DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 412, 413, and 489

[CMS-1533-FC]

RIN 0938-AO70

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates

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

ACTION: 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 certain provisions made by the Deficit Reduction Act of 2005 (Pub. L. 109-171), the Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432), and the Pandemic and All-Hazards Preparedness Act (Pub. L. 109-417). In addition, in the Addendum to this final rule with comment period, 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 the rate-of-increase limits for certain hospitals and hospital units

excluded from the IPPS that are paid on a reasonable cost basis subject to these limits, or

that have a portion of a prospective payment system payment based on reasonable cost

principles. These changes are applicable to discharges occurring on or after

October 1, 2007.

In this final rule with comment period, as part of our efforts to further refine the

diagnosis-related group (DRG) system under the IPPS to better recognize severity of

illness among patients, for FY 2008, we are adopting a Medicare Severity DRG

(MS-DRG) classification system for the IPPS. We are also adopting the structure of the

MS-DRG system for the LTCH prospective payment system (referred to as MS-LTC-

DRGs) for FY 2008.

Among the other policy decisions and changes that we are making, we are making

changes related to: limited revisions of the reclassification of cases to MS-DRGs, the

relative weights for the MS-LTC-DRGs; applications for new technologies and medical

services add-on payments; the wage data, including the occupational mix data, used to

compute the FY 2008 wage indices; payments to hospitals for the indirect costs of

graduate medical education; submission of hospital quality data; provisions governing the

application of sanctions relating to the Emergency Medical Treatment and Labor Act of

1986 (EMTALA); provisions governing the disclosure of physician ownership in

hospitals and patient safety measures; and provisions relating to services furnished to

beneficiaries in custody of penal authorities.

DATES: Effective Date: This final rule with comment period is effective

October 1, 2007 and applies to discharges occurring on or after that date.

Comment Date: We will consider public comments only on the provisions of

section V., Changes to the IPPS for Capital-Related Costs, of the preamble of this final

rule with comment period, if we receive them at one of the addresses provided below, no

later than 5 p.m. on November 20, 2007.

ADDRESSES: In commenting on the provisions of section V. of the preamble of

this final rule with comment period, please refer to file code CMS-1533-FC.

Because of staff and resource limitations, we cannot accept comments by

facsimile (FAX) transmission.

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Baltimore address, please call telephone number (410) 786-7195 in advance to schedule
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IPPS for Capital-Related Costs.

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Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4:00 p.m. To

schedule an appointment to view public comments, phone 1-800-743-3951.

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Acronyms

ACGME   Accreditation Council for Graduate Medical Education

AMGA   American Medical Group Association

AHA   American Hospital Association

AHIMA   American Health Information Management Association

AHRQ   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

CART   CMS Abstraction & Reporting Tool

CBSAs   Core-based statistical areas

CC   Complication or comorbidity

CCR   Cost-to-charge ratio

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

CoP   [Hospital] Condition of participation

CPI   Consumer price index

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
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
GMEC	Graduate Medical Education Committee
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
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, Tenth Edition, Procedure Coding System
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
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

MAC   Medicare Administrative Contractor

MCC   Major complication or comorbidity

MCE   Medicare Code Editor

MCO   Managed care organization

MCV   Major cardiovascular condition

MDC   Major diagnostic category

MDH   Medicare-dependent, small rural hospital

MedPAC   Medicare Payment Advisory Commission

MedPAR   Medicare Provider Analysis and Review File

MEI   Medicare Economic Index

MGCRB   Medicare Geographic Classification Review Board

MIEA-TRHCA   Medicare Improvements and Extension Act, Division B of

             the Tax Relief and Health Care Act of 2006, Pub. L. 109-432

MMA   Medicare Prescription Drug, Improvement, and Modernization Act

             of 2003, Pub. L. 108-173

MPN   Medicare provider number

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
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)
PMSAs	Primary metropolitan statistical areas
PPI	Producer price index
PPS	Prospective payment system
PRA	Per resident amount
PRM	Provider Reimbursement Manual
ProPAC	Prospective Payment Assessment Commission
PRRB	Provider Reimbursement Review Board
PSF	Provider-Specific File
PS&R	Provider Statistical and Reimbursement (System)

QIG   Quality Improvement Group, CMS

QIO   Quality Improvement Organization

RCE   Reasonable compensation equivalent

RHC   Rural health clinic

RHQDAPU   Reporting hospital quality data for annual payment update

RNHCI   Religious nonmedical health care institution

RRC   Rural referral center

RUCAs   Rural-urban commuting area codes

RY   Rate year

SAF   Standard Analytic File

SCH   Sole community hospital

SFY   State fiscal year

SIC   Standard Industrial Classification

SNF   Skilled nursing facility

SOCs   Standard occupational classifications

SOM   State Operations Manual

SSA   Social Security Administration

SSI   Supplemental Security Income

TEFRA   Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248

UHDDS   Uniform hospital discharge data set

VBP   Value-based purchasing

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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

this special payment protection in order to maintain access to services for beneficiaries.

(Until FY 2007, an MDH has received the IPPS rate plus 50 percent of the difference

between the IPPS rate and its hospital-specific rate if the hospital-specific rate is higher

than the IPPS rate. In addition, an MDH does not have the option of using FY 1996 as

the base year for its 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 IPPS, payments are adjusted by the same DRG for the case as they are

under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH,

similar to the adjustments made under the operating IPPS. In addition, hospitals may

receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are

located in 42 CFR Part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded from the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals

and hospital units are excluded from the IPPS. These hospitals and units are:

rehabilitation hospitals and units; long-term care hospitals (LTCHs); psychiatric hospitals

and units; children's hospitals; and cancer hospitals. Religious nonmedical health care

institutions (RNHCIs) are also excluded from the IPPS. Various sections of the Balanced

Budget Act of 1997 (Pub. L. 105-33), the Medicare, Medicaid and SCHIP

[State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999

(Pub. L. 106-113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and

Protection Act of 2000 (Pub. L. 106-554) provide for the implementation of PPSs for

rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)),

LTCHs, and psychiatric hospitals and units (referred to as inpatient psychiatric facilities

(IPFs)), as discussed below. Children's hospitals, cancer hospitals, and RNHCIs continue

to be paid solely under a reasonable cost-based system.

The existing regulations governing payments to excluded hospitals and hospital

units are located in 42 CFR Parts 412 and 413.

a. Inpatient Rehabilitation Facilities (IRFs)

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

b. Long-Term Care Hospitals (LTCHs)

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

existing regulations governing payment under the LTCH PPS are located in 42 CFR Part

412, Subpart O.

c. Inpatient Psychiatric Facilities (IPFs)

Under the authority of sections 124(a) and (c) of Pub. L. 106-113, inpatient

psychiatric facilities (IPFs) (formerly psychiatric hospitals and psychiatric units of acute

care hospitals) 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 and a Federal per diem payment rate, effective for cost

reporting periods beginning on or after January 1, 2005.   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)

        The Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, made a number of

changes to the Act relating to prospective payments to hospitals and other providers for

inpatient services. The final rule implements amendments made by (1) section 5001(a),

which, effective for FY 2007 and subsequent years, expands the requirements for hospital

quality data reporting; and (2) section 5001(c), which requires the Secretary to select, by

October 1, 2007, at least two hospital-acquired conditions that meet certain specified

criteria that will be subject to a quality adjustment in DRG payments during FY 2008.

.   In this final rule with comment period, we also discuss our development of a plan

to implement, beginning with FY 2009, a value-based purchasing plan for section

1886(d) hospitals, in accordance with the requirements of section 5001(b) of

Pub. L. 109-171.

C. Provisions of the Medicare Improvements and Extension Act under Division B, Title I

of the Tax Relief and Health Care Act of 2006

        In this final rule with comment period, we discuss the provisions of section

106(b)(1) of the Medicare Improvements and Extensions Act under Division B, Title I of

the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA), Pub. L. 109-432, which

requires MedPAC to submit to Congress, not later than June 30, 2007, a report on the

Medicare wage index classification system applied under the Medicare Prospective

Payment System. Section 106(b) of the MIEA-TRHCA requires the report to include any

alternatives that MedPAC recommends to the method to compute the wage index under

section 1886(d)(3)(E) of the Act.

In addition, we discuss the provisions of section 106(b)(2) of the MIEA-TRHCA,

which instructs the Secretary of Health and Human Services, taking into account

MedPAC's recommendations on the Medicare wage index classification system, to

include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage

index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the

IPPS.

We note that we published a notice in the **Federal Register** on March 23, 2007

(72 FR 13799) that addressed the provisions of section 106(a) of the MIEA-TRHCA

relating to the extension of geographic reclassifications of hospitals under section 508 of

Pub. L. 108-173 (that expired on March 31, 2007) through September 30, 2007.

D. Provisions of the Pandemic and All-Hazards Preparedness Act

On December 19, 2006, Congress enacted the Pandemic and All-Hazards

Preparedness Act, Pub. L. 109-417. Section 302(b) of Pub. L. 109-417 makes two

specific changes that affect EMTALA implementation in emergency areas during an

emergency period.   Specifically section 302(b)(1)(A) of Pub. L. 109-417 amended

section 1135(b)(3)(B) of the Act to state that sanctions may be waived for the direction or

relocation of an individual for screening where, in the case of a public health emergency

that involves a pandemic infectious disease, that direction or relocation occurs pursuant

to a State pandemic preparedness plan. In addition, sections 302(b)(1)(B) and (b)(1)(C)

of Pub. L. 109-417 amended section 1135(b)(3)(B) of the Act to state that, if a public

health emergency involves a pandemic infectious disease (such as pandemic influenza)

the duration of a waiver or modification under section 1135(b)(3) of the Act (relating to

EMTALA) shall be determined in accordance with section 1135(e) of the Act as that

subsection applies to public health emergencies.

In this final rule with comment period, we are making changes to the EMTALA

regulations to conform them to the sanction waiver provisions of section 302(b) of

Pub. L. 109-417.

E. Issuance of a Notice of Proposed Rulemaking

On May 3, 2007, we issued in the **Federal Register** (72 FR 24680) a notice of

proposed rulemaking that set forth proposed changes to the Medicare IPPS for operating

costs and for capital-related costs in FY 2008. We also set forth proposed changes

relating to payments for GME and IME costs and payments to certain hospitals and units

that continue to be excluded from the IPPS and paid on a reasonable cost basis that would

be effective for discharges occurring on or after October 1, 2007. Below is a summary of

the major changes that we proposed to make:

1. DRG Reclassifications and Recalibrations of Relative Weights

We proposed to adopt a Medicare Severity DRG (MS-DRG) classification system

for the IPPS to better recognize severity of illness. We presented the methodology we

used to establish the MS-DRGs and discussed our efforts to further analyze alternative

severity-adjusted DRG systems and to refine the relative weight calculations for DRGs.

We presented a proposed listing and discussion of hospital-acquired conditions, including infections, which were evaluated and proposed to be subject to the statutorily required quality adjustment in DRG payments for FY 2008.

We proposed limited annual revisions to the DRG classification system in the following areas: intestinal transplants, neurostimulators, intracranial stents, cochlear implants, knee and hip replacements, spinal fusions and spinal disc devices, and endoscopic procedures.

We presented our reevaluation of certain FY 2007 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of the FY 2008 applicant (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 2008. We proposed that the LTC-DRGs would be revised to mirror the proposed MS-DRGs for the IPPS.

2. Proposed Changes to the Hospital Wage Index

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

● The FY 2008 wage index update, using wage data from cost reporting periods that began during FY 2004.

● Analysis and implementation of the proposed FY 2008 occupational mix adjustment to the wage index.

● Proposed changes relating to expiration of the imputed rural floor for the wage index and application of budget neutrality for the rural floor.

● Proposed changes in the determination of the wage index for multicampus hospitals.

● The proposed revisions to the wage index based on hospital redesignations and reclassifications, including reclassifications for multicampus hospitals.

● The proposed adjustment to the wage index for FY 2008 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 were in effect for the FY 2008 wage index.

● The labor-related share for the FY 2008 wage index, including the labor-related share for Puerto Rico.

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

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

● The reporting of hospital quality data as a condition for receiving the full annual payment update increase.

● Development of the Medicare value-based purchasing plan and reports on the "listening sessions" held.

● The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status and a proposed policy change relating to the acquired rural status of RRCs.

● The statutorily-required IME adjustment factor for FY 2008 and a proposed policy change relating to determining counts of residents on vacation or sick leave and in orientation for IME and direct GME purposes.

● Proposed changes relating to the waiver of sanctions for requirements for emergency services for hospitals under EMTALA during national emergencies.

● Proposed policy changes relating to the disclosure to patients of physician ownership of hospitals and patient safety measures.

● Discussion of the fourth year of implementation of the Rural Community Hospital Demonstration Program.

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

In section V. of the preamble to the proposed rule, we discussed the payment policy requirements for capital-related costs and capital payments to hospitals and proposed changes relating to adjustments to the Federal capital rate to address continuous large positive margins.

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

Rate-of-Increase Percentages

In section VI. of the preamble to the proposed rule, we discussed payments to

excluded hospitals and hospital units, and proposed changes for determining LTCH

CCRs under the LTCH PPS.

6. Services Furnished to Beneficiaries in Custody of Penal Authorities

In section VII. of the preamble to the proposed rule, we clarified when individuals

are considered to be in "custody" for purposes of Medicare payment for services

furnished to beneficiaries who are under penal authorities.

7. Determining Proposed Prospective Payment Operating and Capital Rates and

Rate-of-Increase Limits

In the Addendum to the proposed rule, we set forth proposed changes to the

amounts and factors for determining the FY 2008 prospective payment rates for operating

costs and capital-related costs. We also established the proposed threshold amounts for

outlier cases. In addition, we addressed the proposed update factors for determining the

rate-of-increase limits for cost reporting periods beginning in FY 2008 for hospitals and

hospital units excluded from the PPS.

8. 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.

9. 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 2008 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.

10. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2007 recommendations 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. We addressed these recommendations in Appendix B of the proposed rule. For further information relating specifically to the MedPAC March 2007 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.

F. Public Comments Received on the Proposed Rule

We received approximately 900 timely pieces of correspondence in response to the FY 2008 IPPS proposed rule issued in the **Federal Register** on May 3, 2007. These public comments addressed issues on multiple topics in the proposed rule. We present a summary of the public comments and our responses to them in the applicable subject-matter sections of this final rule with comment period.

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 the preamble to the FY 2007 IPPS final rule (71 FR 47881

through 47971), we are focusing our efforts in FY 2008 on making significant reforms to

the IPPS consistent with the recommendations made by MedPAC in its "Report to the

Congress, Physician-Owned Specialty Hospitals" in March 2005. MedPAC

recommended that the Secretary refine the entire DRG system by taking into account

severity of illness and applying hospital-specific relative value (HSRV) weights to

DRGs.[1] We began this reform process by adopting cost-based weights over a 3-year

transition period beginning in FY 2007 and making interim changes to the DRG system

for FY 2007 by creating 20 new CMS DRGs and modifying 32 others across 13 different

clinical areas involving nearly 1.7 million cases. As described below in more detail,

these refinements were intermediate steps towards comprehensive reform of both the

relative weights and the DRG system that is occurring as we undertook further study.

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

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

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 to ensure

that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a

single organ system or etiology and, in general, are associated with a particular medical

specialty. Thus, in order to maintain the requirement of clinical coherence, no final 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

2007, cases are assigned to one of 538 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

	Major Diagnostic Categories (MDCs)
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, under the most recent version of the CMS GROUPER (Version 24.0), there are 9 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

Pre-Major Diagnostic Categories (Pre-MDCs)	
	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 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 diagnosis class 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 entered into the Medicare claims processing systems and subjected to a series of

automated screens called the Medicare Code Editor (MCE). The MCE screens are

designed to identify cases that require further review before classification into 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

payment 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 FY 2000 IPPS final rule (64 FR 41500), we discussed a process for

considering non-MedPAR data in the recalibration process. In order for us to consider

using particular non-MedPAR data, we must have sufficient time to evaluate and test the

data. The time necessary to do so depends upon the nature and quality of the

non-MedPAR data submitted. Generally, however, a significant sample of the

non-MedPAR data should be submitted by mid-October for consideration in conjunction

with the next year's proposed rule. This date allows us time to test the data and make a

preliminary assessment as to the feasibility of using the data. Subsequently, a complete

database should be submitted by early December for consideration in conjunction with

the next year's proposed rule.

As we proposed in the FY 2008 IPPS proposed rule, for FY 2008, we are

adopting significant changes to the current DRGs. As described in detail below, we

proposed significant improvement in the DRG system to recognize severity of illness and

resource usage by proposing to adopt Medicare Severity DRGs (MS-DRGs). The

changes we proposed (and are adopting in this final rule with comment period) will be

reflected in the FY 2008 GROUPER, Version 25.0, and will be effective for discharges

occurring on or after October 1, 2007. As noted in the proposed rule, our DRG analysis

was based on data from the December 2006 update of the FY 2006 MedPAR file, which

contained hospital bills received through December 31, 2006, for discharges occurring in

FY 2006. For this final rule with comment period, our analysis is based on more recent

data from the March 2007 update of the FY 2006 MedPAR file, which contains hospital

bills received through March 31, 2007, for discharges occurring in FY 2006.

2. Yearly Review for Making DRG Changes

Many of the changes to the DRG classifications we make annually are the result

of specific issues brought to our attention by interested parties. As we indicated in the

proposed rule, 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 and, if included, may be

subjected to public review and comment. Therefore, similar to the timetable for

interested parties to submit non-MedPAR data for consideration in the 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 will likely continue to be,

highly iterative, involving a combination of statistical results from test data combined

with clinical judgment. We describe in detail below the process we used to develop the

MS-DRGs that we proposed and are adopting in this final rule with comment period. In

addition, in deciding whether to make further modification to the MS-DRGs for

particular circumstances brought to our attention, we considered whether the resource

consumption and clinical characteristics of the patients with a given set of conditions are

significantly different than the remaining patients in the MS-DRG. We evaluated patient

care costs using average charges and lengths of stay as proxies for costs and relied on the

judgment of our medical advisors to decide whether patients are clinically distinct or

similar to other patients in the MS-DRG. In evaluating resource costs, we considered

both the absolute and percentage differences in average charges between the cases we

selected for review and the remainder of cases in the MS-DRG. We also considered

variation in charges within these groups; that is, whether observed average differences

were consistent across patients or attributable to cases that were extreme in terms of

charges or length of stay, or both. Further, we considered the number of patients who

will have a given set of characteristics and generally preferred not to create a new DRG

unless it would include a substantial number of cases.

C. MedPAC Recommendations for Revisions to the IPPS DRG System

In the FY 2006 and FY 2007 IPPS final rules, we discussed a number of

recommendations made by MedPAC regarding revisions to the DRG system used under

the IPPS (70 FR 47473 through 47482 and 71 FR 47881 through 47939).

In Recommendations 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.

● 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.

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we

proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier).

However, based on public comments received on the FY 2007 IPPS proposed rule, we

decided not to adopt the CS DRGs. Rather, we decided to make interim changes to the

existing DRGs for FY 2007 by creating 20 new DRGs involving 13 different clinical

areas that would significantly improve the CMS DRG system's recognition of severity of

illness. We also modified 32 DRGs to better capture differences in severity. The new

and revised DRGs were selected from 40 existing CMS DRGs that contained 1,666,476

cases and represent a number of body systems. In creating these 20 new DRGs, we

deleted 8 and modified 32 existing DRGs. We indicated that these interim steps for

FY 2007 were being taken as a prelude to more comprehensive changes to better account

for severity in the DRG system by FY 2008. In the FY 2007 IPPS final rule, we

indicated our intent to pursue further DRG reform through two initiatives. First, we

announced that we were in the process of engaging a contractor to assist us with

evaluating alternative DRG systems that were raised as potential alternatives to the

CS DRGs in the public comments. Second, we indicated our intent to review over 13,000

ICD-9-CM diagnosis codes as part of making further refinements to the current

CMS DRGs to better recognize severity of illness based on the work that CMS (then

HCFA) did in the mid-1990's to adopt severity DRGs. We describe in detail below the

progress we have made on these two initiatives, our actions for FY 2008, and our plans

for continued analysis of reform of the DRG system for FY 2009. We note that revising

the DRGs to better recognize severity of illness has implications for the outlier threshold,

the application of the postacute care transfer policy, the measurement of real case-mix

versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these

implications in more detail in the following sections.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to

move to a cost-based HSRV weighting methodology beginning with the FY 2007 IPPS

proposed rule. Although we proposed to adopt HSRV weights for FY 2007, we decided

not to adopt the proposed methodology in the final rule after considering the public

comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we

adopted a cost-based weighting methodology without the hospital-specific portion of the

methodology. The cost-based weights are being adopted over a 3-year transition period

in 1/3 increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final

rule, we indicated our intent to further study the hospital-specific methodology as well as

other issues brought to our attention with respect to the cost-based weights. There was

significant concern in the public comments that we account for charge compression--the

practice of applying a higher charge markup over costs to lower cost than higher cost

items and services--if we are to develop relative weights based on cost. Further, public

commenters expressed concern about potential inconsistencies between how costs and

charges are reported on the Medicare cost reports and charges on the Medicare claims. In

the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine

departmental level cost-to-charge ratios (CCRs) to apply to charges on the Medicare

claims to determine the cost-based weights. The commenters were concerned about

potential distortions to the cost-based weights that would result from inconsistent

reporting between the cost reports and the Medicare claims. After publication of the FY

2007 IPPS final rule, we entered into a contract with RTI International to study both

charge compression and to what extent our methodology for calculating DRG relative

weights is affected by inconsistencies between how hospitals report costs and charges on

the cost report and how hospitals report charges on individual claims. Further, as part of

its study of alternative DRG systems, the RAND Corporation is analyzing the HSRV

cost-weighting methodology.

        As we present below, we believe that revisions to the DRG system to better

recognize severity of illness and changes to the relative weights based on costs rather

than charges are improving the accuracy of the payment rates in the IPPS. We agree with

MedPAC that these refinements should be pursued. Although we continue to caution that

any system that groups cases will always present some opportunities for providers to

specialize in cases they believe to have higher margins, we believe that the changes we

have adopted and the continuing reforms we proposed, and are adopting in this final rule

with comment period, for FY 2008 will improve payment accuracy and reduce financial

incentives to create specialty hospitals.

D. 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 "Medicare-Severity DRGs

(MS-DRGs)" means the revisions that we proposed to make (and are adopting in this

final rule with comment period) to the current CMS DRGs to better recognize severity of

illness and resource use based on case complexity. Although we have found the terms

"CMS DRGs" and "MS-DRGs" useful to distinguish the current DRG system from the

DRGs that we proposed to adopt for FY 2008, we invited public comments on how to

best refer to both the current DRGs and the proposed DRGs to avoid confusion and

improve clarity.

Comment: One commenter responded to our request for name suggestions for the

new DRG system. The commenter agreed that the name should differentiate which DRG

scheme is being referenced. The commenter did not provide an alternative suggestion.

Response: We agree with the importance of being able to differentiate between

the current and the revised DRG system. We believe the name "Medicare Severity DRGs

(MS-DRGs)" is an appropriate name for this revised system. Therefore, we are adopting

as final our reference to the revised DRG system as the "Medicare Severity DRGs (MS-DRGs)."

1. Evaluation of Alternative Severity-Adjusted DRG Systems

    In the FY 2007 IPPS final rule, we stated our intent to engage a contractor to assist us with an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs. We noted it was possible that some of the alternative systems would better recognize severity of illness and are based on the current CMS DRGs. We further stated that if we were to develop a clinical severity concept using the current CMS DRGs as the starting point, it was possible that several of the issues raised by commenters (in response to the CS DRGs, which, in the FY 2007 IPPS proposed rule, we proposed to adopt for FY 2008 or earlier) would no longer be a concern. We noted that if we were to propose adoption of severity DRGs for FY 2008, we would consider the issues raised by commenters on last year's proposed rule as we continued to make further refinements to account for complexity as well as severity to better reflect relative resource use. We stated that we believed it was likely that at least one of several alternative severity-adjusted DRG systems suggested for review (or potentially a system we would develop ourselves) would be suitable to achieve our goal of improving payment accuracy beginning in FY 2008.

    On September 1, 2006, we awarded a contract to the RAND Corporation to perform an evaluation of alternative severity-adjusted DRG classification systems. RAND is evaluating several alternative DRG systems based on how well they are suited to classifying and making payments for hospital inpatient services provided to Medicare

patients. Each system is being assessed on its ability to differentiate among severity of

illness. A final report is due on or before September 1, 2007.

RAND's draft interim report focused on the following criteria:

- Severity-adjusted DRG classification systems.

  ○ How well does each classification system explain variation in resource

use?

  ○ How would the classification system affect a hospital's patient mix?

  ○ Are the groupings manageable, administratively feasible and

understandable?

- Payment accuracy - What are the payment implications of selected models?

In response to our request, several vendors of DRG systems submitted their

products for evaluation. The following products were evaluated by RAND:

3M/Health Information Systems (HIS)

- CMS DRGs modified for AP-DRG Logic (CMS+AP-DRGs)

- Consolidated Severity-Adjusted DRGs (CS DRGs)

Health Systems Consultants (HSC)

- Refined DRGs (HSC-DRGs)

HSS/Ingenix

- All-Payer Severity DRGs with Medicare modifications (MM-APS-DRGs)

Solucient

- Solucient Refined DRGs (Sol-DRGs)

Vendors submitted their commercial (off-the-shelf) software to RAND in late September 2006. The five systems were compared to the CMS DRGs that were in effect as of October 1, 2006 (FY 2007). RAND assigned FY 2004 and FY 2005 Medicare discharges from acute care hospitals to the FY 2007 CMS DRGs and to each of the alternative severity-adjusted DRG systems. RAND's initial analysis provided an overview of each alternative DRG classification system, their comparative performance in explaining variation in resource use, differences in DRG grouping logic, and case-mix change.

A Technical Expert Panel comprised of individuals representing academic institutions, hospital associations, and MedPAC was formed in October 2006. The members received the preliminary draft report of RAND's alternative severity-adjusted DRG systems evaluation in early January 2007. The panel met with RAND and CMS on January 18, 2007, to discuss the preliminary draft report and to provide additional comments. RAND incorporated items raised by the panel into its preliminary draft report and submitted a revised interim report to CMS in mid-March 2007. CMS posted RAND's interim report on the CMS Web site in late March 2007. Interested individuals can view RAND's interim report on the CMS Web site at:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The report may also be viewed on RAND's Web site at

http://www.rand.org/pubs/online/health.

At this time, RAND has completed its evaluation of the alternative severity-adjusted DRG systems. RAND's interim report reflects its evaluation of five

alternative DRG systems using the criteria described above. Since the proposed rule,

RAND evaluated the Medicare Severity DRG (MS-DRG) system using the same criteria

applied to the other DRG systems. We are continuing to work with RAND to evaluate

alternate methodologies for establishing relative weights using the MS-DRGs. Once

RAND completes its work on the alternate methodologies for establishing relative

weights, we will be in a better position to evaluate the issue of charge compression and

potential improvements to our methodology to determine cost-based relative weights.

We plan to review RAND's analysis of these issues and determine if it will be

appropriate to propose additional adjustments to the MS-DRGs or the relative weight

methodology in the FY 2009 IPPS proposed rule.

We instructed RAND to evaluate the MS-DRGs using the same criteria that it

applied to the other DRG systems. Consistent with conclusions we made in the IPPS

proposed rule, RAND's findings demonstrate that MS-DRGs explain 43 percent of the

cost variation; a 9.1 percent improvement over the CMS DRGs. RAND reports that the

explanatory power of the MS-DRGs is higher than the CMS+AP-DRGs, but lower than

the other systems analyzed. The MS-DRGs have the lowest adjusted R^2 values among

the severity-adjusted systems in seven MDCs. In three of these MDCs, the R^2 values are

actually lower than under the CMS DRGs: MDC 19 (Mental Diseases and Disorders),

MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders) and

MDC 22 (Burns). RAND attributes the reduction in R^2 values to how the CMS DRGs

were collapsed to form the base DRGs and recommends future examination. We agree

that RAND's findings provide us with potential issues to examine to further improve the

MS-DRGs for FY 2009.

Although RAND's findings related to R^2 in certain MDCs are of concern, we

believe the MS-DRGs remain an improvement over the current CMS DRGs and have

significant advantages over the other DRG systems being evaluated. Specifically, they

are more up-to-date because of our review of secondary diagnoses and classification into

MCCs and CCs. Further, they are understandable, available in the public domain, and

will have fewer transition issues than the other systems. As MS-DRGs are a modification

of the current CMS DRGs, they allow for updates and maintenance to continue using the

same process as under the current CMS DRGs.

Depending on the criteria being evaluated, the relative merits of each system

being evaluated by RAND are different. For instance, the CS DRGs performed well in

explaining resource variation but have the highest potential for case-mix growth. Other

than the MS-DRGs, the CMS+AP-DRGs did the poorest among the systems evaluated in

explaining variation in resource usage but did the best on producing reliable and stable

results. The remaining systems generally performed somewhere in between on most of

the measures that RAND used in its comparative analysis. The MS-DRGs are the result

of modifications to the CMS DRGs to better account for severity. Unlike the other

systems, the MS-DRGs are available in the public domain, and as a result, systems

implementation and other costs are likely to be at a minimum. As suggested above,

RAND found that the MS-DRGs are an improvement over the CMS DRGs and compare

favorably to the alternative DRG systems being evaluated on some criteria and not as well on others.

As RAND has completed its evaluation of the alternative DRG systems, including the MS-DRGs, consistent with RAND's findings, we believe it is appropriate at this time to adopt the MS-DRG system for the Medicare IPPS in FY 2008. While there will be an opportunity for the public to comment on RAND's findings, we expect to permanently adopt the MS-DRGs for the IPPS. We do not think it is likely that there will be persuasive public comments suggesting that one of the alternative DRG systems being evaluated by RAND is clearly superior. In our view, none of the systems appears to be clearly superior or inferior to the other systems based on the criteria RAND used for the evaluation. Given the strong support in the public comments for the MS-DRGs and the fact they compare well overall to the alternative DRG systems being evaluated by RAND, we believe it is likely that the MS-DRGs will be the system that Medicare uses permanently for the IPPS. However, because we are interested in public input on this issue, we are making RAND's final report available on the CMS Web Site at: http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The report may also be viewed on RAND's Web site at http://www.rand.org/pubs/online/health.

Interested members of the public can write to the following address to make their views known to us about the RAND Report:

Division of Acute Care

Center for Medicaid Management

7500 Security Boulevard, C4-08-06

Baltimore, MD 21244

Attn: Mady Hue

 In the FY 2008 IPPS proposed rule, we proposed to adopt the MS-DRGs for

FY 2008. We are providing the following update on RAND's progress in evaluating the

MS-DRGs against the alternative DRG systems. In the proposed rule, we also invited

public comment regarding RAND's preliminary analysis of each vendor-supplied

alternative severity-adjusted DRG system described below. A summary of any public

comments that we received and our responses to those comments are presented under

each subject area.

a. Overview of Alternative DRG Classification Systems

Analysis of how each of the six severity-adjusted DRG systems performs began

by using the current CMS DRGs as a baseline. Two of the six systems (CS DRGs and

MM-APS-DRGs) are derivatives of all-patient severity-adjusted DRG systems that have

been modified by their developers for the Medicare population and two of the systems

(HSC-DRGs and Sol-DRGs) are all-patient systems that incorporate severity levels into

the CMS DRGs. The CMS+AP-DRGs are a combination of CMS DRGs and a

modification for the Medicare population of the major CC (MCC) severity groupings

used in the AP-DRG system. (The AP-DRG system was developed by 3M/HIS

specifically for the State of New York to capture the non-Medicare population.) The

MS-DRG system modifies the current CMS DRGs by collapsing any paired DRGs

(DRGs distinguished by the presence or absence of CCs and/or age) into base DRGs and then splits the base DRGs into MCC/CC-severity levels.

Table A below shows how each of the six alternative severity-adjusted systems classifies patients into base DRGs and their corresponding severity levels.

Table A.--Logic of CMS and Alternative DRG Systems

	CMS-DRG	CMS+AP-DRG	HSC-DRG	Sol-DRG	MM-APS-DRG	CS DRG	MS-DRG
Number of MDCs	25	25	25	25	25	25	25
Number of base DRGs	379	379	391	393	328	270	335
Total number of DRGs	538	602	1,293	1,261	915	863	745
Number of DRGs < 500 discharges	97 (18%)	97 (16%)	374 (29%)	474 (38%)	115 (13%)	113 (13%)	38 (5.2%)
Number of CC (severity) subclasses	2	3	3 (med) or 4 (surg)	3 (med) or 4 (surg)	3	4	3
CC subclasses	With CC, without CC for selected base DRGs	Without CC, With CC for selected base DRGs and Major CC across DRGs within MDC	No CC, Class C CC, Class B CC, Class A CC (Surgical only)	Minor/no substan-tial CCs, Moderate CCs, Major CCs, Catastro-phic CCs (Surgical only)	Without CC, With CC, With Major CC with some collapsing at base DRG level	Minor, Moderate, Major, Severe with some collapsing at DRG level	Without CC, With CC, With Major CC with collapsing between severity levels for same base DRG
Multiple CCs recognized	No	No	No	No	Yes (in computa-tion of weight)	Yes	No
CC assign-ment logic	Presence / absence	Presence / absence	Presence / absence	Presence / absence	Presence / absence	18-step process	Presence / absence

	CMS-DRG	CMS+AP-DRG	HSC-DRG	Sol-DRG	MM-APS-DRG	CS DRG	MS-DRG
MDC assignment	Principal diagnosis	Principal diagnosis	Principal diagnosis	Principal diagnosis	Principal diagnosis	Principal diagnosis with rerouting	Principal diagnosis
Death used in DRG assignment	Yes (in selected DRGs)	Yes (in selected DRGs)	Yes ("early death" DRGs)	Yes ("early death" DRGs)	Yes (in selected DRGs)	No	Yes (in selected DRGs and CC assign-ments)

RAND's evaluation of the logic for each system demonstrated the following:

● Four systems add severity levels to the base CMS DRGs; the CS DRGs add severity levels to the base APR DRGs, which are comparable but not identical to the base CMS DRGs. Both the CS DRGs and MM-APS-DRGs collapse some base DRGs with low Medicare volume. The MS-DRGs collapse the current CMS DRG splits and either leave the base DRG undivided or divide it into two or three severity levels.

● The HSC-DRGs and the Sol-DRGs use uniform severity levels for each base DRG (three for medical and four for surgical). The general structure of the MS-DRG logic establishes three severity levels for each base DRG: with MCC, with CC, and without CC. However, CMS consolidated severity levels for the same base DRG if they do not meet specific statistical criteria. The general structure of the MM-APS-DRG logic includes three severity levels for each base DRG, but some severity levels for the same base DRG are consolidated to address Medicare low-volume DRGs and nonmonotonicity issues. Monotonicity is when the average costs for a severity group consistently rise as the severity level of the group increases. For example, in a monotonic system, if within a base DRG there are three severity groups and level 1 severity is less than level 2 severity and level 2 severity is less than level 3 severity, the average costs for a level 3 case would

be greater than the average costs for a level 2 case, which would be greater than the

average costs for a level 1 case. When a DRG is nonmonotonic, the mean cost in the

higher severity level is less than the ,mean cost in the lower severity level. The general

structure of the CS DRGs includes four severity levels for each base DRG. However,

severity level consolidations occur to address Medicare low-volume DRGs and

nonmonotonicity. The CS DRGs consolidate both adjacent severity levels for the same

base DRG and the same severity level across multiple base DRGs (especially for severity

level 4).

● Under the CMS+AP-DRGs and MM-APS-DRGs, each diagnosis is assigned a

uniform CC-severity level across all base DRGs (other than CCs on the exclusion list for

specific principal diagnoses). The remaining systems assign diagnoses to CC-severity

level classifications by groups of DRGs.

● Under the grouping logic used by all systems other than the CS DRGs, each

discharge is assigned to the highest severity level of any secondary diagnosis. The

MS-DRGs assign discharges with no CC but certain high cost devices to a higher severity

level. The CS DRGs adjust the initial severity level assignment based on other factors,

including the presence of additional CCs. None of the other systems adjusts the severity

level classification for additional factors or CCs. However, the MM-APS-DRG system

handles additional CCs through an enhanced relative weight.

● The HSC-DRGs and the Sol-DRGs have a medical "early death" DRG within

each MDC. The CS DRGs do not use death in the grouping logic. In addition, most

complications of care do not affect the DRG assignment. The MS-DRGs use death in

making an assignment in selected DRGs and do not count certain conditions as MCCs

and CCs (such as cardiac arrest) in patients who die during the inpatient stay.

b. Comparative Performance in Explaining Variation in Resource Use

In evaluating the comparative performance of each alternative DRG system,

RAND used MedPAR data from FY 2004 and FY 2005. RAND excluded data from

CAHs, Indian Health Service hospitals, and hospitals that have all-inclusive rate charging

practices. Consistent with CMS practice, RAND did not exclude data from Maryland

hospitals, which operate under an IPPS waiver. Records that failed edits for data

consistency or that had missing variables that were needed to determine standardized

costs were also excluded.

RAND reported that evaluation of each alternative severity-adjusted DRG system

is a complex process due to differences in how each of the severity levels are applied, the

number of severity-adjusted DRGs in each system, and the average number of discharges

assigned to each DRG. In addition, the manner in which the DRGs for patients 0 to 17

years of age are assigned in the severity-adjusted systems affects the number of

low-volume DRGs using Medicare discharges. Low-volume, severity-adjusted DRGs

can affect the relative performance of a classification system. However, the percentage

of Medicare discharges assigned to these DRGs is small--approximately 0.7 percent in

the HSC-DRG and Sol-DRG systems compared to 0.1 percent in the CMS DRGs.

To facilitate compatrisons across the severity-adjusted DRG system, RAND

assigned a severity level to each MS-DRG consistent with the method used for the other

DRG systems. The severity level is based on the lowest severity level. If a base

MS-DRG divided into two DRGs, one for both discharges with no CC and discharges

with CCs and the other for discharges with MCCs, RAND assigned Level 0 to the DRG

for discharges with no MCC and Level 2 to the DRG for discharges with MCCs. RAND

also assigned Severity Level 0 to base DRGs that do not split by CC level. Table B

summarizes the distribution of DRGs and discharges across severity levels by

classification system, exclusive of MDC 15, ungroupable discharges, and statistical

outliers. In comparison to the other severity-adjusted systems, the MS-DRGs have a

much higher percentage of discharges assigned to the lowest severity level. This includes

base DRGs that are not divided into severity subgroups, the no CC severity level, and the

no MCC severity level in those base DRGs that are split based on the presence of a MCC

only. Sixty percent of discharges are assigned to Severity Level 0 DRGs compared to

only 20 percent in the CS DRG system. There are several reasons for the higher

percentage, including the reassessment of CC assignments, the collapsing of the no CC

and CC severity levels in 43 base MS-DRGs, and no severity subgroups in 53 base

MS-DRGs.

