	21.0	17.5
140	[1]ANGINA PECTORIS	0.4175	17.0	14.2
141	SYNCOPE & COLLAPSE W CC	0.5891	22.1	18.4
142	[8]SYNCOPE & COLLAPSE W/O CC	0.5891	22.1	18.4
143	[1]CHEST PAIN	0.4175	17.0	14.2
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7715	22.1	18.4
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4292	17.0	14.2
146	[5]RECTAL RESECTION W CC	1.6835	37.1	30.9
147	[6]RECTAL RESECTION W/O CC	0.7819	23.9	19.9
149	[6]MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7819	23.9	19.9
150	[5]PERITONEAL ADHESIOLYSIS W CC	1.6835	37.1	30.9
151	[6]PERITONEAL ADHESIOLYSIS W/O CC	0.4175	17.0	14.2
152	[5]MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6835	37.1	30.9

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
153	[6]MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.6835	37.1	30.9
155	[6]STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.6835	37.1	30.9
156	[6]STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.6835	37.1	30.9
157	[3]ANAL & STOMAL PROCEDURES W CC	0.7819	23.9	19.9
158	[6]ANAL & STOMAL PROCEDURES W/O CC	0.7819	23.9	19.9
159	[5]HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.6835	37.1	30.9
160	[1]HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.4175	17.0	14.2
161	[6]INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	0.4175	17.0	14.2
162	[6]INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4175	17.0	14.2
163	[6]HERNIA PROCEDURES AGE 0-17	0.4175	17.0	14.2
164	[6]APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	0.7819	23.9	19.9
165	[6]APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	0.7819	23.9	19.9
166	[6]APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	0.7819	23.9	19.9
167	[6]APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.7819	23.9	19.9
168	[5]MOUTH PROCEDURES W CC	1.6835	37.1	30.9
169	[6]MOUTH PROCEDURES W/O CC	0.5594	21.0	17.5
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6163	35.8	29.8
171	[3]OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.7819	23.9	19.9
172	DIGESTIVE MALIGNANCY W CC	0.8497	21.8	18.2
173	[2]DIGESTIVE MALIGNANCY W/O CC	0.5594	21.0	17.5
174	G.I. HEMORRHAGE W CC	0.7149	22.9	19.1
175	[2]G.I. HEMORRHAGE W/O CC	0.5594	21.0	17.5
176	COMPLICATED PEPTIC ULCER	0.9514	24.8	20.7
177	[2]UNCOMPLICATED PEPTIC ULCER W CC	0.5594	21.0	17.5
178	[6]UNCOMPLICATED PEPTIC ULCER W/O CC	0.4175	17.0	14.2
179	INFLAMMATORY BOWEL DISEASE	0.8157	23.3	19.4
180	G.I. OBSTRUCTION W CC	0.9126	22.8	19.0
181	[1]G.I. OBSTRUCTION W/O CC	0.4175	17.0	14.2
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7866	21.8	18.2
183	[1]ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.4175	17.0	14.2
184	[6]ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4175	17.0	14.2
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.6634	23.2	19.3

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
186	[6]DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.5594	21.0	17.5
187	[6]DENTAL EXTRACTIONS & RESTORATIONS	0.5594	21.0	17.5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9596	24.4	20.3
189	[2]OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5594	21.0	17.5
190	[6]OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.5594	21.0	17.5
191	[5]PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.6835	37.1	30.9
192	[6]PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9
193	[4]BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	1.1625	29.5	24.6
194	[6]BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.1625	29.5	24.6
195	[5]CHOLECYSTECTOMY W C.D.E. W CC	1.6835	37.1	30.9
196	[6]CHOLECYSTECTOMY W C.D.E. W/O CC	1.1625	29.5	24.6
197	[4]CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.1625	29.5	24.6
198	[6]CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1625	29.5	24.6
199	[3]HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.7819	23.9	19.9
200	[5]HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.6835	37.1	30.9
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.5802	28.8	24.0
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6011	20.2	16.8
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7466	19.6	16.3
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8853	22.1	18.4
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6933	23.1	19.3
206	[8]DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.6933	23.1	19.3
207	DISORDERS OF THE BILIARY TRACT W CC	0.7295	21.5	17.9
208	[1]DISORDERS OF THE BILIARY TRACT W/O CC	0.4175	17.0	14.2
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.4826	41.9	34.9
211	[6]HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6835	37.1	30.9
212	[6]HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6835	37.1	30.9
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1871	33.5	27.9
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.2147	37.6	31.3
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.2414	36.5	30.4

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
218	[5]LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.6835	37.1	30.9
219	[6]LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.6835	37.1	30.9
220	[6]LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	1.6835	37.1	30.9
223	[4]MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1625	29.5	24.6
224	[1]SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.4175	17.0	14.2
225	FOOT PROCEDURES	0.9550	30.6	25.5
226	SOFT TISSUE PROCEDURES W CC	1.0626	34.3	28.6
227	[3]SOFT TISSUE PROCEDURES W/O CC	0.7819	23.9	19.9
228	[3]MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	0.7819	23.9	19.9
229	[6]HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4175	17.0	14.2
230	[5]LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.6835	37.1	30.9
232	[5]ARTHROSCOPY	1.6835	37.1	30.9
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.1724	32.4	27.0
234	[6]OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4175	17.0	14.2
235	[3]FRACTURES OF FEMUR	0.7819	23.9	19.9
236	FRACTURES OF HIP & PELVIS	0.6802	28.9	24.1
237	[1]SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4175	17.0	14.2
238	OSTEOMYELITIS	0.8589	28.4	23.7
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6031	20.6	17.2
240	CONNECTIVE TISSUE DISORDERS W CC	0.7134	22.4	18.7
241	[1]CONNECTIVE TISSUE DISORDERS W/O CC	0.4175	17.0	14.2
242	SEPTIC ARTHRITIS	0.7700	26.2	21.8
243	MEDICAL BACK PROBLEMS	0.6028	22.3	18.6
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5516	22.0	18.3
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4463	19.4	16.2
246	[2]NON-SPECIFIC ARTHROPATHIES	0.5594	21.0	17.5
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.4582	17.6	14.7
248	TENDONITIS, MYOSITIS & BURSITIS	0.7328	23.2	19.3
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6370	24.0	20.0
250	[1]FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.4175	17.0	14.2
251	[6]FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4175	17.0	14.2

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
252	[6]FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.5594	21.0	17.5
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.5609	24.0	20.0
254	[1]FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4175	17.0	14.2
255	[6]FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.5594	21.0	17.5
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7132	23.6	19.7
257	[5]TOTAL MASTECTOMY FOR MALIGNANCY W CC	1.6835	37.1	30.9
258	[6]TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9
259	[3]SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7819	23.9	19.9
260	[6]SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9
261	[2]BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.5594	21.0	17.5
262	[4]BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	1.1625	29.5	24.6
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.2748	38.0	31.7
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.8507	29.9	24.9
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.1019	30.2	25.2
266	[3]SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7819	23.9	19.9
267	[6]PERIANAL & PILONIDAL PROCEDURES	0.7819	23.9	19.9
268	[4]SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1625	29.5	24.6
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.2075	34.7	28.9
270	[3]OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7819	23.9	19.9
271	SKIN ULCERS	0.8269	26.9	22.4
272	MAJOR SKIN DISORDERS W CC	0.6584	23.0	19.2
273	[1]MAJOR SKIN DISORDERS W/O CC	0.4175	17.0	14.2
274	MALIGNANT BREAST DISORDERS W CC	0.7231	21.8	18.2
275	[6]MALIGNANT BREAST DISORDERS W/O CC	0.7819	23.9	19.9
276	[2]NON-MALIGNANT BREAST DISORDERS	0.5594	21.0	17.5
277	CELLULITIS AGE >17 W CC	0.6089	20.9	17.4
278	CELLULITIS AGE >17 W/O CC	0.4254	18.0	15.0
279	[6]CELLULITIS AGE 0-17	0.4175	17.0	14.2
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7148	24.1	20.1
281	[2]TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5594	21.0	17.5
282	[6]TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.5594	21.0	17.5
283	MINOR SKIN DISORDERS W CC	0.6876	23.1	19.3

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
284	[2]MINOR SKIN DISORDERS W/O CC	0.5594	21.0	17.5
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.2418	31.6	26.3
286	[6]ADRENAL & PITUITARY PROCEDURES	1.1625	29.5	24.6
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.0402	33.0	27.5
288	[4]O.R. PROCEDURES FOR OBESITY	1.1625	29.5	24.6
289	[6]PARATHYROID PROCEDURES	1.1625	29.5	24.6
290	[6]THYROID PROCEDURES	1.1625	29.5	24.6
291	[6]THYROGLOSSAL PROCEDURES	1.1625	29.5	24.6
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1549	32.0	26.7
293	[8]OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1549	32.0	26.7
294	DIABETES AGE >35	0.6958	23.9	19.9
295	[2]DIABETES AGE 0-35	0.5594	21.0	17.5
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7092	22.3	18.6
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.4596	19.3	16.1
298	[6]NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.4175	17.0	14.2
299	[3]INBORN ERRORS OF METABOLISM	0.7819	23.9	19.9
300	ENDOCRINE DISORDERS W CC	0.7004	23.7	19.8
301	[2]ENDOCRINE DISORDERS W/O CC	0.5594	21.0	17.5
302	[7]KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[6]KIDNEY AND URETER PROCEDURES FOR NEOPLASM	0.7819	23.9	19.9
304	[4]KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC	1.1625	29.5	24.6
305	[6]KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC	0.7819	23.9	19.9
306	[4]PROSTATECTOMY W CC	1.1625	29.5	24.6
307	[6]PROSTATECTOMY W/O CC	1.1625	29.5	24.6
308	[4]MINOR BLADDER PROCEDURES W CC	1.1625	29.5	24.6
309	[6]MINOR BLADDER PROCEDURES W/O CC	1.1625	29.5	24.6
310	[4]TRANSURETHRAL PROCEDURES W CC	1.1625	29.5	24.6
311	[6]TRANSURETHRAL PROCEDURES W/O CC	1.1625	29.5	24.6
312	[3]URETHRAL PROCEDURES, AGE >17 W CC	0.7819	23.9	19.9
313	[6]URETHRAL PROCEDURES, AGE >17 W/O CC	0.7819	23.9	19.9
314	[6]URETHRAL PROCEDURES, AGE 0-17	0.7819	23.9	19.9
315	OTHER KIDNEY & URINARY TRACT PROCEDURES	1.4016	33.9	28.3
316	RENAL FAILURE	0.8321	22.9	19.1
317	ADMIT FOR RENAL DIALYSIS	0.9102	24.4	20.3
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7565	21.0	17.5
319	[6]KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7819	23.9	19.9
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6200	21.7	18.1

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4450	18.5	15.4
322	[6]KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4175	17.0	14.2
323	[1]URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.4175	17.0	14.2
324	[1]URINARY STONES W/O CC	0.4175	17.0	14.2
325	[2]KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5594	21.0	17.5
326	[6]KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4175	17.0	14.2
327	[6]KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.4175	17.0	14.2
328	[6]URETHRAL STRICTURE AGE >17 W CC	0.5594	21.0	17.5
329	[6]URETHRAL STRICTURE AGE >17 W/O CC	0.5594	21.0	17.5
330	[6]URETHRAL STRICTURE AGE 0-17	0.5594	21.0	17.5
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.7773	22.5	18.8
332	[1]OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.4175	17.0	14.2
333	[6]OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.4175	17.0	14.2
334	[6]MAJOR MALE PELVIC PROCEDURES W CC	0.4175	17.0	14.2
335	[1]MAJOR MALE PELVIC PROCEDURES W/O CC	0.4175	17.0	14.2
336	[4]TRANSURETHRAL PROSTATECTOMY W CC	1.1625	29.5	24.6
337	[6]TRANSURETHRAL PROSTATECTOMY W/O CC	1.1625	29.5	24.6
338	[3]TESTES PROCEDURES, FOR MALIGNANCY	0.7819	23.9	19.9
339	[3]TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.7819	23.9	19.9
340	[6]TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.7819	23.9	19.9
341	[5]PENIS PROCEDURES	1.6835	37.1	30.9
342	[6]CIRCUMCISION AGE >17	0.7819	23.9	19.9
343	[6]CIRCUMCISION AGE 0-17	0.7819	23.9	19.9
344	[3]OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.7819	23.9	19.9
345	[4]OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.1625	29.5	24.6
346	[3]MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7819	23.9	19.9
347	[1]MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4175	17.0	14.2
348	[2]BENIGN PROSTATIC HYPERTROPHY W CC	0.5594	21.0	17.5
349	[6]BENIGN PROSTATIC HYPERTROPHY W/O CC	0.7819	23.9	19.9
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.5606	21.0	17.5
351	[6]STERILIZATION, MALE	0.7819	23.9	19.9
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8209	27.5	22.9
353	[6]PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.1625	29.5	24.6
354	[6]UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1625	29.5	24.6