Table B: Distribution of DRGs and Discharges by Severity-Level Assignments

Distribution of DRGs and Discharges by Severity of Illness Levels					
CMS DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	358	128			25	511
N Discharges	6,782,845	5,074,736			278,401	12,135,982
% Discharges	56%	42%			2%	100%
CMS+AP DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	358	128	64		25	575
N Discharges	5,842,981	3,933,710	2,262,260		97,030	12,135,981
% Discharges	48%	32%	19%		1%	100%
HSC-DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	373	349	348	175		1245
N Discharges	2,788,346	5,501,541	3,145,959	700,136		12,135,982
% Discharges	23%	45%	26%	6%		100%
Sol-DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	368	336	331	169		1204
N Discharges	2,923,930	6,609,026	2,113,606	489,520		12,136,082
% Discharges	24%	54%	17%	4%		100%
MM-APS-DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	325	316	265			906
N Discharges	3,892,398	6,283,024	1,960,560			12,135,982
% Discharges	32%	52%	16%			100%
CS-DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	261	262	263	59		845
N Discharges	2,475,008	5,588,117	3,308,104	764,821		12,136,050
% Discharges	20%	46%	27%	6%		100%
MS-DRGs					
	SOI Level 0	SOI Level 1	SOI Level 2	SOI Level 3	Age 0-17 DRGs	Total
N DRGs	325	196	215			736
N Discharges	14,617,298	5,695,676	3,958,990			24,271,964
% Discharges	60%	23%	16%			100%

Severity-adjusted DRGs are designed to reduce the amount of cost variation within DRGs. To compare how much within-DRG variation occurs in each DRG system, RAND computed the mean standardized cost, standard deviation, and coefficient of variation (CV) for each DRG across the various systems. Each severity-adjusted system has a smaller proportion of DRGs with a CV > 100 percent than the CMS DRGs. Seventeen percent of the 511 CMS DRGs to which Medicare patients were assigned in

2005 had a CV > 100 percent. In contrast, 8 percent of the 736 MS-DRGs have a

CV > 100 percent. This is a slightly lower percentage than in the CMS+AP DRGs but

slightly higher percentage than the other four severity-adjusted DRG systems. Only 1.7

percent of discharges are assigned to MS-DRGs with a CV > 100 percent, which is

comparable to the percentage of discharges assigned to DRGs with a CV > 100 percent in

the CS DRGs and the CMS+AP DRGs. The MM-APS DRGs and CMS+AP DRGs have

slightly lower and higher percentages, respectively, of discharges assigned to DRGs with

a CV > 100 percent.

RAND utilized a general linear regression model to evaluate how well each

severity-adjusted DRG system explains variation in costs per case. The initial results

demonstrate that all six severity-adjusted DRG systems predict cost better than the

CMS DRGs. The CS DRGs have higher adjusted R^2 values (explanatory power) than the

other severity-adjusted systems in nearly every MDC. In general, the adjusted R^2 value

for the CS DRGs is 0.4458, a 13-percent improvement over the adjusted R^2 value for the

CMS DRGs. The HSC-DRGs demonstrate an 11-percent improvement, while the

adjusted R^2 values for the MM-APS-DRGs and Sol-DRGs are 10.0 percent and 9.7

percent higher, respectively, than the CMS DRG R^2 value. The adjusted R^2 value for the

MS-DRGs is 0.4300, a 9.1 percent improvement over the CMS DRGs. The

CMS+AP-DRGs show the smallest improvement, nearly 8 percent.

Another aspect of RAND's evaluation was to identify the validity of each

alternative DRG system as a measurement for resource costs. For a base DRG, the

severity levels should be monotonic; that is, the mean cost per discharge should increase

simultaneously with an increase in the severity level. A distinction between patient

groups and varying treatment costs should be accomplished by the severity levels. When

a DRG is nonmonotonic, the mean cost in the higher severity level is less than the mean

cost in the lower severity level. RAND studied the percentage differences and absolute

differences in cost between the severity levels within the base DRGs for each system

under evaluation. For the analysis, RAND assigned the severity levels for discharges

assigned to the CMS+AP-DRGs and CS DRGs that include several base DRGs to the

base DRG to which they would have been assigned at a lower severity level.

Table C shows the percentage difference between the mean standardized cost for

discharges with severity levels 1 through 3 as applicable to the adjacent lower severity

level within the base DRG (for example, Base DRG 1 Severity Level 1 compared with

Base DRG 1 Severity Level 0). The first column of the table shows the number of DRGs

with severity level 0 and the proportion of discharges assigned to those DRGs. The

"Other DRGs" column, which is not applicable to the MS-DRGs, includes DRGs for age

0 to 17 years and any DRGs for which there was no base DRG with severity level 0 that

could be used in the comparison, for example, no Medicare discharges were assigned to

the base DRG severity level 0. For severity level 1 and higher, RAND computed the

ratio of the mean cost for that level to the mean cost for the adjacent lower level (for

example, mean cost$_{\text{DRG Level 2}}$/mean cost$_{\text{DRG Level 1}}$) and reported the results by the

magnitude of the ratio. RAND used the number of discharges assigned to the higher

severity level to calculate the percentage of discharges assigned to each ratio category.

For the two systems (CMS+AP-DRGs and CS DRGs) that include several base

DRGs, RAND assigned those discharges to the lower severity level base DRG.

Following that methodology, RAND was able to calculate how much more costly the

discharges assigned to the consolidated or lower severity levels were than the discharges

in the base DRG assigned to the next higher severity level. Results demonstrate that,

overall, nonmonotonicity is not a factor across the alternative DRG systems. There are

only a small percentage of discharges that are assigned to nonmonotonic DRGs. Unlike

the other systems, all severity level 1 or level 2 MS-DRGs were monotonic.

Using the data from severity of illness levels 1 through 3 (except for the

MM-APS-DRGs, which do not have a severity of illness level 3), RAND calculated the

discharge-weighted mean cost difference between severity levels and the mean ratio of

the cost per discharge for the higher severity level to the adjacent lower severity level.

The greatest cost discrimination was present in the higher severity levels versus the lower

severity levels across all the systems. Unlike the other systems, each MS-DRG was at

least 20 percent more costly than the adjacent lower severity DRG. The remaining

systems demonstrated equivalent percentage cost differences between the severity levels

as shown in Table C below.

Table C.--Ratio of the Mean Standardized Cost of a Higher Severity Level to That of the Adjacent Lower Severity Level Within the Same Base DRG

DRGs with Severity Level 1-3 (as applicable)								
CMS DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	358	0	0	1	7	118	27	511
% DRGs	70%	0%	0%	0%	1%	23%	5%	100%
% Discharge	56%	0%	0%	1%	2%	39%	2%	100%
Mean $ Difference		NA	NA	$453	$2,222	$3,428	NA	
CMS+AP DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	358	4	0	12	30	366	29	799
% DRGs	45%	1%	0%	2%	4%	46%	3%	100%
% Discharge	48%	1%	0%	2%	8%	39%	1%	100%
Mean $ Difference		-$6,056		$1,480	$2,150	$4,457	NA	
HSC-DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	373	33	53	101	144	536	5	1245
% DRGs	30%	3%	4%	8%	12%	43%	0%	100%
% Discharge	23%	1%	4%	8%	13%	52%	0%	100%
Mean $ Difference		-$1,454	$686	$1,251	$1,796	$4,064	NA	
Sol-DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	368	25	47	77	114	564	9	1204
% DRGs	31%	2%	4%	6%	9%	47%	1%	100%
% Discharge	24%	0%	3%	5%	5%	58%	#REF!	100%
Mean $ Difference		-$1,245	$536	$1,200	$1,982	$4,762		
MM-APS-DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	325	2	6	30	70	473	0	906
% DRGs	36%	0%	1%	3%	8%	52%	0%	100%
% Discharge	32%	0%	2%	4%	11%	51%	0%	100%
Mean $ Difference		-$1,238	$525	$1,540	$2,906	$8,259		
Con-APR-DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	261	3	7	39	81	642	11	1044
% DRGs	25%	0%	1%	4%	8%	61%	1%	100%
% Discharge	20%	0%	1%	8%	16%	54%	1%	100%
Mean $ Difference		-$6,781	$508	$1,780	$1,803	$6,408		
MS-DRGs								
	Level 0 DRGs	<1.0	1.0 to 1.1	1.1 to 1.2	1.2 to 1.3	> 1.3	Other DRGs	Total
N DRGs	325	0	0	1	22	388		736
% DRGs	44%	0%	0%	0%	3%	53%	0%	100%
% Discharge	60%	0%	0%	0%	4%	36%	0%	100%
Mean $ Difference				$3,894	$2,584	$4,620		

In examining whether each of the alternative DRG systems provided stability in the relative weights from year to year, RAND compared the relative weights derived from the MedPAR data in FY 2004 to the relative weights data from FY 2005. RAND's results demonstrate that generally, across all the systems, only a small percentage of DRGs had greater than a 5-percent change in relative weights. RAND did not repeat this

analysis for the MS-DRGs. However, RAND had no reason to expect that the results

would be substantially different for this system. For further details and discussion, we

encourage readers to view RAND's full interim report on the CMS Web site at:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The

report may also be viewed on RAND's Web site at

http://www.rand.org/pubs/online/health.

c. Payment Accuracy and Case-Mix Impact

        Similar to how CMS established the relative weights in the FY 2007 IPPS final

rule, RAND used standardized costs as determined by the national CCR and the FY 2005

MedPAR data to construct relative weights for each of the DRG systems being evaluated.

RAND analyzed the effect of variations in the explanatory power on the distribution of

Medicare payments for each system under evaluation. The preliminary findings indicate

payment accuracy is improved by each severity-adjusted system by redistributing

payment from lower-cost discharges to higher-cost discharges. However, the total

payment redistribution across systems differs and reflects the payment impact of

improved explanatory power. Although these findings are estimates, the percent of total

payment redistributed was the least under the CMS+AP-DRGs (7.1 percent) and the most

under the CS DRGs (11.9 percent). The total payment redistribution under the

MS-DRGs is 8.4 percent of the total payment. The redistribution is less than the

CS DRG system, the same as the HSC-DRG system, and more than in the other systems,

even though some of these systems have higher explanatory power.

Table D shows changes in case-mix index (CMI) by hospital category across alternative severity-adjusted DRG systems. Results demonstrate that, under the severity-adjusted systems, urban hospitals have a higher average CMI than under the CMS DRGs, and rural hospitals have a lower CMI. The analysis suggests that any system adopted to better recognize severity of illness with a budget neutrality constraint will result in payment redistribution that can be expected to benefit urban hospitals at the expense of rural hospitals. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals and the CMS DRGs are not currently recognizing the full extent of these differences. For purposes of the study, RAND assumed no behavioral changes in coding practice or the types of patients treated.

On average, the CMI for urban hospitals increases under the severity-adjusted systems, and that for rural hospitals decreases. The change is greatest in the CS DRGs, where the CMI for rural hospitals is 2.4 percent lower than that under the CMS DRGs. The CMI for large urban hospitals (those located in metropolitan areas with more than 1 million population) and other urban hospitals is 0.6 and 0.1 percent higher, respectively, under the CS DRGs. Under the MS-DRGs, there is a slightly larger increase in the average CMI for large urban hospitals, a reduction in the CMI for other urban hospitals, and a smaller reduction for rural hospitals.

The CMI for larger hospitals increases, while that for smaller hospitals decreases across the systems. This result is consistent with a severity-adjusted DRG system shifting payment from less expensive cases to more expensive cases. Larger hospitals tend to have relatively more complex cases and severely ill patients than smaller hospitals

do. Teaching hospitals also tend to treat more complex cases, but the impact on these

facilities differs by severity-adjusted DRG system. Across all the severity-adjusted

systems, nonteaching hospitals have a lower CMI, ranging from a 0.2 percent reduction

under the HSC-DRGs and Sol-DRGs to a 0.5 percent reduction under the CS DRGs. In

three of the systems (CMS+AP-DRG, HSC-DRG, and MM-APS-DRG), hospitals with

large teaching programs (100 or more residents) would experience a larger increase than

hospitals with smaller teaching programs. Under the Sol-DRG system, hospitals with

large teaching programs would have a 0.1 percent increase, compared with a 0.2 percent

increase for hospitals with smaller teaching programs. Under the CS DRG system, the

CMI for hospitals with large teaching programs would be about the same, but that for

hospitals with smaller teaching programs would increase 0.7 percent relative to the

CMS DRGs.

Table D.--CMI Change in Alternative DRG Systems Relative to the CMS DRG CMI

	Number of Hospitals	Number of Discharges	CMS-DRG CMI	Percentage Change from CMS-DRG CMI					
				CMS+ AP-DRG	HSC-DRG	Sol-DRG	MM-APS-DRG	CS DRG	MS-DRG
ALL	3,890	12,165,763	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
By Geographic Location:									
Large urban areas (pop>1 million)	1,485	5,715,356	1.02	0.5%	0.4%	0.3%	0.6%	0.6%	0.7%
Other urban areas (pop<1 million)	1,186	4,578,447	1.04	-0.2%	-0.2%	-0.1%	-0.2%	0.1%	-0.3%
Rural hospitals	1,219	1,871,960	0.84	-1.3%	-0.9%	-1.0%	-1.4%	-2.4%	-1.7%
Bed Size (Urban):									
0-99 beds	685	611,139	0.91	-1.0%	-1.1%	-1.1%	-1.3%	-1.6%	-1.2%
100-199 beds	875	2,346,922	0.93	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%
200-299 beds	511	2,446,737	1.00	0.1%	0.2%	0.3%	0.3%	0.6%	0.3%
300-499 beds	433	2,965,216	1.08	0.3%	0.3%	0.3%	0.4%	0.8%	0.4%
500 or more beds	167	1,923,789	1.17	0.6%	0.3%	0.2%	0.4%	0.4%	0.5%
Bed Size (Rural):									

	Number of Hospitals	Number of Discharges	CMS-DRG CMI	Percentage Change from CMS-DRG CMI					
				CMS+ AP-DRG	HSC-DRG	Sol-DRG	MM-APS-DRG	CS DRG	MS-DRG
0-49 beds	543	330,242	0.73	-2.5%	-2.1%	-2.2%	-2.7%	-5.0%	-3.0%
50-99 beds	398	595,599	0.80	-1.4%	-1.0%	-1.1%	-1.6%	-2.7%	-2.0%
100-149 beds	160	415,367	0.85	-1.1%	-0.7%	-0.8%	-1.2%	-2.0%	-1.5%
150-199 beds	69	260,910	0.91	-0.8%	-0.6%	-0.7%	-0.8%	-1.5%	-1.0%
200 or more beds	49	269,842	0.99	-0.6%	-0.1%	-0.1%	-0.6%	-0.5%	-0.9%
Urban by Region:									
New England	129	541,471	0.99	0.1%	-0.2%	-0.5%	-0.5%	-0.6%	-0.5%
Middle Atlantic	370	1,621,488	1.00	0.0%	-0.4%	-0.5%	-0.3%	-1.5%	-0.1%
South Atlantic	432	2,208,336	1.04	0.5%	0.7%	0.7%	0.7%	1.4%	0.7%
East North Central	410	1,856,164	1.03	0.6%	0.7%	0.6%	0.8%	1.5%	0.6%
East South Central	168	696,943	1.06	-0.2%	-0.2%	-0.2%	-0.2%	-0.3%	-0.4%
West North Central	164	657,322	1.08	-0.3%	-0.3%	0.0%	-0.3%	0.3%	-0.3%
West South Central	369	1,115,411	1.05	0.1%	0.0%	0.1%	0.3%	0.5%	0.3%
Mountain	153	465,093	1.08	0.4%	0.2%	0.5%	0.4%	1.0%	0.7%
Pacific	423	1,016,135	1.03	0.0%	-0.2%	-0.1%	-0.1%	0.2%	0.3%
Puerto Rico	53	115,440	0.87	-1.1%	-1.4%	-0.1%	-1.2%	-5.1%	-1.3%
Rural by Region:									
New England	34	49,842	0.90	-0.6%	-0.6%	-0.5%	-1.1%	-0.6%	-1.1%
Middle Atlantic	68	139,639	0.85	-1.1%	-0.7%	-0.7%	-1.3%	-1.5%	-1.4%
South Atlantic	191	409,116	0.82	-0.8%	-0.4%	-0.5%	-0.9%	-1.8%	-1.2%
East North Central	163	290,069	0.87	-1.1%	-0.7%	-0.9%	-1.3%	-1.8%	-1.6%
East South Central	201	328,326	0.82	-1.5%	-0.9%	-1.1%	-1.4%	-3.2%	-1.9%
West North Central	184	240,449	0.87	-1.6%	-1.2%	-1.1%	-1.8%	-2.5%	-2.0%
West South Central	227	266,419	0.80	-2.1%	-1.8%	-1.9%	-2.0%	-4.3%	-2.5%
Mountain	91	80,219	0.85	-1.2%	-1.0%	-0.4%	-1.3%	-1.2%	-1.1%
Pacific	60	67,881	0.86	-0.9%	-1.0%	-1.1%	-1.4%	-1.6%	-1.6%
By Payment Classification:									
Teaching Status:									
Non-teaching	2,791	6,115,193	0.92	-0.4%	-0.2%	-0.2%	-0.4%	-0.5%	-0.4%
Fewer than 100 Residents	853	4,061,451	1.04	0.1%	0.2%	0.2%	0.2%	0.7%	0.2%
100 or more Residents	246	1,989,119	1.16	0.8%	0.3%	0.1%	0.5%	0.0%	0.6%

	Number of Hospitals	Number of Discharges	CMS-DRG CMI	Percentage Change from CMS-DRG CMI					
				CMS+ AP-DRG	HSC-DRG	Sol-DRG	MM-APS-DRG	CS DRG	MS-DRG
Urban DSH:									
Non-DSH	778	2,574,640	1.02	-0.1%	0.0%	0.1%	-0.2%	0.5%	0.0%
100 or more beds	1,541	7,378,095	1.05	0.3%	0.2%	0.2%	0.4%	0.4%	0.4%
Less than 100 beds	352	341,068	0.82	-0.9%	-0.8%	-1.0%	-1.1%	-2.0%	-1.1%
Rural DSH:									
Non-DSH	238	300,747	0.87	-1.4%	-1.0%	-0.9%	-1.7%	-1.9%	-1.7%
SCH	402	599,823	0.83	-1.3%	-1.0%	-1.0%	-1.4%	-2.4%	-1.8%
RRC	132	466,395	0.92	-0.8%	-0.3%	-0.5%	-0.7%	-1.4%	-1.1%
Other Rural:									
100 or more beds	60	135,146	0.80	-0.9%	-0.8%	-1.2%	-1.3%	-2.0%	-1.5%
Less than 100 beds	387	369,849	0.74	-2.1%	-1.6%	-1.7%	-2.2%	-4.3%	-2.6%
Urban teaching and DSH:									
Both teaching and DSH	829	4,705,476	1.09	0.5%	0.3%	0.3%	0.5%	0.5%	0.5%
Teaching and no DSH	204	1,108,092	1.06	0.0%	0.1%	0.0%	-0.1%	0.4%	0.1%
No teaching and DSH	1,064	3,013,687	0.95	-0.1%	0.1%	0.0%	0.1%	0.1%	0.1%
No teaching and no DSH	574	1,466,548	1.00	-0.2%	-0.1%	0.1%	-0.3%	0.5%	0.0%
Rural Hospital Types:									
RRC	145	519,808	0.92	-0.8%	-0.4%	-0.5%	-0.7%	-1.4%	-1.1%
SCH	423	457,119	0.79	-1.6%	-1.2%	-1.2%	-1.7%	-3.0%	-2.1%
MDH	180	164,453	0.75	-2.1%	-1.7%	-1.7%	-2.3%	-4.1%	-2.7%
SCH and RRC	76	266,027	0.92	-0.9%	-0.7%	-0.7%	-1.1%	-1.3%	-1.3%
MDH and RRC	8	19,746	0.85	-1.4%	-0.6%	-0.8%	-1.6%	-1.9%	-1.7%
Other Rural:	387	444,807	0.77	-1.6%	-1.2%	-1.4%	-1.8%	-3.3%	-2.1%

RAND also noted that changes in documentation and coding that increase

case-mix will occur with each severity adjusted DRG system they evaluated. Increases in

CMI after adopting the system could be the result of improved coding rather than

increases in actual patient severity. RAND observed that the experience of Maryland

hospitals using the APR DRG system provides some indication of the likely impact on

case-mix of introducing a severity-adjusted system. RAND also noted that coding

behaviors are expected to vary under alternative systems according to RAND. Therefore,

the risk of case-mix growth due to improved documentation and coding exists with any

system. However, RAND advises that the amount of risk can be assessed based on the

logic of the DRG system and result in anticipated changes in coding behavior. For the

analysis we presented in the proposed rule, RAND found that the CMS+AP-DRG system

may have the lowest risk of case-mix increase, while the CS DRGs present the greatest

risk. The remaining systems under evaluation demonstrated equivalent risk, based on the

DRG logic and other features specific to each system.

RAND did not repeat the analysis of the potential for documentation and coding

improvements to increase case-mix using the MS-DRGs because it only worked with

FY 2005 data to evaluate them. Further, CMS did a detailed analysis of the likely impact

of documentation and coding improvements on case-mix using the MS-DRGs. Section

II.D.6. of the preamble of this rule describes in detail the CMI impact under the MS-

DRGs using the State of Maryland's experience and data.

d. Other Issues for Consideration

RAND was asked to examine whether each of the alternative severity-

adjusted DRG systems under evaluation appears to contain logic that is manageable,

administratively feasible, and understandable. RAND's results describe the extent to

which those features are present in the grouping logic of each system. A brief summary

of these findings and other discussion points follow. For more complete details of the

grouping logic for each system evaluated, we encourage readers to review RAND's

interim report at the following CMS Web site:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The

report may also be viewed on RAND's Web site at

http://www.rand.org/pubs/online/health.

        To increase and promote understanding of a DRG classification system, the

grouping logic should include a uniform structure. With the exception of the CS DRGs,

RAND found that there is uniformity in the hierarchical structure for assigning discharges

to MDCs, DRGs, and severity levels for each system evaluated. The CS DRGs utilize a

complex rerouting logic and severity of illness level assignment. However, the result is a

higher explanatory power that accounts for limitations in the current system. Therefore,

due to the complexities associated with that system, it may not easily be understood.

However, if the results yield clinically coherent groups of patients with comparable costs,

RAND concluded that the system may be worth exploring further. The HSC-DRG and

Sol-DRG grouping logic uses a standard number of severity levels for each base DRG,

although the result is an increase in the number of low-volume DRGs. The standard

severity level structure provides increased understanding, although as mentioned

previously, low-volume, severity-adjusted DRGs can affect the relative performance of a

classification system. The MM-APS-DRGs and CS DRGs use standard DRG severity

levels. However, the method of collapsing DRGs varies due to the modifications made

for Medicare use. The underlying logic of the MS-DRG system uses standard severity

levels, but the criteria for establishing severity subgroups result in severity levels that

vary by base DRG. Because the severity levels are often collapsed and the resulting

subgroups depend on the particular DRG, it is a more complicated system to understand

than those systems that uniformly define subgroups according to RAND. By only

collapsing DRGs to determine relative weights, RAND notes it is possible to preserve the

underlying DRG structure, which perhaps would lead to a more understandable system.

As stated earlier, there are also several transition issues that require attention

when evaluating alternative severity-adjusted DRG systems. In determining how

manageable, administratively feasible, and understandable the systems being evaluated

are, consideration should be given to how they crosswalk or map to the current

CMS DRGs. Because four of the systems under evaluation are based on the underlying

CMS DRG grouping logic to establish their base DRGs (CMS+AP-DRGs, HSC-DRGs,

Sol-DRGs, and MM-APS-DRGs), the CMS DRGs are able to crosswalk smoothly to

these severity-adjusted DRGs. Conversely, crosswalking in reverse or backward

mapping from the CMS+AP DRGs to the CMS DRGs is problematic due to the

discharges in one severity level of the CMS+AP-DRG system compared to several base

CMS DRGs. As expected, the CS DRGs do not crosswalk easily to the CMS DRGs due

to the complex grouping logic. The MM-APS-DRGs pose unique complications as well

due to the large number (over 1,000) of DRGs. Although the MS-DRGs are based on the

CMS DRGs, there are challenges in crosswalking discharges between the two systems

because of the revisions in the CC list and the sequential renumbering of the DRGs.

System updates are another important factor that may have serious implications.

All of the DRG systems RAND evaluated were reported to make annual updates to

reflect ICD-9-CM coding changes. However, the CC severity level assignments for each

system have not routinely been reviewed and revised. The CC exclusion list and severity

level assignments should be reviewed where appropriate to reflect current patterns of

care, according to RAND. RAND found that the MS-DRGs are the most updated of the

severity-adjusted DRG systems. CMS reviewed the CC list and severity-level

assignments in developing the MS-DRGs. Further, the MS-DRGs incorporate recent

refinements in the CMS DRGs to account for complexity as well as severity. According

to RAND, the other CMS-based systems use CC lists and severity-level assignments that

are based on outdated analyses of the effect of a condition on treatment costs from either

the 1988 Yale study or the 1994 CMS refinement study. The APR DRGs have not been

reviewed for several years and are not as current as the severity-based systems according

to RAND.

Accessibility to each of the severity-adjusted DRG system's logic and software is

also a concern. Each system RAND analyzed is currently maintained as a proprietary

product. In general, all of the vendors indicated a willingness to place their product in the

public domain, under certain terms. As such, CMS believes it is likely there would need

to be discussion as to whether there would be any limitations (such as the source code as

well as the DRG logic) on the availability of the DRG systems to hospitals or competing

vendors. None of these concerns would be an issue with the MS-DRGs. RAND further

noted that because the MS-DRGs are in the public domain, there should be less

disruption to existing arrangements for acquiring and installing the GROUPER software

and integrating that software with other hospital systems. The intent of each vendor to

provide public access to its GROUPER logic and software is described in further detail in

RAND's interim report.

Comment: One commenter supported the efforts of CMS to evaluate several

alternatives to the existing DRG system. The commenter expressed appreciation that

CMS had incorporated comments submitted by the provider community in setting the

criteria for evaluating the various DRG products. This commenter also stated it looked

forward to reviewing the final recommendations when the RAND report is released.

Response: We appreciate the commenter's support of our efforts. As we

indicated in the proposed rule, we have focused our efforts in response to public

comments regarding the refinement of the current DRG system. With the assistance of

RAND in the evaluation of alternative severity-adjusted DRG systems, our objective has

been to select a classification system that will better recognize severity of illness,

utilization of resources, and complexity of services. The ultimate goal of these combined

objectives is to greatly improve the payment accuracy of the IPPS.

Comment: Several commenters supported the implementation of a severity-based

system. However, they urged CMS to wait until RAND completes the final report before

moving forward with a specific system. One commenter articulated its appreciation of

the thorough analysis conducted on the other alternative severity-adjusted systems.

However, the commenter remains concerned that CMS would consider moving forward

with the MS-DRGs in the absence of completing an analysis of them using the same

criteria applied to the other systems under review. Other commenters expressed concern

that CMS may implement the proposed MS-DRGs for FY 2008 and then switch to a

completely different severity-based system in FY 2009, or phase in a different system in

subsequent years. One commenter stated that, given the potential for heightened

administrative burdens as well as financial consequences, it would seem prudent that

CMS invest the needed time and energy to confirm whether its belief in the proposed

MS-DRG system can be validated. This same commenter added that by stating it is not

precluded from adopting another system for FY 2009, CMS is tacitly acknowledging that

the MS-DRG system may not be the best system. Another commenter stated that CMS'

request for RAND to evaluate the proposed MS-DRGs indicates it is not satisfied that the

MS-DRGs are ready for long-term use in the IPPS.

Response: In the proposed rule, we indicated that we asked RAND to evaluate

the proposed MS-DRG system using the same criteria it is applying to the other

alternative severity-adjusted DRG systems. Our intent in not committing permanently to

the MS-DRGs was not to suggest that we were not satisfied with the long-term

application of the MS-DRG system or that we had concerns about it being the best

system. Rather, we were interested in an objective evaluation of the MS-DRGs by

RAND using the same criteria applied to the other alternative severity-adjusted systems.

That is, before making a permanent commitment to the MS-DRGs, we were interested in

knowing how well it demonstrates the ability to meet the objectives described

previously—better recognition of severity of illness, utilization of resources, complexity

of services and improved payment accuracy over the current CMS DRG system. While

we proposed the MS-DRGs for implementation in FY 2008, we were further interested in

the public's response to the MS-DRGs and RAND's evaluation of them before making a

final decision on a permanent DRG system to use for Medicare payment. Specifically,

public comments on the FY 2007 IPPS proposed rule asked that CMS show evidence that

the alternative system proposed results in an improved payment system compared to the

current system, test the degree to which the variation in costs within cases at the DRG

level is reduced, maintain the improvements made over the years to account for

complexity of service and new technologies, and avoid a proprietary system that lacks

transparency. We considered all these factors in the development of the MS-DRGs and

had we not provided the proposed MS-DRG system to RAND for evaluation, we would

not be able to make a fair comparison and final determination for the best course of

action for Medicare long term. At the time of the proposed rule, we were unsure whether

RAND would be able to complete its evaluation of the MS-DRGs by the time of this final

rule with comment period. However, as summarized above, RAND has completed its

analysis of the MS-DRG system and found that it compares favorably to the other DRG

systems being evaluated on a number of criteria.

As RAND has completed its evaluation of alternative DRG systems, including the

MS-DRGs, consistent with RAND's findings, we believe it is appropriate at this time to

adopt the MS-DRG system for Medicare in FY 2008. We believe the MS-DRGs

represent an improvement over the current CMS DRGs. While there will be an

opportunity for the public to comment on RAND's findings, we expect to permanently

adopt the MS-DRGs for the IPPS.   We do not believe it is likely that there will be

persuasive public comments suggesting that one of the alternative DRG systems being

evaluated by RAND is clearly superior. We plan on using RAND's report to continue to

examine ways to improve and refine the Medicare inpatient payment system and expect

that any future refinements will be based on the MS-DRGs. Therefore, as final policy for

FY 2008, we are adopting the MS-DRGs as the new classification system for the IPPS.

Comment: One commenter agreed that CMS should adopt a transparent and

publicly available DRG system and applauded the proposed MS-DRGs. The commenter

stated that the transparency of the current system has been a critical aspect of its success

over the years, and this will be even more important to ensure the successful adoption of

the new severity-adjusted system chosen.

Response: We appreciate the commenter's support for the proposal to use

MS-DRGs. We agree that transparency is an important factor in the selection of a new

severity-adjusted DRG system. We refer readers to sections II.D.2. and 3. of the

preamble of this final rule with comment period for a complete discussion of the MS-

DRGs.

Comment: One commenter stated CMS should consider adopting a more robust

severity-based DRG system than the proposed MS-DRGs. The commenter admitted that

it regards the APR DRG system highly and indicated it should not be abandoned because

it is more complicated to implement and because of the controversy surrounding its

suggested implementation. The commenter also noted that, as RAND stated in its

preliminary report, it is a more robust, accurate, and precise system, and it was reluctant

to see CMS abandon this superior system entirely before receiving RAND's final report

and recommendations. Further, the commenter stated that, while the MS-DRGs would

unquestionably represent a major improvement over the current CMS DRGs, it believed

CMS has the ability and should proceed with introducing a better and more robust system and continue exploring further options while waiting for RAND's final report.

Response: In the FY 2007 proposed rule (71 FR 24015), we proposed to adopt the CS DRGs which were based on a consolidated version of the APR DRGs. We received a significant number of public comments strongly urging us not to move forward with the CS DRGs. These comments are described in detail in the FY 2007 final rule (71 FR 47906 through 47912). Among other concerns, the public comments suggested that the system was overly complex and difficult to understand. Further, there was concern that the logic and source code would not be available in the public domain like the current CMS DRGs and that many of the improvements and refinements made to the CMS DRGs over the years would be abandoned. For these and other reasons, we decided not to adopt the CS DRGs for FY 2007. Our proposed adoption of MS-DRGs did not raise these same concerns in the public comments. Given that the MS-DRGs are a substantial improvement over the current CMS DRGs in their ability to recognize severity of illness and meet other objectives that we set for IPPS payment reform, we believe it is a better system to select for use by Medicare than the CS DRGs or APR DRGs.

Comment: One commenter, a vendor, submitted its DRG product to RAND for evaluation. The commenter expressed its concern that CMS developed a completely new and untested severity system while there are several alternate systems currently under evaluation by RAND. The commenter noted that its product has been in continuous use for 18 years and is based on the original Yale University methodology and developed

under contract with the Health Care Financing Administration, now CMS, between 1986 and 1989.

The commenter urged CMS to continue with the current CMS DRGs for one more year. According to the commenter, introducing a new temporary severity system, the MS-DRGs, with the expectation that hospitals move to another system for FY 2009, will create unnecessary havoc for the hospital industry. The commenter noted that it is pleased with the work CMS has done in reviewing 13,549 secondary diagnosis codes to refine the CC list and believed the use of this new list will result in a greatly improved DRG GROUPER. However, the commenter stated it is not fair to compare the FY 2008 MS-DRGs (with the new CC list and new codes) with FY 2006 and FY 2007 alternative severity systems using the unrevised CC list. The commenter recommended that CMS create Version 25.0 CMS DRGs with the new CC list and new codes to allow the vendors of the alternative systems until November or December to incorporate the information into updated versions of their systems. The commenter also suggested that the RAND report deadline could be extended beyond September 1, 2007, to allow the comparison of alternative DRG systems to occur with the revised CC list.

In addition, the commenter believed the MS-DRGs have the following shortcomings:

● Although CMS' chief concern is Medicare patients, it is shortsighted to ignore non-Medicare patients in the proposed MS-DRG system, as the health care industry often focuses its attention on the Medicare relative value system for all of its hospital patients.

● The DRG system has always been comprehensive, including all possible

ICD-9-CM diagnoses and procedures. Consolidating low-volume procedures and

procedures now performed primarily in an outpatient setting creates confusion in the

MS-DRG classification system. Procedures such as tonsillectomies, carpal tunnel

release, and cataract extractions are different MDCs and are treated by different medical

specialists. They are similar only with respect to historical cost data and only for the time

being.

● Eliminating newborns, maternity, and congenital anomalies from the usual

MS-DRG severity level approach does not provide a comprehensive severity system.

Lastly, the commenter indicated that whatever software system is chosen for the

public, it should be provided in a modern and accessible software language and format.

The commenter recommended a "C" version, on CDs or DVDs, and suggested that

continuing to place CMS software into the public domain written in IBM assembler and

distributed through the National Technical Information Service (NTIS) on 9-track tapes

or 3480 cartridges seems difficult to imagine, as this technology is over 40 years old.

Response: We disagree that we are implementing a "completely new and

untested severity system." While the MS-DRGs constitute a major reform to better

recognize severity of illness, they are a refinement of the current CMS DRGs that have

been in use for Medicare payment for over 20 years. Further, our proposed rule

analysis—subsequently validated by RAND—suggested that they are major improvement

over the current CMS DRGs. Most of the other systems represent less updated

refinements of the CMS DRGs. While these systems have been in use for other purposes,

we note that (other than the APR DRGs that are used for payment in Maryland and the

AP DRGs that were used in New York's all payer ratesetting system in the 1990s), the

other systems being evaluated have never been used for Medicare payment.

We stated in the FY 2008 IPPS proposed rule that we developed the MS-DRG

system in response to public comments received as a result of the FY 2007 proposed rule

(in response to the proposed CS DRGs). We also stated we submitted the MS-DRG

system to RAND for evaluation and the final report was expected on or before September

1, 2007. At this time RAND has completed the evaluation of alternative severity-

adjusted DRG systems, including the MS-DRGs. In the near future, we will post

RAND's analysis of the MS-DRG system to the following CMS Web site:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The

report may also be viewed on RAND's Web site at

http://www.rand.org/pubs/online/health. This report is referred to as an Addendum to

RAND's interim report that was released in March 2007. A completed final report

incorporating the evaluation of all six severity adjusted DRG systems into one document

will be posted to the CMS Web site after September 1, 2007.

As noted above, we share the commenter's concern about adopting one DRG

system this year and potentially another one next year. We believe the MS-DRGs should

be the system that is adopted for long-term use by Medicare for IPPS payment.

However, we are interested in obtaining further public input on RAND's findings. We do

not believe it is likely that there will be persuasive public comments suggesting that one

of the alternative DRG systems evaluated by RAND is clearly superior to the MS-DRGs.

We appreciate the commenter's support of our efforts in the review of 13,549

secondary diagnosis codes. We agree that a new, updated CC list greatly improves the

ability of a DRG GROUPER to reflect severity of illness and distribute payments more

accurately. The intent of RAND's evaluation was to compare each of the alternative

DRG systems in its current form. The fact that delays would be necessary to allow the

other systems to adopt the improvements that CMS made to the CC list for the MS-DRGs

suggests that the other systems would not be ready for implementation as soon. As noted

elsewhere, we are interested in adopting comprehensive improvements to the DRG

system for severity of illness at the earliest possible date. We do not believe it is in the

public interest to delay adopting these improvements to wait for the alternative DRG

systems to incorporate refinements to the CC list. Further, we note that CMS first

discussed performing a comprehensive review of the CC list over 2 years ago. Each

vendor could have undertaken a similar review of the CC list to improve its DRG product

at any time.

We disagree with the commenter's assertion that our decision should turn on how

the MS-DRGs can be used for non-Medicare payers. As we have stated many times in

the past, we encourage private insurers and other non-Medicare payers to make

refinements to Medicare's DRG system to better suit the needs of the patients they serve.

With respect to the maternity and newborn DRGs, we cannot adopt the same approach to

refine these DRGs that we did with the rest of the MS-DRGs because of the extremely

low volume of Medicare patients there are in these DRGs. Medicare simply does not

have enough cases in these DRGs to apply the same approach we did in the other MDCs.

Whether we made revisions to these DRGs or not, private insurers and other private

payers would have to develop their own DRGs or relative weights to address the needs of

these patients that are not well-represented in the Medicare population. With respect to

other pediatric patients, in our view, a significant advantage of the MS-DRGs over the

prior CMS DRGs is the fewer number of low- volume DRGs. By eliminating pediatric

(ages 0 to 17 years) splits, the MS-DRGs will have fewer low-volume DRGs and less

instability in the DRG relative weights for the cases paid using these DRGs.

        With regards to the software, undere CMS' agreement with its contractor, the

software provided by NTIS is the same public domain software that is provided to CMS

for use by our system maintainers, regional offices, and fiscal intermediaries.MAC. We

will consider this comment as we make updates to our information systems and related

contracts.

        As stated elsewhere in this final rule with comment period, we are adopting the

MS-DRGs for implementation on October 1, 2007 (FY 2008). A detailed discussion

summarizing the public comments received in response to the MS-DRG proposal is

described in section II.D.2. of the preamble of this final rule with comment period.

2. Development of the Medicare Severity DRGs (MS-DRGs)

        As discussed previously, we are committed to continuing our efforts of making

refinements to the current CMS DRGs to better recognize severity of illness. In the

FY 2007 IPPS final rule, we stated that we had begun a comprehensive review of over

13,000 diagnosis codes to determine which codes should be classified as CCs when

present as a secondary diagnosis. We stated that we would also build on the severity

DRG work we performed in the mid-1990's. We received a number of public comments

on last year's proposed rule that supported the refinement of the current CMS DRGs so

that they better recognize severity of illness for FY 2007.

We also committed to performing a more thorough reform of the entire DRG

system to better recognize severity of illness for FY 2008. As a result of this

broad- based analysis, we developed the MS-DRGs that we proposed and are adopting in

this final rule with comment period. The MS-DRGs represent a comprehensive approach

to applying a severity of illness stratification for Medicare patients throughout the DRGs.

As discussed in proposed rule and in section II.D.5. of the preamble of this final rule with

comment period, the MS-DRGs maintain the significant advancements in identifying

medical technology made to the DRGs in past years. At the same time, they greatly

improve our ability to identify groups of patients with varying levels of severity using

secondary diagnoses. Further, they improve our ability to assign patients to different

DRG severity levels based on resource use that is independent of the patient's secondary

diagnosis—referred to in this discussion as "complexity." We proposed to adopt the MS-

DRGs for FY 2008 and also submitted the system to RAND to be considered as part of

its evaluation of alternative DRG systems. In the proposed rule, we encouraged

comments on our proposed methodology to establish a severity DRG system and the

resulting DRGs.

a. Comprehensive Review of the CC List

Our efforts to better recognize severity of illness began with a comprehensive

review of the CC list. Currently, 115 DRGs are split based on the presence or absence of

a CC. For these DRGs, the presence of a CC assigns the discharge to a higher weighted

DRG. The list of diagnoses designated as a CC was initially created at Yale University in

1980-1981 as part of the project to develop an ICD-9-CM version of the DRGs. The

researchers at Yale University developed the ICD-9-CM DRGs using national hospital

data with diagnoses and procedures coded in ICD-9-CM from the second half of 1979.