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
355	[6]UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1625	29.5	24.6
356	[6]FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1625	29.5	24.6
357	[6]UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1625	29.5	24.6
358	[6]UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1625	29.5	24.6
359	[6]UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1625	29.5	24.6
360	[6]VAGINA, CERVIX & VULVA PROCEDURES	1.1625	29.5	24.6
361	[6]LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4175	17.0	14.2
362	[6]ENDOSCOPIC TUBAL INTERRUPTION	0.4175	17.0	14.2
363	[6]D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4175	17.0	14.2
364	[6]D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4175	17.0	14.2
365	[4]OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.1625	29.5	24.6
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9106	21.6	18.0
367	[1]MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4175	17.0	14.2
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7846	21.3	17.8
369	[3]MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7819	23.9	19.9
370	[6]CESAREAN SECTION W CC	0.4175	17.0	14.2
371	[6]CESAREAN SECTION W/O CC	0.4175	17.0	14.2
372	[6]VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4175	17.0	14.2
373	[6]VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4175	17.0	14.2
374	[6]VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4175	17.0	14.2
375	[6]VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4175	17.0	14.2
376	[4]POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1.1625	29.5	24.6
377	[6]POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4175	17.0	14.2
378	[6]ECTOPIC PREGNANCY	0.4175	17.0	14.2
379	[6]THREATENED ABORTION	0.4175	17.0	14.2
380	[6]ABORTION W/O D&C	0.4175	17.0	14.2
381	[6]ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4175	17.0	14.2
382	[6]FALSE LABOR	0.4175	17.0	14.2
383	[1]OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4175	17.0	14.2

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
384	[6]OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4175	17.0	14.2
385	[6]NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4175	17.0	14.2
386	[6]EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.4175	17.0	14.2
387	[6]PREMATURITY W MAJOR PROBLEMS	0.4175	17.0	14.2
388	[6]PREMATURITY W/O MAJOR PROBLEMS	0.4175	17.0	14.2
389	[6]FULL TERM NEONATE W MAJOR PROBLEMS	0.4175	17.0	14.2
390	[6]NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4175	17.0	14.2
391	[6]NORMAL NEWBORN	0.4175	17.0	14.2
392	[6]SPLENECTOMY AGE >17	1.1625	29.5	24.6
393	[6]SPLENECTOMY AGE 0-17	1.1625	29.5	24.6
394	[4]OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.1625	29.5	24.6
395	RED BLOOD CELL DISORDERS AGE >17	0.6651	21.9	18.3
396	[6]RED BLOOD CELL DISORDERS AGE 0-17	0.4175	17.0	14.2
397	COAGULATION DISORDERS	0.8276	20.4	17.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.6278	20.8	17.3
399	[1]RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.4175	17.0	14.2
401	[4]LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.1625	29.5	24.6
402	[6]LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5594	21.0	17.5
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8846	23.9	19.9
404	[3]LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7819	23.9	19.9
405	[6]ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.7819	23.9	19.9
406	[5]MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.6835	37.1	30.9
407	[6]MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1625	29.5	24.6
408	[4]MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1625	29.5	24.6
409	RADIOTHERAPY	0.8416	23.2	19.3
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.2527	28.7	23.9
411	[6]HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5594	21.0	17.5
412	[6]HISTORY OF MALIGNANCY W ENDOSCOPY	0.5594	21.0	17.5
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8429	21.4	17.8
414	[3]OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7819	23.9	19.9
417	[6]SEPTICEMIA AGE 0-17	0.7819	23.9	19.9
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.7961	24.1	20.1
419	[2]FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5594	21.0	17.5

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
420	[2]FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5594	21.0	17.5
421	VIRAL ILLNESS AGE >17	0.7065	20.4	17.0
422	[6]VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.4175	17.0	14.2
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.0426	23.2	19.3
424	[5]O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.6835	37.1	30.9
425	[1]ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.4175	17.0	14.2
426	DEPRESSIVE NEUROSES	0.4038	22.5	18.8
427	[2]NEUROSES EXCEPT DEPRESSIVE	0.5594	21.0	17.5
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.5183	24.5	20.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5326	24.0	20.0
430	PSYCHOSES	0.4024	23.1	19.3
431	[2]CHILDHOOD MENTAL DISORDERS	0.5594	21.0	17.5
432	[1]OTHER MENTAL DISORDER DIAGNOSES	0.4175	17.0	14.2
433	[6]ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4175	17.0	14.2
439	SKIN GRAFTS FOR INJURIES	1.2203	36.0	30.0
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2248	34.4	28.7
441	[2]HAND PROCEDURES FOR INJURIES	0.5594	21.0	17.5
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3670	34.9	29.1
443	[6]OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.5594	21.0	17.5
444	TRAUMATIC INJURY AGE >17 W CC	0.6598	23.2	19.3
445	[2]TRAUMATIC INJURY AGE >17 W/O CC	0.5594	21.0	17.5
446	[6]TRAUMATIC INJURY AGE 0-17	0.5594	21.0	17.5
447	[2]ALLERGIC REACTIONS AGE >17	0.5594	21.0	17.5
448	[6]ALLERGIC REACTIONS AGE 0-17	0.5594	21.0	17.5
449	[3]POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7819	23.9	19.9
450	[2]POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.5594	21.0	17.5
451	[6]POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.7819	23.9	19.9
452	COMPLICATIONS OF TREATMENT W CC	0.9275	25.7	21.4
453	COMPLICATIONS OF TREATMENT W/O CC	0.5790	21.6	18.0
454	[3]OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7819	23.9	19.9
455	[6]OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7819	23.9	19.9
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.1466	32.7	27.3
462	REHABILITATION	0.5823	22.1	18.4
463	SIGNS & SYMPTOMS W CC	0.6082	22.9	19.1
464	SIGNS & SYMPTOMS W/O CC	0.5831	24.3	20.3
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6877	21.2	17.7

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6700	21.7	18.1
467	[3]OTHER FACTORS INFLUENCING HEALTH STATUS	0.7819	23.9	19.9
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1478	40.5	33.8
469	[7]PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[7]UNGROUPABLE	0.0000	0.0	0.0
471	[5]BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.6835	37.1	30.9
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.9917	25.3	21.1
476	[5]PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.6835	37.1	30.9
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5119	35.9	29.9
479	[2]OTHER VASCULAR PROCEDURES W/O CC	0.5594	21.0	17.5
480	[7]LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	0.0000	0.0	0.0
481	[6]BONE MARROW TRANSPLANT	1.1625	29.5	24.6
482	[5]TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.6835	37.1	30.9
484	[6]CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.6835	37.1	30.9
485	[6]LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	1.1625	29.5	24.6
486	[3]OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	0.7819	23.9	19.9
487	[4]OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1625	29.5	24.6
488	[4]HIV W EXTENSIVE O.R. PROCEDURE	1.1625	29.5	24.6
489	HIV W MAJOR RELATED CONDITION	0.9436	22.1	18.4
490	HIV W OR W/O OTHER RELATED CONDITION	0.6456	20.3	16.9
491	[5]MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6835	37.1	30.9
492	[2]CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT	0.5594	21.0	17.5
493	[4]LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1625	29.5	24.6
494	[6]LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1625	29.5	24.6
495	[7]LUNG TRANSPLANT	0.0000	0.0	0.0
496	[4]COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1625	29.5	24.6
497	[5]SPINAL FUSION EXCEPT CERVICAL W CC	1.6835	37.1	30.9
498	[6]SPINAL FUSION EXCEPT CERVICAL W/O CC	1.6835	37.1	30.9
499	[5]BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.6835	37.1	30.9
500	[4]BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1625	29.5	24.6

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
501	KNEE PROCEDURES W PDX OF INFECTION W CC	1.2164	33.3	27.8
502	[3]KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.7819	23.9	19.9
503	[4]KNEE PROCEDURES W/O PDX OF INFECTION	1.1625	29.5	24.6
504	[5]EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	1.6835	37.1	30.9
505	[5]EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	1.6835	37.1	30.9
506	[4]FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1625	29.5	24.6
507	[6]FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.4175	17.0	14.2
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7588	25.6	21.3
509	[1]FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4175	17.0	14.2
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.6720	22.6	18.8
511	[1]NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4175	17.0	14.2
512	[7]SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[7]PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[4]CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.1625	29.5	24.6
518	[6]PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	0.4175	17.0	14.2
519	[4]CERVICAL SPINAL FUSION W CC	1.1625	29.5	24.6
520	[6]CERVICAL SPINAL FUSION W/O CC	1.6835	37.1	30.9
521	[2]ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.5594	21.0	17.5
522	[6]ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	0.5594	21.0	17.5
523	[1]ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	0.4175	17.0	14.2
524	[2]TRANSIENT ISCHEMIA	0.5594	21.0	17.5
525	[6]OTHER HEART ASSIST SYSTEM IMPLANT	1.6835	37.1	30.9
528	[6]INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE	1.6835	37.1	30.9
529	[5]VENTRICULAR SHUNT PROCEDURES W CC	1.6835	37.1	30.9
530	[6]VENTRICULAR SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9
531	[5]SPINAL PROCEDURES W CC	1.6835	37.1	30.9
532	[3]SPINAL PROCEDURES W/O CC	0.7819	23.9	19.9
533	[4]EXTRACRANIAL PROCEDURES W CC	1.1625	29.5	24.6
534	[6]EXTRACRANIAL PROCEDURES W/O CC	1.1625	29.5	24.6
535	[5]CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.6835	37.1	30.9
536	[6]CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.1625	29.5	24.6
537	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W CC	1.4672	39.9	33.3

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
538	[4]LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC	1.1625	29.5	24.6
539	[4]LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	1.1625	29.5	24.6
540	[6]LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC	0.4175	17.0	14.2
541	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	3.8893	58.1	48.4
542	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	2.8689	45.1	37.6
543	[5]CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX	1.6835	37.1	30.9
544	[5]MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.6835	37.1	30.9
545	[5]REVISION OF HIP OR KNEE REPLACEMENT	1.6835	37.1	30.9
546	[6]SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	1.6835	37.1	30.9
547	[6]CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	1.1625	29.5	24.6
548	[6]CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	1.1625	29.5	24.6
549	[6]CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	1.1625	29.5	24.6
550	[6]CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	1.1625	29.5	24.6
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	1.6035	29.5	24.6
552	[4]OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	1.1625	29.5	24.6
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	1.5837	32.5	27.1
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	1.2817	31.6	26.3
555	[3]PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	0.7819	23.9	19.9
556	[6]PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	0.4175	17.0	14.2
557	[4]PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	1.1625	29.5	24.6
558	[6]PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	0.4175	17.0	14.2
559	[6]ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	0.7819	23.9	19.9
560	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	0.9308	25.5	21.3
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	0.8145	22.3	18.6
562	SEIZURE AGE >17 W CC	0.6844	23.2	19.3

LTC-DRG	Description	Relative Weight	Geometric Average Length of Stay	5/6ths of the Geometric Average Length of Stay
563	[2]SEIZURE AGE >17 W/O CC	0.5594	21.0	17.5
564	HEADACHES AGE >17	0.7565	24.1	20.1
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	2.0557	34.7	28.9
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS	1.5445	27.4	22.8
567	[5]STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX	1.6835	37.1	30.9
568	[5]STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX	1.6835	37.1	30.9
569	[5]MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	1.6835	37.1	30.9
570	[5]MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	1.6835	37.1	30.9
571	MAJOR ESOPHAGEAL DISORDERS	0.8214	21.9	18.3
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	0.8505	23.3	19.4
573	[5]MAJOR BLADDER PROCEDURES	1.6835	37.1	30.9
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	0.8106	19.7	16.4
575	SEPTICEMIA W MV 96+ HOURS AGE >17	1.6583	27.8	23.2
576	SEPTICEMIA W/O MV 96+ HOURS AGE >17	0.7925	23.0	19.2
577	[6]CAROTID ARTERY STENT PROCEDURE	1.1625	29.5	24.6
578	O. R. PROCEDURE W PDX EXC POSTOPERATIVE OR POST-TRAUMATIC INFECTION	1.4849	35.7	29.8
579	O. R. PROCEDURE W PDX OF POSTOPERATIVE OR POST-TRAUMATIC INFECTION	1.2978	35.2	29.3

[1] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 1.
[2] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 2.
[3] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 3.
[4] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 4.
[5] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 5.
[6] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2005 MedPAR file.
[7] Relative weights for these LTC-DRGs were assigned a value of 0.0000.
[8] Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

Appendix A - Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule, this interim final rule with comment period, and this notice with comment period 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), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that these rules are a major rule as defined in 5 U.S.C. 804(2). We estimate that the changes for FY 2007 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 finalized in this rule, will result in an approximate $3.4 billion increase in FY 2007 operating and capital payments. This amount does not reflect changes in hospital admissions or case-mix intensity in operating PPS payments, which

would also affect overall payment changes. The $142 million in funds for the loan program for cancer center costs under the Health Care Infrastructure Improvement Program is appropriated specifically for the loan program and not more than $2 million may be used for the administration costs of the program.