Because hospitals only began reporting ICD-9-CM codes in 1979, discharge abstracts at

that time were much less likely to fully report all secondary diagnoses. As a result, the

Yale University researchers developed a liberal definition of a CC as any secondary

diagnosis that "would cause an increase in length of stay by at least 1 day in at least

75 percent of the patients." Because of the likely underreporting of secondary diagnoses

in the 1979 data, the Yale University researchers also used age as a surrogate for

identifying patients with a CC. The original version of the ICD-9-CM DRGs assigned

patients to a CC DRG if they had a secondary diagnosis on the CC list or if the patient

was 70 years or older.

     With the implementation of the IPPS in FY 1984, the coding of secondary

diagnoses by hospitals dramatically improved. During the first 4 years of the IPPS, the

CC definition included the age 70 criterion. With the improved coding and reporting of

diagnoses associated with the implementation of the IPPS, the use of age as a surrogate

for CCs was no longer necessary. Thus, beginning in FY 1988, the age 70 criterion was

removed from the CC definition and a CC DRG was defined exclusively by the presence

of a secondary diagnosis on the CC list.

Except for new diagnosis codes that were added to ICD-9-CM after FY 1984 (for example, HIV), the CC list of diagnoses currently used in the CMS DRGs is virtually identical to the CC list created at Yale University. However, there have been dramatic changes not only in the accuracy and completeness of the coding of secondary diagnoses but also in the characteristics of patients admitted to hospitals and the practice patterns within hospitals as well.

Since the implementation of the IPPS, Medicare average length of stay has dropped dramatically from 9.8 days in 1983 to 5.7 days in 2005. The economic incentives inherent in DRGs motivated a change in practice patterns to discharge patients earlier from the hospital. These changes were facilitated by the increased availability of postacute care services, such as nursing homes and home health services, which allowed problems previously requiring continued hospitalization to be effectively treated outside the acute care hospital. Furthermore, there has also been a dramatic shift to outpatient surgery that avoids costly inpatient stays. Many surgical procedures formerly performed in the hospital are now routinely performed on an outpatient basis. As a result, patients admitted to the hospital today are on average more likely to have a CC than when the IPPS was implemented. The net effect of better coding of secondary diagnoses, reductions in hospital length of stay, increased availability of postacute care services, and the shift to outpatient care is that most patients (nearly 80 percent) admitted to a hospital now have a CC. As a result of the changes that have occurred during the 22 years since the implementation of the IPPS, the CC list as currently defined has lost much of its capacity to discriminate hospital resource use.

Currently, 115 CMS DRGs have a CC subdivision. Up until FY 2002, the

number of DRGs with a CC subdivision remained essentially unchanged from the

original FY 1984 version of the DRGs. As a means of improving the payment accuracy

of the DRGs, beginning with the FY 2002 DRG update, each base CMS DRG without a

CC subdivision was evaluated to determine if a CC subdivision was warranted. Over the

past five DRG updates, only seven base CMS DRGs have had a CC subdivision added.

The primary constraint preventing a significant increase in the number of base

CMS DRGs with a CC subdivision is the low number of patients who would be assigned

to the non-CC group. Thus, the expansion of the number of CMS DRGs subdivided

based on a CC is constrained because the vast majority of patients would be assigned to

the CC group and few patients would be assigned to the non-CC group. To remedy these

problems, we reviewed each of the 13,549 secondary diagnosis codes to evaluate their

assignment as a CC or non-CC using statistical information from the Medicare claims

data and applying medical judgment based on current clinical practice. We refer to this

list in this section as the "revised CC list."

The need for a revised CC list prompted a reexamination of the secondary

diagnoses that qualify as a CC. Our intent was to better distinguish cases that are likely

to result in increased hospital resource use based on secondary diagnoses. Using a

combination of mathematical data and the judgment of our medical advisors, we included

the condition on the CC list if it could demonstrate that its presence would lead to

substantially increased hospital resource use.

Diagnoses may require increased hospital resource use because of a need for such services as:

- Intensive monitoring (for example, an intensive care unit (ICU) stay).

- Expensive and technically complex services (for example, heart transplant).

- Extensive care requiring a greater number of caregivers (for example, nursing care for a quadriplegic).

There are 3,326 diagnosis codes on the current CC list. Our 2006 review of the CC list reduced the number of diagnosis codes on the CC list to 2,583. Based on the current CC list, 77.66 percent of patients have at least one CC present. Based on the revised CC list from our 2006 review, the percent of patients having at least one CC present would be reduced to 40.34 percent.

b. Chronic Diagnosis Codes

The 1979 data used in the original formation of the CC list often did not have the manifestations of a chronic disease fully coded. As a result, the CC list included many chronic diseases with a broad range of manifestations. Such chronic illness diagnoses usually do not cause a significant increase in hospital resource use unless there is an acute exacerbation present or there is a significant deterioration in the underlying chronic condition. Therefore, in the revised CC list, we removed chronic diseases without a significant acute manifestation. Recognition of the impact of the chronic disease is accomplished by separately coding the acute manifestation. For example, the mitral valve disease codes (codes 396.0 through 396.9) are assigned to the current CC list. However, unless the mitral valve abnormalities are associated with other diagnoses

indicating acute deterioration, such as acute congestive heart failure, acute pulmonary

edema, or respiratory failure, they would not be expected to significantly increase

hospital resource use. Therefore, the revised CC list did not include the mitral valve

codes. Recognition of the contribution of mitral valve disease to the complexity of

hospital care would be accomplished by separately coding those diseases on the CC list

that are associated with an acute exacerbation or deterioration of the mitral valve disease.

The revised CC list applied the criterion that chronic diagnoses having a broad

range of manifestations are not assigned to the CC list as long as there are codes available

that allow the acute manifestations of the disease to be coded separately. For some

diseases, there are ICD-9-CM codes that explicitly include a specification of the acute

exacerbation of the underlying disease. For example, for congestive heart failure, the

following codes specify an acute exacerbation of the congestive heart failure:

- 428.21, Acute systolic heart failure

- 428.41, Acute systolic and diastolic heart failure

- 428.43, Acute on chronic systolic heart failure

- 428.31, Acute diastolic heart failure

- 428.33, Acute on chronic diastolic heart failure

These congestive heart failure codes are included on the revised CC list.

However, the following congestive heart failure codes do not indicate an acute

exacerbation and are not included in the revised CC list:

- 428.0, Congestive heart failure not otherwise specified

- 428.1, Left heart failure

- 428.20, Systolic heart failure not otherwise specified

- 428.22, Chronic systolic heart failure

- 428.32, Chronic diastolic heart failure

- 428.40, Systolic and diastolic heart failure

- 428.9, Heart failure not otherwise specified

As a result of this approach, most chronic diseases were not assigned to the revised CC list. In general, a significant acute manifestation of the chronic disease must be present and coded for the patient to be assigned a CC. We made exceptions for diagnosis codes that indicate a chronic disease in which the underlying illness has reached an advanced stage or is associated with systemic physiologic decompensation and debility. The presence of such advanced chronic diseases, even in the absence of a separately coded acute manifestation, significantly adds to the treatment complexity of the patient. Thus, the presence of the advanced chronic disease inherently makes the reason for admission more difficult to treat. For example, under the revised CC list, stage IV, V, or end-stage chronic renal failure (codes 585.4 through 585.6) are designated as a CC, but stage I through III chronic renal failure (codes 585.1 through 585.3) are not. For obesity, a body mass index over 35 (codes V85.35 through V85.4) is a CC, but a body mass index between 19 and 35 is not. End-stage renal failure and extreme obesity are examples of chronic diseases for which the advanced stage of the disease is clearly specified.

However, for most major chronic diseases, the stage of the disease is not clearly specified in the code. These codes were evaluated based on the consistency and intensity

of the physiologic decompensation and debility associated with the chronic disease. For

example, quadriplegia (codes 344.00 through 344.09) requires extensive care with a

substantial increase in nursing services and more intensive monitoring. Therefore,

quadriplegia is considered a CC in the revised CC list.

c. Acute Diagnosis Codes

Examples of acute diseases included on the revised CC list included acute

myocardial infarction (AMI), cerebrovascular accident (CVA) or stroke, acute respiratory

failure, acute renal failure, pneumonia, and septicemia. These six diseases are

representative of the types of illnesses we included on the revised CC list. Other acute

diseases were designated as a CC if their impact on hospital resource use would be

expected to be comparable to these representative acute diseases. For example, acute

endocarditis was included on the CC list but urinary tract infection was not.

The revised CC list is essentially comprised of significant acute disease, acute

exacerbations of significant chronic diseases, advanced or end stage chronic diseases and

chronic diseases associated with extensive debility. Compared to the existing CC list, the

revised CC list requires a secondary diagnosis to have a consistently greater impact on

hospital resource use.

The following Table E compares the current CC list and the revised CC list. There

are 3,326 diagnosis codes on the current CC list. The CC revisions reduce the number of

diagnosis codes on the CC list to 2,583. Based on the current CC list, 77.66 percent of

patients have at least one CC present, using FY 2006 MedPAR data. Based on the

revised CC list, the percent of patients having at least one CC present is reduced to 40.34

percent. The revised CC list increases the difference in average charges between patients

with and without a CC by 56 percent ($15,236 versus $9,743).

Table E.--Comparison of Current CC List and Revised CC List

	Current CC List	Revised CC List
Codes designated as a CC	3,326	2,583
Percent of patients with one or more CCs	77.66	40.34
Percent of patients with no CC	22.34	59.66
Average charge of patients with one or more CCs	$24,538	$31,451
Average charge of patients with no CCs	$14,795	$16,215

The analysis above suggests that merely reviewing and updating the CC list can

lead to significant improvements in the ability of the CMS DRGs to recognize severity of

illness. Although we could potentially adopt this one change to better recognize severity

of illness in the CMS DRGs, we have undertaken additional analyses that further refine

secondary diagnoses into MCCs, CCs and non-CCs as described below.

d. Prior Research on Subdivision of CCs into Multiple Categories

(1) Refined DRGs

During the mid-1980s, CMS (then HCFA) funded a project at Yale University to

revise the use of CCs in the CMS DRGs. The Yale University project mapped all

secondary diagnoses that were considered a CC in the CMS DRGs into 136 secondary

diagnosis groups, each of which was assigned a CC complexity level. For surgical

patients, each of the 136 secondary diagnosis groups was assigned to 1 of 4

CC complexity levels (non-CC, moderate CC, MCC, and catastrophic CC). For medical

patients, each of the 136 secondary diagnosis groups was assigned to 1 of 3 CC

complexity levels (non-CC, moderate/MCC, and catastrophic CC). All age subdivisions

and CC subdivisions in the DRGs were eliminated and replaced by the four CC

subgroups for surgical patients, or the three CC subgroups for medical patients. The Yale

University project did not reevaluate the categorization of secondary diagnosis as a CC

versus a non-CC. Only the diagnoses on the standard CC list were used to create the

moderate, major, and catastrophic subgroups. All secondary diagnoses in a secondary

diagnosis group were assigned the same level, and a patient was assigned to the subgroup

corresponding to the highest level secondary diagnosis. The number of secondary

diagnoses had no effect on the subgroup assigned to the patient (that is, multiple

secondary diagnoses at one level did not cause a patient to be assigned to a higher

subgroup). The DRG system developed by the Yale University project demonstrated that

a subdivision of the CCs into multiple subclasses would improve the predictability of

hospital costs.

(2) 1994 Severity DRGs

        We also examined the work we performed in the mid-1990's to revise the

CMS DRGs to better recognize severity. In 1993, we reevaluated the use of CCs within

the CMS DRGs. The reevaluation excluded the CMS DRGs associated with pregnancy,

newborn, and pediatric patients (MDCs 14 and 15 and DRGs defined based on age 0-17).

The major CC list from the AP-DRGs that are used for Medicaid payment by New York

and other States was used to identify an initial list of MCCs. Using Medicare data, we

reevaluated the categorization of each secondary diagnosis as a non-CC, CC, or an MCC.

The end result was that 111 diagnoses that were non-CCs in the standard CMS DRGs

were made a CC, 220 diagnoses that were a CC were made a non-CC, and 395 CCs were

considered an MCC.

All CC splits in the CMS DRGs were eliminated, and an additional 24 DRGs

were merged together. The resulting base CMS DRGs were then subdivided into three,

two, or no subgroups based on an analysis of Medicare data. The result was 84 DRGs

with no subgroups, 124 DRGs with two subgroups, and 85 DRGs with three subgroups.

An additional 63 pregnancy, newborn, and pediatric DRGs not evaluated resulted in a

total of 652 DRGs.

A patient was assigned to the CC subgroup corresponding to the highest level

secondary diagnosis. Multiple secondary diagnoses at one level did not cause a patient to

be assigned to a higher subgroup. The categorization of a diagnosis as non-CC, CC, or

MCC was uniform across the CMS DRGs, and there were no modifications for specific

DRGs. As part of the FY 1995 IPPS proposed rule, we made a complete file of the

revised DRG descriptions available to the public. However, we never adopted the

revised DRGs (55 FR 27756).

e. Medicare Severity DRGs (MS-DRGs)

We had several options in developing a refinement to the current CMS DRGs to

better recognize increased resource use due to severity of illness. One option would

involve simply taking the work performed in 1994 and then updating it with all the code

changes that have taken place since then. We were reluctant to do this because of

changes in medical practices as well as the substantial changes in ICD-9-CM codes since

that time. Another option would have been to build on current CMS DRGs which

include a number of advancements that better identify medical practices and

technologies. Many commenters on the FY 2007 IPPS proposed rule urged us to take the

latter approach because they believed the current base CMS DRGs clearly differentiate

between the complexities of varying surgical procedures and medical devices. Therefore,

we chose the option of developing a new severity DRG system based on the current

CMS DRGs.

The development of the 1994 Severity DRGs involved three steps:

- Consolidation of existing DRGs into base DRGs.

- Categorization of each diagnosis as an MCC, CC, or non-CC.

- Subdivision of each base DRG into subclasses based on CCs.

We reviewed and revised each of the three steps and applied them to our current

CMS DRGs to develop DRGs that better identify severity of illness among Medicare

patients. We refer to this system that we proposed (and are adopting in this final rule

with comment period) as the Medicare Severity DRGs (MS-DRGs). The purpose of the

MS-DRGs is to more accurately stratify groups of Medicare patients with varying levels

of severity.

(1) Consolidation of Existing CMS DRGs into Base MS-DRGs

The first step in our process was the consolidation of existing CMS DRGs into

new proposed base MS-DRGs. We combined together the 115 pairs of CMS DRGs that

are subdivided based on the presence of a CC. We further consolidated the CMS DRGs

that are split on the basis of a major cardiovascular condition, AMI with and without

major complication (CMS DRGs 121 and 122), and cardiac catheterization with and

without complex diagnoses (CMS DRGs 124 and 125). We also consolidated the three

pairs of burn CMS DRGs that were defined based on the presence of a CC or a

significant trauma (CMS DRGs 506 and 507; 508 and 509; and 510 and 511). Next, we

consolidated the 43 pediatric CMS DRGs that are defined based on age less than or equal

to 17. These pediatric CMS DRGs contain a very low volume of Medicare patients. As

shown in Table 10 of the FY 2007 IPPS final rule (71 FR 48318), only two of these

pediatric CMS DRGs contained more than 100 patients (CMS DRGs 298 and 333).

Seventeen of these pediatric DRGs had no patients (CMS DRGs 30, 33, 41, 48, 54, 58,

137, 252, 255, 282, 330, 340, 343, 393, 405, 446, and 448). As we have stated

frequently, our primary focus in maintaining the CMS DRGs is to serve the Medicare

population. We do not have the data or the expertise to maintain the DRGs in clinical

areas that are not relevant to the Medicare population. We continue to encourage users of

the CMS DRGs (or MS-DRGs that are being adopted) to make relevant adaptations if

they are being used for a non-Medicare patient population.

        In addition to the pediatric CMS DRGs defined by the age of the patient, there are a

number of CMS DRGs that relate primarily to the pediatric or adult population that have

very low volume in the Medicare population, such as male sterilization, tubal interruptions,

circumcisions, tonsillectomies, and myringotomies. These CMS DRGs were consolidated

into the most clinically similar MS-DRG.

        Over the past two decades, the site of service for some elective procedures such as

carpal tunnel release, cataract extraction, and laparoscopy has shifted from the inpatient to

the outpatient setting, resulting in the CMS DRGs associated with these procedures having

very low volume. These CMS DRGs were also consolidated into the most clinically

similar MS-DRG. In addition, there were some clinically related CMS DRGs that had

significant Medicare patient volume but had no significant difference in resource use. For

example, thyroid (CMS DRG 290) and parathyroid (CMS DRG 289) procedures were

virtually identical in terms of hospital resource use and were, therefore, consolidated. In

total, 34 of these CMS DRGs were consolidated. The DRG consolidations are summarized

in Table F below.

Four pairs of MS-DRGs (223 and 224; 228 and 229; 323 and 324; and 551 and

552) were defined based on the presence of a CC or some other condition. For example,

MS-DRG 323 is defined based on the presence of a CC or the performance of

extracorporeal shock wave lithotripsy. For these MS-DRGs, the CC condition was

removed and the pair of DRGs remains separate but defined based only on the other

condition (that is, MS-DRG 323 became urinary stones with extracorporeal shock wave

lithotripsy). As was done in the 1994 severity DRG work, we did not consolidate any of

the CMS DRGs for maternity or newborn cases.

Before proceeding further, we made one additional change to a base DRG

assignment after completing these consolidations. We assigned cranial-facial bone

procedures to a new base DRG (Cranial/Facial Bone Procedures). These cases were

previously assigned to DRGs 52 and 55 through 63. We also created a new base DRG,

MS-DRG 245 (Automatic Implantable Cardiac Defibrillator (ACID) Lead and Generator

Procedures). This DRG was created by removing automatic implantable cardiac

defibrillator leads and generator procedures from the pacemaker DRG (CMS DRG 551;

now new MS-DRGs 242 through 244).

Table F below shows how DRGs in the CMS DRGs (Version 24.0) were

consolidated into new base MS-DRGs. We refer readers to section II.D.2. of the

preamble of the proposed rule and this final rule with comment period for a detailed

discussion of CCs and MCCs under the MS-DRG system.

Table F.--DRG Consolidation

CMS-DRG Version 24.0	DRG Description	MS-DRGs Version 25.0	New Base MS-DRG Description
6	Carpal Tunnel Release	40	Peripheral & Cranial Nerve & Other Nervous System Procedure with MCC, with CC, and without CC/MCC
7	Peripheral & Cranial Nerve & Other Nervous System Procedure	41	
8		42	
36	Retinal Procedures	116	Intraocular Procedures with and without CC/MCC
38	Primary Iris Procedures		
39	Lens Procedures with or without Vitrectomy	117	
42	Intraocular Procedures Except Retina, Iris & Lens		
43	Hyphema	124	Other Disorders of the Eye with and without MCC
46	Other Disorders of the Eye		
47		125	
48			
50	Sialoadenectomy	139	Salivary Gland Procedures
51	Salivary Gland Procedures Except Sialoadenectomy		
52	Cleft Lip & Palate Repair	133	Other Ear, Nose, Mouth &

CMS-DRG Version 24.0	DRG Description	MS-DRGs Version 25.0	New Base MS-DRG Description
55	Miscellaneous Ear, Nose, Mouth & Throat Procedures		Throat O.R. Procedures with and without CC/MCC
56	Rhinoplasty	131	New DRG - Cranial/Facial Bone Procedures with and without CC/MCC
57 58	Tonsillectomy & Adenoidectomy Procedure, Except Tonsillectomy &/or Adenoidectomy Only	132	
59 60	Tonsillectomy &/or Adenoidectomy Only		
61 62	Myringotomy with Tube Insertion		
63	Other Ear, Nose, Mouth & Throat O.R. Procedures		
67	Epiglottitis	152	Otitis Media & Upper Respiratory Infection with and without MCC
68 69 70	Otitis Media & Upper Respiratory Infection	153	
71	Laryngotracheitis		
72	Nasal, Trauma & Deformity	154	Other Ear, Nose, Mouth & Throat Diagnoses with MCC, with CC, without CC/MCC
73 74	Other Ear, Nose, Mouth & Throat Diagnoses	155 156	
185 186	Dental & Oral Diseases Except Extractions & Restorations	157 158	Dental & Oral Diseases with MCC, with CC, without CC/MCC
187	Dental Extractions & Restorations	159	

CMS-DRG Version 24.0	DRG Description	MS-DRGs Version 25.0	New Base MS-DRG Description
199	Hepatobiliary Diagnostic Procedure for Malignancy	420	Hepatobiliary Diagnostic Procedures with MCC, with CC, without CC/MCC
200	Hepatobiliary Diagnostic Procedure for Non-Malignancy	421	
		422	
244	Bone diseases & Specific Arthropathies	553	Bone Diseases & Arthropathies with and without MCC
245		554	
246	Non-Specific Arthropathies		
259	Subtotal Mastectomy for Malignancy *	584	Breast Biopsy, Local Excision & Other Breast Procedures with and without CC/MCC
260		585	
261	Breast Procedures for Non-Malignancy Except Biopsy & Local Excision		
262	Breast Biopsy & Local Excision for Non-Malignancy		
267	Perianal & Pilonidal Procedures	579	Other Skin, Subcutaneous Tissue & Breast Procedures with MCC, with CC, without CC/MCC
268	Skin, Subcutaneous Tissue & Breast Plastic Procedures	580	
269	Other Skin, Subcutaneous Tissue & Breast Procedure	581	
270			
289	Parathyroid Procedures	625	Thyroid, Parathyroid & Thyroglossal Procedures with MCC, with CC, without CC/MCC
290	Thyroid Procedures	626	
291	Thyroglossal Procedures		
		627	
294	Diabetes > 35	637	Diabetes with MCC, with

CMS-DRG Version 24.0	DRG Description	MS-DRGs Version 25.0	New Base MS-DRG Description
295	Diabetes < 35		CC, without CC/MCC
338	Testes Procedures for Malignancy	711	Testes Procedures with and without CC/MCC
339	Testes Procedures, Non-Malignancy	712	
340			
342	Circumcision		Procedure 64.0 changed to non-O.R. Cases with only this procedure will go to medical DRGs.
343			
351	Sterilization, Male	729	Other Male Reproductive System Diagnoses with and without CC/MCC
352	Other Male Reproductive System Diagnoses	730	
361	Laparoscopy & Incisional Tubal Interruption	744	D&C, Conization, Laparascopy & Tubal Interruption with and without CC/MCC
362	Endoscopic Tubal Interruption	745	
363	D&C, Conization & Radio-Implant, for Malignancy		
364	D&C, Conization Except for Malignancy		
411	History of Malignancy without Endoscopy	843	Other Myeloproliferative Disease or Poorly Differentiated Neoplasm Diagnosis with MCC, with CC, without CC/MCC
412	History of Malignancy with Endoscopy	844	
413	Other Myeloproliferative Disease or Poorly Differentiated Neoplasm Diagnosis	845	
414			
465	Aftercare with History of Malignancy as Secondary Diagnosis	949	Aftercare with and without

CMS-DRG Version 24.0	DRG Description	MS-DRGs Version 25.0	New Base MS-DRG Description
466	Aftercare without History of Malignancy as Secondary Diagnosis	950	CC/MCC

*Codes 85.22 and 85.23 in CMS DRGs 259 and 260 were moved to MS-DRG 582 and 583.

As summarized in Table G, the consolidation resulted in the formation of 335

base MS-DRGs.

Table G.--Consolidation of Current CMS DRGs into MS-DRGs

	Number
Current CMS DRGs	538
Elimination of CC subgroups	-114
Elimination of MCC subgroups	-7
Elimination of CC complexity subgroups	-5
Elimination of age 0-17 subgroups	-43
Consolidation due to volume or resource similarity	-34
New DRG	+1
Revised Base DRGs	311
Newborn, maternity and error DRGs	+24
Base DRGs for severity subdivision	335

The end result of the consolidation of the CMS DRGs in the MS-DRGs was

similar to the consolidation performed in the 1994 severity DRGs. The 1994 DRG

consolidations resulted in 356 base DRGs plus 2 error DRGs. The number of the 1994

base DRGs is different because new CMS DRGs have been added since 1994, the 43 age

0-17 pediatric CMS DRGs were not consolidated, and some of the volume shifts to

outpatient care had not yet occurred in 1994. In the 1994 severity DRGs, 24 DRGs were

consolidated due to volume or resource similarity. Sixteen of these 1994 DRG

consolidations are included in the 34 consolidations done in the 2007 consolidations.

However, due to concerns expressed by our physician consultants, 8 of the DRG

consolidations from 1994 were not done. For example, interstitial lung disease (DRGs 92

and 93) was not consolidated with simple pneumonia and pleurisy (DRGs 89, 90, 91) as

was done in the 1994 consolidations.

Comment: One commenter expressed concern that the focus of MS-DRGs was

on the Medicare population. As a result of this focus, many of the DRGs reflect severity

and resource use only for the Medicare population. The commenter stated that certain

diagnoses present differently at different ages or actually represent a different disease

process. For instance, the commenter stated that hypertension in a child represents a very

different disease than for adults. The commenter also stated that CMS DRGs 569 and

570 (Major Small and Large Bowel Procedures with CC and with or without Major

Gastrointestinal Diagnosis, respectively) have different costs for a Medicare patient than

a child. The commenter also indicated that CMS did not perform updates to MDC 14

(Obstetrics) and MDC 14 (Newborns and Other Neonates with Problems Arising in the

Perinatal Period). The commenter stated that the MS-DRGs will not work well for other

populations.

Response: The MS-DRGs were specifically designed for purposes of Medicare

hospital inpatient services payment. As we stated above, we generally use MedPAR data

to evaluate possible DRG classification changes and recalibrate the DRG weights. The

MedPAR data only represent hospital inpatient utilization by Medicare beneficiaries. We

do not have comprehensive data from non-Medicare payers to use for this purpose. The

Medicare program only provides health insurance benefits for people over the age of 65

or who are disabled or suffering from end-stage renal disease. Therefore, newborns,

maternity, and pediatric patients are not well-represented in the MedPAR data that we

used in the design of the MS-DRGs. We simply do not have enough data to establish

stable and reliable DRGs and relative weights to address the needs of non-Medicare

payers for pediatric, newborn, and maternity patients. For this reason, we encourage

those who want to use MS-DRGs for patient populations other than Medicare make the

relevant refinements to our system so it better serves the needs of those patients.

 (2) Categorization of Diagnoses

We decided to establish three different levels of CC severity into which we would

subdivide the diagnosis codes. The proposed three levels are MCC, CC, and non-CC.

Diagnosis codes classified as MCCs reflect the highest level of severity. The next level

of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs.

Non-CCs are diagnosis codes that do not significantly affect severity of illness and

resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG

assignment under either the CMS DRGs or the MS-DRGs.

The categorization of diagnoses as an MCC, CC, or non-CC was accomplished

using an iterative approach in which each diagnosis was evaluated to determine the extent

to which its presence as a secondary diagnosis resulted in increased hospital resource use.

In order to begin this iterative process, we started with an initial categorization of each

diagnosis as an MCC, CC, or non-CC. As noted previously, the 1994 CC revision began

by separating CCs into MCC and CC based on the AP-DRG major CCs. One way to

begin this iterative process would have been to use the 1994 CC categorization.

However, the 1994 CC categorization was based on FY 1992 data and ICD-9-CM

diagnosis codes, which now are 15 years old. Since 1992, 1,897 new diagnosis codes

have been added, and 346 diagnosis codes have been deleted. Because the revised CC

list (explained in section II.C.2.a. of this preamble) was based on current ICD-9-CM

codes and used recent data, we decided to utilize the revised CC list rather than the 1994

categorization as our starting point for determining whether each secondary diagnosis

should be an MCC, a CC, or a non-CC.

The revised CC list categorizes each diagnosis as a CC or a non-CC. We decided

to use this list in combination with the categorization under the AP-DRGs and the

APR DRGs. The AP-DRGs and the APR DRGs are updated annually with current codes

and provide a good comparison source to use with the revised CC list. We designated as

an MCC any diagnosis that was a CC in the revised CC list *and* was an AP-DRG major

CC *and* was an APR DRG default severity level 3 (major) or 4 (extensive). We

designated as a non-CC any diagnosis that was a non-CC in the revised CC list *and* was

an AP-DRG non-CC *and* was an APR DRG default severity level of 1 (minor). Any

diagnoses that did not meet either of the above two criteria was designated as a CC.

The only exception to our approach was for diagnoses related to newborns,

maternity, and congenital anomalies. These diagnoses are very low volume in the

Medicare population and were not reviewed for purposes of creating the revised CC list.

We used the APR DRGs to categorize these diagnoses. For newborn, obstetric, and

congenital anomaly diagnoses, we designated the APR DRG default severity level 3

(major) and 4 (extreme) diagnoses as an MCC, the APR DRG default severity level 2

(moderate) diagnoses as a CC, and the APR DRG default severity 1 (minor) diagnoses as

a non-CC. Table H summarizes the number of codes in each CC category.

Table H.--Initial Categorization of CC Codes

	Number of Codes
MCC	1,096
CC	4,221
Non-CC	8,232
Total	13,549

This initial CC categorization of diagnosis codes was used to begin the iterative

process of determining the proposed final CC categorization for each diagnosis code.

(3) Additional CC Exclusions

For some CMS DRGs, the presence of specific secondary diagnoses affects the

base DRG assignment. For example, in MDC 5 (Diseases and Disorders of the

Circulatory System), the presence of an AMI code as the principal diagnosis or as a

secondary diagnosis will cause the patient to be assigned to the AMI DRGs (CMS DRGs

121 through 123). Therefore, if the AMI code is present as a secondary diagnosis, it

should not be used to assign the CC category for a patient because it is redundant within

the definition of the base DRG. Similarly, for MDC 24 (Multiple Significant Trauma),

specific combinations of significant trauma as principal or secondary diagnosis cause the

assignment to the multiple trauma DRGs (CMS DRGs 484 through 487). Therefore, any

secondary diagnosis of trauma is redundant with the definition of the multiple trauma

DRGs and should not be used to determine the CC category for a patient. Any secondary

diagnoses that are used to assign a specific proposed base MS-DRG were excluded from

the determination of the CC category for patients assigned to that base MS-DRG.

Comment: Several commenters asked that we make changes to the CC and

exclusion list for codes associated with sepsis. The commenters stated that two Systemic

Inflammatory Response Syndrome (SIRS) codes, 995.91 (Sepsis) and 995.92 (Severe

sepsis) are CCs under MS-DRGs. The commenters believed that if a patient has SIRS

and pneumonia, both conditions should be coded, and that this coding would result in a

patient admitted with SIRS being assigned to MS-DRG 871 (Septicemia without

Mechanical Ventilation with MCC). The commenters stated that the pneumonia would

count as a MCC in this case. The commenters requested that CMS exclude pneumonia

from being a MCC when it occurs with sepsis. The commenters believed pneumonia

should be excluded as an MCC for a patient with sepsis because it is an underlying and

related condition, and that these patients should not be assigned to MS-DRG 871. The

commenters stated that the other SIRS codes, 995.93 (Systemic Inflammatory Response

Syndrome due to noninfectious process without acute organ dysfunction) and 995.94

(Systemic Inflammatory Response Syndrome due to noninfectious process with acute

organ dysfunction) are excluded from acting as a CC for pancreatitis (code 577.0). The

commenters asked that CMS not exclude codes 995.93 and 995.94 with code 577.0.

Response: The commenters are mistaken about codes 995.91 and 995.92. While

these two codes are not CCs, they are on the MCC list. Our data and the judgment of our

medical advisors support the assignment of these codes to the MCC list. Furthermore, we

do not believe it is appropriate to exclude pneumonia as an MCC for sepsis and severe

sepsis. These patients would be at an extremely high level of severity. SIRS is not

always associated with pneumonia but when it it, the patient is at a higher severity level.

Therefore, we are not making this change to the CC exclusion list by excluding

pneumonia codes from acting as a MCC with code 995.91 and 995.92. On the second

issue the commenters raised, they are incorrect that codes 995.91 and 995.92 are

excluded from acting as a CC for code 577.0. These codes are not on the CC exclusion

list for code 577.0. Therefore, both would act as a MCC for code 577.0. We are not

making any changes to the CC exclusion list as a result of these comments.

(4) Analysis of Secondary Diagnoses

The 311 base MS-DRGs (335 total base DRGs minus the MDC 14, MDC 5, and

error DRGs) were subdivided into three CC subgroups. Patients were assigned to the

subgroup corresponding to the most extreme CC present. All but four of the base

MS-DRGs had strictly monotonically increasing average charges across the three CC

subgroups (that is, average charges progressively increased from the non-CC to the CC to

the MCC subgroups). The four MS-DRGs that failed to have monotonically increasing

charges all had at least one CC subgroup with very low volume. For example, the

non-CC subgroup for the pancreas transplant DRG (CMS DRG 513) had only 2 cases.

The overall statistics by CC subgroup for the 311 base MS-DRG are contained in Table I.

Patients in the MCC subgroup have average charges that are nearly double the average

charges for patients in the CC subgroup. The CC subgroup with the largest number of

patients is the non-CC subgroup with 41.1 percent of the patients.

Table I.--Overall Statistics for MS-DRGs
Excluding Those in MDCs 14 and 15

CC Subgroup	Number of Cases	Percent	Average Charges
Major	2,604,696	22.2	$44,246
CC	4,293,744	36.6	$24,131
Non-CC	4,818,411	41.1	$18,435

In order to evaluate the initial assignment of secondary diagnoses to the three CC subclasses, we devised a system that determined the impact on resource use of each secondary diagnosis. For each secondary diagnosis, we measured the impact in resource use for the following three subsets of patients:

(a) Patients with no other secondary diagnosis or with all other secondary diagnoses that are non-CCs.

(b) Patients with at least one other secondary diagnosis that is a CC but none that is an MCC.

(c) Patients with at least one other secondary diagnosis that is an MCC.

Numerical resource impact values were assigned for each diagnosis as follows:

Value	Meaning
0	Significantly below expected value for the non-CC subgroup
1	Approximately equal to expected value for the non-CC subgroup
2	Approximately equal to expected value for the CC subgroup
3	Approximately equal to expected value for the MCC subgroup
4	Significantly above the expected value for the MCC subgroup

Each diagnosis for which Medicare data were available was evaluated to determine its impact on resource use and to determine the most appropriate CC subclass (non-CC,

CC, or MCC) assignment. In order to make this determination, the average charge for each

subset of cases was compared to the expected charge for cases in that subset. The

following format was used to evaluate each diagnosis:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3

Count (Cnt) is the number of patients in each subset and C1, C2, and C3 are a measure of

the impact on resource use of patients in each of the subsets. The C1, C2, and C3 values

are a measure of the ratio of average charges for patients with these conditions to the

expected average charge across all cases. The C1 value reflects a patient with no other

secondary diagnosis or with all other secondary diagnoses that are non-CCs. The C2 value

reflects a patient with at least one other secondary diagnosis that is a CC but none that is a

major CC. The C3 value reflects a patient with at least one other secondary diagnosis that

is a major CC. A value close to 1.0 in the C1 field would suggest that the code produces

the same expected value as a non-CC diagnosis. That is, average charges for the case are

similar to the expected average charges for that subset and the diagnosis is not expected to

increase resource usage. A higher value in the C1 (or C2 and C3) field suggests more

resource usage is associated with the diagnosis and an increased likelihood that it is more

like a CC or major CC than a non-CC. Thus, a value close to 2.0 suggests the condition is

more like a CC than a non-CC but not as significant in resource usage as an MCC. A value

close to 3.0 suggests the condition is expected to consume resources more similar to an

MCC than a CC or non-CC. For example, a C1 value of 1.8 for a secondary diagnosis

means that for the subset of patients who have the secondary diagnosis and have either no

other secondary diagnosis present, or all the other secondary diagnoses present are

non-CCs, the impact on resource use of the secondary diagnoses is greater than the

expected value for a non-CC by an amount equal to 80 percent of the difference between

the expected value of a CC and a non-CC (that is, the impact on resource use of the

secondary diagnosis is closer to a CC than a non-CC).

Table J below shows examples of the results.

Table J.--Examples of Impact on Resource Use of Secondary Diagnoses

Code	Cnt1	C1	CntC2	C2	Cnt3	C3	CC Subclass
401.1, Benign essential hypertension	12,308	0.955	40,113	1.715	5,297	2.384	Non-CC
530.81, Esophageal reflux	294,673	0.986	917,058	1.639	122,076	2.302	Non-CC
560.1, Paralytic Ileus	10,651	1.466	87,788	2.320	51,303	3.226	CC
491.20, Obstructive chronic bronchitis	7,003	1.416	32,276	2.193	13,355	3.035	CC
410.71, Subendocardial infarction initial episode	1,657	2.245	30,226	2.778	42,862	3.232	MCC
518.81, Acute respiratory failure	5,332	2.096	118,937	2.936	223,054	3.337	MCC

The resource use impact reports were produced for all diagnoses except obstetric,

newborn, and congenital anomalies (10,690 diagnoses). These mathematical constructs

were used as guides in conjunction with the judgment of our clinical staff to classify each

secondary diagnosis reviewed as an MCC, CC or non-CC. Our clinical panel reviewed

the resource use impact reports and modified 14.9 percent of the initial CC subclass

assignments as summarized in Table K below. The rows in the table are the initial CC

subclass categories and the columns are the final CC subclass categories.

Comment: Several commenters acknowledged the detailed description of the methodology used in categorizing secondary diagnoses as MCCs, CCs, or non-CCs. While they were appreciative of the detailed iterative process outlined in the proposed rule (72 FR 24702), the commenters requested that CMS provide the numerical values (the C1 to C3 values) that were assigned to classify each diagnosis as an MCC, CC or non-CC.

Response: We agree that it would be helpful to share the data we developed and used for each individual code as part of our CC evaluation process. We will post this data on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/ under the Downloads section.

Table K--CC Subclass Modifications

Initial CC Subclass	Final CC Subclass			Total	Percent
	MCC	CC	Non-CC		
MCC	847	62	0	909	8.5
CC	542	2,579	737	3,858	36.1
Non-CC	0	272	5,651	5,923	55.4
Total	1,389	2,913	6,388	10,690	
Percent	13.0	27.2	59.8		

Of the diagnoses initially designated as an MCC, 6.8 percent were made a CC (62/909), and of the diagnoses initially designated as non-CC, 4.6 percent were made a CC (272/5,923). The major shift occurred in the diagnoses initially assigned to the CC subclass. Fourteen percent of the diagnoses initially designated as a CC were made an MCC (542/3858), and 19.1 percent of the diagnoses initially designated a CC were made a non-CC (737/3,858). In determining the CC subclass assigned to a diagnosis, imprecise

codes were, in general, not assigned to the MCC or CC subclass. For example, the

congestive heart failure codes have the following CC subclass assignments:

Code	CC Subclass Assignment
428.21, Acute systolic heart failure	MCC
428.41, Acute systolic & diastolic heart failure	MCC
428.43, Acute on chronic systolic heart failure	MCC
428.31, Acute diastolic heart failure	MCC
428.33, Acute on chronic diastolic heart failure	MCC
428.1, Left heart failure	CC
428.20, Systolic heart failure NOS	CC
428.22, Chronic systolic heart failure	CC
428.32, Chronic diastolic heart failure	CC
428.40, Systolic & diastolic heart failure	CC
428.0, Congestive heart failure NOS	Non-CC
428.9, Heart failure NOS	Non-CC

The acute heart failure codes are MCCs, and the chronic heart failure codes are

CCs. However, Not Otherwise Specified (NOS) heart failure codes are non-CCs. Thus,

the precise type of heart failure must be specified in order for an MCC or CC to be

assigned.