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 government agencies. Most hospitals and most other providers and suppliers are considered to be small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's final rule that sets forth size standards for health care industries at 65 FR 69432, November 17, 2000.) 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 proposed 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 proposed rule constitutes our initial regulatory flexibility analysis. Therefore, in the proposed rule, we solicited comments on our estimates and analysis of the impact of the proposed rule on those small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain

New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital that is located outside of an MSA 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 NECMA. 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 $120 million. This proposed 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 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 rule is consistent with the regulatory philosophy and principles

identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The 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 2007, 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 predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in the previous rules, we solicited comments and information about the anticipated effects of these changes on hospitals and our

methodology for estimating them. Any timely comments we have received in response to the FY 2007 IPPS proposed rule are addressed below under the appropriate subject heading in this final rule.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 36 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 2006, there are 3,595 IPPS hospitals to be included in our analysis. This represents about 60 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,282 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,254 excluded hospitals and 2,305 excluded units that are excluded from the IPPS. These excluded hospitals include psychiatric hospitals and units (now referred to as IPFs), rehabilitation hospitals and units (now referred to as IRFs), long-term care hospitals (now referred to as LTCHs), children's hospitals, and cancer hospitals. Religious Non-Medical Health Care Institutions (RNHCIs) are also included. The impacts of our policy changes on these hospitals and institutions are discussed below.

V. Effects on Excluded Hospitals and Hospital Units

As of July 2006, there were 1,254 hospitals excluded from the IPPS. Of these 1,254 hospitals, 482 IPFs, 81 children's hospitals, 11 cancer hospitals, and 17 RNHCIs are being paid, in whole or in part, on a reasonable cost basis subject to the rate-of-increase ceiling under §413.40. The remaining providers, 271 IRFs and 392 LTCHs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. We note that, currently, there are 16 LTCHs that are being paid under the LTCH PPS transition blend methodology, which is based in part on a reasonable cost that is subject to a rate-of-increase ceiling under §413.40. Effective for cost reporting periods beginning on or after October 1, 2006 (FY 2007), these LTCHs will no longer receive a portion of their payment that is based, in part, on a reasonable cost subject to a rate-of-increase ceiling. Rather, in accordance with §412.533, for FY 2007, all LTCHs are to be paid 100 percent of the adjusted Federal prospective payment amount. In addition, there are 1,293 IPFs (paid on a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment) and 1,012 IRFs (paid under the IRF PPS) co-located in hospitals otherwise subject to the IPPS. Under §413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 93 IPPS excluded hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, 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 2007. For these hospitals (cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, as was proposed the final update will be the percentage increase in the FY 2007 IPPS operating market basket, currently estimated to be 3.4 percent. 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 the percentage increase in the rate-of-increase limits. For RNHCIs, the update will be the percentage increase in the FY 2007 IPPS operating market basket increase, currently estimated to be 3.4 percent.

IRFs are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2007, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not affected by this final rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on a Federal prospective payment amount that is updated annually. Existing LTCHs receive a blended payment that consists of the Federal prospective payment rate and a reasonable cost-based payment rate over a 5-year transition period, unless the LTCH elects to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. Under §412.533, the 5-year transition period for all existing LTCHs subject to the LTCH PPS began with the LTCH's first cost reporting period beginning on or after October 1, 2002, and is extended through the LTCH's cost reporting period

beginning on or after October 1, 2006. In accordance with §412.533, for cost reporting periods beginning on or after October 1, 2006, the LTCH PPS transition blend percentages are 100 percent of the Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles. Therefore, even though FY 2007 is the fifth year of the 5-year transition period established under §412.533, because the reasonable cost principles amount is zero percent for cost reporting periods beginning during FY 2007, LTCHs will no longer receive a portion of their payment that is based in part on a reasonable cost subject to the rate-of-increase ceiling. Thus, there is no longer a need for an update factor for LTCH's TEFRA target amount for FY 2007 and beyond.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) required the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in IPFs. The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers will receive a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. For purposes of determining what the TEFRA payment to the IPF will be, we updated the IPF's TEFRA target amount by the excluded hospital market basket percentage increase of 3.4 percent.

The impact on 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 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. However, at the same time, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the inappropriate spending for patient services.

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 the decision in Bellevue Hosp. Center v. Leavitt, in which the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final rule for more details of this Court decision), we are unable to finalize the FY 2007 wage index data at this time.

Therefore, we are also unable to finalize the relative weights, 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 the final 100 percent occupational mix adjusted wage data is available, we will recalculate impacts and publish them in a separate **Federal Register** notice prior to October 1, 2006.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2007 operating payments will increase 3.5 percent compared to FY 2006 largely due to the statutorily mandated update to the IPPS rates. This amount does not reflect changes in hospital admissions or case-mix intensity, which would 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 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 2005 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 behavioral changes that hospitals may adopt in response to the policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the 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 2005 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 2007 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

• The effect of a reduced update to the standardized amount for hospitals that do not comply with section 1886(b)(3)(B)(viii) of the Act by submitting quality data in accordance with our requirements.

• The effects of the MDH payment changes set forth in section 5003 of Pub. L. 109-171.

• The effects of the revisions we are adopting to our methodology for calculating DRG relative weights.

• The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act. The relative weights used in estimating this impact are not yet final as the wage data used in the relative weight computation is not available at this time.

• The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2003, compared to the FY 2002 wage data are shown in this impact but are not yet final because the occupational mix wage data that will be used to calculate the FY 2007 wage indices are not available at this time.

• The effects of the wage and recalibration budget neutrality factors are shown in this impact but are not yet final because occupational mix adjusted wage indices are yet to be calculated.

• The effects of the remaining labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals are shown in this impact but are not yet final pending calculation of the final occupational mix adjusted wage indices.

• The effects of geographic reclassifications by the MGCRB that will be effective in FY 2007 are shown in this impact but are not yet final because we will be making

reclassification decisions for hospitals subsequent to this final rule prior to October 1, 2006, based on the final occupational mix adjusted wage indices.

• The effects 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, are shown in this impact but are not yet final because the final occupational mix adjusted wage data are not available at this time.

• The total estimated change in payments based on FY 2007 policies and MMA and DRA-imposed changes relative to payments based on FY 2006 policies.

To illustrate the impacts of the FY 2007 changes, our analysis begins with a FY 2006 baseline simulation model using: the FY 2007 market basket update of 3.4 percent; the FY 2006 DRG GROUPER (version 23.0); the CBSA designations for hospitals based on OMB's June 2003 MSA definitions; the FY 2006 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)(vii) of the Act, as added by section 501(b) of Pub. L. 108-173, and amended by section 5001(a) of Pub. L. 109-171, provides that, for FYs 2005 through 2006, the update factors will be reduced by 0.4 percentage points for any hospital that does not submit quality data. Section 5001(a) of Pub. L. 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 or that fails the quality data validation process. At the time this impact was prepared, 117 providers did

not receive the full market basket rate-of-increate for FY 2006 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the payment changes for FY 2007 using a reduced update for these 117 hospitals. However, we do not have enough information to determine which hospitals will not receive the full market basket rate-of-increase for FY 2007 at this time.

Each final and statutory policy change is then added incrementally to this baseline, finally arriving at an FY 2007 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 2006 to FY 2007. 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 have updated standardized amounts for FY 2007 using the most recently forecasted hospital market basket increase for FY 2007 of 3.4 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 2.0 percentage points to 1.4 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.4 percent.

A second significant factor that affects changes in hospitals' payments per case from FY 2006 to FY 2007 is the change in MGCRB status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2006 that are no longer reclassified in FY 2007. Conversely, payments may increase for hospitals not

reclassified in FY 2006 that are reclassified in FY 2007. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2006 will be 4.6 percent of total DRG payments. When the FY 2006 final rule was published, we projected FY 2006 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 2006 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2006 payments per case to estimated FY 2007 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 changes for FY 2007. 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 3,595 hospitals included in the analysis. There are 149 fewer hospitals than were included in the impact analysis in the FY 2006 final rule (70 FR 47690).

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 2,590 hospitals located in urban areas included in our analysis. Among these, there are 1,441 hospitals located in large urban areas (populations over 1 million), and 1,149 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,005 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 2007 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 number of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under 1886(d)(8)(B) and 1886(d)(8)(E) which have implications for capital payments) are 2,608, 1,450, 1,158, and 987, 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 2,511 nonteaching hospitals in our analysis, 843 teaching hospitals with fewer than 100 residents, and 241 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 (sole community hospitals (SCHs), rural referral centers (RRCs), and Medicare dependent hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 187 RRCs, 376 SCHs, 146 MDHs, 98 hospitals that are both SCHs and RRCs, and 8 hospitals that are both MDHs and RRCs.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2004 Medicare cost reports, if available (otherwise FY 2003 data are used).

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2007. The next grouping shows the MGCRB rural reclassifications. The final three rows in Table I contain hospitals located in urban counties, but deemed to be rural under section 1886(d)(8)(E) of the Act, hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act, and hospitals currently reclassified under section 508 of Pub. L. 108-173, which expires on March 31, 2007.

TABLE I.--IMPACT ANALYSIS OF CHANGES FOR FY 2007

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions [3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
All Hospitals	3,595	0.0	0.1	0.2	0.1	0.0	0.0	0.0	0.1	3.5
By Geographic Location:										
Urban hospitals	2,590	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Large urban areas (populations over 1 million)	1,441	0.0	0.0	0.3	0.1	0.1	0.0	-0.4	0.0	3.5
Other urban areas (populations of 1 million or fewer)	1,149	0.0	0.0	0.0	0.2	-0.1	0.0	-0.1	0.1	3.3
Rural hospitals	1,005	0.0	0.4	0.3	-0.1	0.0	0.3	2.4	0.1	3.7
Bed Size (Urban):										
0-99 beds	651	-0.1	0.1	0.3	0.2	0.2	0.0	-0.5	0.0	3.6
100-199 beds	867	0.0	0.0	0.5	0.2	0.5	0.0	-0.1	0.0	3.8
200-299 beds	492	0.0	0.0	0.3	0.1	0.1	0.0	-0.3	0.1	3.6
300-499 beds	413	0.0	0.0	0.1	0.2	-0.1	0.0	-0.4	0.1	3.3
500 or more beds	167	0.0	0.0	0.0	0.0	-0.4	0.0	-0.4	0.0	3.0
Bed Size (Rural):										
0-49 beds	348	-0.1	0.7	0.5	-0.3	0.0	0.1	1.0	0.2	4.2
50-99 beds	370	-0.1	1.1	0.4	-0.2	0.1	0.3	1.3	0.2	4.6
100-149 beds	174	0.0	0.1	0.4	-0.1	0.0	0.6	2.7	0.1	3.4
150-199 beds	68	0.0	0.0	0.2	-0.1	-0.1	0.5	3.9	0.1	3.3
200 or more beds	45	0.0	0.0	-0.1	-0.1	-0.3	0.0	3.4	0.0	2.9
Urban by Region:										
New England	128	0.0	0.0	0.3	0.6	0.6	0.0	0.3	0.0	2.9
Middle Atlantic	357	0.0	0.0	0.4	0.1	0.2	0.0	-0.1	0.1	3.2
South Atlantic	388	0.0	0.0	0.1	-0.3	-0.5	0.0	-0.4	0.0	3.2
East North Central	395	0.0	0.0	0.2	0.3	0.2	0.0	-0.3	0.0	3.6
East South Central	165	0.0	0.0	-0.1	-0.4	-0.8	0.0	-0.4	0.1	2.9
West North Central	157	0.0	0.0	0.0	-0.1	-0.4	0.0	-0.6	0.0	3.2

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions [3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
West South Central	374	0.0	0.0	0.1	-0.5	-0.7	0.0	-0.5	0.0	3.0
Mountain	149	0.0	0.0	0.1	0.6	0.5	0.0	-0.2	0.0	4.3
Pacific	424	0.0	0.0	0.4	0.9	1.0	0.0	-0.4	0.1	4.5
Puerto Rico	53	0.0	0.0	0.2	-1.2	-1.3	0.0	-0.6	0.0	2.2
Rural by Region:										
New England	19	0.0	2.3	0.5	-0.4	0.0	0.0	2.0	0.1	5.6
Middle Atlantic	72	0.0	1.1	0.5	0.1	0.5	0.1	2.3	0.0	5.0
South Atlantic	176	-0.1	0.1	0.4	-0.3	-0.1	0.2	2.5	0.2	3.5
East North Central	125	0.0	0.5	0.2	-0.2	-0.2	0.1	1.8	0.0	3.8
East South Central	180	0.0	0.2	0.3	0.1	0.0	0.2	2.9	0.1	3.4
West North Central	116	0.0	0.7	0.2	0.0	0.0	0.0	2.2	0.1	4.0
West South Central	193	0.0	0.3	0.3	-0.4	-0.3	0.6	3.2	0.2	3.2
Mountain	81	-0.1	0.0	0.3	-0.4	-0.2	2.5	0.9	0.1	3.0
Pacific	43	0.0	0.2	0.3	0.1	0.3	0.0	2.2	0.1	3.7
By Payment Classification:										
Urban hospitals	2,608	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Large urban areas (populations over 1 million)	1,450	0.0	0.0	0.3	0.0	0.1	0.0	-0.4	0.0	3.5
Other urban areas (populations of 1 million or fewer)	1,158	0.0	0.0	0.0	0.2	-0.1	0.0	-0.1	0.1	3.3
Rural areas	987	0.0	0.5	0.3	-0.1	0.0	0.3	2.3	0.1	3.8
Teaching Status:										
Nonteaching	2,511	0.0	0.1	0.4	0.1	0.2	0.0	0.3	0.1	3.8
Fewer than 100 residents	843	0.0	0.0	0.1	0.0	-0.1	0.0	-0.1	0.0	3.3
100 or more residents	241	0.0	0.0	0.0	0.1	-0.1	0.0	-0.3	0.0	3.0
Urban DSH:										
Non-DSH	906	0.0	0.1	0.2	0.1	0.0	0.0	-0.1	0.0	3.6
100 or more beds	1,520	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Less than 100 beds	347	-0.1	0.1	0.6	0.2	0.5	0.0	-0.3	0.0	3.9

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions [3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
Rural DSH:										
SCH	385	-0.1	0.9	0.3	-0.2	0.0	0.3	0.8	0.1	4.2
RRC	199	0.0	0.1	0.2	-0.1	-0.1	0.2	3.8	0.0	3.3
Other Rural:										
100 or more beds	55	0.0	0.0	0.6	-0.1	0.2	1.1	1.0	0.2	3.2
Less than 100 beds	183	-0.1	0.0	0.6	-0.2	0.0	0.5	1.1	0.3	3.4
Urban teaching and DSH:										
Both teaching and DSH	815	0.0	0.0	0.1	0.0	-0.1	0.0	-0.4	0.0	3.2
Teaching and no DSH	201	0.0	0.0	0.1	0.2	0.0	0.0	-0.1	0.1	3.3
No teaching and DSH	1,052	0.0	0.0	0.4	0.2	0.3	0.0	-0.2	0.1	3.8
No teaching and no DSH	540	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.0	3.6
Special Hospital Types:										
RRC	187	0.0	0.0	0.1	0.1	-0.1	0.2	3.4	0.1	3.4
SCH	376	0.0	0.0	0.2	-0.2	0.0	0.3	0.5	0.1	3.4
MDH	146	-0.1	4.7	0.5	-0.2	0.2	0.0	0.8	0.1	8.2
SCH and RRC	98	0.0	0.0	0.1	-0.2	-0.3	0.0	2.3	0.0	3.2
MDH and RRC	8	0.0	11.5	0.3	-0.2	0.2	0.0	1.1	0.0	13.1
Type of Ownership:										
Voluntary	2,102	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.1	3.4
Proprietary	880	0.0	0.0	0.3	-0.1	-0.1	0.1	0.0	0.0	3.6
Government	603	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	3.5
Unknown	10	0.0	0.0	2.2	0.1	1.9	0.0	-0.2	0.2	7.7
Medicare Utilization as a Percent of Inpatient Days:										
0-25	243	0.0	0.0	0.5	0.2	0.5	0.0	-0.3	0.0	4.0
25-50	1,328	0.0	0.0	0.2	0.1	-0.1	0.0	-0.4	0.0	3.3
50-65	1,478	0.0	0.1	0.2	0.1	0.0	0.0	0.4	0.1	3.5
Over 65	462	0.0	0.3	0.1	-0.1	-0.2	0.0	0.6	0.1	3.6
Unknown	84	0.0	0.0	0.9	-0.2	0.4	0.0	-0.5	0.1	4.6

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions [3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications:	325	0.0	0.0	0.2	0.3	0.2	0.0	2.1	0.0	3.6
Urban Nonreclassified, First Half FY 2007:	2,240	0.0	0.0	0.2	0.1	0.0	0.0	-0.6	0.1	3.4
All Urban Hospitals Reclassified Second Half FY 2007:	385	0.0	0.0	0.2	0.2	0.2	0.0	1.6	0.0	3.4
Urban Nonreclassified Hospitals Second Half FY 2007:	2,180	0.0	0.0	0.2	0.1	0.0	0.0	-0.7	0.1	3.4
All Rural Hospitals Reclassified Full Year FY 2007:.....	375	0.0	0.4	0.2	-0.1	-0.1	0.1	4.0	0.0	3.5
Rural Nonreclassified Hospitals Full Year FY 2007:	569	-0.1	0.5	0.5	-0.2	0.1	0.7	-0.4	0.3	4.0
All Section 401 Reclassified Hospitals:	33	0.0	1.2	0.2	0.1	0.3	0.0	0.2	0.0	5.3
Other Reclassified Hospitals (Section 1886(d)(8)(B)).....	60	-0.1	0.6	0.6	-0.1	0.3	0.0	3.5	0.0	4.4
Section 508 Hospitals.....	95	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	1.7
Specialty Hospitals										
Cardiac specialty Hospitals	21	-0.1	0.0	-2.0	-0.1	-2.4	0.0	-0.6	0.0	1.2

[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 2005, and hospital cost report data are from reporting periods beginning in FY 2004 and FY 2003.
[2] This column displays the payment impact for hospitals that either did not submit quality update information or failed the validation requirements in FY 2006. At this time, information is not available to us about whether hospitals will meet the requirements for the full hospital market basket increase for FY 2007. In the absence of these data, we are simulating rates for FY 2007 using the same list of hospitals that did not meet the requirements for the full hospital market basket increase in FY 2006.
[3] This column displays the impact of the Deficit Reduction Act section 5003 that apply to Medicare Dependent Hospitals.
[4] This column displays the **tentative** payment impact of the changes to the V24 GROUPER and the recalibration of the DRG HSRVcc weights based on FY 2005 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.
[5] This column displays the tentative payment impact of updating the wage index data with no occupational mix adjustment applied to the FY 2003 cost report data.
[6] This column displays the tentative payment impact of the budget neutrality factor for DRG and wage index changes (no occupational mix adjustment applied to the wage index) data in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[7] Shown here are the tentative effects of providing rural hospitals formerly located in urban areas with urban wage index values in FY 2007. The effects reflected here are budget neutral: this column therefore includes the effect of the 0.999605 adjustment that we have applied to the rates to ensure budget neutrality.
[8] Shown here are the tentative effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2007 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2007. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991850.
[9] This column displays the tentative impact of the FY 2007 implementation 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.
[10] This column shows tentative changes in payments from FY 2006 to FY 2007. It incorporates all of the changes displayed in Columns 3, 4, 7, 8, and 9 (the changes displayed in Columns 5 and 6 are included in Column 7). It also reflects the impact of the FY 2007 update, changes in hospitals' reclassification status in FY 2007 compared to FY 2006, and the changes in payments as a result of continuing the reclassifications under section 508 of Pub. L. 108-173. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

C. Effects on the Hospitals that Failed the Quality Data Submission Process (Column 2)

Column 2 of Table I shows the effect of assigning a reduced update to the standardized amount to hospitals that either fail to submit quality data or fail the data validation requirements. This column shows the effect of paying these providers based on an update of market basket, less 2.0 percentage points (1.4 percent) relative to a full market basket update (3.4 percent), for FY 2007. There are 117 hospitals in this analysis that did not receive the full market basket update for FY 2006. Most of these hospitals are either small rural or small urban hospitals. For purposes of simulation only, we used these same hospitals to simulate the effects on IPPS payments receiving a reduced FY 2007 update. However, at this time, information is not available to determine the hospitals that do not meet the requirements for the full hospital market increase for FY 2007. If the same hospitals were to fail to meet the requirements for the full market basket rate-of-increase for FY 2007 as in FY 2006, we project that hospitals in the small urban and rural hospital categories (0-99 beds) will receive an overall decrease in payments of 0.1 percent.

D. Effects of the DRA Provision Related to MDHs (Column 3)

In Column 3 of Table I, we show the effects of implementing section 5003 of Pub. L. 109-171 for MDHs. Section 5003(b) requires MDHs to rebase their hospital-specific rate to the FY 2002 cost reporting period, if doing so increases their target amount. Section 5003(c) increases the hospital-specific payment amount from the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific amount (presuming the hospital-specific amount exceeds the Federal

amount) to the Federal rate plus 75 percent of the difference. In addition, MDHs are no longer subject to the 12-percent cap on their DSH payments, effective FY 2007.

This column compares the FY 2007 payment rates under the section 5003 provisions to payments under the FY 2006 MDH provisions. (The MDH provisions were set to expire at the end of FY 2006 but were extended by section 5003(a)(1).) Overall, hospitals experience a 0.1 percent increase. This is primarily due to the substantial increase in payments to MDH providers; MDH providers experience a 4.7 percent increase, while MDH/RRC combination providers experience an 11.5 percent increase.

E. Effects of the Changes to the DRG Reclassifications and Relative Cost-Based Weights (Column 4)

In Column 4 of Table I, we present the combined effects of the DRG reclassifications and recalibration, 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, we are changing the relative weight calculation methodology from a charge-based method to a cost-based method. Further, we are implementing the new methodology under a 3-year transition such that weights in FY 2007 are 1/3 cost-based and 2/3 charge-based. In this column, we compare aggregate payments using the FY 2007 blended relative weights(GROUPER Version 24) to the FY 2006 DRG relative charge weights (GROUPER Version 23.0) so the percentages shown here illustrate the effect of changes to the DRGs and relative

weights. The method of calculating the relative weights and the reclassification changes to the GROUPER are described in more detail in section II. of the preamble to this final rule. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This tentative budget neutrality factor of 0.997968 is applied to payments in Column 6 and not Column 4 because it is a combined DRG reclassification and recalibration and wage index budget neutrality factor.

In general, surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or intensive care unit (ICU) cost center groups. As discussed in the preamble of this final rule, the CCRs for ancillary cost center groups are lower than the cost to charge ratios for routine and ICU cost center groups, indicating that the charge markups for ancillary services are higher. Because the standardized cost-based relative weight methodology adjusts the weights to remove differential mark-ups in charges, the FY 2007 cost-based weights are redistributed among medical and surgical DRGs, which will result in a redistribution of payments among hospitals according to the types of cases they provide. For instance, hospitals that perform more surgical procedures are likely to experience decreases in payments while hospitals with heavy concentrations of medical DRGs are expected to experience increases in payments. Hospitals with a case-mix that is equal to average will see little or no change in payment.

Due to the fact that we significantly modified our proposal and are adopting cost weights without the hospital-specific portion of the methodology, the impacts for the final rule are much smaller than those we proposed. The payment impacts are further moderated because we are implementing the change to the relative weights over a 3-year transition period. Therefore, the impacts shown in this column are generally smaller than those for the proposed rule. Rural DSH hospitals with less than 100 beds and small rural hospitals (0-49 beds) have payment increases of 0.6 percent and 0.7 percent, respectively. Cardiac specialty hospitals experience the greatest decline in payments of 2.2 percent and rural hospitals with more than 200 beds and urban hospitals in the East South Central Region have the next largest decreases of 0.1 percent.

F. Effects of Wage Index Changes (Column 5)

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 2007 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003. However, we note that this impact is calculated on wage data with no occupational mix adjustment due to the decision in Bellevue Hosp. Center v. Leavitt, in which the Court of Appeals for the Second Circuit ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final rule for more details of this Court decision). Because the effects of the wage index data are dependent, in part, upon the occupational mix adjusted wage index, and due to the short timeframe for implementing the Court's order, we are not able to provide the final

occupational mix adjusted wage data impacts with this FY 2007 IPPS final rule. We will include the FY 2007 occupational mix adjusted wage index and related impacts in a separate **Federal Register** notice to be published prior to October 1, 2006. We believe these procedures comply with section 1886(d)(6) of the Act because, by August 1, we will have described our data and methods for calculating the wage index and IPPS rates in this FY 2007 IPPS final rule, but the actual impacts concerning the wage index will not be issued until a later date.

The estimated impact of the new wage data (with no occupational mix applied) on hospital payments is isolated in Column 5 by holding the other payment parameters constant in this simulation. That is, Column 5 shows the percentage changes in payments when going from a model using the FY 2006 wage index, based on FY 2002 wage data and having a 10-percent occupational mix adjustment applied, to a model using the FY 2007 pre-reclassification wage index, based on FY 2003 wage data with no occupational mix applied. The wage data collected on the FY 2003 cost report are the same as the FY 2002 wage data that were used to calculate the FY 2006 wage index. The impacts shown in Column 5 are likely to change with the application of the occupational mix adjustment to 100 percent of the wage index. The final impacts will be shown and discussed in a subsequent **Federal Register** notice to be published prior to October 1, 2006.

G. Combined Effects of DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 6)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to 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 2006 and FY 2007 using the FY 2005 Medicare utilization data after applying the changes to the DRG relative weights and the wage index. However, we note that the payment impact and budget neutrality factors are calculated by applying an occupational mix adjustment to 10 percent of the FY 2006 wage index and zero percent of the FY 2007 wage index due to the decision in Bellevue Hosp. Center v. Leavitt, as stated previously.

We computed a tentative wage and DRG recalibration budget neutrality factor of 0.997030. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and the updated wage index are shown in Column 6. The changes in this column are the sum of the changes in Columns 4 and 5, combined with the budget neutrality factor for the wage index, including the wage index floor for urban areas required by section 4410 of Pub. L. 105-33. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

Currently, we project that large urban hospitals will show a 0.1 percent increase, other urban hospitals will experience a 0.1 percent decrease, and rural hospitals will not be affected. We are not able to provide the final DRG and wage index budget neutrality impacts with this FY 2007 IPPS final rule due to the short timeframes for implementing the Court's order for implementation of the occupational mix adjustment. However, we will recalculate the budget neutrality factor to include the effects of the 100 percent occupational mix adjustment when the data become available, and we will publish updated payment impacts in a subsequent **Federal Register** notice document prior to October 1, 2006.