There are currently 13,549 ICD-9-CM diagnosis codes. The external cause of

injury and poisoning codes (E800 through E999) and congenital abnormality codes were

not included in our current CC review for the MS-DRGs. We excluded the external cause

of injury and poisoning codes from consideration as an MCC or a CC because they

describe how an injury occurred, and not the exact nature of the injury. For instance, if a

patient fell on the deck of a boat and fractured his or her skull, one would assign an E code

to describe the fall on the boat. A separate diagnosis code would be assigned to describe

the exact nature of any resulting injury such as a contusion, fractured bone, or skull fracture

and concussion. A patient would be assigned to a severity level based on the exact nature of the injury and not the manner in which the injury occurred. Therefore, we decided not to classify any of the E codes as either an MCC or a CC. The congenital abnormality codes describe abnormalities when a baby is born. At times, a beneficiary may live with these congenital abnormalities for years without a problem. The congenital abnormalities may later lead to complications that require hospital admissions. Should these congenital abnormalities lead to medical problems that result in a hospital admission for a Medicare beneficiary, the exact nature of the condition being treated would also be assigned a code. This more precise code would be evaluated to determine whether or not it was an MCC or a CC. Therefore, we decided not to classify congenital abnormality codes as an MCC or a CC, but to instead use the other reported diagnosis codes that better describe the reason for the admission. Excluding the external cause of injury codes, we reviewed 10,690 diagnosis codes.

As was done in our 1994 severity proposal, diagnoses that were closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died. These diagnoses are:

- 427.41, Ventricular fibrillation

- 427.5, Cardiac arrest

- 785.51, Cardiogenic shock

- 785.59, Other shock without mention of trauma

- 799.1, Respiratory arrest

Resource use for patients with these diagnoses who were discharged alive was consistent with an MCC. Resource use for patients with these diagnoses who died was consistent with a non-CC. Further, most patients who died could legitimately have one of these diagnoses coded. As a result, these diagnoses are assigned an MCC subclass for patients who lived and a non-CC subclass for patients who died.

For some secondary diagnoses assigned to the CC subclass, our medical advisors identified specific clinical situations in which the diagnosis should not be considered a CC. In such clinical situations, the CC exclusion list was used to exclude the secondary diagnosis from consideration in determining the CC subgroup, essentially making the secondary diagnosis a non-CC. For example, primary cardiomyopathy (code 425.4) is designated as a CC. However, for patients admitted for congestive heart failure, our medical advisors believed that primary cardiomyopathy should be treated as a non-CC. In order to accomplish that, the congestive heart failure principal diagnoses were added to the CC exclusion list for primary cardiomyopathy as a secondary diagnosis.

The list of diagnosis codes that we proposed to classify as an MCC (which we are adopting in this final rule with comment period) was included in Table 6J in the Addendum to FY 2008 IPPS proposed rule. The diagnosis codes that we proposed to classify as a CC (which are adopting in this final rule with comment period) were included in Table 6K in the Addendum to the proposed rule. The E-codes, which are diagnosis codes used to classify external causes of injury and poisoning, are not included in this list. All E-codes are designated as non-CCs under the current CMS DRG system and our evaluation supports this non-CC designation as appropriate. We are including a list of changes to the

MCC and CC lists as a result of public comments on the proposed rule later in section

II.G.13. of the preamble of this final rule with comment period. We will post a complete

final list of the MCC and CC codes on the CMS Web site at:

http://www/cms/hhs/gov/AcuteInpatientPPS/ under the Files for Download section.

Comment: One commenter supported the basic methodology used to identify

MCCs and CCs. The commenter's analysis of discharge data generally confirms the

notion that the presence of chronic disease does not usually have material impact on the

expected cost of care. The commenter agreed that the emphasis on acute manifestations

of chronic diseases is both clinically and financially appropriate. The commenter stated

that the current CC list is nearly 25 years old and does not reflect the extent to which

clinical practice has changed during that period, with concomitant changes in expected

resource use. The commenter further stated that the current CC list also does not reflect

the nature of changes in coding practices during that period, changes that have

undermined the value of the current CC list. The commenter stated that the elimination

of common secondary diagnoses such as code 428.0 (Congestive heart failure,

unspecified) and code 427.31 (Atrial fibrillation) from the CC list will help to restore CC

status as a meaningful indicator of differential expected resource use. The commenter

also believed that elimination of these diagnosis codes will address the current situation

in which nearly 80 percent of Medicare discharges contain one or more CCs.

Response: We agree that it was important to perform a careful review of the CC

list to develop lists that more accurately identify patients with significantly different

severity levels. We believe that by using both statistical data as well as input from our

medical advisors, we were able to develop the MCCs and CCs that do a much better job

of classifying Medicare patients with varying levels of severity. We also agree that is

important to remove chronic diagnoses from the CC list that do not have a significant

impact on severity. We also believe that nonspecific codes such as code 428.0 should not

be included on the CC list. The ICD-9-CM coding system has more specific codes to

identify the specific type of heart failure. These more specific codes have data

supporting their inclusion on the MCC and CC list. Our medical advisors also supported

the inclusion of the more specific heart failure codes on the MCC and CC list. We also

agree that patients with atrial fibrillation (code 427.31) do not necessarily have a higher

level of severity. The Medicare data suggest that when this condition appears on the

claim and the patient has no other secondary diagnosis that is a CC, the charge data

suggest the condition produces an expected value for a non-CC rather than a CC case.

Further in the judgment of our medical advisors, the condition should not be on the CC

list. When the atrial fibrillation leads to additional cardiac problems, the additional

problems may be represented by codes that are on the MCC or CC list. We agree that by

removing codes from the CC list that do not contribute to significantly higher levels of

severity, we can better recognize severity of illness and more accurately reimburse

hospitals.

We spent extensive time carefully reviewing the ICD-9-CM diagnosis codes to

develop the MCC and CC list. Our current CC list for Version 24.0 of the CMS DRGs

contains 3,326 codes. The MS-DRGs have 3,342 codes on the MCC list and 4,922 codes

on CC list. While we did remove codes from the CC list and add others to the list, we

believe that the end result is a better classification of conditions for identifying

differences in severity of illness. We appreciate the commenter's support for our efforts.

Comment: Several commenters supported the MCC and CC lists as a better

means of identifying severity. The commenters recommended that CMS consider

adopting the revised CC list in FY 2008 as an interim step toward IPPS reform. The

commenters recommended that CMS delay implementation of the new severity system

until FY 2009 but adopt the revised CC list in FY 2008. The commenters stated that by

implementing the revised CC list in FY 2008, CMS could move forward in its goal of

utilizing a system that more accurately recognizes the severity of illness of patients. The

commenters believed this option would allow a more accurate DRG system to be in place

while CMS is evaluating the final RAND report to determine which severity-based DRG

system to propose for implementation in FY 2009.

Another commenter who supported the move to MS-DRGS and CMS' efforts in

creating the MCC and CC lists stated that it had been working with CMS for years to

develop a mechanism to appropriately account for the resources involved in the care of

patients with severe sepsis. The commenter believed that the MS-DRGs in which severe

sepsis is recognized as a major complication, along with acute respiratory distress

syndrome, organ failure, and other conditions where resource use is more intense, will go

a long way towards better recognition of severity of illness.

One commenter applauded CMS for the work it has put into developing a system

that will consider complexity of care as well as severity of illness in determining

Medicare payment for hospital inpatient services. The commenter particularly supported

the recognition of hemophilia and end-stage renal disease as MCCs. The commenter

stated that these conditions clearly meet the criteria for treatment as MCCs because they

often require "expensive and technologically complex" services that lead to substantially

increased resource use and reflect the highest level of severity. The commenter

encouraged CMS to add other diagnoses as the evidence warrants.

Response: Comments and responses on whether to implement MS-DRGs in

FY 2008 or at a later date are discussed in detail in section II.D. of the preamble of this

final rule with comment period. We appreciate the support for our efforts in creating the

MCC and CC lists and agree that it is important to examine data using the system and

continue to refine the MCC and CC lists.

Comment: One commenter commended CMS on the systematic way it reviewed

13,549 secondary diagnosis codes to evaluate their assignment as a CC or non-CC using

a combination of mathematical data and the judgment of its medical advisors. The

commenter stated that, as part of the effort to better recognize severity of illness, CMS

conducted the most comprehensive review of the CC list since the creation of the DRG

classification. However, the commenter disagreed with the classification of many

common secondary diagnoses as non-CCs. Specifically, the commenter questioned

threshold levels that were used and at what point in the analysis CMS decided that a code

was not a CC. For example, the commenter asked what was considered "intensive

monitoring," inquiring whether intensive monitoring refers to additional nursing care on a

daily basis, additional testing, intensive care unit care, extended length of stay, all of

these factors, or some other factor. In some instances, the commenter noted that similar

or comparable codes within the same group have remained a CC/MCC, while other

clinically similar codes or codes requiring similar resources may have been omitted.

Without greater transparency, and a code-by-code explanation, the commenter was

unable to determine why significant secondary diagnoses requiring additional resources

have been removed from the CC list. For the most part, the commenter's analysis

concentrated on reviewing current CCs that have been omitted from the revised CC list.

The commenter made the following overall recommendations with regard to the

CC list:

● CMS should make the final revised CC list publicly available as quickly as

possible so that hospitals may focus on understanding the impact of the revised CC list,

training and educating their coders, and working with physicians for any documentation

improvements required to allow the reporting of more specific codes where applicable.

● CMS should consider additional refinements to the revised CC list and, in

particular, address issues where the ICD-9-CM codes may need to be modified to provide

the distinction between different levels of severity.

● In situations where a new code is required, CMS should default to leaving the

codes as CCs until new codes can be created.

Response: The process of evaluating both claims data and clinical issues is a

challenging one. Our medical advisors performed an extensive evaluation of codes for

the MCC and CC lists, combining their medical judgment and claims data. We have

reviewed a number of specific codes raised by commenters and considered whether or

not the codes should be a MCC or CC. These numerous code requests are discussed

below. Also, as mentioned earlier, we plan to post the data we used to evaluate each code

on the CMS Web site. These data may assist the public in making recommendations for

additional changes to the MCC and CC lists. Any revisions made to the MS-DRGs or the

MCC and CC lists are being made available with this final rule with comment period. As

suggested by the commenter, we plan to evaluate further refinements to the MCC and CC

lists each year as we obtain additional recommendations and data under the MS-DRG

system.

Comment: One commenter acknowledged the significant effort and consideration

CMS has given to developing both the mathematical and clinical judgment criteria in

determining severity classifications. However, the commenter did not believe it was

possible to fully assess the assignment of diagnosis codes in the severity classification

because there was an incomplete description of the process in the proposed rule.

Response: As stated earlier, we plan to post on the CMS Web site the data used

in analyzing how to classify each ICD-9-CM code as an MCC, CC, or non-CC. Our

process for making CC/MCC decisions was an iterative one involving data review and

clinical analysis. In the FY 2008 IPPS proposed rule (72 FR 24702 through 24705), we

explained in detail our methodology for determining whether a secondary diagnosis

qualified as an MCC, CC, or non-CC. Although posting these data results on the CMS

Web site may be helpful in illustrating for commenters the data we used in classifying

conditions as MCCs, CCs or non-CCs, we note that these data were combined with

clinical judgment to make the final determinations. That is, the data were used an adjunct

to the judgment of our medical advisors. Clinical judgment may differ by individual

physician. Thus, the data alone may be helpful but not definitive in helping commenters

understand the reasons for some of our decisions. Nevertheless, we welcome further

public input on potential revisions to the MCC and CC lists for FY 2009. We anticipate

making updates to the MCC and CC lists each year as we receive additional

recommendations and data. Again, below we respond to comments about specific codes.

Comment: One commenter commended CMS for undertaking a long-overdue

comprehensive review and revision of the CC list. However, the commenter stated that

more industry input is needed regarding the revised CC and MCC designations in the

MS-DRG system. The commenter stated that the brevity of the public comment period,

in combination with insufficient detail associated with the process and rationale for

categorization of diagnoses as MCCs, CCs, and non-CCs, made it very difficult to

conduct a thorough analysis of all of the codes on the MCC and CC lists. Another

commenter stated that its members have only had an opportunity to do a cursory

comparison of the current CMS CC list to the MS-DRG MCC and CC lists. The

commenter stated that it should have the ability to do a complete analysis prior to

implementation. The commenter believed such a review would be time intensive and

likely to take a number of months of information exchange before it could be completed.

Although the commenter acknowledged that the MCC and CC lists were included in the

Federal Register notice and posted on the CMS Web site, the commenter believed the

review was hampered by a lack of GROUPER software and a GROUPER Definitions

Manual from being able to complete their review. The commenter also expressed

concern that the analysis of secondary diagnoses was based on charges instead of costs.

The commenter stated that if CMS' intent is to convert to a cost-based structure, a

determination of the impact of secondary diagnoses should not be based on charges. The

commenter added that this analysis appeared to be inconsistent with the evolution to a

cost-based DRG weight system.

Response: We recognize the extensive time that is required by the public in order

perform a review of the MCC and CC lists. However, we note that a DRG Definitions

Manual and GROUPER have never been made available until after completion of the

final rule in past years and public commenters never before suggested that we need to

delay implementation of proposed changes to the IPPS. While we acknowledge that the

changes proposed for FY 2008 are significantly more comprehensive than the changes we

propose in a typical year, the base DRG assignments under the MS-DRGs are largely

unchanged from the prior CMS DRGs. The major changes result from assignment of a

case to a DRG severity level using the new classification of secondary diagnoses as

MCCs, CCs or non-CCs. For this reason, we made extensive information available to

allow public commenters to perform a variety of analyses. The proposed rule included

comprehensive lists of the codes that we classified as MCCs and CCs, and we made this

information available electronically on the CMS Web site. The FY 2006 MedPAR data

that were used to simulate proposed rule policies were made available simultaneous with

public display of the FY 2008 proposed rule. This data file included both the CMS DRG

assigned to the case using the Version 24.0 GROUPER and the proposed MS-DRG

assignment. Further, we provided—at no extra cost to the purchaser—an FY 2005

version of the MedPAR that also included the CMS and MS-DRG assignment at the case

level. For these reasons, we do not believe the lack of availability of a GROUPER or a

DRG Definitions Manual should have precluded commenters from being able to analyze

the revised MCC and CC lists. In fact, we note that a number of public commenters did

provide suggestions for further revisions to these lists, suggesting there was ample time to

be able to do these analyses.

We have considered the suggestion that we analyze changes to the MCC and CC

lists using average costs instead of charges. We adopted a cost-based weighting

methodology because of our concern that differential markups among routine and

ancillary services made charges a poor proxy for costs when setting relative weights for

dissimilar types of cases. That is, different types of cases would use very different mixes

of routine and ancillary services with variable markups and could create distortions in

relative weights that are based on charges. However, we are less concerned about using

charges when comparing cases that share the same primary diagnosis, which are likely to

use similar mixes of services when deciding whether to make a DRG change. In these

cases, we believe charges may provide a reasonable proxy for costs because the cases use

similar services with similar markups.

The methodology that we use to develop cost-based weights is very complex and

works well to give us a measure of relative average resource use when combining high

number of cases together in a single DRG. We would need to analyze whether a

methodology that tries to determine average costs at the case or code level would provide

reliable results for making decisions about MCCs and CCs or DRG changes.

Nevertheless, we appreciate this comment and will continue to give it further

consideration as we evaluate alternative approaches to updating the MCC and CC lists

and the MS-DRGs in the future.

Comment: One commenter stated that CMS should address the inconsistencies

within the CC list identified by its physician and hospital reviewers. The commenter

also recommended that, where necessary, CMS should obtain additional input from

physicians in the appropriate specialties to determine the standard of care and consequent

increased hospital resource use of some of the conditions. The commenter provided a list

conditions that were removed from the revised CC list and urged CMS to maintain them

on the CC list.

Response: We agree that the review of codes for the MCC and CC list was a

daunting task requiring careful review by our panel of medical advisors. We used a

number of physicians in this process, including internists and surgeons, to evaluate the

effect of specific codes on a patient's severity levels. When necessary, our panel

contacted other medical specialists, such as orthopedists and oncologists, to obtain

additional input. We appreciate the CC issues brought to our attention. We reexamined

specific codes brought to our attention below. We expect that we will continue to revise

and update both the CC list and MCC list as we gain experience and data under the MS-

DRG system. We anticipate making additional changes in the future with this added

information.

Comment: One commenter stated that, in some cases, the current ICD-9-CM

classification system does not adequately distinguish between acute and chronic forms of

a condition. In the MS-DRG system, this distinction appears to be critical in predicting

resources utilized at the patient level. The commenter recommended that CMS work

with the NCHS to make ICD-9-CM code modifications to improve this acute and chronic

distinction. Additionally, the commenter suggested that CMS and HHS should take

immediate steps for the adoption of ICD-10-CM, as this system is much better than

ICD-9-CM at distinguishing clinical severity, which is a key aspect of any severity-

adjusted DRG system. The commenter believed that continued use of ICD-9-CM

severely limits the ability of a severity-adjusted DRG system to recognize severity of

illness.

Response: We encourage anyone with specific recommendations for revisions to

the ICD-9-CM diagnosis codes to contact Donna Pickett, National Center for Health

Statistics, Centers for Disease Control and Prevention at: (301) 458-4434. Information

on requesting changes to the ICD-9-CM diagnosis codes can be found on the Web site at:

http://www.cdc.gov/nchs/icd9.htm The Department is continuing to evaluate whether to

move to ICD-10.

Comment: One comment disagreed with CMS' elimination of many chronic

conditions from the CC list. The commenter stated that patient care resources are utilized

to prevent acute exacerbation of a chronic condition. The commenter believed that to not

include these conditions on a CC list is a major flaw in the logic. The commenter

supported inclusion of chronic conditions on the CC list as means to recognize the

resources utilized to manage these conditions effectively, whether they are currently in an

acute phase. The commenter did not mention specific chronic conditions that should be

added to the MCC and CC lists.

Response: We address comments on specific conditions below. However, as a general matter, we found the Medicare data do not generally support that chronic or "unspecified" conditions are more resource intensive than conditions with an acute manifestation of a chronic disease that are described by specific codes. After carefully considering this issue, our medical advisors agreed that unspecified or chronic conditions generally are not suggestive of a higher level of severity of illness in and of themselves when there are more specific codes available to further describe the patient's specific condition or an acute manifestation of a chronic disease. We note that unspecified and chronic conditions are very commonly found in the Medicare patient population. The purpose of the MS-DRGs is to identify those conditions that lead to higher severity of illness and resource use *relative* to the average Medicare patient. These conditions suggest average or less than average resource use across the entire Medicare population. If we were to classify chronic and unspecified conditions as MCCs and CCs, the MS-DRGs ability to better recognize severity of illness would be significantly diminished.

Condition-Specific Comments

We received a number of recommendations of codes to be added to the CC list and the MCC list. We have divided these recommendations into three general categories and will address them accordingly. The three categories are:

- Nonspecific codes

- Symptoms, chronic conditions, and low severity conditions

- High severity codes that were erroneously left off of the CC or MCC list.

The first category of recommendations includes a number of codes that are nonspecific. For instance, one frequent recommendation for addition to the CC list is the nonspecific code 428.0 (Congestive heart failure, unspecified). This code is one of several codes that identify patients who have heart failure. Depending on the degree of certainty by the physician of the exact nature of the heart failure, a code can be assigned to indicate a very specific and acute form of heart failure, or a more general, nonspecific code can be assigned to represent a patient with heart failure, but the exact nature of the heart failure is unknown. Other nonspecific conditions include disorders of a heart valve. If the exact nature of the disorder of a heart valve is known, a specific code can be assigned. If the exact nature or degree of the disorder of the valve is not known, a more general, nonspecific code can be assigned. As discussed earlier in this final rule with comment period, our claims data and the clinical analysis of our medical advisors indicate that patients described by the more general, nonspecific codes are not at a higher severity level. If a patient's condition worsens and develops additional diagnoses or complications, these more specific conditions may be on the CC list or MCC list. The most frequently mentioned, nonspecific code by commenters was code 428.0. Therefore, we will provide a detailed summary of these comments and our response. There were a number of other nonspecific conditions suggested for additions to the CC list. We will address these conditions after summarizing the comments on congestive heart failure.

The second category includes a variety of codes representing symptoms, chronic conditions, and other conditions that do not describe a high level of severity. These conditions do not themselves indicate a high severity level using our mathematical

analysis of the claims data combined with the clinical analysis by our medical advisors.

As stated earlier, we did not include most chronic conditions on the CC list or the MCC

list unless the code also indicates an acute exacerbation that would raise the severity

level. If a patient has a chronic condition that deteriorates or develops into an acute

complication, the more acute condition or complication may be on the CC list or the

MCC list.

The third category of codes includes codes that commenters suggested should

have been included on the CC list or the MCC list because they clearly describe a high

level of severity. Upon further review, we agree that this third group of codes meet the

criteria for being included on the CC list or MCC list. The claims data and our medical

advisors' clinical analysis clearly support the addition of these codes to the CC list or the

MCC list.

(a) Codes Representing Nonspecific Conditions

● Congestive Heart Failure – Code 428.0

Comment: One commenter endorsed the implementation of the revised CC list.

The commenter stated that CMS used new criteria for refining the CC and MCC lists,

which led to the removal of codes currently on the CC list. The commenter compared the

old and revised CC lists and found that the revision added 2,002 codes and dropped 425

codes, for a net increase of 1,577 codes. The commenter stated that, even though the

number of added codes far exceeds the number of dropped codes, in the last three

MedPAR files, the dropped codes were used an average of 40,864 times, while the added

codes were used an average of only 887 times. The commenter stated that many of the

dropped codes pertain to unspecified conditions for which more specific codes are

available and included on the revised CC list. The highest volume code, code 428.0, was

applied to an average of 2.3 million Medicare fee-for-service cases a year during the past

3 years. This code is the most widely used secondary diagnosis code, despite the fact that

12 more specific codes were added in FY 2003. The additional codes are shown in the

Table L below.

Table L.--Incidence of Secondary Diagnosis Coding for Heart Failure
FY 2004–FY 2006

ICD-9-CM Code	Description	New in FY 2003
428.0	Congestive heart failure, unspecified	
428.1	Left heart failure	
428.20	Systolic heart failure; unspecified	x
428.21	Systolic heart failure; acute	x
428.22	Systolic heart failure; chronic	x
428.23	Systolic heart failure; acute on chronic	x
428.30	Diastolic heart failure; unspecified	x
428.31	Diastolic heart failure; acute	x
428.32	Diastolic heart failure; chronic	x
428.33	Diastolic heart failure; acute on chronic	x
428.40	Combined systolic and diastolic heart failure; unspecified	x
428.41	Combined systolic and diastolic heart failure; acute	x
428.42	Combined systolic and diastolic heart failure; chronic	x
428.43	Combined systolic and diastolic heart failure; acute on chronic	x
428.9	Heart failure, unspecified	

The commenter stated that, by making code 428.0 a non-CC, hospitals will react

by coding more precisely using the more definitive heart failure codes, raising the CMI,

which results in documentation and coding-related overpayments. The commenter

argued that, if the revised CC list were implemented before hospitals had a chance to

improve their coding to accommodate the revisions, "case-mix creep and IPPS

overpayments would ensure."

Response: This commenter suggests reasons why Medicare should adopt the

MS-DRGs over a transition period and does not appear to be opposed to our decision not

to classify congestive heart failure as either an MCC or a CC. The commenter also

suggests how hospitals will respond to the coding incentives that will be presented by

revisions to the MCC and CC lists as well as the MS-DRGs. The issue of adopting the

MS-DRGs over a transition is addressed in detail in section II.E. of the preamble of this

final rule with comment period. We further address the implications of the coding

incentives raised in this public comment in section II.D.6. of the preamble of this final

rule with comment period that discusses an adjustment to IPPS rates for improvements in

documentation and coding.

Comment: A number of other commenters urged CMS to classify the condition

under code 428.0 as a CC. The commenters indicated that code 428.0 identifies an acute

condition, not a benign or a chronic condition. Some commenters stated that any

inpatient with congestive heart failure requires increased nursing care to closely monitor

and assess physical symptoms and vital signs for indications of increased congestion.

Patients often need to undergo repeated laboratory studies.

Another commenter stated that the proposed rule incorrectly characterized the

diastolic and systolic heart failure codes as congestive heart failure. The commenter

pointed out that according to the Fourth Quarter 2002 issue of *Coding Clinic for ICD-9-*

CM, congestive heart failure is not an inherent component of the codes in category 428

for systolic and diastolic heart failure. Therefore, according to *Coding Clinic*, the

commenter stated that code 428.0 should be assigned as an additional code when the

patient has systolic or diastolic congestive heart failure. The commenter added that code

428.0 may appropriately be assigned by itself when congestive heart failure is

documented, but there is no documentation of systolic or diastolic heart failure. The

commenter stated that, in ICD-9-CM, there is no distinction between an acute

exacerbation of congestive heart failure and chronic congestive heart failure. Code 428.0

is assigned for both. The commenter added that codes 402.11 (Benign hypertensive heart

disease with congestive heart failure) and 402.91 (Unspecified hypertensive heart disease

with congestive heart failure) are on the CC list. The commenter suggested that code

428.0 be included on the revised CC list as well.

Another commenter who objected to the removal of code 428.0 from the CC list

stated that, currently, ICD-9-CM codes do not distinguish between acute, chronic, or

acute exacerbation of chronic congestive heart failure. All forms of this condition are

assigned to code 428.0. The commenter indicated that medical record documentation

may not typically include information on whether the congestive heart failure is systolic

or diastolic (acute versions of heart failure with this specificity are considered MCCs).

The commenter requested that code 428.0 be added as an MCC until a new code can be

created to identify acute exacerbation of congestive heart failure. The commenter stated

that the fact that there is "congestion" is medically more problematic and more resource

intensive and may necessitate care in the intensive care unit and a prolonged hospital

stay. The commenter stated that coding guidelines necessitate that acute pulmonary

edema of cardiac origin be assigned code 428.0.

Response: Given the number of public comments on this one condition, our

medical advisors reviewed the data and clinical issues surrounding code 428.0 again.

They strongly recommend that we not change this code to a CC. There are three reasons

for this recommendation. First, as stated earlier, we developed a policy of classifying

nonspecific codes as non-CCs when a more specific code was available that identified the

more specific nature of the patient's illness. Second, data for this and other nonspecific

codes do not support assigning it to a higher severity level. Third, in the clinical

judgment of our medical advisors, the use of a nonspecific code means that the physician

had not identified a medical condition that indicates the patient is at a higher severity

level or requires greater resources. This code is vague and does not provide any

description of the exact nature of the heart failure. Data for this very commonly reported

code clearly indicate that these patients are at a low severity level. However, claims data

and our general policy of assigning nonspecific codes to a lower severity level were not

the only factors that we used to classify a code as an MCC, CC, or non-CC. As stated

above, the data were only used as an adjunct to the judgment of our medical advisors. In

the judgment of our medical advisors, the condition described by code 428.0 does not

suggest an increase in patient severity of illness. In this case, 12 more specific codes are

available to indicate the more severe forms of heart failure. If the physician includes

more precise information in the medical record that would allow the coder to identify a

more specific code to describe the type of heart failure, the documentation will reflect

that the hospital treated a more severely ill patient and the case will be assigned to a higher severity level.

While we decided to classify code 428.0 as a non-CC based on our policy concerning nonspecific codes, the data, and the judgment of our medical advisors, we note that heart failure is an important national health issue. We believe it is very important for hospitals and physicians to use the most specific codes that describe the incidence of heart failure in their patients. In order to accurately and completely evaluate health care outcomes for the treatment of heart failure, detailed and accurate information is needed on patients with this condition. Physicians and hospitals will undermine efforts to obtain more information on patients with this disease when they use a nonspecific code when there is a more detailed code to describe their patient. We highly encourage physicians and hospitals to work together to use the most specific codes that describe their patients' conditions. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population.

Comment: As stated earlier, a number of commenters requested CMS to add additional nonspecific codes to the CC list. These codes represent a variety of nonspecific conditions affecting multiple body systems. The commenters stated that the following nonspecific codes may increase the severity level for a patient, and should, therefore, be added to the CC list.

- 070.70, Unspecified viral hepatitis C

- 287.30, Primary thrombocytopenia, unspecified

- 287.5, Thrombocytopenia, unspecified

- 303.00, Acute alcohol intoxication, unspecified

- 345.90, , Epilepsy, unspecified, without intractable epilepsy

- 403.90, Hypertensive chronic kidney disease, unspecified, with chronic kidney

disease stage I through stage IV, or unspecified

- 424.0 Mitral valve disorders

- 424.1, Aortic valve disorders

- 426.13, Other second degree atrioventricular block

- 426.6, Other heart block

- 426.9, Conduction disorder, unspecified

- 447.6, Arteritis, unspecified

- 458.9, Hypotension, unspecified

- 451.2, Thrombophlebitis of lower extremities, unspecified.

- 459.0, Hemorrhage, unspecified

- 585.5, Chronic kidney disease, unspecified

- 707.0, Decubitus ulcer, unspecified

- 780.39, Other convulsions

Response: As previously stated, we did not classify nonspecific codes to the

MCC list or the CC list when more specific codes were available to identify the condition

of the patient. In general, we found that the data did not support classifying unspecified

codes as either MCCs or CCs. Further, after detailed discussions of potential clinical

scenarios among our medical advisors, there was a consensus that a specified condition

for the patient generally signals higher degree of severity of illness. If the physician was

to diagnose additional information about the patient's condition or should the patient's

condition worsen, a more precise code would be assigned that may be a CC or an MCC.

As a result of these comments, our medical advisors again reviewed these codes and

determined that their original decisions were correct. That is, they do not believe that

these nonspecific codes should be classified as MCCs or CCs when more specific codes

are available that provide more information about patient severity of illness. For these

reasons, we are not adding the codes listed above to the CC list.

(b) Symptoms, Chronic Conditions, and Low Severity Conditions

Comment: Commenters requested that we add a number of codes to the CC list

that describe symptoms, chronic conditions, and low severity conditions. These

conditions include the following codes:

- 070.54, Chronic viral hepatitis C

- 250.4x, Diabetes mellitus with renal manifestations

- 250.5x, Diabetes mellitus with ophthalmic manifestations

- 250.6x, Diabetes mellitus with neurological manifestations

- 250.7x , Diabetes mellitus with peripheral circulatory disorders

- 250.8x, Diabetes mellitus with other specified manifestations

- 263.0, Moderate Malnutrition

- 263.1, Mild malnutrition

- 276.51, Dehydration

- 276.52, Hypovolemia

- 276.6, Fluid overload

- 276.7, Hyperpotassemia

- 276.9, Electrolyte and fluid disorders

- 280.0, Iron deficiency anemias, secondary to blood loss (chronic)

- 284.8, Aplastic anemias, not elsewhere clasified

- 287.39 Other primary thrombocytopenia

- 287.4 Secondary thrombocytopenia

- 303.01 Acute alcohol intoxication, continuous

- 303.02 Acute alcohol intoxication, episodic

- 306.00, Blindness

- 389.9, Deafness

- 413.9, Angina pectoris

- 427.31,Atrial fibrillation

- 428.1, Left heart failure (change from CC to MCC)

- 451.0, Thrombophlebitis of superficial vessels of lower extremities;

- 492.8, Other emphysema

- 496, Chronic airway obstruction, not elsewhere classified

- 585.3, Chronic kidney disease, stage III (moderate)

- 599.7, Hematuria

- 710.0, Systemic lupus erythematosus

- 731.3, Major osseous defects

- 786.03, Apnea

- 788.20, Urinary retention

- 799.02, Hypoxemia

- V45.1, Renal dialysis status

Response: As discussed earlier, we did not assign chronic conditions to the CC

list or the MCC list. These conditions do not themselves indicate a high severity level

using our mathematical analysis of the claims data combined with the clinical judgment

by our medical advisors. As stated earlier, we did not include most chronic conditions on

the CC list or the MCC list unless the code also indicates an acute exacerbation that

would raise the severity level. If the chronic condition worsens and the patient develops

an acute complication, the more specific code for the acute exacerbation would identify

the increased level of severity of illness and, if warranted, would be on the CC or the

MCC list. We also did not include general symptoms on the CC list because, alone, they

do not suggest a high level of severity of illness. Codes identifying symptoms such as

hematuria, apnea, or hypoxemia that are found in many patients may indicate a wide

range of patient severity and describe a transient finding. Should the physician diagnose

a more specific condition that led to the symptoms, more information about the patient

and their severity of illness would be known. The specific diagnosis may indicate higher

severity of illness and the code that describes it may be included on the CC list or the

MCC list. We also did not include conditions on the CC list or the MCC list that do not

generally raise the severity level of a patient. If the code describes patients who range

from mild to severe, we believe it is best to use additional secondary diagnosis codes that

would be reported to better describe the true nature of the patient's condition. These more precise codes may be on the CC list or the MCC list.

Our clinical advisors reviewed claims data and the clinical issues surrounding patients who had the symptoms, chronic diagnoses, and less severe conditions listed above. They recommend that we not add the codes listed above to the CC list because these conditions do not significantly increase a patient's severity of illness. Therefore, we are not adding the codes listed above to the CC list.

(c) High Severity Codes That Were Erroneously Left Off of the CC List or the MCC List

As stated earlier, a number of commenters recommended the addition of codes to the CC list or the MCC list for conditions that the commenters stated clearly represented a high severity level. The commenters provided information on the degree to which these conditions are life threatening and require extensive amounts of resources. The commenters questioned why these conditions were left off of the CC and MCC lists. Commenters recommended the removal of two codes from the CC list because the commenters believed they do not increase the patient's severity level or lead to more resource use. We discuss these conditions below.

Comment: Commenters requested that we add the following five codes to the CC list. The commenters stated that these conditions clearly increase the severity level and lead to more resource use.

- 285.1, Acute posthemorrhagic anemia

- 403.91, Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease

● 426.53, Other bilateral bundle branch block

● 426.54, Trifascicular block

● 451.11, Phlebitis and thrombophlebitis, femoral vein (deep) (superficial)

Response: We agree with the commenters that the five codes listed above should

have been included on the CC list. Upon further review of our data and discussions

among our medical advisors, there was consensus that these codes describe patients with

a higher severity level. Therefore, we are adding them to the CC list.

Comment: Commenters requested that we remove the following two codes from

the CC list and make them non-CCs. The commenters indicated that there are more

specific heart failure codes that would be assigned along with these codes that would

indicate whether or not the patient had a severe form of heart failure. The commenters

stated that these two codes do not indicate the exact nature of the heart failure and

therefore should not be on the CC list.

● 402.11, Hypertensive heart disease, benign, with heart failure

● 402.91, Hypertensive heart disease, unspecified, with heart failure

Response: We agree with the commenters. Upon further review, we do not

believe the codes meet the criteria to be considered CCs.   The codes do not describe the

exact nature of the heart failure. The more specific heart failure codes that would be

reported along with these codes would be used to justify the assignment to a high severity

level. Therefore, we are removing the two codes from the CC list.

Comment: Commenters requested that we add the following four codes to the

MCC list. The commenters indicated that these four codes describe patients at the

highest level of severity. Patient with these conditions would use extensive amount of

resources. Furthermore, the commenters added, codes that describe similar conditions

are currently on the MCC list. The commenters believed these codes were erroneously

excluded from the MCC list.

- 282.69, Other sickle-cell disease with crisis

- 345.2, Petit mal status

- 345.71, Epilepsia partialis continua, with intractable epilepsy

- 780.01, Coma

Response: We agree that we made an error in excluding these four codes from

the MCC list. Therefore, we are adding the four codes to the MCC list. We provide a

summary of all the additions and deletions to the CC list and the MCC list at the end of

this section.

Additional Comments on CC List

We received several additional comments concerning the CC and MCC lists

which we summarize below. Some of the comments involved the commenter's

confusion about our proposed CC and MCC lists. Others involved a disagreement with

our proposal of not making significant changes to the DRGs to better distinguish severity

of illness in pregnancies and newborns, even though they are not a significant part of the

Medicare population. We also received recommendations for alternative ways to classify

conditions as CCs that do not meet our current criteria. In addition, we received

comments on our proposal of not classifying specific conditions as a CC/MCC when the

patient dies. We discuss these issues below.

● Other Myelopathy - Code 336.8

Comment: One commenter requested that we add code 336.8 (Other myelopathy) to the CC list.

Response: Code 336.8 is already on the CC list. Therefore, we are not making any further change for code 336.8.

● Ascites - Code 789.5

Comment: One commenter requested that we add the code 789.5 (Ascites) to the CC list

Response: We note that code 789.5 is being deleted as of October 1, 2007, when two new codes are being created, code 789.51 (Malignant ascites) and code 789.59 (Other ascites). Both of these new codes are on the CC list. Therefore no additional change is required for ascites.

● Aplastic Anemias, Not Elsewhere Classified - Code 284.8

Comment: One commenter objected to the removal of code 284.8 (Aplastic anemias, not elsewhere classified (NEC)) from the CC list.

Response: Code 284.8 was placed on the MCC list. Thus, while it is not classified as a CC as the comment suggested, it is an MCC. We are maintaining code 284.8 on the MCC list, as we agree that this is a condition that places a patient at a high severity level.

● Complications of Pregnancy, Childbirth and Puerperium - Codes 630 through 677

Comment: One commenter objected to the removal of codes from category 630 through 677 (Complications of pregnancy, childbirth and puerperium) of the CC list. The

commenter was concerned about the number and wide breadth of codes from Chapter 11

of the ICD-9-CM, Complications of pregnancy, childbirth and puerperium (categories

630-677), that are being removed from the CC list . The commenter acknowledged CMS'

position that, due to the low volume in the Medicare population, diagnoses related to

newborns, maternity and congenital anomalies codes in this section were not reviewed.

Of special concern to the commenter were conditions such as infections, acute renal

failure, air and pulmonary embolism, cardiac arrest, shock, among others, that are MCCs

or CCs and would be coded as such if not for the fact that the ICD-9-CM classification

considers problems associated with pregnancy, childbirth and the puerperium to be so

clinically significant that they require special combination codes. The combination codes

are intended to identify that the presence of the pregnancy complicates the condition. For

example, code 415.19 (Other pulmonary embolism and infarction) is an MCC, while

code 673.20 (Obstetrical blood-clot embolism, unspecified) is not even a CC.

The commenter recommended that codes in Chapter 11 be carefully evaluated and

validated with clinical experts, similar to the process to which the codes in other chapters

were submitted. The commenter believed that combination codes should be treated

consistently. If the condition is considered a CC or MCC in a nonpregnant patient, the

corresponding pregnancy-related combination code also should be a CC or MCC.

Response: As we stated in our proposed rule and elsewhere in this final rule with

comment period, we focused our attention in developing the MS-DRGs for the Medicare

population. We did not conduct a detailed review of Chapter 11 codes. We encourage

other payers who want to use MS-DRG to update the system for their own population.

Diagnoses related to newborns, maternity, and congenital anomalies are very low volume

in the Medicare population and were not reviewed for purposes of creating the MCC and

CC lists. We used the APR DRGs to categorize these diagnoses. This DRG system is

used for the all-payer ratesetting system in Maryland and will be based on data that better

reflects the newborn and maternity population than Medicare. For newborn, obstetric,

and congenital anomaly diagnosis, we classified severity level 3 (major) and 4 (extreme)

diagnoses as an MCC. We designated default severity level 2 (moderate) diagnoses as a

CC and all other diagnoses as a non-CC. We encourage the commenter to review the

MCC and CC lists in on the CMS Web site. Many codes in the 630 to 677 range appear

on the MCC list.