H. Effects of the 3-Year Provision Allowing Urban Hospitals that Were Converted to Rural as a Result of the FY 2005 Labor Market Area Changes to Maintain the Wage Index of the Urban Labor Market Area in Which They Were Formerly Located (Column 7)

To help alleviate the decreased payments for urban hospitals that became rural under the new labor market area definitions, for purposes of the wage index, we adopted a policy in FY 2005 to allow them to maintain the wage index assignment of the MSA where they were located for the 3-year period FY 2005, FY 2006, and FY 2007. Column 7 shows the impact of the remaining labor market area transition, for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. Section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. Therefore, we applied a tentative adjustment of 0.999605 to ensure that the effects of reclassification are budget neutral as

indicated by the zero effect on payments to hospitals overall. However, we note that this budget neutrality factor and this impact are both calculated using FY 2007 wage data with no occupational mix adjustment due to the decision in Bellevue Hosp. Center v. Leavitt. We are not able to provide the final urban to rural hold harmless budget neutrality impacts with this FY 2007 IPPS final rule. This information will also be include in a separate **Federal Register** notice to be published prior to October 1, 2006. Currently, the rural hospital row shows a 0.3 percent benefit from this provision as these hold harmless hospitals are now considered geographically rural.

I. Effects of MGCRB Reclassifications (Column 8)

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, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in Column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2007 which affect hospitals' wage index area assignments.

By February 28 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. The FY 2007 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2007. The wage index values also reflect any decisions

made by the CMS Administrator through the appeals and review process through February 28, 2006.

For FY 2007, as stated in the FY 2006 IPPS final rule (70 FR 47382, August 12, 2005), we established procedural rules under section 1886(d)(10)(D)(v) of the Act to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to allow previously approved reclassifications to continue through March 31, 2007, and new section 1886(d)(10) reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year.

The first and second half fiscal year section 1886(d)(10) reclassifications permitted under these procedural rules have implications for the calculation of the reclassified wage indices and the reclassification budget neutrality factor. Section 1886(d)(8)(c) of the Act provides requirements for determining the wage index values for hospitals that were reclassified as a result of the MGCRB decisions under 1886(d)(10) of the Act. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent.

Because of the half-year reclassifications permitted under the procedural rules, in this final rule, we are issuing two separate wage indexes for affected areas (one effective

from October 1, 2006, through March 31, 2007 and a second reclassified wage index effective April 1, 2007, through September 30, 2007). The FY 2007 wage index values are calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year. The impact of this policy is modeled in Column 8 of Table I above.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. In this final rule, we are calculating one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively. Therefore, we applied a tentative adjustment of 0.991850 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.) However, we note that this budget neutrality factor and this impact are both calculated using wage adjustment applied due to the decision in Bellevue Hosp. Center v. Leavitt. As noted earlier, CMS will apply a reclassification decision for FY 2007 on behalf of hospitals to give them the highest wage index. Hospitals will then have 30 days from the date of public display of the separate notice to be published prior to October 1, 2006 at the Office of the Federal Register 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 Table 9A in the Addendum to this final rule will retain their approved reclassifications for FY 2007 once the final occupational mix adjusted wage indices are known. We will include the FY 2007 occupational mix adjusted wage index 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, 2006.

J. Effects of the Wage Index Adjustment for Out-Migration (Column 9)

Section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 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 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. We note that this impact is based on the section 505 wage index adjustments in place as of FY 2006. As the FY 2007 adjustments must be calculated using wage data with an occupational mix adjustment and because we do not yet have these data due to the decision in Bellevue Hosp. Center v. Leavitt, we were unable to assess whether any new counties would qualify for section 505 adjustments for FY 2007 prior to the publication of this final rule. In the notice that we publish in the **Federal Register notice** prior to October 1, 2006, we will show any new counties that qualify for the section 505 adjustment for FY 2007 and any related impacts that result from application of the out-migration adjustment to the revised occupational mix adjusted wage indices.

K. Effects of All Changes (Column 10)

Column 10 compares our estimate of payments per case between FY 2006 and FY 2007, incorporating all changes reflected in this final rule for FY 2007 (including statutory changes). This column includes all of the policy changes. We note that this impact is calculated using standardized amounts, outlier estimates, and budget neutrality factors based on wage data with no occupational mix adjustment applied due to the decision in Bellevue Hosp. Center v. Leavitt.

Currently, Column 10 reflects the impact of all FY 2007 changes (other than the final occupational mix adjusted wage indices) relative to FY 2006, including those shown in Columns 2 through 9 as well as other factors that are not applied until the final rates are calculated. The average increase for all hospitals is approximately 3.5 percent. This increase includes the effects of the 3.4 percent market basket update. It also reflects the 0.5 percentage point difference between the projected outlier payments in FY 2006 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2006 (4.6 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 0.5 percentage points lower in FY 2006 than originally estimated, resulting in a 0.5 percentage point greater increase for FY 2007 than would otherwise occur. In addition, the impact of section 505 adjustments accounted for a 0.1 percent increase. Indirect medical education formula changes for teaching hospitals under section 502 of Pub. L. 108-173, changes in payments due to the difference between the FY 2006 and FY 2007 wage index values assigned to providers reclassified under section 508 of

Pub. L. 108-173, and changes in the incremental increase in payments from section 505 of Pub. L. 108-173 out-migration adjustments account for the remaining -0.6 percent.

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 10 may not equal the product of the percentage changes described above.

The overall change in payments per case for hospitals in FY 2007 would increase by 3.5 percent. Hospitals in urban areas would experience a 3.4 percent increase in payments per case compared to FY 2006. Hospitals in large urban areas would experience a 3.5 percent increase in payments and hospitals in other urban areas would experience a 3.3 percent increase in payments. Hospitals in rural areas, meanwhile, would experience a 3.7 percent payment increase.

Among urban census divisions, the largest payment increases would be 4.5 percent in the Pacific region and 4.3 percent in the Mountain region. The smallest urban increase is 2.2 percent in Puerto Rico.

Among rural regions in Column 10, no hospital category would experience overall payment decreases. The New England and Middle Atlantic regions would benefit the most, with 5.6 and 5 percent increases, respectively. The smallest increase would occur in the Mountain region, with a 3.0 percent increases in payments.

Among special categories of rural hospitals in Column 10, MDH/RRC providers receive an increase in payments of 11.5 percent and MDH providers receive an increase of 4.7 percent, primarily due to the changes to MDH payments set forth in section 5003 of Pub. L. 109-171.

Urban hospitals reclassified for the first half of FY 2007 are anticipated to receive an increase of 3.6 percent, while urban hospitals that reclassified for the second half of FY 2007 are expected to receive an increase of 3.4 percent. The same set of rural hospitals is reclassified for the first and second half of FY 2007. Rural hospitals reclassifying for the entire year of FY 2007 are anticipated to receive a 3.5 percent payment increase. Those hospitals located in rural counties, but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.4 percent. Hospitals that were reclassified under section 508 of Pub. L. 108-173, which is only effective through March 31, 2007, are expected to receive an increase of 1.7 percent. This lower estimated increase in payment is due to the expiration of the higher section 508 wage indices in effect for 6 months of FY 2007. We caution that all of these impacts will be revised prior to October 1, 2006 when the occupational mix wage indices are calculated for FY 2007.

L. Effects of Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2007, we are continuing to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that two providers would receive the low-volume adjustment for FY 2007. We included these additional payments to providers in the impact table shown above and we estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $89,000.

M. Impact Analysis of Table II

Table II presents the projected impact of the changes for FY 2007 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 2006 with the average estimated per case payments for FY 2007, 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 10 of Table I.

TABLE II.--IMPACT ANALYSIS OF CHANGES FOR FY 2007 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)

	Number of Hospitals (1)	Average FY 2006 Payment Per Case[1] (2)	Average FY 2007 Payment Per Case[1] (3)	All FY 2007 Changes (4)
All hospitals	3,595	8,535	8,830	3.5
By Geographic Location:				
Urban hospitals	2,590	8,950	9,256	3.4
Large urban areas (populations over 1 million)	1,441	9,367	9,699	3.5
Other urban areas (populations of 1 million or fewer)	1,149	8,443	8,719	3.3
Rural hospitals	1,005	6,206	6,437	3.7
Bed Size (Urban):				
0-99 beds	651	6,727	6,968	3.6
100-199 beds	867	7,489	7,774	3.8
200-299 beds	492	8,400	8,700	3.6
300-499 beds	413	9,405	9,720	3.3
500 or more beds	167	11,388	11,736	3.0
Bed Size (Rural):				
0-49 beds	348	5,196	5,413	4.2
50-99 beds	370	5,601	5,858	4.6
100-149 beds	174	6,182	6,391	3.4
150-199 beds	68	6,915	7,140	3.3
200 or more beds	45	7,870	8,102	2.9
Urban by Region:				
New England	128	9,388	9,660	2.9
Middle Atlantic	357	9,833	10,151	3.2
South Atlantic	388	8,476	8,746	3.2

	Number of Hospitals (1)	Average FY 2006 Payment Per Case[1] (2)	Average FY 2007 Payment Per Case[1] (3)	All FY 2007 Changes (4)
East North Central	395	8,561	8,868	3.6
East South Central	165	8,209	8,449	2.9
West North Central	157	8,683	8,959	3.2
West South Central	374	8,447	8,703	3.0
Mountain	149	8,799	9,174	4.3
Pacific	424	10,741	11,228	4.5
Puerto Rico	53	4,190	4,281	2.2
Rural by Region:				
New England	19	8,092	8,548	5.6
Middle Atlantic	72	6,254	6,567	5.0
South Atlantic	176	6,023	6,233	3.5
East North Central	125	6,415	6,658	3.8
East South Central	180	5,969	6,172	3.4
West North Central	116	6,392	6,648	4.0
West South Central	193	5,660	5,839	3.2
Mountain	81	6,554	6,749	3.0
Pacific	43	7,567	7,850	3.7
By Payment Classification:				
Urban hospitals	2,608	8,938	9,243	3.4
Large urban areas (populations over 1 million)	1,450	9,355	9,686	3.5
Other urban areas (populations of 1 million or fewer)	1,158	8,429	8,703	3.3
Rural areas	987	6,255	6,492	3.8
Teaching Status:				
Non-teaching	2,511	7,118	7,388	3.8
Fewer than 100 Residents	843	8,636	8,924	3.3
100 or more Residents	241	12,605	12,988	3.0
Urban DSH:				
Non-DSH	906	7,719	7,994	3.6
100 or more beds	1,520	9,423	9,743	3.4
Less than 100 beds	347	6,154	6,395	3.9
Rural DSH:				
SCH	385	5,779	6,021	4.2
RRC	199	6,935	7,164	3.3
Other Rural:				
100 or more beds	55	5,737	5,920	3.2
Less than 100 beds	183	5,104	5,279	3.4
Urban teaching and DSH:				
Both teaching and DSH	815	10,366	10,699	3.2
Teaching and no DSH	201	8,599	8,881	3.3
No teaching and DSH	1,052	7,614	7,904	3.8
No teaching and no DSH	540	7,282	7,545	3.6
Rural Hospital Types:				
RRC	187	7,277	7,523	3.4
SCH	376	6,161	6,370	3.4

	Number of Hospitals (1)	Average FY 2006 Payment Per Case[1] (2)	Average FY 2007 Payment Per Case[1] (3)	All FY 2007 Changes (4)
MDH	146	5,171	5,594	8.2
SCH and RRC	98	7,350	7,584	3.2
MDH and RRC	8	6,397	7,234	13.1
Unknown				
Type of Ownership:				
Voluntary	2,102	8,676	8,972	3.4
Proprietary	880	7,711	7,987	3.6
Government	603	8,772	9,081	3.5
Unknown	10	13,196	14,214	7.7
Medicare Utilization as a Percent of Inpatient Days:				
0-25	243	12,181	12,663	4.0
25-50	1,328	9,737	10,061	3.3
50-65	1,478	7,432	7,696	3.5
Over 65	462	6,650	6,887	3.6
Unknown	84	9,920	10,374	4.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:				
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications:	325	8,736	9,051	3.6
Urban Nonreclassified, First Half FY 2007:	2,240	8,993	9,298	3.4
All Urban Hospitals Reclassified Second Half FY 2007:	385	8,954	9,259	3.4
Urban Nonreclassified Hospitals Second Half FY 2007:	2,180	8,961	9,267	3.4
All Rural Hospitals Reclassified Second Half FY 2007:	375	6,730	6,967	3.5
Rural Nonreclassified Hospitals Second Half FY 2007:	569	5,519	5,739	4.0
All Section 401 Reclassified Hospitals:	33	6,968	7,336	5.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	60	5,909	6,168	4.4
Section 508 Hospitals	95	9,309	9,471	1.7
Specialty Hospitals				
Cardiac Specialty Hospitals	21	11,363	11,502	1.2

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

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 LTC-DRG Reclassifications and Relative Weights for LTCHs

In section II.F. of the preamble to this final rule, we discuss the changes in the LTC–DRG relative weights for FY 2007, which are based on the Version 24.0 of the CMS GROUPER (including the changes in the classifications, relative weights and geometric mean length of stay for each LTC–DRG). As also discussed in that same section of this final rule, currently, there is no statutory or regulatory requirement that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. As discussed above in section II.F. of the preamble of this final rule, the LTCH PPS is still in the midst of a transition from a reasonable cost-based payment system to fully Federal PPS payments, during which time LTCH treatment patterns and coding practices, which are reflected in the LTCH claims data, appear to continue to change as LTCHs adapt to this new payment system.

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). Therefore, the FY 2005 MedPAR data used to compute the FY 2007 LTC-DRG relative weights in this final rule are based on LTCH claims data taken from only the second full year of the LTCH PPS. Based on LTCH cases in the

March 2006 update of the FY 2005 MedPAR files, we estimate that the changes to the LTC-DRG classifications and relative weights for FY 2007 would result in an aggregate decrease in LTCH PPS payments of approximately 1.3 percent based on the data from the 369 LTCHs in our database. (We note that this estimated aggregate decrease in LTCH PPS payments of approximately 1.3 percent was determined based on the current payment rates and policies established in the RY 2007 LTCH PPS final rule (71 FR 27798 through 27939) and the revised LTC-DRG classifications, relative weights and average lengths of stay established for FY 2007 in this final rule).

When we compared the GROUPER Version 23.0 (FY 2006) LTC–DRG relative weights to the GROUPER Version 24.0 (FY 2007) LTC–DRG relative weights, we found that approximately 68 percent of the LTC–DRGs would have a higher relative weight under Version 23.0, while the remaining approximately 32 percent of the LTC–DRGs would have a higher relative weight under Version 24.0. We also found that, based on FY 2005 LTCH cases, the GROUPER Version 23.0 LTC-DRG relative weights were, on average, approximately 3.3 percent higher than the GROUPER Version 24.0 LTC–DRG relative weights. In addition, based on an analysis of the most recent available LTCH claims data from the FY 2005 MedPAR file, we continue to observe that the average LTC–DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year.

Contributing to this increase in these relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system

to a PPS. The impact of including additional cases with relatively lower charges into LTC–DRGs that had a relatively higher relative weight in the GROUPER Version 23.0 (FY 2006) is a decrease in the average relative weight for those LTC-DRGs in the GROUPER Version 24.0. As noted above in section II.F. of the preamble to this final rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 538 valid GROUPER Version 24.0 LTC–DRGs, 183 LTC-DRGs have no LTCH cases. In addition, another 180 LTC–DRGs are categorized as ‘‘low volume’’ (that is, have less than 25 cases annually). Consequently, only about 175 LTC-DRGs are used by most LTCHs on a ‘‘regular basis’’ (that is, nationally LTCHs discharge, in total, an average of 25 or more of these cases annually).

Of these 175 LTC–DRGs that are used on a "regular basis," we found that approximately 65 percent of the LTC–DRGs would have higher relative weights under GROUPER Version 23.0 in comparison to GROUPER Version 24.0, and the remaining 35 percent of the 175 LTC–DRGs that are used on a "regular basis" would have higher relative weights under GROUPER Version 24.0 in comparison to GROUPER Version 23.0. In addition, about 30 percent of the 175 LTC–DRGs that are used on a ‘‘regular basis’’ would experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2004 data, which generally results in a lower relative weight. Moreover, of the175 LTC–DRGs that are used on a "regular basis," approximately 62 percent of those LTC-DRGs would experience a change in the average charge per case from FY 2004 LTCH data as compared to FY 2005

LTCH data that is less than the increase in overall average LTCH charges across all LTC–DRGs from FY 2004 to FY 2005 of about 8.3 percent. Accordingly, those LTC-DRGs would also have a reduction in their relative weight as compared to the relative weight in FY 2006. For those LTC–DRGs in which the average charge within the LTC–DRG increase is less than 8.3 percent, the relative weights for those LTC-DRGs would decrease because the average charge for each of those LTC–DRGs is being divided by a larger number (that is, the average charge across all LTC–DRGs). For the reasons discussed above, we believe that the changes in the LTC-DRG relative weights for FY 2007, which include a significant number of LTC-DRGs with lower relative weights, would result in approximately a 1.3 percent decrease in estimated aggregate LTCH PPS payments.

B. Effects of New Technology Add-On Payments

In section II.G. of the preamble to this final rule, we discuss add-on payments for new medical services and technologies. As explained in that section, we are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, we are still providing an estimate of the payment increases here, as they will have an impact on total payments made in FY 2007. New technology add-on payments are limited to the lesser of 50 percent of the costs of the technology, or 50 percent of the costs in excess of the DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, we are estimating the increase in payment for FY 2007 as if every claim with these add-on payments will receive the maximum add-on payment. As discussed in

section II.G. of the preamble to this final rule, we are approving the X STOP Interspinous Process Decompression System for new technology add-on payments. As stated in the proposed rule, the applicant estimated that there would be a total of 2,124 patients (424 in DRG 499 and 1,700 in DRG 500) eligible to receive the device in FY 2007. Therefore, we estimate that payments for this technology will increase overall FY 2007 payments by $9.35 million.

In addition, we are continuing to make add-on payments in FY 2007 for two technologies that were approved for FY 2006 new technology add-on payments: Restore® Rechargeable Implantable Neurostimulator and GORE TAG. We estimate these payments for these technologies will increase overall FY 2007 payments by $6.01 million and $16.61 million, respectively.

The total increase in payments for these three new technologies, approximately $31.97 million, is not reflected in the tables.

C. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section IV.A. of the preamble to this final rule, we discuss new requirements for hospital reporting of quality data based on our continuing experience with this program and recent legislation. Section 5001(a) of Pub. L. 109-171 (DRA) sets out extensive new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of Pub. L. 108-173 (MMA). Section 5001(a) of Pub. L. 109-171 revised the mechanism used to update the standardized amount for payment for hospital inpatient

operating costs. New 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 will 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.

We have modeled the payment impact of this change in Table 1 of this Appendix, and discussed it in section VI. of this Appendix. We discuss other policy changes we are making to the RHQDAPU program in section IV.A. of the preamble to this final rule.

We also note that, for the FY 2007 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2005 (third quarter CY 2005 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 19,000 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 140 pages. Thus, the agency will have expenditures of approximately $380,000 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.

D. Effects of Other Policy Changes Affecting Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

In section IV.C. of the preamble to this final rule, we discuss the payment changes for MDHs made by section 5003 of Pub. L. 109-171. We modeled the payment impact of these changes in Table 1 of this Appendix and discussed them in section VI. of this Appendix.

In addition, in section IV.C.2. of the preamble to this final rule, we discussed changes to the data source and methodology that we will use to compute the volume decrease adjustment for MDHs and SCHs. 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 that these changes will have any significant impact on Medicare payment to these hospitals.

E. Effects of Policy on Payment for Direct Costs of Graduate Medical Education

1. Determination of Weighted Average GME PRAs for Merged Teaching Hospitals

In section IV.H.2. of the preamble to this final rule, we discuss our changes related to determining the weighted average GME PRA for a merged teaching hospital. Our current policy is that when two or more teaching hospitals merge, we determine a weighted PRA for the surviving merged hospital using GME costs and resident data from the base year cost report for each teaching hospital in the merger. We are revising our policy to determine a merged teaching hospital's PRA by using PRA data and FTE

resident data from the most recent settled cost reports of the merging hospitals, rather than using the direct GME cost data from the hospitals' base year cost report. This policy revision is administrative in nature, and we do not foresee that the revision will result in payment increases to merged teaching hospitals.

2. Determination of PRAs for New Teaching Hospitals

In section IV.H.3. of the preamble to this final rule, we discuss the methodology for determining the hospital-specific PRA for new teaching hospitals and we make a change to the existing regulations at §413.77(e) in order to specify a base period for certain situations, that is, for new teaching hospitals that did not have residents on duty during the first month of the cost reporting period in which the hospital became a new teaching hospital. The base period for these hospitals would be the next cost reporting period following the cost reporting period where any residents were on duty at the new teaching hospital. Because this change is administrative in nature, we do not foresee that it will result in a financial impact for FY 2007.

3. Requirements for Counting and Appropriate Documentation of FTE Residents

In section IV.H.4. of the preamble to this final rule, we are clarifying the policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes. Because this is a clarification of existing policy, there is no financial impact for FY 2007.

4. Resident Time Spent in Nonpatient Care Activities as Part of an Approved Residency Program

In section IV.H.5. of the preamble to this final rule, we are clarifying our policy that, with respect to residency training in nonhospital settings, only the time residents spend in patient care activities may be counted for purposes of direct GME and IME payments; and with respect to training in the hospital, residents training in all areas of the hospital complex may be counted for direct GME purposes, but may only be counted for IME purposes if the residents are furnishing patient care. Because we are clarifying existing policy, there is no financial impact of this clarification for FY 2007.

F. Effects of Policy Changes Relating to Emergency Services under EMTALA

In section IV.J. of the preamble to this final rule, we discuss several policy changes under the EMTALA requirements. We are clarifying that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We note that this proposed revision does not reflect any change in current CMS policy. We further note that the revision will not require hospitals without dedicated emergency departments to open dedicated emergency departments nor will it impose any EMTALA obligation on these hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Thus, there will be no impact on Medicare payment policies or practices.

In addition, we are modifying the definition of "labor" to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The effect of this change will be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition. This change will have a Medicare payment effect, if any, only on payments to physicians and nonphysician practitioners under the physician fee schedule. The amount of any impact will be negligible because only a very small number of Medicare beneficiaries are women of childbearing age.

G. Effects of Policy on Rural Community Hospital Demonstration Program

In section IV.L. of the preamble to this final rule, we discuss our implementation of section 410A of Pub. L. 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." As discussed in section IV.L. 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 2007

that will be made to each participating hospital under the demonstration will be approximately $1,021,985. 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. For the 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The adjustment factor to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

H. Effects of Policy on Hospitals-within-Hospitals and Satellite Facilities

In section VI.A.5. of the preamble to this final rule, we discuss our revision of the regulations for grandfathered HwHs, grandfathered hospital satellites and grandfathered satellite units at §§412.22(f), 412.22(h), and 412.25(e), respectively, to allow these facilities to increase or decrease their square footage or decrease the number of beds without jeopardizing their grandfathered status.

We estimate that there will be no net effect on the treatment of such hospitals as a result of this final rule. Payments to most HwHs and satellites are made on a prospective rate basis. For these facilities, our policy of allowing either increases or decreases in square footage would have no cost impact, since the prospective rates are not affected by a facility's changes in square footage. However, if grandfathered HwHs and satellites facilities were to decrease their number of beds, as provided by the policy revision that we are finalizing, the effect of this change will likely be a reduction in Medicare payments to such hospitals and satellite facilities because they will probably have fewer discharges.

A small number of grandfathered HwHs and satellite facilities, specifically children's and cancer hospitals and satellites of these facilities, are paid on a cost-related basis under the TEFRA system. Under that system, increases or decreases in square footage may cause corresponding increases or decreases in the costs on which payments to the facilities are based. However, any increases in costs caused by increased square footage may be offset by other factors. For example, under our policy a grandfathered HwH or satellite facility could reduce its number of beds and the decreased utilization flowing from this change may offset any added costs resulting from an increase in the square footage of a grandfathered hospital or satellite facility paid under the TEFRA system. Moreover, an increase in facility square footage to modernize a physical facility or to accommodate new equipment or technology may also result in improved efficiency, leading to reduced operating costs. The cost savings resulting from these increases in efficiency could also partially or entirely offset any cost increases. Because we cannot predict which grandfathered HwHs or satellite facilities will opt to increase or decrease their size or to decrease their bed numbers, we are unable to quantify the impact of these changes. (We are only aware of one cancer hospital and three children's hospitals that are HwHs.) However, overall we expect that there will be offsetting cost increases and reductions, with no net change in costs.

I. Effects of Policy Changes to the Methodology for Determining LTCH CCRs and the Reconciliation of LTCH PPS Outlier Payments

In section VI.A.6. of the preamble to this final rule, we discuss our revision and clarification of the existing policies governing the determination of LTCHs' CCRs and

the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. Under the LTCH PPS high-cost outlier and short-stay outlier policies, CCRs are used to determine the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case.

In that section, specifically, we present a revision of our methodology for determining the annual LTCH CCR ceiling. Based on the most recent complete IPPS total CCR data, we are establishing a total CCR ceiling of 1.321 under the LTCH PPS effective October 1, 2006. This ceiling was determined based on the same data used to determine the separate IPPS operating CCR ceiling (1.26) and IPPS capital CCR ceiling (0.154). The LTCH CCR ceiling determined under our current "combined" methodology will result in a slightly higher LTCH CCR ceiling (that is, 1.26 + 0.154 = 1.414) for FY 2007 compared to the "total" CCR ceiling of 1.321 for FY 2007. However, we note that, based on the most recent complete IPPS and LTCH CCR data, there are no LTCHs that currently have a CCR that is greater than the ceiling of 1.321 (the highest LTCH CCR in the database of 392 LTCHs is 1.1277). Therefore, based on these data, because no LTCHs currently have a CCR that is in excess of the LTCH CCR ceiling we are establishing for FY 2007 in this final rule, we believe that there will be no significant impact on LTCH PPS payments based on this policy.