● Extreme Immaturity - Code 765.0

    Comment: One commenter objected to codes in category 765.0 (Extreme

immaturity) not being classified as CCs. The commenter stated that codes in category

765.0 represent infants with a birth weight of less than 1000 gm. The commenter

indicated that common problems with very low birthweight babies are low oxygen levels

at birth; inability to maintain body temperature; difficulty feeding and gaining weight;

infection; breathing problems, such as respiratory distress syndrome; neurological

problems, such as intraventricular hemorrhage; gastrointestinal problems, such as

necrotizing enterocolitis; and sudden infant death syndrome (SIDS). The commenter

stated that while some of these problems have unique ICD-9-CM codes that could be

reported, not all of them do (for example, inability to maintain body temperature).

Response: While we appreciate the commenter's concern about the CC

classifications for newborns, we state again that we did not examine these newborn codes

as part of our development of the MS-DRGs. We focused our efforts on the Medicare

population and used the APR DRG classification for newborn diagnoses for Medicare. If

the APR DRG classification of this condition were to change, we would also adopt the

same designation for Medicare.

● Exclusion of MCCs and CC When a Patient Dies

Comment: Several commenters addressed codes that represent diagnoses

associated with patient mortality. The commenter indicated that, in the proposed rule,

CMS noted that diagnoses that were closely associated with patient mortality were

assigned different CC subclasses, depending on whether the patient lived or died.

These diagnoses are:

- 427.41, Ventricular fibrillation;

- 427.5, Cardiac arrest;

- 785.51, Cardiogenic shock;

- 785.59, Other shock without mention of trauma; and

- 799.1, Respiratory arrest.

The commenters agreed that these diagnoses should be considered MCCs for

patients who are discharged alive. However, the commenters disagree with CMS'

proposal to make these diagnoses non-CCs when a patient dies. The commenters urged

CMS to consider the patient's length of stay or other factors when these codes are

reported and count them as an MCC when a patient dies during the admission. The

commenters agreed that a patient who expires soon after admission may not have

significant resources associated with these conditions. However, the commenters

believed that this is not true when a patient has been hospitalized longer, such as for a

week.

Response: Our medical advisors examined this issue again and continue to

believe it is not appropriate to classify a case as an MCC based on one of the codes above

if the patient dies. While we understand the concern of the commenters, we do not

believe that a long length of stay patient will necessarily lead to the conclusion that it is

appropriate to code these conditions in a patient that dies in the hospital. It is a possible

that a terminally ill patient with a long length of stay required no special resuscitation

efforts that would suggest higher resource use associated with coding of these conditions.

We are concerned that changing our policy to allow use of these codes for a patient that

died in the hospital could lead to accurate and widespread coding of the conditions when

they are not indicative of a higher patient resource costs. Therefore, we are continuing

our policy of classifying the diagnoses listed above as MCCs only if the patient is

discharged alive. We will evaluate alternative approaches such as looking at the length

of stay and other factors for these patients and make future DRG revisions, as needed.

● Selected Conditions in Joint Replacement Patients

Comment: One commenter asked that we classify certain codes as MCCs or CCs

for patients having a joint replacement. The commenter specifically requested that the

following codes be made either MCCs or CCs when occurring in a joint replacement

patient:

- 731.3, Major osseous defect

- 278.0, Obesity

- 278.01, Morbid obesity

- V85.35, Body mass index 35.0 -35.9, adult

- V85.37, Body mass index 37.0 – 37.9 adult

Response: We do not believe that we should make further changes to the

MS-DRG assignments based on combinations of selected diagnoses. These types of

analyses could be done with virtually any MS-DRG and would add significant

complexity to the DRG system that we do not believe is warranted at this time. Our

medical advisors reviewed both the data and clinical issues surrounding these codes and

determined that they would not significantly increase the severity level for Medicare

patients on average across all patients. Therefore, they are not CCs.   We are not

changing these codes to CCs. They will remain non-CC for all cases.

The following table summarizes changes to the proposed MCC (Table 6J) and CC

(Table 6K) lists published in the proposed rule. These changes are a result of review of

comments and were discussed in detail above. A complete, updated CC and MCC list

will be posted on the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/

under Downloads. We will continue to evaluate our criteria for the development of the

CC and MCC list sto determine if refinements to these criteria are needed. As we gain

data and experience under MS-DRGs, we believe that there may be refinements to these

criteria.

CHANGES TO MCC AND CC LIST
AS A RESULT OF COMMENTS

Add to CC list

285.1	Acute posthemorrhagic anemia
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
426.53	Other bilateral bundle branch block
426.54	Trifascicular block
451.11	Phlebitis and thrombophlebitis, femoral vein (deep) (superficial)

Remove from CC list

345.2	Petit mal status
345.71	Epilepsia partialis continua, with intractable epilepsy
402.11	Hypertensive heart disease, benign, with heart failure
402.91	Hypertensive heart disease, unspecified, with heart failure
780.01	Coma

Add to MCC list

282.69	Other sickle-cell disease with crisis
345.2	Petit mal status
345.71	Epilepsia partialis continua, with intractable epilepsy
780.01	Coma

Remove from MCC list

None

3. Dividing MS-DRGs on the Basis of the CCs and MCCs

In developing the MS-DRGs, two of our major goals were to create DRGs that would more accurately reflect the severity of the cases assigned to them and to create groups that would have sufficient volume so that meaningful and stable payment weights could be developed. As noted above, we excluded the CMS DRGs in MDCs 14 and 15 from consideration because these DRGs are low volume. As stated previously, we do not have the expertise or data to maintain the CMS DRGs for newborns, pediatric, and maternity patients. We continue to maintain MDCs 14 and 15 without modification in order to have MS-DRGs available for these patients in the rare instance where there is a Medicare beneficiary admitted for maternity or newborn care.

In designating an MS-DRG as one that will be subdivided into subgroups based on the presence of a CC or MCC, we developed a set of criteria to facilitate our decision-making process. In order to warrant creation of a CC or major CC subgroup within a base MS-DRG, the subgroup had to meet all of the following five criteria:

● A reduction in variance of charges of at least 3 percent.

● At least 5 percent of the patients in the MS-DRG fall within the CC or MCC subgroup.

● At least 500 cases are in the CC or MCC subgroup.

● There is at least a 20-percent difference in average charges between subgroups.

● There is a $4,000 difference in average charges between subgroups.

Our objective in developing these criteria was to create homogeneous subgroups that are significantly different from one another in terms of resource use, that have enough

volume to be meaningful, and that improve our ability to explain variance in resource use.

These criteria are essentially the same criteria we used in our 1994 severity analysis. In

developing the MS-DRGs, we continued to apply our longstanding policy that each DRG

should contain patients who are similar from a clinical perspective.

To begin our analysis, we subdivided each of the base MS-DRGs into three

subgroups: non-CC, CC, and MCC. Each subgroup was then analyzed in relation to the

other two subgroups using the volume, charge, and reduction in variance criteria. The

criteria were applied in the following hierarchical manner:

● If a three-way subdivision met the criteria, we subdivided the base MS-DRG into

three CC subgroups.

● If only one type of two-way subdivisions met the criteria, we subdivided the base

MS-DRG into two CC subgroups based on the type of two-way subdivision that met the

criteria.

● If both types of two-way subdivisions met the criteria, we subdivided the base

MS-DRG into two CC subgroups based on the type of two-way subdivision with the

highest R^2 (most explanatory power to explain the difference in average charges).

● Otherwise, we did not subdivide the base MS-DRG into CC subgroups.

For any given base MS-DRG, our evaluation in some cases showed that a

subdivision between a non-CC and a combined CC/MCC subgroup was all that was

warranted (that is, there was not a great enough difference between the CC and MCC

subgroups to justify separate CC and MCC subgroups). Conversely, in some cases, even

though an MCC subgroup was warranted, there was not a sufficient difference between the

non-CC and CC subgroups to justify separate non-CC and CC subgroups.

Based on this methodology, a base MS-DRG may be subdivided according to the

following three alternatives, rather than the current "with CC" and "without CC" division.

● DRGs with three subgroups (MCC, CC, and non-CC).

● DRGs with two subgroups consisting of an MCC subgroup but with the CC and

non-CC subgroups combined. We refer to these groups as "with MCC" and "without

MCC."

● DRGs with two subgroups consisting of a non-CC subgroup but with the CC and

MCC subgroups combined. We refer to these two groups as "with CC/MCC" and "without

CC/MCC."

As a result of the application of these criteria, 745 MS-DRGs were created as

shown in the following table.

Table M.--Number of CC Subgroups

Subgroups	Number of Base MS-DRGs	Number of MS-DRGs
No Subgroups	53	53
Three subgroups	152	456
Two subgroups: CC and major CC; non-CC	43	86
Two subgroups: non-CC and CC; major CC	63	126
Subtotal	311	721
MDC 14	22	22
Error DRGs	2	2
Total	**335**	**745**

The 745 MS-DRGs represent an increase over the 652 DRGs we proposed in our

1994 CC revision analysis. The increase in the number of DRGs is primarily the result of

an increase in the number of proposed base MS-DRGs that are subdivided into three CC

subgroups. The distribution of patients across the different types of CC subdivisions is

contained in Table N below. The table shows that 51.7 percent of the patients are

assigned to base MS-DRGs with three CC subgroups, and only 11.8 percent of the

patients are assigned to base MS-DRGs with no CC subgroups.

Table N.--Distribution of Patients by Type of CC Subdivision

CC Subdivision	Count	Percent
None	1,382,810	11.8
(MCC and CC), Non-CC	629,639	5.4
MCC, (CC and Non-CC)	3,650,321	31.2
MCC, CC, and Non-CC	6,054,081	51.7

Using Medicare charge data (without applying any criteria to remove statistical

outlier cases), the reduction in variance (R^2) was computed for current CMS DRGs, the

MS-DRGs with all 311 base MS-DRGs subdivided into 3 CC subgroups, and the

MS-DRGs collapsed into 745 DRGs. Table O below shows that the R^2 for the MS-DRGs

with all 311 base MS-DRGs subdivided into 3 CC subgroups (957 DRGs composed of

311 base MS-DRGs subdivided into 3 CC subgroups plus an additional 22 MDC 14 and

MDC 15 DRGs as well as 2 error DRGs) is 10.62 percent higher than the current CMS

DRGs. Collapsing the 957 MS-DRGs down to 745 MS-DRGs lowers this increase in R^2

slightly to 9.41 percent. Although adopting a 3-way split for each base MS-DRG would

produce a DRG system with higher explanatory power, the 957 MS-DRGs would not

meet the criteria we specified above for subdividing each base DRG. The criteria we

specified above would create a monotonic DRG system. We believe that the value of

having a monotonic DRG system outweighs the slight decrease in explanatory power.

For this reason, we proposed to adopt the 745 MS-DRGs.

Table O.--Explanatory Power (R^2) for MS-DRGs

	R^2	Percent Change
Current CMS DRG	36.19	—
2007 CMS Severity DRGs with 3 CC Subgroups	40.03	10.62
2007 CMS Severity DRGs Collapsed to 714 DRGs	39.59	9.41

Comment: One commenter supported our five criteria for establishing severity

subgroups. The commenter believed the use of specific quantitative criteria to determine

how specific base DRGs are divided into terminal categories that reflect severity levels is

logical and designed to ensure that only substantively important differences in resource

requirements are recognized by the MS-DRG system. The commenter did note that CMS

had not explicitly included statistical significance in these criteria and urged CMS to

consider CC or MCC splits only when they meet minimal standards of both size and

statistical significance.

Response: We appreciate the commenter's support for our five criteria for

establishing severity subgroups. We will consider the commenter's other suggestion as

we make further refinements to the MS-DRGs.

Comment: One commenter disagreed with our five criteria for establishing

severity subgroups. The commenter stated that these criteria are too restrictive, lack face

validity, and create perverse admission selection incentives for hospitals by significantly

overpaying for cases without a CC and underpaying for cases with a CC. The commenter

recommended that the existing five criteria be modified for low-volume subgroups to

assure materiality. For higher volume MS-DRG subgroups, they recommended that two

other criteria be considered, particularly for nonemergency, elective admissions. These

two criteria are:

● Is the per-case underpayment amount significant enough to affect admission

vs. referral decisions on a case-by-case basis?

● Is the total level of underpayments sufficient to encourage systematic

admission vs. referral policies, procedures, and marketing strategies?

The commenters also recommended refining the five existing criteria for

MCC/CC/without subgroups as follows:

● Create subgroups if they meet the five existing criteria, with cost difference

between subgroups ($1,350) substituted for charge difference between subgroups

($4,000).

● If a proposed subgroup meets criteria # 2 and # 3 (at least 5 percent of

discharges in the subgroup and at least 500 cases) but fails one of the others, create the

subgroup if either of the following criteria is met:

- At least $1,000 cost difference per case between subgroups; or

- At least $1,000,000 overall cost should be shifted to cases with a CC (or MCC)

within the base DRG for payment weight calculations.

The commenter stated that this approach would affect DRGs where the total

dollars under consideration may be quite high (for example, in the hundreds of millions),

due to large numbers of procedures, but the percentage difference in average charges falls

short of the 20 percent difference in average charges between subgroups.

Response: We disagree that the five criteria for establishing severity subgroups

are too restrictive and will lead to overpayments for cases without a CC and underpay for

cases with a CC. Relative to the current CMS DRGs, the statistical data above suggest

that the construction of the MS-DRGs using these criteria will improve payment

accuracy. The explanatory of the MS-DRGs to predict resource use is more than 9

percent greater than under the current CMS DRGs. Further, under the current CMS

DRGs, nearly 78 percent of patients are in the highest severity level, while only 22.2

percent are in the highest severity level under the MS-DRGs. In addition to having a

better distribution of cases among severity levels, the MS-DRGs have more significant

difference in average charges over the different severity levels compared to the current

CMS DRGs (72 FR 24706).

The commenter does not appear to disagree with these statistics suggesting that

improvements will result from the MS-DRGs. Rather, the commenter is suggesting that

we should create more subgroups with smaller differences in average charges (or costs).

We do not believe the first two alternative criteria are practical or necessary to apply.

They would require us to make subjective judgments about whether a hospital would

treat patients or refer them elsewhere solely based on payment incentives. We do not

believe it is possible or appropriate for us to make judgments about whether a hospital

would decide to treat or not treat a patient based on how much they are paid. Further,

with the exception of cardiac specialty hospitals, we have no evidence hospitals are

selectively treating or avoiding particular types of patients because of incentives present

in Medicare's IPPS payments. The reforms we are making are intended to pay hospitals

more accurately for the patients they are already treating and avoid incentives for more

specialty hospitals to form. Therefore, we do not believe it is practical or necessary to

use the first two criteria suggested by the commenter.

With respect to the last criteria, we note that the MS-DRGs represent a significant

expansion in the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The

commenter is suggesting that we create additional subgroups with less variation between

the subgroups. Payments under a prospective payment system are predicated on

averages. Thus, most individual cases within any DRG system will have costs that are

either higher or lower than the average for that group. While creating groups that have

lower differences in average charges or costs between the groups may lessen variation

around the average and improve explanatory power, it will also create more low-volume

groups and increase the likelihood that the relative weights will be nonmonotonic and

have instability in their values from year to year. We believe the value of a lower number

of DRGs outweighs the benefit we would obtain from a slight increase in R^2 and the risk

of having nonmonotonic DRGs that would come from adopting the commenter's

suggestions.

4. Conclusion

We believe the MS-DRGs represent a substantial improvement over the current

CMS DRGs in their ability to differentiate cases based on severity of illness and resource

consumption. As developed, the MS-DRGs increase the number of DRGs by 207, while

maintaining a reasonable patient volume in each DRG. The MS-DRGs increase the

explanation of variance in hospital resource use relative to the current CMS DRGs by

9.41 percent. Further, the data shown below in Table P and Table Q illustrate how

assignment of cases to different severity of illness subclasses improves in the MS-DRGs

relative to the CMS DRGs.

Table P.--Overall Statistics for CMS DRGs

CC Subclass - Current CMS DRG	Percent	Average Charges
One or more CCs	77.66	$24,538
Non-CC	22.34	$14,795

Table Q.--Overall Statistics for MS-DRGs

CC Subgroup	Number of Cases	Percent	Average Charges
MCC	2,607,351	22.2	$44,219
CC	4,298,362	36.6	$24,115
Non-CC	4,826,980	41.1	$18,416

Under the current CMS DRGs, 78 percent of cases are assigned to the highest

severity levels (CC) and the remaining 22 percent are assigned to the lowest severity

level (non-CC). Applying the three severity subclasses to FY 2006 data would result in

approximately 22 percent of patients being assigned to the severity subgroup with the

highest level of severity (MCC), 41 percent being assigned to the lowest severity subclass

(non-CC), and the remaining 37 percent being assigned to the middle severity subclass

(CC). Adding the new MCC subgroup greatly enhances our ability to identify and pay

hospitals for treating patients with high levels of severity. As Table Q above shows, the

new subgroups also have significantly different resource requirements. The MCC

subgroup contains patients with average charges almost twice as large as for those in the

CC group ($44,219 compared to $24,115).

In addition to resulting in improvements in the DRG system's recognition of

severity of illness, we believe the MS-DRGs are responsive to the public comments that

were made on last year's IPPS proposed rule with respect to how we should undertake

further DRG reform. In the FY 2007 IPPS final rule, we identified three major concerns

in the public comments about our proposed adoption of CS DRGs:

We received comments after the FY 2007 IPPS final rule suggesting that further

adjustments were needed to the proposed DRG system. The commenters believed that

the CS DRGs did not incorporate many of the changes to the 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 using the

CMS DRGs as the starting point to better recognize severity.

We believe that the MS-DRGs are responsive to these suggestions. The

MS-DRGs use the CMS DRGs as the starting point for revising the DRGs to better

recognize resource complexity and severity of illness. We are generally retaining all of

the refinements and improvements that have been made to the base DRGs over the years

that recognize the significant advancements in medical technology and changes to

medical practice. At the same time, the MS-DRGs greatly improve our ability to identify

groups of patients with varying levels of severity. They retain all of the improvements

made to the DRGs over the years, while providing a more equitable basis for hospital

payment.

We received many comments on the FY 2007 IPPS rule about the potential use of

a proprietary DRG system. The comments about the CS DRGs raised compelling issues

about the potential government use of a proprietary system, including concerns about the

availability, price, and transparency of the source code, logic and documentation of the

DRG system. The commenters noted that CMS makes available these resources in the

public domain for purchase through the National Technical Information Service at

nominal fees to cover costs. The commenters urged CMS not to adopt a proprietary DRG

system that would not be available on the same terms as the current CMS DRGs.

There are no proprietary issues associated with the MS-DRGs. The MS-DRGs

will be available on the same terms as the current CMS DRGs through the National

Technical Information Service.

We also received other comments on the FY 2007 IPPS rule concerning the use of

CS DRGs. The commenters stated that no alternatives to CS DRGs had been evaluated.

The commenters suggested that alternative DRG systems can better recognize severity

than the CS DRGs and should be evaluated before CMS decides which system to adopt.

In response to these concerns, we contracted with RAND Corporation to evaluate several

alternative DRG systems, including the MS-DRGs that we proposed and are finalizing in

this final rule with comment period for FY 2008.

As indicated above, we believe the MS-DRGs offer significant improvements to

the DRG system without many of the liabilities the public commenters on the FY 2007

IPPS rule identified with the CS DRGs. Thus, we believe the MS-DRGs offer significant

improvements in recognition of severity of illness and complexity of resources and are

adopting them for FY 2008.

Comment: Many commenters supported the MS-DRGs. One commenter stated

that "your proposal showcases the best of CMS, evidenced, for example, by an elegant

and reasonable framework for severity-adjusted DRGs." Another commenter stated that

it was "about time that Medicare adopted a DRG system that allows for more equitable

reimbursement for cases of severe illness with high risk of death or significant

morbidity." Other commenters stated that it was very apparent that CMS dedicated an

extensive amount of thought, planning, and resources toward the development of the

MS-DRGs, and that the system appears to be a very reasonable approach toward

stratifying the patient grouping system more distinctly based on the severity of the

patient's illness.

Many commenters found the MS-DRGs to represent a reasonable approach to

DRG refinement, stating they are, in principle, a positive advancement and will create a

more equitable and accurate payment system. Other commenters stated that the

MS-DRGs are an effective method for incorporating greater refinements to reflect

variations in patient severity. Other commenters stated that hospitals providing services

to more complex patients should be paid in a manner that reflects the nature of that care.

These commenters stated that they do not want to see a payment system that rewards

hospital inefficiency and it is reasonable that Medicare reimbursement policy assures that

services are appropriately compensated. Other commenters stated that, over time, some

DRGs have become more profitable than others. The commenters stated that making

adjustments in rates helps to restore balance to the entire hospital inpatient payment

system. These commenters endorsed CMS' efforts to achieve these goals through the

adoption of the MS-DRGs.

Other commenters expressed their appreciation for CMS' recognition and

consideration of issues raised in the public comments on last year's proposal to adopt

CS DRGs. The commenters indicated that CMS took account of the public comments in

crafting this year's MS-DRG proposal. The commenter applauded CMS for addressing

many concerns that were expressed regarding CS DRGs. One of these commenters stated

that MS-DRGs are significantly superior to the CS DRGs that were proposed last year.

One commenter indicated that it had asked CMS to do the following when considering

adoption of a new DRG system:

● Show evidence that the alternative resulted in an improved hospital payment

system compared to the existing DRG system;

● Test the degree to which the variation in costs within cases at the DRG level is

reduced;

● Consider whether there were easier ways to adjust for severity similar to the

differentiation of patients in FY 2006 based on the absence or existence of a major

cardiovascular diagnosis;

● Maintain the improvements made to differentiate cases based on complexity in

the existing system; and

● Avoid creating a system that is proprietary and lacks transparency.

The commenter indicated that CMS made a concerted effort to develop a system that incorporates all of these goals and indicated their support for these meaningful improvements to the IPPS. Like this commenter, several other commenters were also in agreement that the proposed DRG system should not be proprietary to avoid limiting public access to the system. Another commenter who expressed appreciation for CMS' responsiveness to issues raised in last year's IPPS rule indicated that the MS-DRGs are logical, transparent, and nonproprietary, which well suits the needs of the health care community. Other commenters also expressed support for CMS' decision to make the MS-DRGs nonproprietary, open, and accessible, and available on the same terms as the current DRGs.

Another commenter stated that it had decades of experience doing work with DRG systems and believe that there has been a need for a severity adjustment mechanism in the CMS DRGs to facilitate more accurate payment under the IPPS. In its view, the MS-DRG methodology is an appropriate mechanism to add severity adjustments to IPPS for FY 2008. According to the commenter, the MS-DRGs' advantages include:

● They are based on the current CMS DRGs, whose technical features, data structures, and program algorithms have been fine-tuned over the years to accommodate the insertion and deletion of DRGs, changes in code/criteria lists, changes to CC and CC exclusion lists, changes in hierarchy, addition or deletion of DRG criteria, among others.

● Additional severity adjustments will not require substantial modifications to this basic, extensible, and highly efficient architecture. The architecture will facilitate the

addition of new categories necessitated by the introduction of new technologies or the

application of the methodology to non-Medicare populations.

The commenter recommended that CMS plan for a more flexible, four-character

nomenclature in the severity DRG system as soon as reasonably possible. The

commenter noted that all commercially available severity-adjusted DRG systems have

adopted a nomenclature that employs an initial 3-digit base DRG designation followed by

a 1-digit severity score. This approach is far more flexible and transparent. More

importantly, the approach lends itself more readily to the addition of new base DRGs and

the evolution of more granular severity-adjustment.

Many commenters were supportive of the MS-DRGs because they were derived

from the existing system and, therefore, preserve the numerous policy decisions made

over the years and embodied in the CMS DRGs. These commenters appreciated that

severity stratifications were created from the existing base DRGs with the result of

redistribution within, rather than across, the DRGs. Commenters also stated that the

MS-DRGs provide CMS with the flexibility of making DRG reassignments within a base

MS-DRG by moving more complex services up a severity level. Other commenters

stated that the MS-DRG system does a better job than last year's proposed CS DRGs or

the current CMS DRGs of reflecting advancements in medical technology and other

improvements in medical care.

Some commenters stated that, with the development and proposal of MS-DRGs,

they saw little reason for CMS to continue assessing and considering alternative patient

classification systems in the foreseeable future. These commenters stated that the

MS-DRG system is more transparent, accessible, and understandable than the alternative

systems being evaluated by RAND.

Some commenters stated that the MS-DRGs provide more accurate grouping for

severity of illness while retaining the CMS-DRG refinements to account for more

accurate payment of resource utilization. However, these commenters recommended that

the implementation of MS-DRGs be delayed for one year to wait for the final RAND

report and the availability of a GROUPER. One commenter stated that the MS-DRGs are

an excellent attempt to define severity of illness based on DRGs for the Medicare

population but urged us not to implement them in FY 2008 unless it is deemed to be the

final system adopted from the ones being studied by RAND. Several commenters stated

that hospitals will undergo enormous costs to "educationally gear up" for the MS-DRGs.

The commenter stated that the hospital community must expend educational dollars in its

attempt to improve coding to optimize each case's DRG assignment. These comments

were concerned about the burden and expense that would be imposed on hospitals from

adopting one significant DRG reform this year and another one next year. A number of

other similar comments urged CMS not to move to MS-DRGs if it plans to implement

another new severity system in FY 2009.

Response: We appreciate the support for MS-DRGs. We agree that, building on

the current DRG system, we have maintained the best aspects of our past efforts while

adding additional refinements to better identify severity. We also agree that it is

beneficial to consider moving to a four-character nomenclature for MS-DRGs. We have

already developed on internal version with four characters, with the fourth character

indicating the severity levels. Systems restrictions prevent us from using this four-

character numbering system in Medicare's data systems at this time. However, we will

continue to evaluate the possibility of moving to such a numbering system.

    With respect to the comments about the RAND project and the concern about

adopting two different DRG reforms in succeeding years, we note that RAND has

completed its evaluation of alternative DRG systems, including the MS-DRGs.

Consistent with RAND's findings, we believe it is appropriate at this time to adopt the

MS-DRG system for Medicare in FY 2008. While there will be an opportunity for the

public to comment on RAND's findings, we expect to permanently adopt the MS-DRGs

for the IPPS. We do not believe it is likely that there will be persuasive public comments

suggesting that one of the alternative DRG systems being evaluated by RAND is clearly

superior.

    Comment: One commenter fully endorsed the move to MS-DRGs, but stressed

the need of maintaining the current level of transparency in the DRG system, regardless

of the chosen methodology. The commenter stated that many companies offer software

that hospitals and health plans utilize in managing the billing, coding, and payment for

hospital inpatient services under the DRGs. The development of this software is possible

only because the current DRG methodology is a transparent system. By that, they mean

that members of the public can obtain full access to the details underlying the system by

purchasing information and software from the National Technical Information Service

(NTIS) at a nominal charge in a timely manner (well in advance of the implementation of

changes). The commenter appreciated the agency's commitment in the FY 2007 final

rule to "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." The commenter commended CMS for its continued attention to the transparency issue and appreciates CMS' proposal to make the MS-DRGs available on the same terms as they currently do CMS DRGs through NTIS.

Response: We agree that it is important to provide updates and modifications to the DRG system in a transparent manner. We intend to continue our efforts to do so by providing the necessary information through our regulations, Web sites, and through NTIS. The MS-DRGs will be available to the public on the same terms as the CMS DRGs.

Comment: MedPAC reviewed the MS-DRGs and commended CMS for its commitment to improve the accuracy of Medicare payments for hospital acute inpatient services. MedPAC stated that CMS staff had made significant progress toward achieving this goal with the development of MS-DRGs coupled with cost-based weights. MedPAC's analysis showed that MS-DRGs will result in a substantial improvement in payment accuracy. MedPAC took several steps to evaluate the proposed MS-DRGs. First, they examined their face validity. An effective patient classification system, in the context of a payment system, should group together clinically similar cases that have similar costs. In addition, MedPAC stated that relative weights calculated for the classification groups (MS-DRGs) generally should exhibit a consistent hierarchy of values across levels of severity of illness for different conditions. Therefore, one issue is how much costs vary around the mean cost per case for cases grouped within MS-DRGs.

Another issue is whether relative weights for different severity levels show the expected

hierarchy across most clinical conditions. For comparison, MedPAC also looked at the

cost variation and relationships among relative weights for cases grouped in the current

DRGs and in the severity categories of the APR DRGs. MedPAC also examined how the

MS-DRGs would affect payment accuracy in the IPPS, measured by how closely

payments would track costs for different types of cases. MedPAC compared payment

accuracy under the MS-DRGs with the results under the current CMS DRGs and the

severity categories of the APR DRGs.

MedPAC found that MS-DRGs did a better job of grouping cases with similar

costs into the same category. This was expected because the MS-DRGs break out high

severity (and high cost) cases with MCCs into separate DRGs. For comparison,

MedPAC also calculated the amount of variation in costs among cases within the severity

classes of APR DRGs (Version 23). The average absolute difference for the APR DRGs,

in turn, was 7.4 percent lower than the value for DRGs. MedPAC stated that this

suggests that at least some opportunities are available for further refinement of the

MS-DRGs. Although MedPAC found the MS-DRGs were not perfect, and may need to

be further refined over time, it believed they represent a significant improvement over the

current CMS DRGs. MedPAC's analysis showed that payment accuracy increased

substantially when moving from the current DRGs to one based on the MS-DRGs.

Response: We agree with MedPAC that the MS-DRGs represent a significant

improvement over the current CMS DRGs. As suggested above, we intend to use

RAND's evaluation of the MS-DRGs to make further improvements to it. We appreciate

MedPAC's suggestion to use the APR DRGs to also help us identify potential areas
where further improvements can be made to the MS-DRGs.

Comment: One comment stated that the "Crosswalk from CMS DRGs to MS-
DRGs" was somewhat misleading. The commenter was concerned that some entities are
interpreting it as a one-to-one mapping. The commenter suggested that it be clarified that
an individual DRG code cannot be mapped directly to a MS-DRG. The commenter
recommended that MS-DRG implementation be delayed so that CMS can release the
MS-DRG GROUPER and allow hospitals time to analyze the impact prior to
implementation.

Response: After public display of the proposed rule, we were asked to provide
additional information on the CMS Web site showing how the current CMS DRGs map
to the new MS-DRGs. Although we provided this information, we were concerned about
its usefulness because of the very issue raised in this public comment. That is, there is
not a one-to-one crosswalk between the 538 DRGs that exist under the CMS DRGs and
the 745 MS-DRGs. While this information may not have been as useful as originally
anticipated by members of the public that requested it, we believe the fact that there is not
a one-to-one crosswalk between the CMS DRGs and the MS-DRGs was well understood
by the public based on the description of each system in the proposed rule. In addition,
we made other information available to the public that would allow for a detailed analysis
of the MS-DRG proposal as well as the continuing transition to cost-based weights. We
made available two MedPAR files (FY 2005 and FY 2006) that included the CMS DRG
and MS-DRG assignment for each case. In addition, we made available charge-based,

cost-based, and blended weights under the CMS DRGs and the blended weights under the

MS-DRGs. With this information, we believe the public had detailed information to be

able to do a comprehensive analysis of our proposal to adopt MS-DRGs. We do not

believe that there should have been any confusion associated with the publicly requested

CMS DRG to MS-DRG crosswalk on the CMS Web site, and we do not see this

comment as a reason to delay implementation of the MS-DRGs.

Comment: A number of commenters urged CMS to process more than nine

diagnosis and six procedure codes. The commenters stated that this particular concern is

more acute with MS-DRGs where a hospital needs to make sure that CMS processes

codes that are MCCs and CCs because they determine DRG assignment. The

commenters also stated that vendors and health care groups make decisions about quality

of care based upon the CMS claim file. The commenters asked CMS to commit to a

timeframe when it will revise its systems to accept all 25 diagnosis and procedure codes

provided via electronic transmissions.

Response: We recognize the importance of using and analyzing as much clinical

data from claims as possible. Unfortunately, current system limitations preclude CMS

from processing more than nine diagnoses and six procedures at this time. We will

continue to review this matter in conjunction with our other information systems

priorities.

Comment: Several commenters stated that ICD-10-CM and ICD-10-PCS would

provide a much better foundation for a severity-adjusted DRG system than ICD-9-CM.

The value of MS-DRGs or any other severity-adjusted DRG system that relies on claims

data will be limited by the continued use of an obsolete, non-specific classification

system. ICD-10-CM and ICD-10-PCS would provide greater clinical detail, and up-to-

date clinical information for capturing information on disease severity, including

complications, comorbidities and risk factors, as well as more detailed information on the

use of medical technology and its impact on resource utilization and outcomes. The

longer adoptions of contemporary classifications are delayed, the more CMS must

develop alternatives that become costly to administer and for providers costly to

continually implement.

One commenter stated that, in previous years, the commenter's recognition of the

industry's need for consistency in medical coding, improved data integrity, and more

precise and contemporary data reflecting 21st century medicine has led it to advocate for

adoption and coordinated implementation of ICD-10-CM and ICD-10-PCS in their

previous comments on the IPPS. The commenter stated that it is unfortunate that, as new

initiatives that rely heavily on coded data gain momentum (such as present on admission

reporting, pay-for-performance, and DRG refinements to better recognize severity of

illness), ICD-10-CM and ICD-10-PCS still have not been implemented as replacements

for ICD-9-CM.

One commenter stated that if the obsolete ICD-9-CM coding system had been

replaced earlier, claims data that would significantly add to the knowledge needed to

measure severity, quality, and other factors under consideration would now be available.

The commenter stated that the proposed MS-DRG system and other proposals in this

year's proposed rule are excellent examples of how ICD-10-CM and ICD-10-PCS could

improve the ability to refine reimbursement systems in order to better reflect severity of illness. The commenter urged CMS and HHS to take immediate action to secure the adoption and implementation of these two classification systems, and supporting transaction standards as early as possible.

Response: We are continuing to carefully analyze issues associated with implementing ICD-10.

Comment: Several commenters opposed the reuse of the current CMS DRG numbers in the MS-DRG system. Although one commenter acknowledged the advantages of maintaining the current 3-digit numerical scheme, it believed the use of the same DRG numbers in both the CMS DRG and MS-DRG systems will create confusion when analyzing longitudinal data, given the same DRG number will have a different meaning in the two systems. The commenter suggested that delaying implementation of a severity-adjusted DRG system until FY 2009 would allow additional time for making more extensive systems modifications, such as adopting an alphanumeric or 4-digit numerical structure for the new DRG system. Another commenter suggested that CMSbegin numbering with a 4-digit number so that there will not be confusion about which system is being used.

Response: We agree that it is beneficial to consider moving to a 4-character nomenclature for MS-DRGs. We have already developed an internal version with four characters, with the fourth character indicating the severity levels. Systems restrictions prevent us from using this 4-character numbering system in Medicare's data systems at this time. However, we will continue to evaluate the possibility of moving to such a

numbering system in the future. We do not expect the changes to our data systems that

would be necessary to adopt a 4-digit DRG numbering system will occur with a year's

delay of the MS-DRGs. Therefore, we do not believe that we should delay the

improvements in recognition of severity of illness in our payment system for this reason.

If there is public interest, we will make our internal 4-digit numbering system available

on the CMS Web site to assist the public in understanding the future numbering system

we would be likely to adopt. Such information may also be useful to the public to engage

in the types of analysis suggested by this public comment.

Comment: One commenter stated that the Medicare CMS DRG GROUPER is

used by some payers for their commercial, non-Medicare business. The commenter

understands that CMS may want to move to MS-DRGs for Medicare patients, but is

concerned about its continued access to the current GROUPER program, should

Medicare decide to replace CMS DRGs with MS-DRGs. The commenter requested that

the existing CMS GROUPER remain intact for commercial insurers to utilize for their

non-Medicare contracts. The commenter suggested this could be done by keeping the

GROUPER in the CMS database with the title "CMS GROUPER." The commenter

stated CMS would not need to update the weights of the CMS GROUPER or make any

other adjustments.

Response: The focus of CMS' efforts is in developing and maintaining a DRG

system that is appropriate for its Medicare population. We have, and will continue to,

encourage other payers to make any necessary modifications to this program to meet their

needs. The current versions of the CMS DRGs will remain in the public domain.

However, we do not intend to make any updates to them once we move to the MS-DRGs

or another severity DRG system. We do not believe that Medicare should undertake the

effort and expense to maintain and update a DRG system that will have no application for

Medicare beneficiaries. We encourage other payers to avail themselves of any DRG

logic in our nonproprietary system from past years and use this information as

appropriate to develop updates and refinements annually to suit the needs of their own

patient populations.

5. Impact of the MS-DRGs

Unlike the CS DRGs we proposed last year for FY 2008, the payment impacts

from the MS-DRGs we proposed to adopt (and are finalizing in this final rule with

comment period) for FY 2008 would largely be redistributive within each base MS-DRG.

Such a result occurs because we collapse the current CC/non-CC, age and other

distinctions that exist in the CMS DRGs and redivide them based on MCCs, CCs, and

non-CCs.   Thus, within each base MS-DRG, some cases will be paid more and some

less, but the base MS-DRGs are retained so there is no redistribution between types of

cases as would have occurred under the proposed CS DRGs. In the proposed rule, we

encouraged readers to review Table 5 in the Addendum to the proposed rule for a list of

the proposed MS-DRGs and the proposed respective relative weight from the revisions

we proposed to better recognize severity of illness to better understand how payment for

cases within each base MS-DRG will be affected.

As indicated above, all of the severity DRG systems being evaluated by RAND

can be expected to result in similar redistributions in case-mix among hospitals. The

payment models used by RAND and CMS (and RTI as well) all assume static utilization.

That is, payment impact models simulate the effects of a change in policy, assuming no

change to Medicare utilization. Any system adopted to better recognize severity of

illness with a budget neutrality constraint will result in case-mix changes that can be

expected to benefit urban hospitals at the expense of rural hospitals. This impact occurs

because patients treated in urban hospitals are generally more severely ill than patients in

rural hospitals and the CMS DRGs are not currently recognizing the full extent of these

differences. Similarly, there will be differential impacts among other categories of

hospitals (for example, teaching, disproportionate share, large urban, and other urban

hospitals) depending on the mix of cases that each hospital treats. The impact of the

MS-DRGs can be expected to have similar effects on case-mix as the DRG systems being

analyzed by RAND. These conclusions are confirmed by RAND's analysis earlier in this

final rule with comment period as well as the payment impacts we illustrated in the

proposed rule and again in this final rule with comment period.

Comment: One commenter believed that a "stop loss" provision should be

instituted as part of the transition. Similar to that under the IPF PPS, no hospital can

receive less than 70 percent of what they would otherwise have been paid under the old

system. Another commenter asked that CMS investigate mechanisms for dampening

large payment rate fluctuations.

Response: Changes in payments from MS-DRGs will be mitigated in any single

year by adopting them over a 2-year transition period. We believe a 2-year transition

period for implementation of the MS-DRGs addresses the concern of these commenters.

Further information is provided in section II.E. of the preamble of this final rule with comment period.about how MS-DRG relative weights are being determined to reflect implementation over a 2-year period.

6. Changes to Case-Mix Index (CMI) from the MS-DRGs

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), which we use as a proxy measurement for severity of illness. We had projected the rate of growth in case-mix for the period 1981 to 1984 to be 3.4 percent. The realized rate of growth during this period, which included the introduction of the IPPS, was 8.4 percent, a variance in excess of 1.6 percent per year. The unexpected growth in payments was due to increases in the hospital case-mix index (CMI) beyond the previously projected trend. Hospitals' CMI values measure the expected treatment cost of the mix of patients treated by a particular hospital. There are three factors that determine changes in a hospital's CMI:

(a) 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);

(b) 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

(c) Changes in documentation (more complete medical records) and coding

practice (more accurate and complete coding of the information contained in the medical

record).

We note that changes in patient-mix and medical practice signal <u>real</u> changes in

underlying resource utilization and cost of treatment. While these changes may have

occurred in response to incentives from IPPS policies, they represent real changes in

resource needs. In contrast, 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.[2]

The Medicare Trustees Technical Review Panel[3] has previously determined the

annual measured change in CMI for inpatient hospital services to oscillate around an

underlying real trend of 1 percent annual growth. In 1991 the Medicare-specific trend in

real CMI growth was found in a then-HCFA funded study[4] to be within a range of 1 to

1.4 percent. In the annual study conducted by CMS, there has been no evidence to

support a real case-mix increase in excess of the annually projected 1 percent upper

bound in the period. MedPAC findings have echoed this with its recent study of real

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

[3] Review Of Assumptions and Methods of The Medicare Trustees' Financial Projections ; Technical Review Panel on the Medicare Trustees Reports, December 2000.

[4] "Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988"; Carter, Newhouse, Relles ; R-4098-HCFA/ProPAC (1991).

case-mix change finding growth rates for years 2002, 2003, and 2004 of 1 percent, 0.6

percent, and 0.4 percent, respectively.[5]

In the proposed rule, we indicated that we believe that adoption of the proposed

MS-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 increase 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' 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."[6]

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 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

CMS DRGs may result in a case being assigned to a higher paid DRG under the proposed

MS-DRGs. Thus, more accurate and complete documentation and coding may occur

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[5] Medicare Payment Advisory Commission: Report to the Congress, March 2006 (p 52).
[6]Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 42.

because it will result in higher payments under the MS-DRG system. For the proposed

rule, we stated that the potential for more accurate and complete documentation and

coding will apply equally under the acute IPPS as well as under the LTCH PPS because

the same DRGs are used for both payment systems. However, for reasons explained

elsewhere in this final rule with comment period, we are limiting this analysis to the

IPPS.

CMS in the past has adjusted standardized amounts under the IRF PPS to account

for case-mix increases due to improvements in documentation and coding. In 2004,

RAND[7] published a technical report as part of the follow-up to the implementation of the

IRF PPS. The initial weights used within the IRF PPS were based on a mix of CY 1999

and CY 1998 data. The study reviewed the changes between this base data set and the

IRF PPS implementation year of 2002. The report found that the weight per discharge

for IRFs had grown by 3.4 percent between the CY 1999 data set and the CY 2002 data

set. In a detailed analysis of both statistical patterns in acute stay records and directly

measured coding practices, RAND found that the level of case-mix increase associated

with documentation and coding-induced changes in the transition year ranged between

1.9 and 5.8 percent, with the upper end of the estimate associated with real declines in

resource use. (We note that RAND revised its report in late 2005 to reflect an upper

bound of 5.9 percent, instead of the 5.8 percent that we reported in the FY 2006 IRF PPS

proposed and final rules.)

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[7] Carter, Paddock: Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient
Rehabilitation Facility Prospective Payment System, RAND, 2004.

We used the results of this analysis to justify a 1.9 percent adjustment to payment

rates for IRFs in FY 2006 (70 FR 47904) and a 2.6 percent adjustment to payment rates

for IRFs in FY 2007 (71 FR 48370), for a combined total adjustment of 4.5 percent. The

implementation year was marked by the transitioning of hospitals to the IRF PPS

payment based on cost reports beginning January 1, 2002, and staggered to

October 1, 2002. A combination of increased familiarity with the system by providers

and the staggered transition could mean that documentation and coding-induced case-mix

change continued as hospitals experienced ongoing changes in the early years of the

IRF PPS and as the incentives within the system were more widely recognized. We also

recognize that significant changes in IRF patient populations may be occurring as a result

of recent regulatory changes, such as the phase-in of the 75 percent rule compliance

percentage. We intend to continue analyzing changes in coding and case-mix closely,

using the most current available data, as part of our ongoing monitoring of the IRF PPS

and, based on this analysis, we intend to propose additional payment refinements for

IRFs in the future as the analysis indicates such adjustments are warranted.

Furthermore, as part of our analysis of this issue, we considered the recent

experience of the State of Maryland with adopting the APR DRG system. Maryland

introduced APR DRGs for payment for three teaching hospitals in 2000. Between State

fiscal years (SFYs) 2001 and 2005[8], the remaining hospitals continued to be paid using

modified CMS DRGs. In June 2004, the remaining hospitals were notified that Maryland

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[8] Maryland uses a July 1 to June 30 State fiscal year. Prior to FY 2003, Maryland had a 6-month lag in the data used to calculate the hospital base case-mix index and case-mix change. Maryland used 12 months data ending December even though the hospitals' rate year was July 1 to June 30. In FY 2003, Maryland moved to what it call "Real Time Case-Mix" and started using 12 months data ending June 30 to calculate case-mix index and case-mix change for a rate year beginning July 1.

would expand the use of APR DRGs throughout its all payer charge-per-case system

beginning in July 2005. Hospitals in Maryland improved coding and documentation in

response to the adoption of APR DRGs. As a result of this improved documentation and

coding, reported CMI increased at a greater rate than real CMI. Given the similarity

between coding incentives using the APR DRGs in Maryland and the MS-DRGs that are

being proposed for Medicare, we analyzed Maryland data to develop an adjustment for

improved documentation and coding.

For the Maryland analysis, we assume that, in SFY 2005, those hospitals not

already being paid under the APR DRG system began acting as if the transition to the

new DRG logic had already taken place. This assumption is supported by the following

facts: (a) Maryland hospitals were reporting to the Health Services and Cost Review

Commission (HSCRC), Maryland's governing body of its all-payer ratesetting system

using the APR DRG GROUPER in 2005; (b) hospitals were provided training in coding

under the APR DRG GROUPER; (c) hospitals had access to reports based on APR DRG

logic; and (d) hospitals were given large amounts of feedback as to their performance

under the GROUPER by the HSCRC relative to peer hospitals.

The incentives for Maryland hospitals are to code as completely and accurately as

possible because, beginning in July 2005, all Maryland hospitals were paid using

APR DRGs. SFY 2005 was an important year in Maryland, as it marked the beginning of

the 2-year period of transition after which a hospital's revenues were reduced if coding

was not as complete as a peer hospital. Under the current CMS DRGs, each secondary

diagnosis code is recognized as either a CC or non-CC. Hospitals in Maryland and

nationally for Medicare only needed to code one secondary diagnosis as a CC when paid

using CMS DRGs for the patient to be assigned to a higher-weighted DRG split based on

the presence or absence of a CC. Under the APR DRGs, each secondary diagnosis is

designated as minor, moderate, major, or extreme. Under the MS-DRGs, each secondary

diagnosis is designated as a non-CC, CC, or MCC. Hospitals in Maryland have

incentives under the APR DRGs to code until a case is assigned to the highest of the four

severity levels within a base DRG. Under the MS-DRGs, hospitals will have incentives

to code until a case is assigned to one of up to three severity levels within a base DRG.

Although the APR DRGs and the MS-DRGs may be different, we believe that hospitals

have the same incentive under both systems to code as completely as possible. For this

reason, we believe that the Maryland experience is a reasonable basis for projecting

changes in coding practices for the wider national hospital population for the first 2 years

of the MS-DRGs.

We believe the analysis presented below provides a reasonable analysis of the

potential growth in CMI due to improved documentation and coding. In addition to the

similarity between coding incentives under the proposed MS-DRGs and the APR DRGs,

we note that Maryland is an all-payer State; therefore, hospitals are paid by all third party

payers—not just the State's Medicaid program—using the APR DRGs. Coding has been

very important for each hospital's overall revenue for many years, and the incentives are

uniform across all third party payers. The transition to APR DRGs was known well in

advance of the actual date and, as stated above, hospitals were provided training in

coding under the APR DRGs. It is reasonable to expect that hospitals' experience with

improved documentation and coding will occur over a period of at least 2 years. Thus,

the experience in Maryland may be similar to expectations for case-mix growth for the

nation as a whole. Finally, in reviewing the results from Maryland, we note that three

large teaching hospitals began using APR DRGs prior to SFY 2005. These facilities

generally treat a wider variety of patients with higher acuity that gives them a greater

potential for increasing coding under the APR DRG system than other hospitals

throughout Maryland. Because these hospitals were paid using the APR DRGs earlier

than other Maryland hospitals, we believe data for these hospitals need to be analyzed

from an earlier time period. However, based on the consultations with the HSCRC, we

believe there were special issues with one of these hospitals that may have made its

case-mix growth during the early years of the transition to the APR DRGs atypical of the

other teaching hospitals.[9] Therefore, we did not separately analyze the data for this

hospital from the earlier time period and, as stated below, included its data with the rest

of the Maryland hospitals.

As part of its contract with CMS, 3M Health Information Systems reviewed the

Maryland data in the context of our proposed changes to adopt MS-DRGs. 3M grouped

Medicare cases in Maryland through both the CMS DRGs Version 24.0 and the proposed

MS-DRGs for FY 2008. At our request, 3M deleted two of the three early transition

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[9] The HSCRC informed us that it began using APR DRGs for this hospital to calculate the CMI and case-mix change to set the hospital's charge per case target (CPC) that is used in Maryland's all-payer ratesetting system for payment. However the HSCRC also compared the reasonableness of hospital rates and costs for this hospital relative to peer institutions using modified CMS DRGs to calculate CMI and case-mix change. This use of dual systems to calculate CMI and case-mix change made it difficult for the hospital to code aggressively in the first few years of using APR DRGs.

hospitals from the data. It compared the results of the observed growth in case-mix from

these data to the same process applied to Medicare data, excluding Maryland hospitals.

The MedPAR data file for Federal fiscal year (FFY) 2006 (October 2005 through

September 2006) was used to create relative weights for both CMS DRG Version 24.0

and the MS-DRGs. The MedPAR data file contained 12,794,280 records. In constructing

the weights, the following edits were used:

● Cases with zero covered charges or length of stay were excluded.

● Cases with length of stay greater than 2 years were excluded.

● Only hospitals contained in the impact file for the FY 2007 IPPS final rule

were included.

The latter criterion excluded providers reimbursed outside of the IPPS, including

Maryland hospitals, from the weight calculation. 3M employed standardized

charge-based relative weights developed in accordance with the CMS methodology.

Cost-based weights were not used and no adjustment to the charge weights was made for

application of CMS transfer and postacute care transfer payment policy.

3M further grouped 2 years of MedPAR data from FY 2004 and FY 2005, using

CMS DRG Version 24.0 and the MS-DRGs for hospitals nationally. Using 2 years of

MedPAR data with one version of each DRG system further required 3M to make

adjustments to the data to reflect revisions to ICD-9-CM codes that are made each year.

MedPAR data for Maryland IPPS acute care providers within the IPPS data set were

similarly assigned to the MS-DRGs and CMS DRGs for FYs 2004 through 2006.

Each Maryland record, exclusive of the two early transition teaching hospitals for the 3 observed years (SFY 2004 to SFY 2006), was assigned to a proposed MS-DRG based on the ICD-9-CM codes the hospital submitted. The same results were obtained from data at the national level using the MS-DRGs. Further, we obtained data from the HSCRC showing the weighted average increase in case-mix for calendar years 2001 to 2003 for the two large academic medical centers that began an early transition to the APR DRGs. In addition, we also obtained case-mix increases under the CMS DRGs for FYs 2004 through 2006. The Medicare Actuary examined the data below:

Table R.--Maryland and National Data Used for Case-Mix Adjustment Analysis

	FY 2004 to 2005	FY 2005 to 2006	FY 2004 to 2006
Rest of Maryland MS-DRG CMI Δ	2.30%	2.57%	4.93%
			CY 2000 to FY 2003
Early Transition Hospitals	4.4%	6.7%	11.4%
National MS-DRG CMI Δ	0.47%	2.65%	3.13%
National CMS DRG CMI Δ	-0.04%	1.20%	1.16%
Blend of MS-DRG & CMS DRG Δ using 0.47 Percent for 2005 and 1.2 Percent for 2006			1.68%
Difference between Maryland Early Transition Hospitals and National Data			9.58%
Difference between Rest of Maryland and National Data			3.20%
Medicare Actuary Estimate (75%/25%) Δ between Early Transition and Rest of Maryland			4.8%

The data above show that case-mix for hospitals increased by 4.93 percent from SFYs 2004 to 2006, during which Maryland adopted the APR DRGs for most hospitals.

Case-mix for the two large teaching hospitals that were paid using the APR DRGs earlier

than other hospitals in the State increased by 11.4 percent from SFYs 2001 to 2003. The

weighted average increase in Maryland from these two categories of hospitals is 5.58

percent. Case-mix using the MS-DRGs would have increased 0.47 percent in FY 2005

and 2.65 percent in FY 2006. Nationally, Medicare case-mix using the CMS DRGs

decreased by 0.04 percent in FY 2005 and increased by 1.2 percent in FY 2006. The

Actuary calculated a Medicare case-mix increase nationally over 2 years using a blend of

these data from the MS-DRGs for FY 2005 and national Medicare data for FY 2006 from

the CMS DRGs. The Actuary did not use either the -0.04 percent for the CMS DRGs or

the 2.65 percent for the MS-DRGs to create this blended case-mix because these figures

appeared atypical to national trends. Therefore, the Actuary dropped one atypically high

and low number from each of the 2 years of data and calculated an average increase of

1.68 percent from FY 2004 to FY 2006. These data demonstrate that the measure of

average CMI for Medicare cases is growing more rapidly within Maryland than

nationally. Case-mix for the Maryland teaching hospitals and the rest of Maryland

increased 9.58 percent and 3.20 percent more, respectively, than the national average

over 2 years, suggesting that improved documentation and coding lead to perceived, but

not real, changes in case-mix.

The Actuary noted that the case-mix increase in Maryland for two large teaching

hospitals over a 2-year period was much higher in the early years of the APR DRGs than

other Maryland hospitals (11.4 percent compared to 4.93 percent for the rest of

Maryland). Further, teaching hospitals generally treat cases with higher acuity than other

hospitals and have more opportunity to improve coding and documentation to increase

case-mix than other hospitals. Teaching hospitals also represent a higher proportion of

national Medicare data than they do of the data in Maryland. The two early transition

teaching hospitals in Maryland account for approximately 10 percent of the Medicare

discharges in Maryland. Nationally, teaching hospitals account for approximately

50 percent of Medicare discharges. Therefore, the Actuary believes that the teaching

hospitals should be given a higher weight in the national data than they represent in

Maryland. However, like other hospitals, teaching hospitals vary in size and patient-mix

and not all have the same opportunity to improve documentation and coding. Therefore,

we believe the weight given to teaching hospitals should be higher than the 10 percent for

the two early transition hospitals in Maryland but lower than the 50 percent of discharges

that they account for in Maryland. The Actuary gave a weight of 25 percent for teaching

hospitals and 75 percent for the rest of Maryland to the excess growth in case-mix over

the national average and estimates that an adjustment of 4.8 percent will be necessary to

maintain budget neutrality for the transition to the MS-DRGs. This analysis reflects our

current estimate of the necessary adjustment needed to maintain budget neutrality for

improvements in documentation and coding that lead to increases in case-mix.

Consistent with the statute, we will compare the actual increase in case-mix due to

documentation and coding to our projection once we have actual data to revise the

Actuary's estimate and the adjustment we make to the standardized amounts.

Based on the Actuary's analysis, using the Secretary's authority under section

1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of

changes in coding or classification of discharges that do not reflect real changes in

case-mix, we proposed to reduce the IPPS standardized amounts by 2.4 percent each year

for FY 2008 and FY 2009. We indicated that we were considering proposing a 4.8

percent adjustment for FY 2008. However, we believed it would be appropriate to

provide a transition because we would be making a significant adjustment to the

standardized amounts. In the proposed rule, we expressed interest in receiving public

comments on whether we should apply the proposed adjustment in a single year, over 2

years, or in different increments than ½ of the adjustment each year. Section

1886(d)(3)(A)(vi) of the Act further gives the Secretary authority to revisit adjustments to

the standardized amounts for changes in coding or classification of discharges that were

based on estimates in a future year. Consistent with the statute, we will compare the

actual increase in case-mix due to documentation and coding to our projection once we

have actual data for FY 2008 and FY 2009 for the FY 2010 and FY 2011 IPPS rules. At

that time, if necessary, we may make a further adjustment to the standardized amounts to

account for the difference between our projection and actual data.

Comment: Many commenters opposed the documentation and coding adjustment,

which they believed would reduce payments to hospitals by $24 billion over the next

5 years. The commenters did not believe this reduction is warranted. They suggested the

adjustment for documentation and coding is a "backdoor attempt" to reduce Medicare's

inpatient hospital payments. One commenter stated that the documentation and coding

adjustment would result in a total estimated reduction in payment for Pennsylvania

hospitals of $67.5 million in FY 2008, and an estimated $1.6 billion over the next 5 years.

The commenter stated that such reductions and attempts at backdoor budget cuts would only further erode scarce resources and challenge hospitals in their ability to care for patients. The commenter stated that until MS-DRGs are fully implemented, and CMS can document and demonstrate that any increase in case-mix results from changes in coding practices rather than real changes in patient severity, there should be no documentation and coding adjustment.

Response: We stress that there are no savings attached to this adjustment. This adjustment is not a "backdoor" attempt to reduce Medicare inpatient hospital payments. Without a documentation and coding adjustment, the changes to MS-DRGs would not be budget neutral. Substantial evidence supports our conclusion that the CMI will increase as a result of adoption of MS-DRGs without corresponding growth in patient severity. We have provided evidence from studies going back over 20 years that show that hospitals respond to incentives when payment classifications are changed to improve documentation and coding to receive higher payments. Maryland provides a recent example demonstrating the validity of the finding that hospitals respond to changes in payment classification groups by changing documentation and coding practices. Furthermore, we are not aware of a situation in which a new or revised payment system provided a payment incentive to improve documentation and coding, yet hospitals did not improve documentation and coding.

Comment: Many commenters stated that the documentation and coding adjustment is based on assumptions made with little to no data or experience about how medical record documentation and coding practices will change as a result of the

implementation of MS-DRGs. One commenter stated that the proposed adjustment has

no basis in actual data or research pertaining to inpatient hospital coding practices**.** One

commenter objected to the -2.4 percent adjustment for documentation and coding stating

it could not understand the proposal and noted that the hospitals are utilizing the coding

system that the Department of Health and Human Services has created. The commenter

stated that if, in fact, the new severity DRGs were designed to better recognize the

resources needed to treat the various DRG conditions, the argument can be made that

CMS has been underpaying institutions for over 20 years. Other commenters objecting to

the documentation and coding adjustment further indicated that hospitals have operated

under the current DRG system for 23 years and hospitals are already expert in their

ability to maximize coding for payment. These commenters stated that not even in the

initial years of the IPPS was coding change found to be in the magnitude of CMS'

proposed FY 2008 and FY 2009 cuts. The commenters stated that the proposed

MS-DRGs would be a *refinement* of the existing system; the underlying classification of

patients and "rules of thumb" for coding would be the same. They stated that there is no

evidence that an adjustment of 4.8 percent over 2 years is warranted when studies by

RAND, cited in the preamble, are looking at claims between 1986 and 1987 at the

beginning of the IPPS that showed only a 0.8 percent growth in case-mix due to coding.

The commenters stated that even moving from the original reasonable cost-based system

to a new patient classification-based PPS did not generate the type of coding changes

CMS contends will occur under the MS-DRGs.

Many commenters disagreed with the applicability of generalizing from the experience in Maryland to Medicare. One commenter indicated that MS-DRGs and APR DRGs are two completely different ways to classify patients, and generalizing from one system to the other cannot be done. The existing classification rules will change only marginally with the introduction of MS-DRGs, whereas they are very different under the APR DRG system. Differences include:

● APR DRGs consider multiple CCs in determining the placement of the patient and, ultimately, the payment. In fact, to be placed in the highest severity level, more than one high-severity secondary diagnosis is required.

● APR DRGs consider interactions among primary and secondary diagnoses. Thus, factors that increase the severity level for a case under the APR DRGs will not occur under the MS-DRGs.

● APR DRGs consider interactions among *procedures* and diagnoses as well. MS-DRGs do not.

● APR DRGs have four severity subclasses for *each* base DRG, while MS-DRGs have three tiers, and this is only for 152 base DRGs--106 base DRGs only have two tiers and 77 base DRGs are not split at all.

● Less than half the number of patient classifications in the MS-DRG system are dependent on the presence or absence of a CC--410 for MS-DRGs versus 863 for APR DRGs.

The commenters believed that all of these differences make the Maryland experience an invalid comparison. They suggested there is significantly less possibility for changes in coding to affect payment under the MS-DRGs.

Another commenter indicated that the CMS analysis is not applicable to Medicare because Maryland hospitals were not paid using a DRG system prior to APR DRG implementation. DRG data were collected for statistical purposes, but DRGs were not used for reimbursement. The commenter added that coding practices under APR DRGs are not necessarily comparable to MS-DRGs because they were not designed for reimbursement purposes. Further, the commenter found that the system logic is not always consistent with nationally recognized coding rules and guidelines, resulting in possible changes in coding practices that do not necessarily represent improved coding. The commenter stated that hospitals have little ability to change their classification and coding practices. Another commenter stated that Maryland's hospitals were paid prior to the APR DRGs under a State ratesetting system where an incentive to code accurately did not significantly affect what a hospital was paid. The commenter stated that APR DRGs are also much more complicated than MS-DRGs. The commenter stated that generalizing the Maryland experience to the rest of the nation's hospitals is an "apples-to-oranges" comparison.

One commenter also disagreed with CMS' use of the example of the IRF PPS to justify the coding adjustment. The commenter believed that the IRF experience is an inappropriate comparison. The commenter stated that coding changes seen under the IRF PPS were the result of moving from a cost-based system to a PPS, not the marginal

difference of moving from the existing CMS DRGs to the refined MS-DRGs. In

addition, coding under the IRF PPS is driven by the Inpatient Rehabilitation Patient

Assessment Instrument (IRF-PAI). This tool provides an incentive for IRFs to code in a

way that differs from the IPPS, which does not utilize a patient assessment instrument.

The commenter believed that coding for the IRF-PAI differs significantly from the

longstanding coding rules that inpatient PPS hospitals have followed for the following

reasons:

● The IRF-PAI introduced a new data item into coding--namely, "etiological

diagnosis." The definition of this new diagnosis and the applicable coding rules are

significantly different than the "principal diagnosis" used to determine the DRG. More

importantly, the Official Coding Guidelines that apply to all other diagnostic coding do

not apply to the selection of the ICD-9-CM etiologic diagnoses codes.

● The Official Coding Guidelines do not consistently apply to the coding of

secondary diagnoses on the IRF-PAI. Several different exceptions to the guidelines have

been developed by CMS for the completion of the IRF-PAI.

● The definition of what secondary diagnoses may be appropriately reported

differs under the IRF-PAI from the definition used by other inpatient coders.

● Most hospitals are already coding as carefully and accurately as possible

because of other incentives in the system to do so, such as risk adjustment in various

quality reporting systems. Analysis of Medicare claims from 2001 to 2005 suggests that

hospitals have been coding CCs at high rates for many years. More than 70 percent of

claims already include CCs, and more than 50 percent of claims have at least eight

secondary diagnoses (the maximum number accepted in Medicare's DRG GROUPER).

Hospitals' assumed ability to use even more CCs under MS-DRGs is very low.

The commenter also indicated that according to an article in the magazine

Healthcare Financial Management, the level of coding on claims suggests that the

presence of a CC on a bill is not strongly influenced by financial gain. The proportion of

surgical cases with a CC code is higher for cases where there is no CC split and, thus, no

financial benefit, than on those cases where there is a CC split and a corresponding higher

payment. Thus, coding is driven primarily by coding guidelines and what is in the

medical record rather than by financial incentives according to this commenter. In

addition, the commenter believed that many cases simply do not have additional CCs to

be coded. For many claims, additional codes are simply not warranted and not supported

by the medical record. Therefore, there is no opportunity for a coding change to increase

payment.

The commenter analyzed the all-payer health care claims databases from

California, Connecticut, Florida, and Michigan because, unlike the MedPAR files, these

databases include all 25 diagnoses reported on the claims. This analysis showed that only

0.25 percent of claims had an MCC or CC appear for the first time in positions 10

through 25. The commenter believed this strongly suggests that hospitals will not be able

to "re-order" their secondary diagnoses to appear higher on the claim so that Medicare

will pay a higher rate. The commenter's coding experts note that most hospitals use

software that automatically re-sorts the secondary diagnoses to ensure that those pertinent

to payment are included in positions two through nine.

The commenter also examined secondary diagnosis codes and found that there were relatively few non-specific codes listed among the common secondary diagnoses of discharges without a MCC/CC. The commenter believed that this means hospitals cannot shift large numbers of discharges to MCCs or CCs based on coding a more specific code to replace a nonspecific code.

The commenter further indicated that there is no opportunity for increased payment due to a change in coding for 77 base DRGs under the MS-DRG system, as there is only one severity class and no differentiation in payment. Additionally, there are MS-DRGs that are now split between "with MCC" and "without MCC" (a combined non-CC and CC MS-DRG) that have historically contained a single CC/non-CC split. These DRGs already required secondary diagnosis coding; thus, the codes to qualify the case as an MCC already would have been present. In these cases, it is very unlikely that the medical record would justify an MCC that is not already present in the medical record. Coders must code strictly based on what the physician notes in the chart. Therefore, the commenter believed it is highly unlikely that a coder will be able to select an MCC that was not previously present in the medical record.

One commenter stated that case-mix will and should increase from adoption of the MS-DRGs. According to the comment, changes in case-mix due to improved accuracy in documentation and coding have been observed since the introduction of DRG payments in 1983. These changes have occurred in every refinement of every classification system across every care setting. The commenter stated that changes are driven primarily by the fact that documentation and numbers of diagnoses coded is

inevitably incomplete due to time pressures for completion of paperwork and limitations

of computer systems to identify this information. If an item is not used and/or not

important, it is less well documented. Refinements in patient classification make certain

paperwork more important, encouraging providers to improve their documentation and

reporting accuracy. This, in turn, increases apparent case mix that depends on these

codes according to this commenter. The commenter stated that coding changes that

affect CMI are desirable in the long run, since they represent more accurate data and

evidence-based care, payments, quality measurement, management decisions, and policy

are all enhanced. This increase in accuracy is not only desired, it is necessary to truly

reform health care (severity adjusted payments, quality measurement and reporting,

value-based-purchasing, among others), where "bad data" is frequently cited as an excuse

to defer reform efforts. This commenter stated that it is impossible to accurately predict

the total magnitude and timing of case-mix changes. Every hospital will have their own

documentation and coding accuracy baseline, and their own real CMI based on accurate

data for their patient mix. Each will have a different commitment to increasing their

accuracy, resources to do so, and learning curve for implementation. The commenter

believed that, like any prediction of the future, it will inevitably be wrong, particularly

due to its complexity.

Response: Many of the commenters ascribed the term "behavioral offset" to our

proposed rule and believed that CMS was pejoratively describing hospital motives. We

note that we did not use the term "behavioral offset" to describe the proposed -2.4 percent

adjustment to IPPS rates for FYs 2008 and 2009 for changes in documentation and

coding. We regret that the term "behavioral offset" has been attributed to us. The

proposed rule uses the phrase "documentation and coding adjustment" to refer to the

proposed -4.8 percent (-2.4 percent each year for FYs 2008 and 2009) adjustment to the

IPPS standardized amounts to maintain budget neutrality for the MS-DRGs consistent

with the statute. Further, we believe it is important to address the notion in some of the

public comments that CMS believes changes in how services are documented or coded

that is consistent with the medical record is inappropriate or otherwise unethical. We do

not believe there is anything inappropriate, unethical or otherwise wrong with hospitals

taking full advantage of coding opportunities to maximize Medicare payment that is

supported by documentation in the medical record. In its public comments, MedPAC

recommended an adjustment for improvements in documentation and coding and also

noted that hospitals' efforts to improve the specificity and accuracy of documentation and

coding are perfectly legitimate.[10]

We encourage hospitals to engage in complete and accurate coding. Section

1886(d)(3)(A)(vi) of the Act authorizes the Secretary 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. In its public comments, MedPAC indicated that the

increases in payments that result from improvements in documentation and coding are

not warranted because the increase in measured case-mix does not reflect any real change

in illness severity or the cost of care for the patients being treated. Therefore, offsetting

adjustments to the PPS payment rates are needed to protect the Medicare program and

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[10] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11,
2007, page 12.

those who support it through taxes and premiums from unwarranted increases in

spending.[11]

In response to the comment that stated, "moving from the original reasonable

cost-based system to a new patient classification-based PPS did not generate the type of

coding changes CMS contends will occur under the MS-DRGs," we believe the estimates

for improvements in documentation and coding are within the range of those projected

under the original IPPS. As stated above, for the implementation of the IPPS in 1983,

RAND found that 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.[12] This study found a 2 percent *annual*

change in case-mix from improvements in documentation and coding during the original

adoption of the IPPS, while we are forecasting a 4.8 percent *total* increase due to the

MS-DRGs. MedPAC's public comments citing a study in *Health Affairs* found that the

original adjustment for anticipated increases in case mix due to documentation and

coding "were substantially smaller than the actual change in case mix which increased

more than 7 percent from the pre-PPS period to the first full year of the PPS system."[13]

MedPAC further noted that CMI increases due to improvements in documentation can be

expected to occur over many years. It stated that the Prospective Payment Assessment

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[11] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 12.

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

[13] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 12 citing Steinwald, B. and L. Dummit. 1989. "Hospital Case-mix change: Sicker patient or DRG Creep?" *Health Affairs*. Summer, 1989.

Commission (a predecessor of MedPAC) considered case-mix change in developing its

annual update recommendations to the Congress and made offsetting adjustments for

continuing coding improvements for 10 consecutive years from 1986 to 1995.[14] For

these reasons, we disagree with the comment that our forecast of changes in case-mix

from improvements in documentation and coding are not within the range of those

projected when the original IPPS was implemented.

With respect to comments about the use of the APR DRG system in Maryland to

forecast an adjustment for improvements in documentation and coding for Medicare, we

agree that there are differences between the APR DRGs being used in Maryland and the

MS-DRGs being proposed for use by Medicare. We believe that coding incentives in

Maryland under the APR DRGs and nationally under the MS-DRGs are similar, not

identical. The Maryland experience provides a useful example to forecast the potential

increase in case mix from improvements in documentation because it is a recent and

similar change to what we plan to adopt for Medicare. Although the APR DRGs and the

MS-DRGs may be different, we believe that hospitals have the same incentive under both

systems to code as completely as possible. Moreover, as explained above, we estimated

CMI growth using the MS-DRG and CMS DRG GROUPERs, not APR DRG

GROUPER. We used Medicare claims from Maryland hospitals for our analysis, but we

grouped the claims under the CMS DRG GROUPER and proposed MS-DRG

GROUPER.

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[14] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 11.

For these reasons, we continue to believe that the Maryland experience is a reasonable basis for projecting increased case mix in the wider national hospital population for the first 2 years of the MS-DRGs. MedPAC supported using the Maryland experience to forecast potential increases in case mix by stating: "The case-mix reporting changes that occurred in Maryland-when that state adopted APR DRGs in its all payer rate-setting system—provide one of the few recent benchmarks for comparison outside of Medicare's historical experience."[15]

The reference to the IRF PPS was not intended to suggest that we used the experience with that system to forecast a potential adjustment under the IPPS. Rather, we were merely noting that the adoption of a PPS system for IRFs also produced an increase in case-mix as a result of the new incentives presented by going to a different payment system. The example suggests that there is strong evidence that hospitals—whether they are IRFs, acute care IPPS hospitals, or LTCHs—respond to coding incentives presented by their respective payment systems and will react accordingly. MedPAC's public comments also supported this point. In its public comments on the FY 2008 IPPS proposed rule, MedPAC stated that there were increases in case mix with the introduction of prospective payment systems for IRFs and LTCHs.[16]

The comments about reordering of codes and substituting specific codes for nonspecific codes suggests that hospitals are already maximizing coding opportunities and there is no further changes they can make that would result in an increase in

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[15] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 12.
[16] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 11.

Medicare payment. With respect to reordering of codes, the commenter argues that

MCCs and CCs will already be found in the first 9 fields on the Medicare claim and the

codes that are stored or processed from fields 10 to 25 cannot be moved up higher on the

claim to increase payment. While this public comment suggests that there will be no

opportunity to increase case mix by moving secondary diagnoses higher on a claim,

another public comment provided a specific estimate of how much this practice could

increase case-mix. The commenter examined data from New York State discharges and

indicated that if MCC and CC codes that are currently provided beyond the original 9

diagnoses on the claim that are used by Medicare are moved to the first 9 positions,

case-mix would increase by 0.5 percent. This reaffirms CMS' views that hospitals focus

their documentation and coding efforts to maximize reimbursement. Again, we believe

these examples provide evidence from the public comments supporting the necessity for

us to apply an adjustment for documentation and coding to meet the requirements of the

law.

We believe increases in case-mix do not only have to come from moving codes

higher on the claim. A hospital can merely change the order of a principal and secondary

diagnosis for closely related conditions to affect payment. The selection of a principal

diagnosis that was previously coded as secondary can increase hospital payment. Again,

we found a public comment suggesting that reordering of principal and secondary

diagnoses can increase case mix. The commenter stated some DRG groups only count a

code in "the primary position while others only count a code in a secondary position."

The commenter is noting that many DRGs are split based on the presence or absence of

an MCC or CC as a secondary diagnosis.   According to the commenter, many Medicare

patients have multiple conditions occasioning their admission, suggesting that reordering

the principal and secondary diagnosis codes can result in an increase in case-mix.

We also disagree with the comments suggesting that hospitals do not have the

opportunity to substitute a specified for an unspecified code to increase case mix. In fact,

we believe these incentives will be very strong under the MS-DRGs with the

reclassification of many unspecified codes as non-CCs. Again, we found statements in

the public comments that support the notion that hospitals will have opportunities to

substitute a specified for an unspecified condition to increase case-mix under the

MS-DRGs. One commenter indicated that the CC list revisions encourage coding of

more detailed codes and estimates that switching from "not otherwise specified" codes to

detailed codes could increase case mix by 0.5 percent. Another commenter states: "The

most dramatic example is ICD-9-CM code 428.0, Congestive heart failure, unspecified,

which was applied to an average of 2.3 million Medicare fee-for-service cases a year

during the past three years. This was the most widely used secondary diagnosis code,

despite the fact that 12 more specific codes were added in FY 2003… if the revised CC

list were implemented before hospitals had a chance to improve their coding to

accommodate the revisions, then case-mix creep and inpatient prospective payment

system (IPPS) overpayments would ensue."

We further note that many of the public comments arguing against the

documentation and coding adjustment also request a year's delay in implementation of

the MS-DRGs so "hospitals may focus on understanding the impact of the revised CC

list, training and educating their coders, and working with their physicians for any

documentation improvements required to allow the reporting of more specific codes

where applicable." We believe this comment provides a strong indication that, even

though many public commenters themselves argue against the need for the

documentation and coding adjustment, the same commenters would like a year's delay to

take the very actions that they say make an adjustment unnecessary. The MS-DRGs are

not making any changes to ICD-9-CM codes. While the MS-DRGs do include some

consolidations of base DRGs, the major changes from the current DRGs simply involve

adding severity levels to many of the new MS-DRGs. The move to MS-DRGs will not

necessitate additional data elements or changes in reporting practices. Therefore,

hospitals may continue to document and code as they do currently to be paid by Medicare

under the MS-DRGs. The only reason hospitals would need a delay in the MS-DRGs is

to have more time to understand how their revenues are affected by coding under the new

DRG system. In our view, there is a clear indication in these comments that hospitals

will change their documentation and coding practices and increase case mix consistent

with the payment incentives that are provided by the MS-DRG system.

As further evidence that documentation and coding practices are affected by

payment, we note a recent article in the *Journal of AHIMA* (American Health Information

Management Association) which discusses methods for improving clinical

documentation in order to increase reimbursement. The article describes a program at a

hospital utilizing clinical documentation specialists that work on the hospital treatment

floors to encourage improvements in clinical documentation. The article states that one

year after implementing the program, the hospital gained an additional $1.5 million in

reimbursement. In the second year, the hospital gained $900,000. The article reports a

similar program at another hospital where the "the academic hospital was overly

conservative in its coding practices and 'leaving money on the table."[17] These examples

provide strong support for concluding that there were opportunities under the current

CMS DRGs to improve coding and increase payment. With incentives changing under

the MS-DRGs, we believe there will be additional opportunities to improve

documentation and coding. We believe this article supports our contention that hospital

coders and physicians will respond to incentives available under MS-DRGs by improving

documentation and coding to increase case-mix.

Comment: One commenter stated that the *ICD-9-CM Official Guidelines for*

Coding and Reporting and the American Hospital Association's *Coding Clinic for*

ICD-9-CM provide official industry guidance on complete, accurate ICD-9-CM coding,

without regard to the impact of code assignment on reimbursement. AHIMA's Standards

of Ethical Coding stipulate that "coding professionals are expected to support the

importance of accurate, complete, and consistent coding practices for the production of

quality healthcare data." The commenter believed that all diagnoses and procedures

should be coded and reported in accordance with the official coding rules and guidelines

and does not advocate the practice of only coding enough diagnoses and procedures for

correct DRG assignment. The commenter stated that increased attention to the quality of

coding and documentation as a result of the role coding plays in DRG assignment has led

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[17] Dimick, Chris "Clinical Documentation Specialists," *Journal of AHIMA*, July-August 2007, pages 44 -
50.

to much-improved coding practices since the adoption of the IPPS in 1983. The

commenter further noted that hospitals code more completely so CMS has more complete

data to make DRG modifications that would recognize the resource-intensiveness of a

diagnosis or procedure.

Response: We believe the commenter's assertion supports our point that

improvements in documentation and coding occurred as a result of the payment

incentives provided by the IPPS. That is, the commenter is saying that the adoption of

the original IPPS in 1983 led hospitals to improve documentation and coding practices

because "of the role coding plays in DRG assignment." The commenter believed that

MS-DRGs will not lead to changes in documentation and coding practices and cites—

among other sources—AHIMA's Standards of Ethical Coding. AHIMA is a professional

association representing more than 51,000 health information professionals who work

throughout the healthcare industry whose work is closely engaged with the diagnosis and

procedure classification systems that serve to create the DRGs. The article cited above

from the July-August issue of the *Journal of AHIMA* provided documented examples of

how hospitals can change coding practices to maximize payments. Thus, there is an

assertion in this comment that official coding rules and guidelines require all diagnoses

and procedures to be reported on the claim minimizing opportunities for changes in

documentation and coding to increase case mix. However, AHIMA's own professional

journal provides strong evidence of opportunities that exist for improvements in coding to

increase payment. As we stated previously and suggested by the article in the Journal of

AHIMA, we believe that payment incentives lead hospital staff to carefully examine

documentation and coding practices, work with physicians to improve the precision of clinical documentation in order to make subsequent changes in coding.

Comment: A number of commenters requested that CMS not make the documentation and coding adjustment until hospitals have had experience with the MS-DRGs. Once the MS-DRGs are fully implemented, the commenters indicated that CMS can investigate whether payments have increased due to coding rather than the severity of patients and determine if an adjustment is necessary. Several commenters stated that CMS is not required to make a prospective adjustment to IPPS rates to account for improvements in documentation and coding and should not do so without an understanding of whether there will even be coding changes in the first few years of the refined system. Another commenter stated that CMS should retrospectively determine the national rate reduction to offset increases in case-mix from improvements in documentation and coding even though the reduction would be made to future rates and would not account for potential increases in payment that would occur until the adjustment is made. The commenter indicated that section 1886(d)(3)(A)(vi) of the Act authorizes just such an adjustment and it is the only way to ensure that the level of the reduction is accurate. All of these commenters argued that CMS can always correct for additional payments made as a result of coding changes in a later year when there is sufficient evidence and an understanding of the magnitude.