Also in section VI.A.6. of the preamble to this final rule, we discuss our revision of our methodology for determining the applicable statewide average LTCH CCRs. Based on the most recent complete IPPS total CCR data, the LTCH PPS statewide average CCRs that would be effective October 1, 2006, are presented in Table 8C of the

Addendum to this final rule. A comparison of the statewide average total CCRs in Table 8C of the Addendum to this final rule to the "combined" statewide average CCRs that would be calculated under our existing methodology from the operating PPS statewide average CCRs in Table 8A of the Addendum to this final rule and the capital PPS statewide average CCRs in Table 8B of the Addendum to this final rule shows that the changes to our methodology for determining LTCH statewide average CCRs will result in minor changes in the average CCR for each state. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, which will be assigned the national average total CCR as discussed in section VI.A.6 of the preamble of this final rule) will be in urban Wyoming (-0.7 percent), and there is currently only one LTCH located in Wyoming. The largest increase in a statewide average CCR will be in urban District of Columbia (0.7 percent), and there are currently only two LTCHs located in the District of Columbia. Thus, we believe that the change in the methodology for determining the applicable statewide average LTCH CCRs established in this final rule will result in no significant impact on LTCH PPS payments.

In addition, in section VI.A.6 of the preamble of this final rule we discussed our codification in Subpart O of 42 CFR Part 412 the provisions governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under the LTCH PPS, including modifications and editorial clarifications to our existing methodology. These changes are similar or almost identical (except for the minor clarifications and modifications) to our current policy governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under

the LTCH PPS, and therefore, there will be no expected impact if such policies were codified.

J. Effects of Policy on Payment for Services Furnished Outside the United States

In section VII. of the preamble to this final rule, we discuss our clarification of our regulations regarding payment for Medicare services furnished outside the United States. The clarification revises references in our regulations that could be read to limit Medicare payment for certain services furnished outside the United States to services furnished in Canada or Mexico, contrary to the provisions of the Act. Only a small fraction of Medicare claims are paid as a result of services furnished outside of the United States. Moreover, we are unaware of any claims for payment that would otherwise satisfy the requirements under the Act that have not been paid due to the language in our current regulations. Therefore, because we are clarifying existing policy, this clarification has little or no financial impact for FY 2007.

K. Effects of Policy on Limitation on Payments to SNFs

In section IX. of the preamble to this final rule, we discuss the implementation of section 5004 of Pub. L. 109-171, which mandated that, for cost reporting periods beginning on or after October 1, 2005, Medicare payments to SNFs for certain otherwise allowable debt amounts attributable to the coinsurance amounts for patients who are not certain specified dual eligible individuals be reduced by 30 percent. We anticipate that the provisions of section 5004 of Pub. L 109-171 will result in a savings to the Medicare program of $490 million over the 5-year period from FY 2006 to FY 2010.

L. Effects of Policy on CAP for Outpatient Drugs and Biologicals under Part B for the Purpose of Calculating the Average Sales Price

We have reviewed the effects of the provisions of XII. of this final rule as required by Executive Order 12866, the RFA, section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995, and Executive Order 13132. We believe the change to the definition of "unit" will be beneficial to CAP drug vendors, as they will be able to exclude from the ASP calculation, for the initial 3-year contract period under the CAP, units of CAP drugs sold to an approved CAP vendor for use under the CAP drug program.

VIII. Impact of Changes in the Capital PPS

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.

In accordance with §412.312, the basic methodology for determining a capital PPS payment is:

(Standard Federal Rate) x (DRG weight) x (Geographic Adjustment Factor (GAF)) x (Large Urban Add-on, if applicable) x (COLA for hospitals located in Alaska

and Hawaii) x (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

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 2006 update of the FY 2005 MedPAR file and the March 2006 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 2006 update of the most recently available hospital cost report data (FYs 2003 and 2004) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. Third, 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 2006 update of the FY 2005 MedPAR file, we simulated payments under the capital PPS for FY 2006 and FY 2007 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 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, disproportionate share, large urban add-on, 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 2006 and 2007.

- We estimate that the Medicare discharges will be 13.5 million in FY 2006 and 13.1 million in FY 2007 for a 3.0 percent decrease from FY 2006 to FY 2007.

- 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. The FY 2007 update is 1.1 percent (see section III.A.1.of the Addendum to this final rule).

- In addition to the FY 2007 update factor, the tentative FY 2007 capital Federal rate was calculated based on a tentative GAF/DRG budget neutrality factor of 0.9994, a tentative outlier adjustment factor of 0.9568, and an exceptions adjustment factor of 0.9997.

B. Results

We used the actuarial model described above to estimate the potential impact of our changes for FY 2007 on total capital payments per case, using a universe of 3,595 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2006 update of the FY 2005 MedPAR file, the March 2006 update to the Provider-Specific File, and the most recent cost report data from the March 2006 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2006 compared to FY 2007 based on the FY 2007 payment policies. Column 2 shows estimates of payments per case under our model for FY 2006. Column 3 shows estimates of payments per case under our model for FY 2007. Column 4 shows the total percentage change in payments from FY 2006 to FY 2007. The change represented in Column 4 includes the 1.1 percent update to the capital Federal rate, a 0.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the hospital wage index on the GAF), and reclassifications by the MGCRB. 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 can be expected to increase 2.3 percent in FY 2007. In addition to the 1.1 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to the change in the DRG recalibration process methodology for FY 2007 as discussed in section II.C. of the preamble. The tentative GAF and tentative outlier factor impose equal but opposite effects on capital payments (-0.2 percent and

0.2 percent, respectively), and therefore have a zero net effect on capital payments per case.

The results of our comparisons by geographic location and by region are consistent with the results we expected after applying the changes to the DRG recalibration methodology. The geographic comparison shows that urban hospitals are expected to experience a 2.3 percent increase in IPPS capital payments per case, while rural hospitals are expected to experience a 2.1 percent increase in capital payments per case. This difference is mostly due to the changes to the methodology used to recalibrate DRGs discussed in section II.C. of the preamble of this final rule. As discussed in greater detail in that section of this final rule, analysis of our current methodology for setting DRG weights (using gross charges) indicates that bias is introduced into the weighting process. Specifically, we have also observed that ancillary service cost centers, in general, have higher charge markups than routine and ICU service cost centers, and therefore, higher weights for DRGs that use more ancillary services as opposed to DRGs that use more routine services. Surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or ICU cost center groups. The bias in our current methodology results in artificially higher DRG relative weights for hospitals that are generally more expensive, such as teaching hospitals and specialty hospitals. Hospitals with these characteristics are generally found in urban locations.

The redistributive impact of our proposals to reform the current DRG system was evident in the capital impact analysis as discussed in the proposed rule. Consequently,

the proposed rule impact analysis showed greater capital increases per case for rural hospitals, as expected, than for hospitals in urban locations. In response to comments on the proposed rule, significant modifications were made to our DRG proposals. The modifications made in this final rule to our proposed changes to the DRG system are intended to moderate the payment redistribution, and the capital impact analysis reflects those modifications accordingly. Further mitigating the effects of the changes is moving to a 3-year transition period to apply the new methodology. The capital impact was also somewhat affected by the wage-index changes from the proposed rule to the final rule because the GAF values are derived from the wage index. The wage index used in the proposed rule included an occupational mix component. Due to circumstances as described in section III.C. of the preamble to this final rule, the wage index used in these calculations is tentative, and will be updated in a future Federal Register document, as well as on the CMS Web site.

All regions are estimated to receive an increase in total capital payments per case from FY 2006 to FY 2007. Changes vary by region from a minimum increase of 0.4 percent (Puerto Rico) urban to a maximum increase of 3.2 percent (Pacific) urban. The change in payments per case for all hospitals is 2.3 percent and is similar to the change indicated in the proposed rule. However, the differences between urban and rural hospitals in this final rule are noticeably less than the differences observed in the proposed rule. As previously discussed, the increases in payments are largely attributable to changes in the DRG recalibration methodology, and the lesser degree of difference between rural and urban hospitals' capital payment increases from the proposed rule and

this final rule is due to the modifications made to the proposed DRG reforms. By type of ownership, the increases in payment are similar among all three types. Government hospitals and proprietary hospitals are both projected to have a 2.4 percent increase in total payments, while payments to voluntary hospitals are expected to increase 2.3 percent.

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 Pub. L. 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 2007. Reclassification for wage index purposes also affects the GAF because that factor is constructed from the hospital wage index.

As discussed in section III.H.5. of the preamble of this final rule, procedural rules were established in the FY 2006 final rule (70 FR 47382) to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year. These half fiscal year reclassifications have implications for the calculation of reclassified wage indices and therefore, affect capital payments because GAF values are calculated from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2007, we show the average payments per case for reclassified hospitals for each half of FY 2007

compared to the average payments per case for the same time period in FY 2006. The reclassified groups are compared to all other nonreclassified hospitals for the same time period. These categories are further identified by urban and rural designation. In general, the average payments per case in the first half of FY 2007 is the same as the average payments per case in the second half of FY 2007 with the exception of urban reclassifications, which decreases by 0.1 percent (2.5 percent to 2.4 percent) for the second half of FY 2007. Rural nonreclassified hospitals are expected to have the largest increases in payments (2.5 percent in both halves), as compared to the 2.0 percent increase for rural reclassified hospitals (for both halves of FY 2007). Falling between the percentage increase for rural non-reclassified hospitals and the increase for rural reclassified hospitals are the urban hospitals. Reclassified (urban) hospitals are projected to have increases of 2.5 percent and 2.4 percent in the first and second halves of FY 2007, respectively, while nonreclassified (urban) hospitals are projected to have a slightly lesser increase of 2.3 percent.

As discussed in section VI.B. of the preamble of this final rule, we are making a technical revision to §412.316(b) and §412.320 to clarify that hospitals reclassified as rural under §412.103 are not eligible for the large urban add-on or for capital DSH to reflect our historic policy that hospitals reclassified as rural under §412.103 also are considered rural under capital PPS regulations. Currently, there are 38 hospitals that reclassified under this regulation and only 12 of these hospitals (about 0.3 percent of all IPPS hospitals) will be affected by the technical revisions to sections §412.316(b) and §412.320 concerning the treatment of hospitals reclassified as rural under section

§412.103. Based on the most recent available data, we estimate that the impact of these changes will be a less than 0.00001 percent decrease in aggregate IPPS payments.

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2006 Payments Compared To FY 2007 Payments]

	Number of hospitals	Average FY 2006 payments/ case	Average FY 2007 payments/ case	Change
By Geographic Location:				
All hospitals	3,595	753	771	2.3
Large urban areas (populations over 1 million)	1,441	849	870	2.5
Other urban areas (populations of 1 million of fewer)	1,149	731	746	2.1
Rural areas	1,005	513	524	2.1
Urban hospitals	2,590	796	814	2.3
0-99 beds	651	617	632	2.4
100-199 beds	867	673	691	2.7
200-299 beds	492	751	769	2.4
300-499 beds	413	827	845	2.2
500 or more beds	167	1,005	1,027	2.1
Rural hospitals	1,005	513	524	2.1
0-49 beds	348	422	433	2.5
50-99 beds	370	469	481	2.5
100-149 beds	174	516	526	2.0
150-199 beds	68	564	574	1.8
200 or more beds	45	642	652	1.6
By Region:				
Urban by Region	2,590	796	814	2.3
New England	128	853	870	2.0
Middle Atlantic	357	873	893	2.3
South Atlantic	388	755	770	2.0
East North Central	395	782	802	2.6
East South Central	165	720	733	1.8
West North Central	157	783	799	2.1
West South Central	374	740	755	2.0
Mountain	149	787	811	3.1
Pacific	424	920	949	3.2
Puerto Rico	53	347	349	0.4
Rural by Region	1,005	513	524	2.1
New England	19	686	699	1.9
Middle Atlantic	72	518	532	2.6
South Atlantic	176	497	509	2.2
East North Central	125	547	558	2.0
East South Central	180	476	486	2.2
West North Central	116	540	550	2.0
West South Central	193	464	473	1.9
Mountain	81	535	544	1.6
Pacific	43	616	631	2.4
By Payment Classification:				
All hospitals	3,595	753	771	2.3
Large urban areas (populations over 1 million)	1,450	848	869	2.5
Other urban areas (populations of 1 million of fewer)	1,158	730	746	2.1
Rural areas	987	515	526	2.1
Teaching Status:				
Non-teaching	2,511	630	645	2.5
Fewer than 100 Residents	843	765	782	2.2
100 or more Residents	241	1,100	1,125	2.2

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2006 Payments Compared To FY 2007 Payments]

	Number of hospitals	Average FY 2006 payments/ case	Average FY 2007 payments/ case	Change
Urban DSH:				
100 or more beds	1,520	821	840	2.3
Less than 100 beds	347	543	558	2.7
Rural DSH:				
Sole Community (SCH/EACH)	385	464	475	2.2
Referral Center (RRC/EACH)	199	569	580	1.9
Other Rural:				
100 or more beds	55	475	485	2.0
Less than 100 beds	183	423	433	2.5
Urban teaching and DSH:				
Both teaching and DSH	815	902	922	2.2
Teaching and no DSH	201	816	834	2.3
No teaching and DSH	1,052	667	684	2.6
No teaching and no DSH	540	700	717	2.4
Rural Hospital Types:				
Non special status hospitals	288	451	461	2.4
RRC/EACH	142	577	590	2.2
SCH/EACH	339	477	487	2.2
Medicare-dependent hospitals (MDH)	127	433	445	2.7
SCH, RRC and EACH	83	580	588	1.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2007 Reclassifications:				
All Urban Reclassified 1st Half	325	775	795	2.5
All Urban Non-Reclassified 1st Half	2,240	800	819	2.3
All Rural Reclassified 1st Half	375	558	569	2.0
All Rural Non-Reclassified 1st Half	569	450	462	2.5
All Urban Reclassified 2nd Half	385	800	819	2.4
All Urban Non-Reclassified 2nd Half	2,180	796	815	2.3
ALL Rural Reclassified 2nd Half	375	558	569	2.0
All Rural Non-Reclassified 2nd Half	569	450	462	2.5
All Section 401 Reclassified Hospitals	33	548	554	1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	53	516	527	2.2
Type of Ownership:				
Voluntary	2,102	771	789	2.3
Proprietary	880	679	696	2.4
Government	603	740	757	2.4
Medicare Utilization as a Percent of Inpatient Days:				
0-25	243	999	1,030	3.0
25-50	1,328	855	875	2.3
50-65	1,478	663	679	2.3
Over 65	462	597	609	2.1

IX. Impact of Changes Relating to the Loan Program for Capital Cost under the Health Care Infrastructure Improvement Program

In section XI. of the preamble to this final rule, we finalize the provisions of a September 30, 2005 interim final rule with comment period and the proposed changes in a September 30, 2005 proposed rule relating to the selection criteria and the forgiveness of indebtedness for loans made to certain hospitals engaged in research in the causes, prevention, and treatment of cancer under the Health Care Infrastructure Improvement Program. This section of this final rule affects qualifying hospitals as defined in section 1897 of the Act that have been selected to receive funds under the loan program.

This provision will have little impact on the Medicare Trust Fund. The Congress provided $142 million for the loan program effective July 1, 2004, through September 30, 2008, and of the $142 million, not more than $2 million may be used for the administration of the loan program for each of the fiscal years (that is, 2004 through 2008).

X. Alternatives Considered

This final rule contains a range of policies, including some changes related to specific DRA and MMA provisions. The preamble of this final rule provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our decisions and, where relevant, alternatives that were considered.

In addition, we did not consider any alternatives to the policies we are implementing in this final rule relating to the implementation of the loan program under

the Health Care Infrastructure Improvement Program because the statute specifically authorized the conditions under which the Secretary may forgive a loan provided under the program.

XI. Overall Conclusion

The changes 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 2007. Table I of section VI of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for DRG and wage index changes, for the hold harmless transition for rural hospitals formerly classified as urban, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 3.4 percent in operating payments, which, in conjunction with the estimated 2.0 percent increase in capital payments to IPPS providers shown in Table III of section VIII of this Appendix, should result in a net increase of $3.33 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.

XII. 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 on providers as a result of the changes to the IPPS, the

LTCH case-mix, and the limitation on payments to SNFs for bad debt presented in this rule. All expenditures are classified as transfers to Medicare providers.

The Congress provided $142 million for the loan program, effective July 1, 2004, through September 30, 2008. Of the $142 million, not more than $2 million may be used for the administration of the loan program for each of the fiscal years (that is FY 2004 through FY 2008).

Table IV.—Accounting Statement: Classification of Estimated Expenditures from FY 2006 to FY 2007

Category	Transfers
Annualized Monetized Transfers	$3.889 Billion
From Whom to Whom	Federal Government to IPPS Medicare Providers, LTCHs, and SNFs
Total	$3.889 Billion

XIII. 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 Medicare Payment Advisory Commission (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 care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish factors recommended by the Secretary in the final IPPS rule. Accordingly, we are publishing our final recommendations for the appropriate update factors for the IPPS 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.

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109-171, sets the FY 2007 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 under section 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 the Office of the Actuary's second quarter 2006 forecast of the FY 2007 market basket increase of 3.4 percent, the FY 2007 update

to the standardized amount for hospitals subject to the acute inpatient prospective payment system is 3.4 percent (that is, 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 is 1.4 percent (that is, the market basket rate-of-increase minus 2.0 percentage points). (In the proposed rule, the most recent estimate of the market basket increase was also 3.4 percent.)

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2007 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 also 3.4 percent.

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 for years after FY 2002. 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 Pub. L. 106-113, as amended by section 307(b) of Pub. L. 106-554, provides the statutory authority for updating payment rates under the LTCH PPS.

Some LTCHs and IPFs are transitioning to 100 percent of the Federal rate and currently receive a blend of reasonable cost-based payments computed under the TEFRA methodology and their respective Federal payment rates. As discussed below, the transition ends for LTCHs (not defined as new and that have not elected to be paid under 100 percent of the Federal rate) for cost reporting periods beginning on or after October 1, 2006. Therefore, because no portion of LTCHs' prospective payments will be based on reasonable costs for cost reporting periods beginning on or after October 1, 2006, we are not providing an FY 2007 rate-of-increase adjustment under section 1886(b)(3)(B)(ii) of the Act for LTCHs.

Currently, children's hospitals, cancer hospitals and RNHCIs are the remaining three types of hospitals still reimbursed fully under reasonable costs. As we discuss in section IV. of the Addendum to this final rule, we are providing the FY 2007 IPPS operating market basket percentage increase (3.4 percent) that is being used to update the target limits for children's hospitals, cancer hospitals, and RNHCIs. (In the proposed rule, the most recent estimate of the market basket increase was also 3.4 percent for children's hospitals, cancer hospitals, and RNHCIs.)

Effective since cost reporting periods beginning FY 2003, LTCHs have been paid under the LTCH PPS, which was implemented with a 5-year transition period for LTCHs not defined as new under §412.23(e)(4) (hereafter referred to as "existing"). (Refer to 67 FR 55954, August 30, 2002.) An existing LTCH could have elected to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. During this transition period, if an existing LTCH did

not elect to be paid 100 percent of the Federal prospective payment rate, it received a payment which consisted of a blend of its reasonable cost-based payment (subject to the TEFRA rate-of-increase limits) and the Federal prospective payment rate. Because the transition period ends with LTCH cost reporting periods beginning on or after October 1, 2006, those LTCHs who now receive blended payments will be paid based on 100 percent of the Federal prospective rate.

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 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. During a transition period between January 1, 2005 and January 1, 2008, existing IPFs are paid based on a blend of the reasonable cost-based payments, subject to the TEFRA limit, and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2007, the portion of the IPF PPS transitional blend payment based on reasonable costs would be determined by updating the IPF's TEFRA limit by the current estimate of the excluded hospital market basket, which is estimated to be 3.4 percent. The update factor of 4.3 percent to the Federal per diem rate for July 1, 2006, through June 30, 2007, was provided in the RY 2007 IPF final rule (71 FR 27046).

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. (Refer to the IRF final rule (69 FR 45721).) In the FY 2007 IRF PPS proposed rule (71 FR 28106 and 28125), we proposed an update factor of 3.4 percent to the IRF PPS for FY 2007. The final update factor for the FY 2007 IRF PPS will be published in the FY 2007 IRF PPS final rule.

Comment: One commenter believed the market basket update of 3.4 percent is inadequate. The commenter claimed that data for 1998 through 2006 indicate that hospital costs increased 37.9 percent, while Medicare payments increased 19.7 percent, resulting in a shortfall of $4.4 billion. The commenter noted that continual underfunding by CMS will further threaten the financial viability of not-for-profit hospitals in Michigan, thus limiting their ability to provide service to Medicare beneficiaries and others.

Response: The current market basket forecast update of 3.4 percent is based on Global Insight, Inc.'s (GII) 2006 second quarter forecast with historical data through the first quarter of 2006. GII is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. In the FY 2006 IPPS rule, we noted that over the last several years, dramatic fluctuations in the price of certain costs (mainly energy costs) have made it difficult to forecast the IPPS market basket. With our input and consultation, GII recently evaluated and modified its forecasting models to help enhance their accuracy. GII's latest forecast is based on these improved models and takes into account national and global economic trends.

We will continue to monitor both the accuracy of our market basket updates and the profitability of IPPS hospitals, as well as work with GII to ensure the most accurate updates possible.

Comment: One commenter was concerned that GII's methodology has a built-in bias of under projecting during the period when the overall economy is transitioning from a high growth and low inflation era to a low growth and high inflation period. The commenter explained that, during a transition period, the extrapolation of historical data tends to have larger projection variances and therefore adjustments should be made to correct for these systematic projection biases during the time of major business cycle reversals. As a result, the commenter recommended that CMS include an adjustment in its projection methodology to correct for this systematic bias or adjust the projection error in its subsequent years' payments.

Response: CMS and GII recognize the complexities associated with projecting prices during times of major business cycle reversals. GII includes adjustments in their forecasts to account for these systematic biases. GII employs a simultaneous equation approach to solve both macro and micro simulation models for the underlying components of the hospital market basket. Using this simultaneous approach facilitates the accurate inclusion of broader economic conditions, such as economy-wide growth and inflationary pressures, to be more accurately reflected in the micro level components that comprise the market basket. In addition, as part of these micro models, underlying businesses cycles, seasonal changes, and market fluctuations are incorporated to ensure forecasts accurately control for these market conditions during forecast cycles.

Comment: One commenter was concerned that it is consistently disproportionately negatively affected by Medicare rate policies. The commenter recommended that no hospital receive less payments in the current year than the previous year or optimally CMS should provide a minimum payment increase of 2 percent.

Response: We thank the commenter for its comments. However, as noted above, section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109-171, ties the FY 2007 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. Therefore, we do not have the statutory authority to implement the changes to the update factors that the commenter is requesting.

II. Secretary's Final Recommendation for Updating the Prospective Payment System Standardized Amounts

In recommending an update, the Secretary takes into account the factors such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate payment to health care providers. In years prior to FY 2006, in making a recommendation, we included an update framework that analyzed hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effects of reclassification on recalibration and forecast error correction. As we stated in the FY 2007 proposed rule, we are no longer including this analysis in our recommendation for the update (71 FR 24420).

In the FY 2007 IPPS proposed rule, we proposed to recommend an update of 2.95 percent, which reflected the CMS Office of the Actuary's most recent forecast of the FY 2007 market basket increase minus an adjustment factor of 0.45 percentage points based on the FY 2007 President's budget. We did not receive any public comments regarding this issue. In this final rule, we are also recommending an update for IPPS hospitals based on the forecasted market basket increase of 3.4 percent from the Office of the Actuary's most recent (second quarter) 2006 forecast of the FY 2007 market basket increase minus an adjustment factor of 0.45 percentage points based on the FY 2007 President's budget. Thus, the Secretary's final recommendation for the update to the IPPS standardized amount for all hospitals is 2.95 percentage points for hospitals that provide the required quality data.

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. Using the 2006 second quarter forecast from the Office of the Actuary of the FY 2007 market basket increase and an adjustment factor based on the FY 2007 President's budget, for FY 2007, for SCHs and MDHs, we are also recommending an update of 2.95 percent.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units

We did not receive any public comments concerning our proposed recommendations for updating the rate-of-increase for FY 2007 for cancer hospitals, RNHCIs, and children's hospitals. Our final recommendation does not differ from the

proposed recommendation. The second quarter forecast from the Office of the Actuary of the FY 2007 market basket increase is also 3.4 percent for these excluded hospitals and hospital units. Thus, using an adjustment factor based on the FY 2007 President's budget, the Secretary's final recommendation is for a 2.95 percent increase to the target limits for cancer hospitals, RNHCIs, and children's hospitals.

Further, we did not receive any public comments concerning our proposed recommendations for the update factors for IPFs. For IPFs that are currently paid a blend of reasonable cost-based (subject to the TEFRA limits) and Federal prospective payment amounts, based on the estimate from the Office of the Actuary and an adjustment factor from the FY 2007 President's budget, in the proposed rule, we recommended an update factor of 3.15 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits. Based on second quarter data from the Office of the Actuary and an adjustment factor from the FY 2007 President's budget, we are recommending a final update of 2.95 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits.

Consistent with the RY 2007 LTCH PPS proposed rule (71 FR 4648), in the FY 2007 IPPS proposed rule, we recommended that the Federal rate remain unchanged for FY 2007. In this final rule, consistent with the RY 2007 LTCH final rule (71 FR 27826), we are recommending that the Federal rate to the LTCH PPS remain unchanged for FY 2007.

In the RY 2007 IPF PPS proposed rule (71 FR 3620) and in the FY 2006 IPPS proposed rule, we proposed an update factor of 4.5 percent to the IPF PPS for RY 2007.

The proposed update reflected an increase from the 18-month period beginning January 1, 2005, when the IPF PPS was first adopted. However, in the RY 2007 IPF final rule (71 FR 27040), we recommended an update factor of 4.3 percent. Consistent with the RY 2007 IPF final rule, in this IPPS final rule, we are recommending an update factor of 4.3 percent for IPFs.

In the FY 2007 IPPS proposed rule, consistent with the President's FY 2007 budget, we recommended the Federal rate to the IRF PPS remain unchanged for FY 2007. We note, as mentioned above, in the FY 2007 IRF PPS proposed rule (71 FR 281206 and 28125), we proposed an update factor of 3.4 percent to the IRF PPS for FY 2007. The final update factor for the FY 2007 IRF PPS will be published in the FY 2007 IRF PPS final rule. Therefore, in this final rule, consistent with FY 2007 IRF PPS final rule, we are recommending the update factor that will be published in the FY 2007 IRF PPS final rule. We refer readers to the FY 2007 IRF PPS final rule to view the update factor.

IV. Secretary's Recommendation for Updating the Capital Prospective Payment Amounts

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 payment rates is discussed in section III. of the Addendum to this final rule.