One commenter suggested that CMS defer (but not eliminate) adjustments for improvements in documentation and coding. This commenter suggested that CMS make the adjustment at a later time when there is actual data suggesting how much

improvements in documentation have increased case mix but that we consider a "stop

loss" if initial coding changes appear to far exceed the current 4.8 percent estimate. The

commenter indicated that CMS should encourage facilities to improve their

documentation and coding accuracy sooner (that is, prior to adjusting for documentation

and coding), and not do any MCC/CC consolidations until after coding improvements

have occurred (that is, have 3 severity levels for all DRGs).

Another commenter noted that RAND's evaluation of alternative severity DRG

systems included an assessment of how coding behaviors are expected to vary under each

system. However, RAND did not evaluate the MS-DRGs and further noted that it was

not able to empirically assess the relative risk the alternative severity-adjusted systems

pose for case mix increases attributable to coding improvement without having the

opportunity to observe actual changes in coding behavior when a DRG system is used for

payment. The commenter did not believe any payment adjustment to account for case

mix increases, which are attributable to coding improvements, should be made until CMS

has conducted appropriate research to determine the extent to which improvements in

coding becomes an issue under the proposed MS-DRG system. While the design of the

MS-DRG system may encourage an increased level of coding specificity, the commenter

stated that it is unknown what effect, if any, this might have on the CMI.

Response: RAND did not repeat the analysis of the potential for documentation

and coding improvements to increase case mix using the MS-DRGs because it only

worked with FY 2005 data to evaluate them. The RAND report refers readers to the

analysis CMS did of the likely impact of documentation and coding improvements on case mix using the MS-DRGs.[18]

With respect to delaying making any adjustments for documentation and coding, the commenters are correct that section 1886(d)(3)(A)(vi) of the Act gives the Secretary authority to revisit adjustments to the standardized amounts for changes in coding or classification of discharges that were based on estimates in a future year. We also note that section 1886(d)(4)(C) of the Act requires that "changes in classifications or weighting factors" not increase or decrease aggregate inpatient hospital payments. We believe that Congress has expressed its clear preference that all changes to DRG reclassifications be budget neutral. Substantial evidence indicates that, unless we make an adjustment to account for improvements in documentation and coding, aggregate payments under the IPPS will increase when we adopt MS-DRGs as a result of these improvements in documentation and coding. Further, as discussed above, the independent Office of the Actuary validated the -1.2 percent adjustment to the standardized amount to ensure that improvements in documentation and coding do not increase case-mix and IPPS payments.

In addition, by revisiting the adjustment at a later date when we have actual data, we can ensure that the standardized amounts are permanently set at the level they otherwise would have been had the increase in case mix due to improvements in documentation and coding been known. That is, any overestimate or underestimate of the adjustment for improvements in documentation would not be permanently embedded

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[18] Wynn, Barbara O., Beckett, Megan, et. al., "Evaluation of Severity Adjusted DRG System: Draft Interim Report," RAND HEALTH, August, 2007, Addendum, page 27.

in the IPPS standardized amount for subsequent years. While any differences between

projected and actual data could result in higher or lower payments to hospitals for the

intervening years, MedPAC believes that CMS should provide an adjustment that lies

somewhere in the middle of its own estimate of 2.0 percent and CMS' estimate of 4.8

percent. In its comments, MedPAC recommended that CMS should adopt an adjustment

for improvements in documentation and coding between 1.6 and 1.8 percent per year that

would "put both Medicare and the hospital industry at some risk that the actual value will

turn out to be higher or lower than the adjustment that is applied."[19]

Comment: Several commenters agreed with RAND's assertion that the

magnitude of coding improvement is likely to vary across hospitals, depending on how

strong their current coding practices are and the resources they are able to devote to

improving them. One commenter stated that the hospitals that already use the more

specific codes and those with a low proportion of cases in split DRGs would receive

fewer, if any, overpayments because their case mix indices would not increase as much,

or at all. The commenter stated that New York hospitals, in particular, would have less

opportunity for coding improvement than other hospitals because the union of the

Medicare CC list and the New York State CC list has 279 more codes than the Medicare

CC list alone. Thus, moving from the union of the CC list to the revised CC list would

add only 1,298 codes, 279 fewer codes than in the rest of the country. Furthermore, New

York hospitals are well-practiced in using specific codes because the New York State

AP-DRG grouper differentiates between CCs and major CCs, as the MS-DRG grouper

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[19] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007, page 13.

would do. This commenter and others that cited the RAND study agree that CMS'

practice of making an across-the-board adjustment to PPS payments to address case mix

increases attributable to coding improvements raises an equity issue that CMS needs to

consider.   The adjustment to the standardized amount for documentation and coding for

hospitals that have already improved coding would result in significant payment losses

according to the commenter rather than offsetting higher case mix indices. The

commenter stated that these changes are not uniform, creating unintended distributional

impacts. The commenter stated that the process to make adjustments for documentation

and coding is an across the board adjustment to the standardized amount, while actual

changes will vary widely. This will create unintended distributional impacts across

patient types, providers, and states that will in turn, according to the commenter, create

push-back in providers, states, Congress, and potentially the courts.

One of these commenters acknowledged that CMS may not have the option to

recoup overpayments on a hospital-specific basis, as is done in New York.   The

commenter suspected that the proposed documentation and coding adjustment is too high

because hospitals in other states—particularly New York—have more experience with

secondary diagnosis coding than the Maryland hospitals had before their change to

APR DRGs. Therefore, hospitals in other states probably have less opportunity to

generate documentation and coding improvements that increase case mix.

Response: We agree that completeness of hospital coding practices may well

vary across hospitals. Although we recognize this variability, we believe there will be

potential for coding improvements to increase case mix for all hospitals. For instance, as

noted above, a hospital can change the order of a principal and secondary diagnosis for

closely related conditions to affect payment. The selection of a principal diagnosis that

was previously coded as secondary can increase hospital payment. This type of potential

coding change to increase case mix could be available to all hospitals irrespective of

whether or not they maximized coding in the past. As noted above, a commenter

examined data from New York State discharges and indicated that if MCC and CC codes

that are currently provided beyond the original 9 diagnoses on the claim that are used by

Medicare are moved to the first 9 positions, case mix would increase by 0.5 percent.

Thus, this comment indicates that there will be at least some opportunity to increase case

mix through improvements in documentation and coding in States like New York that

have used sophisticated DRG systems in the past for payment. Similarly, there are public

comments suggesting hospitals can select a specified condition in place of an unspecified

one to increase payment under the MS-DRGs but that this change in documentation and

coding practice will not be applicable in areas of the country where a DRG system is in

use that distinguishes between MCCs and CCs. As noted above, congestive heart failure,

unspecified appears on an average of 2.3 million cases per year from FY 2004 to FY

2006 or on over 20 percent of the Medicare claims. In our view, billing of an unspecified

code on this magnitude of claims suggests potential improvements in coding from

substituting a specified for an unspecified code are widespread. While improvements in

documentation and coding that increase case mix may be variable, section

1886(d)(3)(A)(vi) of the Act only allows us to apply the adjustments that are a result of

changes in the coding or classification of discharges that do not reflect real changes in

case mix to the standardized amounts.

Comment: Several commenters indicated that there should be a transition to the

MS-DRGs. A number of commenters supported a 4-year transition period for

implementing the MS-DRGs. The commenters stated that such a transition would allow

hospitals the opportunity to educate their employees and physicians to assure proper,

accurate coding, along with allocation of required resources through their budgetary

process. The commenters recommended that FY 2008 be used to prepare for and test the

MS-DRGs. In FY 2009 through 2011, the DRG weights would be computed as a blend

of the MS-DRGs and the current DRGs. These commenters believed a 1-year delay

would provide hospitals adequate time to implement and test the new system and adjust

operations and staffing for predicted revenues. They also suggested that the 1-year delay

would provide CMS adequate time to finalize data and a CC list, introduce and test

software for case classification and payment, and train its fiscal agents. It would also

allow vendors and State agencies time to incorporate such changes into their respective

software and information systems. Other commenters were concerned that CMS would

implement the MS-DRGs in FY 2008 and then, as a result of the final RAND report,

move to another new system for FY 2009. These commenters urged CMS to delay the

implementation of the MS-DRGs if there was a possibility for another completely new

system in FY 2009. These commenters stated that hospitals will expend a large number

of hours educating their coding staff about the MS-DRGs so that they can attempt to

legitimately optimize their payment. Some commenters recommended that CMS

implement the MS-DRGs effective October 1, 2007, with a 3-year phase-in approach of

the relative weights.

One commenter indicated that CMS should phase in the revised CC list and MS-

DRGs to reduce the amount of documentation and coding related overpayments that

would be made "in the first place." The commenter recommended that the MS-DRGs not

be implemented in FY 2008. Instead, they recommend that the revised CC list be used

with a Version 25.0 of the current CMS DRGs and allow vendors of the alternative

severity systems being evaluated by RAND to incorporate this information into an

updated version of their systems. The commenter stated that the updated version of the

CMS DRGs using the revised CC list would produce a greatly improved DRG

GROUPER. The commenter recommended a 5-year phase-in during which the old

CC list/CMS-DRG weights and the new CC list/MS-DRG weights would be blended in

the following proportions: 80/20 percent in FY 2008, 60/40 percent in FY 2009, 40/60

percent in FY 2010, 20/80 percent in FY 2011, and 0/100 percent in FY 2012. The

commenter stated that CMS should release the MS-DRG grouper software as soon as

possible and should also encourage vendors to release products as soon as possible that

ensure that both old and new CCs are listed among the first eight secondary diagnoses, as

these are the only ones that can be used for payment purposes. With respect to the phase-

in, the commenter believed it is prudent to begin to use the new CC list/MS-DRGs in FY

2008 so that hospitals are compelled as soon as possible (1) to improve their coding, and

(2) to educate their physicians about complete documentation. However, the commenter

would not want the new DRG weights to represent a majority of the blend until they can

be based on the first year of corrected data. The FY 2010 weights would be based on the

FY 2008 cases, so they would reflect the first year's coding corrections and would

presumably be more accurate. Because it can take several years for hospitals and

physicians to adjust to new documentation and coding requirements, continuing blended

payments in FY 2011 would be important to minimize documentation and coding related

overpayments, according to the commenter.

The commenter stated that the goal is to minimize the aggregate level of

documentation and coding related overpayments so that hospitals not generating

increases in case mix are not unfairly penalized by an across-the-board reduction. If

overpayments could be recouped on a hospital-specific basis, the commenter stated that

an attenuated phase-in would not be necessary. The commenter stated that they realized

that their recommended phase in would be cumbersome because each case would have to

be grouped twice to determine the DRG assignment under the CMS DRG and MS-DRG

GROUPERS. However, the commenter believed this is the better policy option since the

alternative for good-coding hospitals and those with relatively few patients in split DRGs

would be to effectively eliminate the IPPS update for 2 years.

Response: We received many comments in support of the MS-DRGs, particularly

because they are so structurally similar to the current DRGs, and therefore, we believe

that a full year's delay is unwarranted. While the MS-DRGs include some consolidations

of base DRGs, the major changes from the current DRGs simply involve adding severity

levels to many of the new MS-DRGs. The move to MS-DRGs will not necessitate

additional data elements or changes in reporting practices. Providers will be submitting

the same clinical information on their claims. In our view, the issues in the comments

concerning the need to examine the new system in detail do not justify delaying the move

to this new system. We have provided detailed information in both the proposed and

final rule as well as on our Web site on the formation of the MS-DRGs. We believe the

significant benefits of the new system outweigh concerns by the provider community that

they have not had time to analyze the details of the new system. We are confident that

once they start working with the new system, they will find it simple to understand and

far better at identifying and paying for more costly and severely ill patients. Accordingly,

we do not believe that extensive preparation for implementation of the MS-DRGs is

necessary, and therefore, we are not delaying adoption of the MS-DRGs until FY 2009.

MedPAC also carefully evaluated the options of implementing MS-DRGs in

FY 2008 versus deferring the implementation until FY 2009 and agrees with our

assessment that there is not sufficient cause to delay the proposed adoption of MS-DRGs

beyond FY 2008. While MedPAC agreed that MS-DRGs should be implemented in

FY 2008, it also stated that the transition should coincide with the transition to cost-based

weights—that is, implement the MS-DRGs over a 2-year period beginning in FY 2008.[20]

We agree with MedPAC that the MS-DRGs should be implemented over a 2-year

transition period that coincides with the phase-in of cost-based weights. Therefore, we

will implement MS-DRGs beginning in FY 2008 over a 2-year transition period where

the DRG relative weights will be a blend of 50 percent each of the CMS DRG and

MS-DRG weights. We have provided more detail in section II.D.2. of the preamble of

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[20] Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11,
2007, page 10.

this final rule with comment period about the DRG relative weight calculations over this 2-year transition period.

There appears to be a suggestion in many of the public comments both here and above that delaying implementation of MS-DRGs will allow the improvements in documentation and coding to occur before they have any financial impact on the Medicare program because hospitals would know and be encouraged to code using the incentives provided under the MS-DRGs, while Medicare would continue to be using the current CMS DRGs for payment. As discussed, one comment suggested that we could lessen the need for the documentation and coding adjustment by minimizing the financial impact of improvements in documentation and coding through a long transition period (5 years). We believe hospitals will not improve documentation and coding consistent with the incentives provided under the MS-DRGs unless they have a financial incentive to do so. As indicated in one public comment, "Documentation and numbers of diagnosis codes is inevitably incomplete due to time pressures for completion of 'paperwork' and limitation of computer systems to capture this information. If an item is not used and/or not important, it is less well documented."

If there is a delay in MS-DRGs, the coding incentives that would come with its adoption would not be present and, therefore, likely would not occur. While we appreciate the suggestion for adopting a long transition period to provide an incentive to improve coding but minimize its financial impact on Medicare, such an idea may well just extend the period of time that documentation and coding improvements occur while delaying the improvements in recognition of severity of illness that would result from

adopting MS-DRGs. Again, we do not believe that either delaying or adopting MS-

DRGs over a long period of time will reduce the need to apply a documentation and

coding adjustment of the magnitude we estimated. We believe that adopting either of the

ideas would only result in us needing to delay or extend the period of time over which the

documentation and coding adjustment is applied.

Comment: MedPAC indicated that case-mix might increase more or less than the

4.8 percent we estimated from Maryland's experience. MedPAC recommended an

adjustment between 1.6 and 1.8 percent a year for 2 years. This adjustment is based on a

comparison between the MS-DRGs in Maryland and nationally (2.0 percent over 2 years)

increased:

● To reflect their view that many hospitals do not respond quickly to improve

reporting after major changes in the DRG definitions; and

● The estimated change in case-mix for hospitals in the rest of the nation may

reflect some improvements in documentation and coding in response to changes in the

DRG definitions that were adopted in 2006 (such as the refinements to the cardiac care

DRGs among others).

MedPAC recommended that we apply an adjustment that is somewhere in the

middle between their estimate of 2.0 and the CMS figure of 4.8 percent. According to

MedPAC, a middle point in the range of 1.6 to 1.8 percent per year would put both

Medicare and the hospital industry at some risk that the actual value will turn out to be

higher or lower than the adjustment that is applied. If the actual increase due to

improvements in case-mix reporting turns out to be higher, the Medicare program will

have paid more than it should have. If the actual increase is lower, the hospitals will have

been paid less than they should have. MedPAC noted that we have already stated a

willingness to correct for any difference between our forecast and the actual increase in

case mix due to improved coding when data become available in 2009 when we prepare

the proposed rule for fiscal year 2010. MedPAC further suggested that CMS plan on

taking coding adjustments for longer than two years. CMS may want to adopt a series of

adjustments that takes somewhat higher adjustments in the first few years of the MS-

DRG changes, on the assumption that history has shown that previous coding

adjustments have underestimated the impact of the changes.

    Response: We proposed to adjust the IPPS standardized amounts by -2.4 percent

each year for FYs 2008 and 2009 for improvements in documentation and coding that

will increase case-mix. As we are adopting the MS-DRGs over a 2-year transition

period, we do not believe that the incentives to improve documentation and coding will

be as strong in the first year as we previously estimated. Further, as suggested above by

the evidence when the IPPS was first implemented, MedPAC, and other public

comments, it can take several years for hospitals and physicians to adjustment their

documentation and coding practices in response to payment incentives. For these

reasons, we believe the documentation and coding adjustment should be applied over a

period of 3 rather than 2 years. We do not agree with MedPAC that a larger adjustment

"should be taken in the first few years of the MS-DRGs on the assumption that history

has shown that previous coding adjustments have underestimated the impact of changes."

Rather, as stated above, we believe that the coding incentives during the first year of MS-

DRGs will be lessened because we are adopting them over a 2-year transition period.

Therefore, we believe a smaller adjustment should be applied in the initial year. We

continue to believe that our analysis justifies a -4.8 percent adjustment for improvements

in documentation and coding at this time. Therefore, we are applying an adjustment

of -1.2 percent in this final rule with comment period to the IPPS standardized amounts

for FY 2008 and based on current projections will apply adjustments of -1.8 percent each

year to the IPPS standardized amounts for FYs 2009 and 2010.

Consistent with the statute, we will compare the actual increase in case-mix due to

documentation and coding to our projection once we have actual data to revise the

Actuary's estimate and the adjustment we make to the standardized amounts. With these

adjustments occurring over 3 rather than 2 years, we will have information in 2009 as we

prepare the IPPS rule for FY 2010 to reevaluate how the actual increase in case mix

compares to our estimate. We may also have partial year information in 2008 to inform

any proposal for FY 2009. Therefore, we will consider revising the planned adjustments

for FY 2009 and FY 2010 if information in the Medicare billing data suggests that our

projections are either too high or low compared to actual experience.

Based on the Actuary's analysis, using the Secretary's authority under section

1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of

changes in coding or classification of discharges that do not reflect real changes in

case-mix, we are reducing the IPPS standardized amount by -1.2 percent for FY 2008.

Section 1886(d)(3)(A)(vi) of the Act further gives the Secretary authority to revisit

adjustments to the standardized amounts for changes in coding or classification of

discharges that were based on estimates in a future year. Consistent with the statute, we

will compare the actual increase in case-mix due to documentation and coding to our

projection once we have actual data for FY 2008. At that time, if necessary, we may

make a further adjustment to the standardized amounts to account for the difference

between our projection and actual data.

7. Effect of the MS-DRGs on the Outlier Threshold

       To qualify for outlier payments, a case must have costs greater than Medicare's

payment rate for the case plus a "fixed loss" or cost threshold. The statute requires that

the Secretary set the cost threshold so that outlier payments for any year are projected to

be not less than 5 percent or more than 6 percent of total operating DRG payments plus

outlier payments. The Secretary is required by statute to reduce the average standardized

amount by a factor to account for the estimated proportion of total DRG payments made

to outlier cases. Historically, the Secretary has set the cost threshold so that 5.1 percent

of estimated IPPS payments are paid as outliers. The FY 2007 cost outlier threshold is

$24,485. Therefore, for any given case, a hospital's charge adjusted to cost by its

hospital-specific CCR must exceed Medicare's DRG payment by $24,485 for the case to

receive cost outlier payments.

       Adoption of the MS-DRGs will have an effect on calculation of the outlier

threshold. For the proposed rule and this final rule with comment period, we analyzed

how the outlier threshold would be affected by adopting the MS-DRGs. Using FY 2005

MedPAR data, we have simulated the effect of the MS-DRGs on the outlier threshold.

By increasing the number of DRGs from 538 to 745 to better recognize severity of

illness, the MS-DRGs would be providing increased payment that better recognizes

complexity and severity of illness for cases that are currently paid as outliers. That is,

many cases that are high-cost outlier cases under the current CMS DRG system would be

paid using an MCC DRG under the MS-DRGs and could potentially be paid as nonoutlier

cases. For this reason, we expected the FY 2008 outlier threshold to decline from its FY

2007 level of $24,485. We proposed an FY 2008 outlier threshold of $23,015. In this

final rule with comment period, we are establishing an FY 2008 outlier threshold of

$22,650. In section II.A.4. of the Addendum to this final rule with comment period, we

provide a more detailed explanation of how we determined the final FY 2008 cost outlier

threshold. We address any comments received on the FY 2008 proposed outlier

threshold in section II.A.4. of the Addendum to this final rule with comment period.

8. Effect of the MS-DRGs on the Postacute Care Transfer Policy

Existing regulations at §412.4(a) define discharges under the IPPS as situations in

which a patient is formally released from an acute care hospital or dies in the hospital.

Section 412.4(b) defines transfers from one acute care hospital to another. Section

412.4(c) establishes the conditions under which we consider a discharge to be a transfer

for purposes of our postacute care transfer policy. In transfer situations, each transferring

hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG

payment that would have been made if the patient had been discharged without being

transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full

DRG payment by the geometric mean length of stay for the DRG. Based on an analysis

that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day. The purpose of the IPPS postacute care transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Beginning with the FY 2006 IPPS, the regulations at §412.4 specified that, effective October 1, 2005, we make a DRG subject to the postacute care transfer policy if, based on Version 23.0 of the DRG Definitions Manual (FY 2006), using data from the March 2005 update of FY 2004 MedPAR file, the DRG meets the following criteria:

- The DRG had a geometric mean length of stay of at least 3 days;

- The DRG had at least 2,050 postacute care transfer cases; and

- At least 5.5 percent of the cases in the DRG were discharged to postacute care prior to the geometric mean length of stay for the DRG.

In addition, if the DRG was one of a paired set of DRGs based on the presence or absence of a CC or major cardiovascular condition (MCV), both paired DRGs would be included if either one met the three criteria above.

If a DRG met the above criteria based on the Version 23.0 DRG Definitions Manual and FY 2004 MedPAR data, we made the DRG subject to the postacute care transfer policy. We noted in the FY 2006 final rule that we would not revise the list of DRGs subject to the postacute care transfer policy annually unless we make a change to a specific CMS DRG. We established this policy to promote certainty and stability in the postacute care transfer payment policy. Annual reviews of the list of CMS DRGs subject to the policy would likely lead to great volatility in the payment methodology with certain DRGs qualifying for the policy in one year, deleted the next year, only to be reinstated the following year. However, we noted that, over time, as treatment practices change, it was possible that some CMS DRGs that qualified for the policy will no longer be discharged with great frequency to postacute care. Similarly, we explained that there may be other CMS DRGs that at that time had a low rate of discharges to postacute care, but which might have very high rates in the future.

The regulations at §412.4 further specify that if a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first became effective, using the most recent complete year of MedPAR data:

● The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs; and

● The proportion of short-stay discharges to postacute care to total discharges in

the DRG exceeds the 55th percentile for all DRGs. A short-stay discharge is a discharge

before the geometric mean length of stay for the DRG.

A DRG also is a qualifying DRG if it is paired with another DRG based on the

presence or absence of a CC or MCV that meets either of the above two criteria.

The MS-DRGs that we proposed to adopt (and are finalizing in this final rule with

comment period) for FY 2008 are a significant revision to the current CMS DRG system.

Because the new MS-DRGs are not reflected in Version 23.0 of the DRG Definitions

Manual, consistent with §412.4, we proposed to recalculate the 55th percentile thresholds

in order to determine which MS-DRGs would be subject to the postacute care transfer

policy. Further, under the MS-DRGs, the subdivisions within the base DRGs will be

different than those under the current CMS DRGs. Unlike the current CMS DRGs, the

MS-DRGs are not divided based on the presence or absence of a CC or MCV. Rather,

the MS-DRGs have up to three subdivisions based on: (1) the presence of a MCC; (2)

the presence of a CC; or (3) the absence of either an MCC or CC. Consistent with our

existing policy under which both DRGs in a CC/non-CC pair are qualifying DRGs if one

of the pair qualifies, we proposed that each MS-DRG that shared a base MS-DRG would

be a qualifying DRG if one of the MS-DRGs that shared the base DRG qualified. We

proposed to revise §412.4(d)(3)(ii) to codify this policy.

Similarly, we believe that the changes to adopt MS-DRGs also necessitate a

revision to one of the criteria used in §412.4(f)(5) of the regulations to determine whether

a DRG meets the criteria for payment under the "special payment methodology." Under

the special payment methodology, a case subject to the special payment methodology that is transferred early to a postacute care setting will be paid 50 percent of the total IPPS payment plus the average per diem for the first day of the stay. Fifty percent of the per diem amount will be paid for each subsequent day of the stay, up to the full MS-DRG payment amount. A CMS DRG is currently subject to the special payment methodology if it meets the criteria of §412.4(f)(5). Section 412.4(f)(5)(iv) specifies that if a DRG meets the criteria specified under §412.4(f)(5)(i) through (f)(5)(iii), any DRG that is paired with it based on the presence or absence of a CC or MCV is also subject to the special payment methodology. Given that this criterion would no longer be applicable under the MS-DRGs, we proposed to add a new §412.4(f)(6) that includes a DRG in the special payment methodology if it is part of a CC/non-CC or MCV/non-MCV pair. We proposed to update this criterion so that it conforms to the proposed changes to adopt MS-DRGs for FY 2008. The revision would make an MS-DRG subject to the special payment methodology if it shares a base MS-DRG with an MS-DRG that meets the criteria for receiving the special payment methodology.

Comment: One commenter urged CMS to "suspend application of the postacute care transfer policy for one year, until sufficient data is available, and then apply the criteria anew to the MS-DRGs." As an alternative to ceasing the application of the postacute care transfer policy for one year, the commenter recommended that CMS limit the application of the postacute care transfer policy as much as possible until better data are available and not to increase the average length of stay for less complicated DRGs over their current levels.

Response: Under both the CMS DRGs and MS-DRGs, there were two criteria for

making a DRG subject to the postacute care transfer policy. These criteria are:

● The total number of discharges to postacute care in the DRG must equal or

exceed the 55th percentile for all DRGs; and

● The proportion of short-stay discharges to postacute care to total discharges in

the DRG must equal or exceed the 55th percentile for all DRGs.

While these criteria are identical under the CMS DRGs and the MS-DRGs, we

needed to recalculate the 55th percentile thresholds in order to determine which

MS-DRGs would be subject to the postacute care transfer policy to conform the existing

policy to the new DRG system. Further, we also needed to make a conforming change to

our policy that a DRG is subject to the postacute care transfer policy if it is one of a

paired set of DRGs based on the presence or absence of a CC or MCV where one of the

DRGs in the set meets the numerical criteria specified above. As the MS-DRGs have

subdivisions based on MCC, CCs and non-CCs rather than MCVs, CCs and non-CCs, we

needed to amend the regulatory text to reflect the nomenclature of the MS-DRG system.

Therefore, our policy for making a DRG subject to the postacute care transfer policy

under the MS-DRGs is unchanged other than to make it conform to the new DRG system.

As our policy is unchanged, we do not believe that either suspending or limiting

application of the postacute care transfer policy under the MS-DRGs is warranted.

Comment: One commenter opposed CMS' "proposal to significantly expand the

list of the DRGs subject to the postacute care transfer policy." The commenter, a

hospital, noted that "manual processes" would have to take place in order to identify

patients meeting the home health criteria. Specifically, the commenter stated that,

"hospitals [would] either have to contact patients to determine if they have received home

health services within 3 days after discharge or wait for the fiscal intermediary to let the

hospital know that a patient received home care that was not planned at the time of

discharge which requires coders to review and correct the disposition and for the

Business Office to resubmit the claim."

Response: We note that we did not propose to change or expand the postacute

care transfer policy provision in this year's proposed rule. Rather, we applied existing

post-acute transfer policy to the new MS-DRG system. Thus, the criteria that would have

made a CMS-DRG subject to the postacute care transfer policy last year were the same as

those applied to the MS-DRGs for FY 2008. We note that in FY 2007, 190 CMS DRGs

of 538 CMS DRGs were subject to the postacute care transfer policy, or about 35 percent.

For FY 2008, 273 out of 745 MS-DRGs are subject to the postacute care transfer policy

or about 36 percent. Therefore, the proportion of postacute care transfer MS-DRGs

subject to the policy is very similar to what it was last year under the CMS DRGs. Thus,

we disagree there has been a "significant expansion" of DRGs subject to the postacute

care transfer policy. Rather, we are simply conforming the existing postacute care

transfer policy to the new MS-DRGs.

In response to the commenter's concern about it being administratively

burdensome to identify patients who received home health care services subsequent to

discharge from the acute care hospital, we note that, under section 1886(d)(5)(J)(ii)(III)

of the Act, the term "qualified discharge" includes a discharge from an IPPS hospital

upon which the patient is provided home health services from a home health agency if

such services relate to the condition or diagnosis for which the patient received hospital

inpatient services. The proposed rule did not make any change to application of the

postacute care transfer policy in this circumstance. We note that, in most instances,

patients are discharged from the acute hospital with a written plan of care for the

provision of home health services, so hospitals would usually know if a patient was going

to receive home health care services at the time of discharge. Additionally, we do not

expect that the administrative burden of identifying patients discharged to home for the

provision home health services within 3 days will be any greater under the MS-DRG

system than it was under the CMS DRG system because the proportion of DRGs subject

to the postacute care transfer policy is very similar under both systems.

Comment: One commenter stated that it is unreasonable to categorize all three

MS-DRGs in the same base DRG as subject to the postacute care transfer policy if only

one of the three meets the criteria. The commenter suggested that, for base MS-DRGs

where there are three base-DRGs, two of the three base-DRGs should meet the postacute

care transfer criteria (on their own) for all of them to be subject to the postacute care

transfer policy and that if only one meets the criteria, none should be subject to the

postacute care transfer policy.

Response: Under the CMS DRG system, some DRGs were paired with others

(with CC or without CC). Under that system, if one DRG qualified for the postacute care

transfer policy, we included its paired DRG so as not to create an incentive for hospitals

not to include any code that would identify a complicating or comorbid condition. The

same logic applies under the MS-DRG system: if one DRG in a set meets the postacute

care transfer criteria, we believe that it is appropriate to include the paired or grouped

DRGs so as not to create any coding incentives to bypass the postacute care transfer

payment. Therefore, we disagree with the commenter that it is "unreasonable" to include

a group of MS-DRGs where only one MS-DRG in the group meets the postacute care

transfer criteria on its own. We also note that we apply the same logic to the special-pay

MS-DRGs. That is, if an MS-DRG qualifies to receive the special payment

methodology, any other MS-DRGs that share the same base MS-DRG also qualify to

receive the special payment methodology.

In this final rule with comment period, we are adopting the proposed postacute

care transfer policy conforming changes as final.

In addition, §412.4(f)(3) states that the postacute care transfer policy does not

apply to CMS DRG 385 for newborns who die or are transferred. We proposed to make

a conforming change to this paragraph to reflect that this CMS DRG would become

MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) under our

proposed DRG changes for FY 2008. We did not receive any comments on this proposal

and, therefore, are finalizing this conforming change as proposed.

These revisions do not constitute a change to the application of the postacute care

transfer policy. Therefore, any savings attributed to the postacute care transfer policy

will be unchanged as a result of adopting the MS-DRGs. Consistent with section

1886(d)(4)(C)(iii) of the Act, aggregate payments from adoption of the MS-DRGs cannot

be greater or less than those that would have been made had we not made any DRG

changes.

We also proposed and are adopting as final technical changes to §§412.4(f)(5)(i)

and (f)(5)(iv) to correct a cross-reference and a typographical error, respectively.

E. Refinement of the Relative Weight Calculation

In the FY 2007 IPPS final rule (71 FR 47882), effective for FY 2007, we began to

implement significant revisions to Medicare's inpatient hospital rates by basing the

relative weights on hospitals' estimated costs rather than on charges. This reform was one

of several measured steps to improve the accuracy of Medicare's payment for inpatient

stays that include using costs rather than charges to set the relative weights and making

refinements to the current CMS DRGs so they better account for the severity of the

patient's condition. Prior to FY 2007, we used hospital charges as a proxy for hospital

resource use in setting the relative weights. Both MedPAC and CMS have found that the

limitations of charges as a measure of resource use include the fact that hospitals cross-

subsidize departmental services in many different ways that bear little relation to cost,

frequently applying a lower charge markup to routine and special care services than to

ancillary services. In MedPAC's 2005 Report to the Congress on Physician-Owned

Specialty Hospitals, MedPAC found that hospitals charge much more than their costs for

some types of services (such as operating room time, imaging services and supplies) than

others (such as room and board and routine nursing care).[21] Our analysis of the MedPAC

report in the FY 2007 IPPS proposed rule (71 FR 24006) produced consistent findings.

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[21] Medicare Payment Advisory Commission: Report to the Congress: Physician-Owned Specialty
Hospitals, March 2005, p. 26.

In the FY 2007 IPPS proposed rule, we proposed to implement cost-based

weights incorporating aspects of a methodology recommended by MedPAC, which we

called the hospital-specific relative value cost center (HSRVcc) methodology. MedPAC

indicated that an HSRVcc methodology 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. After studying Medicare cost report data, we proposed to

establish 10 national cost center categories from which to compute 10 national CCRs

based upon broad hospital accounting definitions. We made several important changes to

the HSRVcc methodology that MedPAC recommended using in its March 2005 Report to

the Congress on Physician-Owned Specialty Hospitals. We refer readers to the FY 2007

IPPS proposed rule (71 FR 24007 through 24011) for an explanation and our reasons for

the modification to MedPAC's methodology. In its public comments on the FY 2007

IPPS proposed rule, MedPAC generally agreed with the adaptations we made to its

methodology. MedPAC further recommended that we expand the number of distinct

hospital department CCRs being used from 10 to 13, which we subsequently adopted in

the FY 2007 IPPS final rule.

We did not finalize the HSRVcc methodology for FY 2007 because of concerns

raised in the public comments on the FY 2007 IPPS proposed rule (71 FR 47882 through

47898). Rather, we adopted a cost-based weighting methodology without the hospital-

specific relative weight feature. In response to a comment from MedPAC, we also

expanded the number of distinct hospital departments with CCRs from 10 to 13. We

indicated our intent to study whether to adopt the HSRVcc methodology after we had the

opportunity to further consider some of the issues raised in the public comments. In the

interim, we adopted a cost-based weighting methodology over a 3-year transition period,

substantially mitigating the redistributive payment impacts illustrated in the proposed

rule, while we engaged a contractor to assist us with evaluating the HSRVcc

methodology.

Some commenters raised concerns about potential bias in cost-based weights due

to "charge compression," which is the practice of applying a lower percentage markup to

higher cost services and a higher percentage markup to lower cost services. These

commenters were concerned that our proposed weighting methodology may undervalue

high cost items and overvalue low cost items if a single CCR is applied to items of

widely varying costs in the same cost center. The commenters suggested that the

HSRVcc methodology would exacerbate the effect of charge compression on the final

relative weights. One of the commenters suggested an analytic technique of using

regression analysis to identify adjustments that could be made to the CCRs to better

account for charge compression. We indicated our interest in researching whether a

rigorous model should allow an adjustment for charge compression to the extent that it

exists. We engaged a contractor, RTI International (RTI), to study several issues with

respect to the cost-based weights, including charge compression, and to review the

statistical model provided to us by the commenter for adjusting the weights to account for

it. We discuss RTI's findings in detail below.

Commenters also suggested that the cost report data used in the cost methodology

are outdated, not consistent across hospitals, and do not account for the costs of newer

technologies such as medical devices. However, the relationship between costs and

charges (not costs alone) is the important variable in setting the relative weights under

this new system. Older cost reports also do not include the hospital's higher charges for

these same medical devices. Therefore, it cannot be known whether the CCR for the

more recent technologies will differ from those we are using to set the relative weights.

The use of national average cost center CCRs rather than hospital-specific CCRs may

mitigate potential inconsistencies in hospital cost reporting. Nevertheless, in the FY 2007

IPPS final rule, we agreed that it was important to review how hospitals report costs and

charges on the cost reports and on the Medicare claims and asked RTI to further study

this issue as well.

In summary, we proposed to adopt HSRVcc relative weights for FY 2007 using

national average CCRs for 10 hospital departments. Based on public comments

concerned about charge compression and the accuracy of cost reporting, we decided not

to finalize the HSRVcc methodology, but adopted cost-based weights without the

hospital-specific feature. In response to comments from MedPAC, we expanded the

number of hospital cost centers used in calculating the national CCRs from 10 to 13.

Finally, we decided to implement the cost-based weighting methodology gradually, by

blending the cost-based and charge-based weights over a 3-year transition period

beginning with FY 2007, while we further studied many of the issues raised in the public

comments. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for more

details on our final policy for calculating the cost-based DRG relative weights.

1. Summary of RTI's Report on Charge Compression

In August 2006, we awarded a contract to RTI to study the effects of charge

compression in calculating DRG relative weights. The purpose of the study was to

develop more accurate estimates of the costs of Medicare inpatient hospital stays that can

be used in calculating the relative weights per DRG. RTI was asked to assess the

potential for bias in relative weights due to CCR differences within the 13 CCR groups

used in calculating the cost-based DRG relative weights and to develop an analysis plan

that explored alternative methods of estimating costs with the objective of better aligning

the charges and costs used in those calculations. RTI was asked to consider methods of

reducing the variation in CCRs across services within cost centers by:

● Modifying existing cost centers and/or creating new centers.

● Using statistical methods, such as the regression adjustment for charge

compression. Some commenters on the FY 2007 IPPS proposed rule suggested that we

use a regression adjustment to account for charge compression.

As part of its contract, RTI convened a Technical Expert Panel composed of

individuals representing academic institutions, hospital associations, medical device

manufacturers, and MedPAC. The members of the panel met on October 27, 2006, to

evaluate RTI's analytic plan, to identify other areas that are likely to be affected by

compression or aggregation problems, and to propose suggestions for adjustments for

charge compression. We posted RTI's draft interim report on the CMS Web site in

March 2007. For more information, interested individuals can view RTI's report at the

following Web site:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292. The

report may also be viewed on RAND's Web site at

http://www.rand.org/pubs/online/health.

As the first step in its analysis, RTI compared the reported Medicare program

charge amounts from the cost reports to the total Medicare charges summed across all

claims filed by providers. Using cost and charge data from the most recent available

Medicare cost reports and inpatient claims from IPPS hospitals, RTI was charged with

performing an analysis to determine how well the MedPAR charges matched the cost

report charges used to compute CCRs. The accuracy of the DRG cost estimates is

directly affected by this match because MedPAR charges are multiplied by CCRs to

estimate cost. RTI found consistent matching of charges from the Medicare cost report to

charges grouped in the MedPAR claims for some cost centers but there appeared to be

problems with others. For example, RTI found that the data between the cost report and

the claims matched well for total discharges, days, covered charges, nursing unit charges,

pharmacy, and laboratory. However, there appeared to be inconsistent reporting between

the cost reports and the claims data for charges in several ancillary departments (medical

supplies, operating room, cardiology, and radiology). For example, the data suggested

that hospitals often include costs and charges for devices and other medical supplies

within the Medicare cost report cost centers for Operating Room, Radiology or

Cardiology, while other hospitals include them in the Medical Supplies cost center.

RTI found that some charge mismatching results from the way in which charges

are grouped in the MedPAR file. Examples include the intermediate care nursing charges

being grouped with intensive care nursing charges and electroencephalography (EEG)

charges being grouped with laboratory charges. RTI suggested that reclassifying

intermediate care charges from the intensive care unit to the routine cost center could

address the former problem.

As the second step in its analysis, RTI reviewed the existing cost centers that are

combined into the 13 groups used in calculating the national average CCRs. RTI

identified CCRs with potential aggregation problems and considered whether separating

the charge groups could result in more accurate cost conversion at the DRG level. The

analysis led RTI to calculate separate CCRs for Emergency Room and Blood and Blood

Administration, both of which had been included in "Other Services" in FY 2007.

During this second step, RTI noted that a variation of charge compression is also

present in inpatient nursing services because most patients are charged a single type of

accommodation rate per day that is linked to the type of nursing unit (routine,

intermediate, or intensive), but not to the hours of nursing services given to individual

patients. Unlike the situation with charge compression in ancillary service areas, there

are virtually no detailed charge codes that can distinguish patient nursing care use.

Therefore, any potential bias cannot be empirically evaluated or adjustments made

without additional data.

Next, RTI examined individual revenue codes within the cost centers and used

regression analysis to determine whether certain revenue codes in the same cost center

had significantly different markup rates. Those revenue codes include devices,

prosthetics, implants within the Medical Supplies cost center, IV Solutions within the

Drugs cost center, CT scanning and MRI within the Radiology cost center, Cardiac

Catheterization within the Cardiology cost center, and Intermediate Care Units within the

Routine Nursing Care cost center. Devices, prosthetics, and implants within the Medical

Supplies cost center have a lower markup and, as a result, a higher CCR than the

remainder of the medical supplies group according to RTI's analysis. Within the Drugs

CCR, IV Solutions have a much higher markup and much lower CCR than the other

drugs included in the category. Within the Radiology CCR, CT scanning and MRI have

higher markups and lower CCRs than the remaining radiology services. RTI's results for

Cardiac Catheterization and Intermediate Care Units were ambiguous due to data

problems.

RTI's analysis also determined the impact of the disaggregated CCRs on the

relative weights. Differences in CCRs alone do not necessarily alter the DRG relative

weights. The impact on the relative weights is the result of the interaction of CCR

differences and DRG differences in the proportions of the services with different CCRs.

In FY 2007, we calculated relative weights using CCRs for 13 hospital departments. The

RTI analysis suggests expanding the number of distinct hospital department CCRs from

13 to 19. Of the additional six CCRs, two would result from separating the Emergency

Department and Blood (Products and Administration) from the residual "Other Services"

category. Four additional CCRs would result from applying a regression method similar

to a method suggested in last year's public comments to three existing categories:

supplies, radiology, and drugs. This method, as adapted by RTI, used detailed coding of

charges to disaggregate hospital cost centers and derive separate, predicted alternative

CCRs for the disaggregated services. RTI's analysis suggests splitting Medical Supplies

into one CCR for Devices, Implants, and Prosthetics and one CCR for Other Supplies;

splitting Radiology into one CCR for MRIs, one CCR for CT scans, and one CCR for

Other Radiology; and splitting Drugs into one CCR for IV Solutions and one CCR for

Other Drugs.

RTI's draft report provides the potential impacts of adopting these changes to the

CCRs. We note that RTI's analysis was based on Version 24.0 of the CMS DRGs.

Because the proposed MS-DRGs were under development for the FY 2008 IPPS

proposed rule, they were unavailable to RTI for their analysis. The results of RTI's

analysis may be different if applied to the MS-DRGs. However, it seems reasonable to

believe that the impact of RTI's suggestions will be consistent using Version 24.0 of the

CMS DRGs and the MS-DRGs, as both systems generally use the same base DRGs while

applying different subdivisions to recognize severity of illness. Of all the adjusted CCRs,

the largest impact on weights came from accounting for charge compression in medical

supplies for devices and implants. The impact on weights from accounting for CCR

differences among drugs was modest. The impact of splitting MRI and CT scanning

from the radiology CCR was greater than the impact of modifying the Drugs CCRs, but

less than the impact of splitting the Medical supplies group. Separating Emergency

Department and Blood Products and Administration from the "Other Services" category

would raise the CCR for other services in the group.

RTI found that disaggregating cost centers may have a mitigating effect on the

impact of transitioning from charge-based weights to cost-based weights. That is, the

changes being suggested by RTI will generally offset (fully or more than fully in some

cases or in part in other cases) the impacts of fully implemented cost-based weights that

we are adopting over the FY 2007 – FY 2009 transition period. Thus, RTI's analysis

suggests that expanding the number of distinct hospital department CCRs used to

calculate cost-based weights from 13 to 19 will generally increase the relative weights for

surgical DRGs and decrease them for the medical DRGs compared to the fully

implemented cost-based weights to which we began transitioning in FY 2007.

2. RTI Recommendations

In its report, RTI provides recommendations for the short term, medium term, and

long term, to mitigate aggregation bias in the calculation of relative weights. We

summarize RTI's recommendations below and respond to each of them.

a. Short-Term Recommendations

Most of RTI's short-term recommendations have already been described above.

The most immediate changes that RTI recommends implementing include expanding

from 13 distinct hospital department CCRs to 19 by:

● Disaggregating "Emergency Room" and "Blood and Blood Products" from the

"Other Services" cost center;

● Establishing regression-based estimates as a temporary or permanent method

for disaggregating the Medical Supplies, Drugs, and Radiology cost centers; and

● Reclassifying intermediate care charges from the intensive care unit cost center

to the routine cost center.

We believe these recommendations have significant potential to address issues of

charge compression and potential mismatches between how costs and charges are

reported in the cost reports and on the Medicare claims.

RTI's recommendations show significant promise in the short term for addressing

issues raised in the public comments on the cost-based weights in the FY 2007 IPPS

proposed rule. However, in the time available for the development of the proposed rule,

we were unable to investigate how RTI's recommended changes may interact with other

potential changes to the DRGs and to the method of calculating the DRG relative

weights. As we noted above, RTI's analysis was done on the Version 24.0 of the

CMS DRGs and not the MS-DRGs we proposed for FY 2008. For the proposed rule and

this final rule with comment period, we were not able to examine the combined impacts

of the MS-DRGs and RTI's recommendations. In addition, we believe it is also

important to consider that, in the FY 2007 IPPS final rule (71 FR 47897), we anticipated

undertaking further analysis of the HSRVcc methodology over the next year in

conjunction with the research we were to do on charge compression. Analysis of the

HSRVcc methodology will be part of the second phase of the RAND study of alternative

DRG systems to be completed by September 1, 2007, that has not been completed in time

for this final rule with comment period. As a result, we have also been unable to consider

the effects of the HSRVcc methodology together with the MS-DRGs and RTI's

recommendations. Finally, we note that in order to complete the analysis in time for the

proposed rule or this final rule with comment period, RTI's study used only hospital

inpatient claims. However, hospital ancillary departments typically include both

inpatient and outpatient services within the same department and only a single CCR

covering both inpatient and outpatient services can be calculated from Medicare cost

reports. Although we believe that applying the regression method used by RTI to only

inpatient services is unlikely to have had much impact for the adjustments recommended

by RTI, the preferred approach would be to apply the regression method to the combined

inpatient and outpatient services. The latter approach would ensure that any potential

CCR adjustments in the IPPS would be consistent with potential CCR adjustments in the

OPPS. We hope to expand their analysis to incorporate outpatient services during the

coming year.

Although we did not propose to adopt RTI's recommendations for FY 2008, we

solicited public comments on expanding from 13 CCRs to 19 CCRs. Again, we noted

that RTI's analysis suggests significant improvements that could result in the cost-based

weights from adopting its recommendations to adjust for charge compression. Therefore,

we also expressed interest in public comments on whether we should proceed to adopt the

RTI recommended changes for FY 2008 in the absence of a detailed analysis of how the

relative weights would change if we were to address charge compression while

simultaneously adopting an HSRVcc methodology together with the MS-DRGs. Given

the change in the impacts that were illustrated in last year's FY 2007 IPPS final rule

(71 FR 47915-47916), going from a hospital-specific to a nonhospital- specific cost-

weighting methodology, we believe that sequentially adjusting for charge compression

and later adopting an HSRVcc methodology could create the potential for instability in

IPPS payments over the next 2 years (that is, payments for surgical DRGs would increase

and payment for medical DRGs would decrease if we were to adopt the RTI

recommended changes for FY 2008, but could potentially reverse direction if we were to

adopt an HSRVcc methodology for FY 2009). Again, we solicited public comments on

all of these issues before making a final decision as to whether to proceed with the RTI's

short-term recommendations in the final rule for FY 2008.

Comment: **M**any commenters commented on whether we should proceed in

adopting the recommendations made by RTI in its January 2007 report, particularly

concerning changes in cost reporting practices and the additional, regression-based

CCRs. Several commenters focused on problems highlighted by RTI with the

inconsistent and varying methods in which hospitals group their charges in MedPAR and

report costs and charges on the Medicare cost report, which can result in distortions in the

DRG weights. Some commenters asserted that mismatching is not caused by the failure

of hospitals to prepare their cost reports correctly, as appeared to be suggested by the RTI

study. Other commenters noted that RTI recommends the incorporation of edits to reject

cost reports or require more intensive review by auditors to resolve the lack of uniformity

in cost reporting. However, the commenters believed that such edits or audits will not

solve the mismatch problem because hospitals' reporting is consistent with the cost

reporting instructions. The commenters described that, currently, cost report instructions

included with the CMS Form-339 allow for three methods of reporting Medicare charges.

The method selected by each hospital is specific to its information systems and based on

the method that most accurately aligns Medicare program charges on Cost Report

Worksheet D-4 (inpatient) and/or Worksheet D, Part IV (outpatient) with the overall cost

and charges reported on Worksheets A and C. Many hospitals elect to allocate some or

all of the Medicare program charges from the Medicare Provider Statistical and

Reimbursement (PS&R) data to various lines in the cost report based on hospital-specific

financial system needs. Under this scenario, total hospital CCRs are aligned with the

hospital's program charges, but would not match the charge groupings used in MedPAR.

Instead of increased edits or cost report rejections, the commenters believed that

hospitals must be educated to report costs and charges, particularly for supplies, in a way

that is consistent with how MedPAR groups charges. The commenters are launching

such an educational campaign, which would encourage consistent reporting that they

believe would, in turn, produce consistent groupings of departments within the 13 cost

center groups that are currently used to create the cost-based weights, or any future

expansion of the categories that may occur. The commenters stated that their educational

efforts will take time and CMS should recognize that some hospitals will be in a better

position to adopt certain cost report changes more rapidly because the changes may be

more expensive and timeconsuming for some hospitals to adopt relative to others. The

commenters requested that CMS communicate with its fiscal intermediaries/ MAC that

such action is appropriate and encouraged for improvements in Medicare's cost-based

weights. The commenters were concerned that, without direction from CMS, the fiscal

intermediaries./.MAC may not allow hospitals to change how they report costs.

Although one commenter supported the education of hospitals in better cost

reporting, this commenter opposed mandating hospitals to make these cost reporting

changes. One commenter stated that "it is important to note that charge compression

results from hospitals' markup practices," and that the problem would be eliminated if

hospitals would use a single markup for all items and services included within all revenue

centers. Another commenter asserted that hospitals are not consistent in their cost

reporting and the first step should be to issue cost report instructions. The next step

would be to allocate audit resources to the fiscal intermediary/MAC in order to determine

whether these instructions are properly implemented because reporting of costs and

charges does have an indirect effect on payments to hospitals. Another commenter stated

that CMS needs to place more emphasis and audit resources toward ensuring that

hospitals properly complete their cost reports. However, while another commenter

supported scrutiny and auditing for extreme CCRs, the commenter also appreciated that

CMS has limited audit resources. One commenter stated that adjustments to revenue

codes reported on the standard UB-04 claims forms may also be appropriate to better

match charges on claims forms with the charges (and costs) reported on the Medicare

cost report. Other commenters stated that the costing of the weights should be done at

the UB revenue code level. Given the variety of ways in which hospitals report their

costs and charges, it is impossible to make assumptions related to revenue codes across

all hospitals without the assistance of the PS&R crosswalk, which is submitted with the

filed cost report as an attachment to the CMS-339 form. The commenters noted that if

CMS is going to continue a transition to cost-based weights, hospitals will need time to

align their mapping of cost centers into departments or cost categories for purposes of

cost reporting and claims reporting. The accurate costing of claims would be in line with

the original MedPAC recommendations.

In light of the cost reporting and MedPAR mismatch problems, the commenters did not believe that a temporary, regression-based adjustment that does not fix the underlying concerns with cost reporting is appropriate. The commenters are concerned that, for the sake of expediency, the use of estimates (a regression analysis approach), as opposed to efforts to collect accurate data at the appropriate cost center level, would be insufficient. In addition, the commenters expressed doubt that a regression model can be easily validated, as the DRG weights are modified on an annual basis. One commenter argued that CMS did not include details of the regression-based adjustment in the proposed rule and, consequently, the commenter could not assess the impact of implementing the adjustment. The commenter agreed with CMS' assessment that RTI's adjustments might change if they are implemented jointly with MS-DRGs, and if estimated using both inpatient and outpatient costs and charges. This commenter, along with others, believed that, at the very least, implementation of the regression-based CCRs should be delayed, and once short-term educational efforts and CMS' long-term cost report evaluation are underway, it would be more appropriate to have an informed discussion on which cost report changes are needed to alleviate the issue of charge compression.

Response: In the FY 2008 IPPS proposed rule (72 FR 24715), we stated that because we did not have sufficient time to investigate how RTI's recommended changes might interact with other possible changes to the DRGs and the DRG relative weights, and because RTI's regression method was only applied to inpatient services and not also outpatient services, we decided not to propose implementing RTI's recommendations for

FY 2008. However, we also stated that, despite these concerns, we believe RTI's

recommendations have the potential to significantly address the issues of charge

compression and potential mismatches between how costs and charges are reported in the

cost reports and on the Medicare claims. Therefore, we solicited comments on whether

we should expand the 13 CCRs to 19 CCRs for FY 2008.

We have carefully considered all comments, ranging from those urging us to

adopt all 19 CCRs in FY 2008, to those believing that the regression-based CCRs should

be delayed for at least a year, if used at all. Because of concerns that we and some

commenters continue to have about premature adoption of the regression-based CCRs

without the benefit of knowing how they will interact with other DRG changes, and the

arguments in the comments summarized above concerning cost and claims reporting, we

have decided to finalize our proposal to not implement the four regression-based CCRs

for medical supplies and devices, IV drugs, and radiology (MRI and CT scans) for

FY 2008. However, as we explain in more detail in response to comments below, we are

adopting the two cost report-based CCRs for "Emergency Room" and "Blood and Blood

Products" for a total of 15 national average CCRs for FY 2008. We believe these

changes to the relative weight methodology do not have the disadvantages that are of

concern to the commenters. That is, recognizing these additional departments will allow

us to use information that is already being reported by hospitals in their cost reports and

adopt some of the changes being recommended by RTI without going to a regression-

based model at this time.

Many of the concerns in the comments summarized above related to how

hospitals' report costs and charges on the cost report and how hospitals include charges

on their bills for inpatient services or the way the charges are grouped in the MedPAR.

RTI indicated that more precise cost reporting is the best solution to address the issue of

charge compression in the long term. Many commenters believed that rather than rely on

increased edits and audits to resolve the lack of uniformity in cost reporting, hospitals

must be educated to report costs and charges in a manner that is consistent with the way

in which MedPAR groups charges, and the commenters were launching an educational

campaign accordingly. We agree with the educational initiative of these commenters.

Participation in these educational initiatives by hospitals is voluntary. Hospitals are not

required to change how they reports costs and charges if their current cost reporting

practices are consistent with rules and regulations and applicable instructions. However,

to the extent allowed under current regulations and cost report insturctions, we encourage

hospitals to report costs and charges consistently with how the data are used to determine

relative weights. We believe achieving this goal is of mutual benefit to both Medicare

and hospitals.

The commenters also suggested that CMS should inform the fiscal

intermediary/MAC that hospitals may be changing their cost reporting and allocation

methodologies in response to the educational initiative, that such action is encouraged,

and that more audit resources should be allocated to fiscal intermediaries/MAC to ensure

that any new cost reporting instructions are being implemented properly. First, we intend

to notify the fiscal intermediaries/MAC of this cost reporting educational initiative

subsequent to the issuance of this final rule with comment period, and provide both fiscal

intermediaries/MAC and hospitals with guidance on how to address requests for changes

in cost reporting practices from hospitals. Second, each hospital that wishes to change its

cost reporting practices must follow the directives at §413.53(a)(1) of our regulations and

PRM-1, section 2203, regarding matching the charges to the costs reported in each cost

center. We recommend that the hospital also disclose the changes made in a cover letter

with the submission of the cost report.

Commenters submitted suggestions about how MedPAR could be modified to

further distinguish categories of charges. As we stated in the proposed rule, we will

consider suggestions for adding additional revenue codes to MedPAR in conjunction with

other competing priorities for our information systems. We cannot create additional

revenue codes. Requests for new revenue codes on hospital bills have to be made to and

approved by the National Uniform Billing Committee (NUBC).

Comment: Some commenters were uncertain whether RTI's recommendations

to expand certain cost categories through regression analysis is the appropriate solution to

address the issue of charge compression and potential inconsistencies in how hospitals

report costs and charges. The commenters supported the expansion of categories to

include CCRs based on cost centers that already exist on the cost report, such as

emergency department and blood products, and possibly others after further examination.

Another commenter stated that creating a CCR for blood and blood products will reflect

more accurately the cost of blood and will help ensure future IPPS updates will account

more adequately for these products. Although one commenter understood that CMS has

not been able to analyze the effect of implementing the regression adjustments with the

proposed MS-DRGs, the commenter believed that CMS should adopt RTI's adjustment

to the CCRs for drugs and IV solutions for FY 2008, and subsequently analyze and report

on the effects of this adjustment on MS-DRGs. Another commenter noted that while the

RTI regression estimates provide a practical short-term approach to address charge

compression for drugs, supplies, and radiology revenue cost centers, this method does not

identify all of the charge compression that occurs at each hospital in these revenue

centers, nor does it address charge compression that may be occurring in other revenue

centers such as cardiology, or the routine and intensive care revenue cost centers where

nursing costs per day are currently treated as if they were uniform across patient

categories.

Another commenter also asked that CMS remember that the primary use of the

cost report is to determine a hospital's costs of treating Medicare patients. The

commenter noted that the cost report is still used for cost-based payment for many

hospitals, such as CAHs, SCHs, and MDHs, and many State Medicaid plans and other

payers also rely on data from the cost report to determine payment rates. Because of

these uses, the commenters asked CMS to proceed cautiously with changing the cost

report to avoid unintended consequences for hospitals where the cost report determines a

significant portion of current payment. The commenter offered its services in reviewing

and discussing cost report changes that Medicare may propose. Another commenter

recommended that CMS work with hospital finance experts so the most appropriate and

accurate instructions are issued, with very specific instructions as to where services are to

be classified on the cost report and that subcategories should be eliminated.

Another commenter did not support RTI's recommendations for revising the cost

reports to reduce cost and charge misalignment and to create new cost centers because of

"the enormous amount of work hospitals would have to perform" to change internal

operations and data collection to accommodate the revisions. The commenter expressed

concern that this would lead to "rising inefficiency and administrative costs." This

commenter, and others, believed that "clear, detailed instructions from CMS" would be

needed to differentiate between a "device," "implant," or "IV solution," and other "new

nomenclature that distinguishes and separates tens of thousands of items and drugs, for

instance, implantable spinal screws, bandages and bone cement, into specific cost

centers" would be necessary.

Response: As we noted in the proposed rule and in response to comments above,

we believe that RTI's regression-based CCRs may be a promising means for addressing

charge compression in the short term. However, because we do not yet know how the

additional regression-based CCRs would interact with the MS-DRGs or with the HSRV

methodology, and the significant concerns raised by a number of commenters about

adopting regression-based CCRs, we are not adopting the adjustments to address charge

compression in the FY 2008 IPPS final rule. We note RTI's long-term recommendations

suggest addressing charge compression through adding new cost centers to the cost report

and undertaking additional activities such as improvements in how hospitals report costs

and charges. Thus, we believe that RTI and many of the public comments conclude that

ultimately improved and more precise cost reporting is the best way to minimize charge

compression. While we are not adopting the regression-based adjustments to address

charge compression, we believe that the FY 2008 IPPS final rule relative weights should

take advantage of additional information that is already reported on the cost report.

Because the cost report currently allows for the creation of specific CCRs for Emergency

Room and Blood and Blood Products, and some commenters expressed explicit support

for expanding the number of CCRs based on cost centers that already exist on the cost

report, we have decided to separate Emergency Room costs and charges and Blood and

Blood Products costs and charges from the current "Other Services" CCR for the

purposes of calculating the cost-based portion of the FY 2008 relative weights. That is,

in accordance with RTI's short-term recommendation, for FY 2008, we are adding two

additional CCRs to the current list of 13 CCRs, for a total of 15 CCRs. We are using line

61 on Worksheets C, Part I and D-4 to create the Emergency Room CCR and lines 46 and

47 on Worksheets C, Part I and D-4 to create a CCR for Blood and Blood Products. We

are modifying the table listing the 15 cost center groupings in section II.H. of the

preamble of this final rule with comment period accordingly.

     With respect to the commenters that asked CMS to remember that the primary use

of the cost report is to determine a hospital's costs of treating Medicare patients, we

intend to proceed cautiously as the commenters suggest. To the extent that the cost report

changes that we make improve consistency and accuracy of cost reporting, these benefits

will extend to providers whose payments are based on reasonable costs (CAHs) or

otherwise use the cost report to determine hospital-specific rates (SCHs and MDHs). As

we stated above, we intend to work with finance and cost report experts in the hospital

community if we decide to modify the cost report or its instructions to address issues with

the DRG relative weights. We also understand that hospitals may be concerned about the

resources that may be required to adapt to potential cost report changes. Any changes

that would be made to the Medicare cost report would be done under the Paperwork

Reduction Act and, by law, could not be undertaken without considering the burden that

would be imposed on all hospitals.

Comment: Some commenters supported making adjustments to address charge

compression. These commenters noted that charge compression was first identified in

2000 and MedPAC and other researchers have also recognized this issue. The

commenters recommended implementation of a regression-based adjustment in the

FY 2007 final rule and stated that this methodology has been evaluated and validated

through RTI's study. Many commenters believe that RTI's results provide ample

evidence of charge compression that justifies the implementation of their

recommendations for the FY 2008 final rule. Furthermore, commenters stated that RTI's

regression-based adjustment is appropriate and can be implemented immediately without

any administrative burdens to the hospital. Several commenters emphasized that CMS

should make it a priority to apply the regression methodology to the Medical supplies

CCR. These commenters noted that in the proposed rule, CMS stated: "of all the adjusted

CCRs, the largest impact on weights came from accounting for charge compression in

medical supplies for devices and implants," which demonstrates that a regression

approach should be applied at least to disaggregate the medical supplies category into one

CCR for "Devices and Implants" and a separate CCR for "Other Supplies."

One commenter disagreed with the reasons CMS expressed in the proposed rule

for delaying implementation of RTI's recommendations, and found them to be "rather

insubstantial." The commenter did not believe that the combined impact of RTI's

recommendations and the proposed MS-DRGs need to be studied before CMS could

proceed with implementing the regression-based CCRs. The commenter noted that the

relative independence of RTI's recommendations from the proposed MS-DRG changes

was confirmed by a study commissioned by AdvaMed. The commenter also stated that

the fact that RTI's analysis only included inpatient claims is relatively insignificant. The

commenter believed that if further adjustments need to be made to incorporate outpatient

claims into the regression estimate next year, they can be done with a fairly minor

impact. This commenter, and others, urged CMS to implement a regression that uses

both inpatient and outpatient claims when making an adjustment for charge compression

for the CY 2008 OPPS, and use the same regression in subsequent years for both the

IPPS and OPPS.

Another commenter stated that, although it understood that CMS wishes to

understand the various interactions of regression-based CCRs with other aspects of the

IPPS, the effect of charge compression is "demonstrable and measurable" and should be

implemented in FY 2008 for the "sake of payment accuracy." Another commenter stated

that CMS' concern about the interaction between addressing charge compression and

other proposed changes appeared "disingenuous, as CMS is proposing so many changes

that the interaction of the various components cannot be estimated." The commenter also questioned CMS' hesitation to make changes to the cost report to accommodate RTI's recommendation due to limited information system resources, time constraints, and inconvenience. The commenter asserted that "hospitals find the defense of scarce resources, compressed implementation lead times and cost justification vis-a-vis outcomes an interesting option for CMS given the fact that it is manifestly unavailable to hospitals who have similar issues."

Response: We disagree with the notion of the commenter that found us to be "disingenuous" because the "interaction of various components [of the IPPS] cannot be estimated." We refer the commenter to the payment impact section of the IPPS proposed rule (72 FR 25119) and this final rule with comment period as well as the FY 2007 IPPS proposed rule (71 FR 24025) where we simulate the interaction of a number of different payment reforms including the adoption of cost-based weights, severity DRGs, and other changes. We note that for some categories of hospitals, the impact of adopting MS-DRGs is significant. The RTI work suggests that further changes to the relative weights will also be significant and potentially result in additional redistributions of Medicare payment. In our view, the "interactions of various components" can be determined and before we adopt potential policy options in a final rule, the public should be fully informed on the potential impacts. As we discussed in the FY 2008 proposed rule, we have concerns about implementing regression-based CCRs in the final rule without specifically proposing them because of concerns about how these changes would

interact with the transition to MS-DRGs, the calculation of cost-based relative weights, and possibly the HSRV method.

Despite the commenters' support for the regression-based CCRs, we are still concerned about the accuracy of using regression-based estimates to determine relative weights rather than the Medicare cost report. Many public commenters, including several national hospital associations, shared these same concerns. However, we believe that more specific CCRs will improve payment accuracy for several DRGs. Therefore, as we stated above, we are implementing RTI's recommendation to expand the current 13 CCRs to 15 CCRs without the use of a regression-based adjustment.

In the proposed rule, we indicated there was insufficient time to assess how RTI's recommendations may interact with other potential changes to the DRGs and to the method of calculating the DRG relative weights. We noted that RTI's study examined charge compression within Version 24.0 of the CMS DRGs, and we could not examine their interactive effects with the MS-DRGs and be able to timely publish the FY 2008 proposed rule. For this reason, we requested public comment on whether to adopt these changes in the final rule without having fully analyzed them for the proposed rule. While there was strong support for adopting the regression-based charge adjustments in these comments, many other commenters believed that we should provide the public with modeled payment impacts and an opportunity to comment before implementing regression-based CCRs.

We are also continuing to consider whether to adopt an HSRV payment methodology for FY 2009. We anticipate undertaking further analysis of the HSRV

methodology and would like to incorporate RTI's recommendations into that analysis.

Although its evaluation of alternative severity DRG systems is complete, we are currently

working with RAND to study the HSRV methodology. Furthermore, we continue to

believe that adjusting for charge compression and later adopting the HSRV methodology

could create payment instability over the next 2 years and it would be preferable to

consider simultaneously adopting these changes.

Finally, if we were to adopt adjustments for charge compression, the preferred

approach would be to apply the regression method to the combined inpatient and

outpatient services. The RTI report discussed the notion that separating services that are

generally delivered in outpatient settings might improve the accuracy of CCRs for

inpatient services, and these areas include therapeutic radiology, nuclear medicine,

chemotherapy, electroconvulsive therapy and outpatient surgery. RTI noted that while

these charges are not significant under the IPPS, aggregation bias may be present in these

outpatient services which would affect the overall department CCR. Therefore, we will

consider expanding our analysis to include outpatient services.

Comment: One commenter urged CMS to separately distinguish intermediate

(step-down) level nursing care costs. Another commenter argued that it is illogical that

nursing costs are reflected in the relative weights only through flat room and board

charges, given that nursing care is a variable, rather than a fixed cost. The commenter

asserted that, as a result, a significant amount of money is being misallocated across

hospitals for required nursing care. The commenter urged CMS to give serious

consideration to the RTI report's recommendation to establish study groups and research

options for improving patient-level charging within nursing units, as the outcomes could

improve precision in relative resource weights without adding substantial administrative

costs to either Medicare or to hospitals. Specifically, the commenter strongly supported

the creation of a separate direct and indirect cost center at each hospital and the inclusion

of these data in the annual Medicare cost report, the reporting and collection of nursing

intensity data, and adjustment of the Medicare payment for severity of illness by

modifying the proposed APR DRG severity adjustment formula to incorporate nursing

intensity and cost within each diagnosis and severity category. The commenter also

mentioned the New York State Medicaid model, which was the first prospective payment

system to recognize and reimburse for relative nursing resource consumption levels

among DRGs through the use of Nursing Intensity Weights (NIWs). The NIWs, which

were developed by an expert panel, have been reevaluated and updated periodically to

maintain consistency with changes in the DRG definitions. The commenter

recommended that, because this program has been successfully implemented in a large

state for a number of years, a Medicare demonstration project based on this model should

be launched.

Response: The commenters' raise interesting concerns related to nursing costs

that are variable but are reflected in the DRG weights only as fixed costs through flat

room and board charges. There are currently no detailed charge codes that can be used to

distinguish the intensity in nursing services provided by type of patient. In its report, RTI

noted "because intensity of nursing is likely correlated with DRG assignment, this could

be a significant source of bias in DRG weights." Particularly because nursing comprises

such a significant portion of hospital costs and charges, we agree that this issue should be further studied. We are interested in knowing whether the public has any ideas for how the relative weight methodology can systematically recognize and reimburse for differences in nursing resource consumption provided across hospital inpatients. We will consider whether we should study the possibility of using NIWs to recognize nursing intensity in the DRG relative weights.

Comment: Commenters supported adopting the regression CCRs to alleviate charge compression, but some commenters were concerned that the application of this adjustment methodology to capital intensive radiology services is premature and requires additional analysis. The commenters noted that the RTI report found that within the Radiology CCR, CT scanning and MRI have higher markups and lower CCRs than the remaining radiology services. Implementing RTI's recommendation to apply a regression method to split Radiology into one CCR each for MRIs, CT scans and Other Radiology could potentially result in lower CCRs for the CT and MRI categories. One commenter cited an analysis conducted by Direct Research, LLC, that found that the majority of hospitals do not allocate the capital costs of MRI and CT scan machines to the radiology cost center. Rather, the capital costs could be allocated more broadly across hospital services on a squre footage basis. However, the commenter noted that RTI's analysis for radiology services assumes a detailed capital allocation for these services that results in differential CCRs found in MRIs and CT scans, which the commenter suggested is actually not found in the data. Therefore, the commenters requested that the regression-based CCRs for radiology not be adopted at this time.

Response: We appreciate the comment on the limitations of the regression-based

CCR on radiology. This is another example of how changes to cost reporting can

potentially improve the accuracy of CCRs for radiology and other departments. In our

view, the commenter raises another issue that requires additional analysis before we

adopt regression-based adjustments to address charge compression.

Comment: One comment addressed our proposal to move cost report line 54 for

EEG out of the Cardiology cost center group into the Laboratory cost center group. The

commenter noted that where providers elect to report EEG separately on line 54, this

seems appropriate. However, some providers combine EEG with EKG on line 53

(usually because the EEG services are purchased as outside services and not a separate

cost center for the hospital). In those instances, moving only the EEG costs would be

impossible. The commenter noted that CMS did not indicate what portion of providers

separately report EEG services on line 54, but the commenter was concerned that there

will be continued mismatching under either grouping. The commenter encouraged CMS

to consider expanding the MedPAR database to include separate fields for all revenue

codes so that detailed analyses and accurate matching of costs and charges can be

performed. The commenter also concurred with CMS' recommendation to move

radioisotope costs to the radiology services grouping and out of "other services."

Response: We responded earlier that suggestions for adding additional revenue

codes to MedPAR will be considered in conjunction with other competing priorities for

our information systems. In the FY 2008 proposed rule, we decided to move the costs for

cases involving EEG from the Cardiology cost center group to the Laboratory Cost center

group to maintain consistency with their corresponding EEG MedPAR claims, which are

categorized under Laboratory charges. Although the commenter indicated that hospitals

may be combining EEG costs with EKG costs on line 53 instead of reporting it as a

separate cost on line 54, we believe the MedPAR is clear in categorizing EEG claims

under revenue codes 0740 and 0749, and therefore, costs for EEG should be reported on

line 54 of the cost report as well. For this reason, we are finalizing our proposal to move

the costs for cases involving EEG from the Cardiology cost center group to the

Laboratory Cost center for purposes of calculating the DRG relative weights. As

described in the FY 2008 IPPS proposed rule, we will also calculate the DRG relative

weights for FY 2008 by moving radioisotope costs from the Other Services CCR to the

Radiology Services CCR.

Comment: One commenter was concerned that hospitals do not have consistent

charging and billing practices on an inpatient and outpatient basis for the administration

of medications by injection and/or infusion at the bedside.

Response: We did not propose any changes on this issue. However, we will

consider this issue as we research potential improvements that can be made to how

hospitals report costs and charges.

Comment: One commenter stated that it believed it is important for CMS to

explicitly recognize the "limitations" of the cost-based weighting methodology and its

applicability to non-Medicare patients because this is a "major precedent setting change

for the entire hospital field." The commenter stated that in studies that it conducted, it

found that the use of departmental CCRs presents a bias in that the higher unit costs of

services provided to children that are labor intensive in terms of nursing and respiratory

therapy are not reflected in the department-wide CCRs. The commenter requested that,

at a minimum, CMS recognize in the final rule that there are cost issues in the Medicare

CCR methodology that have implications for non-Medicare patient populations.

Response: The cost-based relative weights were developed solely using Medicare

data. We do not have non-Medicare data that can be used to set DRG relative weights.

For this reason, we are concerned that non-Medicare payers may be using our payment

systems and rates without making refinements to address the needs of their own

populations. As stated earlier, we encourage non-Medicare payers to adapt the MS-

DRGs and the relative weight methodology to better serve their needs.

Among its other short-term recommendations, RTI also suggested that we

incorporate edits to reject or require more intensive review of cost reports from hospitals

with extreme CCRs. This action would reduce the number of hospitals with excluded data

in the national CCR computations, and would also improve the accuracy of all

departmental CCRs within problem cost reports by forcing hospitals to review and

correct the assignment of costs and charges before the cost report is filed. Although we

do not have a substantive disagreement with the recommendation, we generally focus our

audit resources on areas in which cost report information directly affects payments to

individual providers.

RTI further suggested revising cost report instructions to reduce cost and charge

mismatching and program charge misalignment in its short-term recommendations.

Although RTI suggests such an action could be immediately effective for correcting the

reporting of costs and charges for medical supply items that are now distributed across

multiple cost centers, we note that changes to improve cost reporting now will not

become part of the relative weights for several years because of lags between the

submission of hospital reports and our ability to use them in setting the relative weights.

Currently, we expect there will continue to be a 3-year lag between a hospital's cost

report fiscal year and the year it is used to set the relative weights. Thus, even if it were

possible to issue instructions immediately beginning for FY 2008, revised reporting

would not affect the relative weights until at least FY 2011. Nevertheless, we agree with

this recommendation, and in the proposed rule, we welcomed public input on potential

changes to cost reporting instructions to improve consistency between how charges are

reported on cost reports and in the Medicare claims. We indicated that we would

consider these changes to the cost reporting instructions as we consider further changes to

the cost report below.

In the summary of the comments above, we stated that some commenters believed

that RTI's recommendation to incoporate edits to reject cost reports or require more

intensive audits will not solve the mismatch problem because hospitals' reporting is

consistent with cost reporting instructions. The commenters instead recommended that

hospitals be educated to report costs and charges in a manner that is consistent with how

MedPAR groups charges. However, other commenters supported more intensive

auditiing of cost reports. In response to these comments, we stated above that we agree

with the initiative to educate hospitals to improve cost reporting and that we intend to

inform the fiscal intermediaries/MAC of this educational initiative. We also stated that

we intend to provide the fiscal intermediaries/MAC of this educational initiative. We

also stated that we intend to provide fiscal intermediaries/MAC and hospitals with

guidance on how to address requests for changes in cost reporting practices from

hospitals.

Comment: Some commenters supported the use of the Standard Analytic File

(SAF) to calculate CCRs, as used by RTI in its study, as the SAF provides more detailed

charge data on supplies, drugs and radiology services, which would improve the payment

accuracy for those revenue centers with significant charges.

Response: We appreciate the comment on the use of the SAF to calculate

national CCRs. The RTI study used the SAF to extract detailed charge information for

selected revenue codes with potential aggregation bias and used this information in the

creation of the synthetic CCRs. However, because we are not expanding the CCRs using

regression adjustments for FY 2008, it is not necessary to use the SAF to compute the

relative weights in this final rule with comment period. Rather, we are using the FY 2006

MedPAR file and FY 2005 hospital cost reports to calculate the national CCRs.

Comment: Many commenters noted that, while the proposed rule seems to

suggest that methods of addressing charge compression should be considered together

with implementation of an HSRV methodology, these two issues (charge compression

and HSRV) need not and should not be linked. The commenters reiterated their

opposition to implementation of the HSRV methodology, as previously expressed in

comments on the FY 2007 proposed rule, arguing that the method is flawed and may

even introduce more bias into the relative weight calculations. Another commenter (who

also opposed implementation of the HSRV methodology) stated that should the HSRV

method be implemented, many DRG weights could move in one direction if the charge

compression adjustments were implemented in FY 2008, and then move in the other

direction if the HSRV method were to be implemented in FY 2009. This commenter

requested that CMS delay both changes for at least one year, and implement the HSRV

method and the regression-based CCRs only after issuing a formal proposal with a

thorough analysis that is made available to the public for review and comment. One

commenter stated that the RTI revisions should be reviewed in combination with the

severity-based system recommended by RAND and should not be adopted in FY 2008.

The commenter stated that CMS and the provider community should evaluate these

recommendations and implement them together in FY 2009. One commenter stated that

the combined use of hospital-specific charges and a national CCR will result in a

distortion of the DRG weights and a shifting of Medicare payments among hospitals, <u>not</u>

based on resource utilization, but rather on a mathematical calculation. This commenter

recommended that CMS review the impact of using hospital-specific charges and costs to

determine whether the national CCR has created inaccurate DRG weights.

        MedPAC commented that adopting cost-based HSRV weights would result in

substantial additional improvements in payment accuracy. MedPAC believed that the

HSRV methodology removes all of the differences in the level of costs across hospitals,

and is preferable to CMS' current method used for standardization, which is incomplete

and introduces avoidable errors into the computation of payment weights. Two other

commenters supported the adoption of the HSRV methodology and strongly opposed the

current methodology and believed it is flawed for the following reasons: (1) The

proposed formula derives a national average charge based on all hospitals being weighted

equally, which disadvantages hospitals located in historically "low charge" States, and

results in small, rural hospitals carrying the same weight as large, urban hospitals; (2) The

data being used are outdated and do not reflect the cost of new technology; (3) Costs in

excess of 25 percent are omitted by CMS from "high cost" hospitals in the cost base,

while leaving in all of the charges from those same "high cost" hospitals and assigning a

relative value on reduced costs. Since the costs are being excluded, but not the charges,

there is a corresponding mismatching of revenues and costs; (4) The data contain only

audited data, and hospitals that have not been audited would not be included in the data.

These two commenters stated that CMS should test the sensitivity of weights

using various methodological assumptions and share the resulting data with the public.

The commenters requested that CMS should "strive" to create a system that improves

payments and does not include the "obvious flaws" listed above.

Response: Many commenters expressed their concerns and opposition to the

HSRV methodology last year. As we explained in response to those comments in the

FY 2007 IPPS final rule, we decided not to adopt the HSRV methodology to standardize

charges for FY 2007 but stated that we would undertake further analysis of the method.

As we indicated in the FY 2008 IPPS proposed rule, we engaged RAND as the contractor

to study alternative DRG systems. The second phase of the RAND's study will include

evaluating the HSRV methodology; the evaluation report will not be available until after

the issuance of this final rule with comment period. Therefore, we will consider those

results as we plan changes as part of the FY 2009 IPPS rulemaking process. We intend to

carefully analyze how the relative weights would change if we were to adopt regression-

based CCRs to address charge compression while simultaneously adopting an HSRV

methodology using fully phased-in MS-DRGs. Although many commenters do not

believe that the HSRV methodology and addressing charge compression should be

linked, we believe, as did one commenter, that sequentially adjusting for charge

compression and later adopting the HSRV methodology could create instability in IPPS

payments over the next 2 years. Accordingly, we intend to include a detailed description

and discussion of RAND's and any other analyses that we may undertake on these issues

in the FY 2009 IPPS proposed rule.

In response to the commenters who supported adopting the HSRV methodology

and believed it superior to the method used by CMS currently, in the FY 2007 IPPS final

rule (71 FR 47883), we stated that there are certain administrative difficulties with

adjusting charges to costs using hospital-specific CCRs. Therefore, at least until we have

the opportunity to analyze the results of RAND's analysis, we are utilizing national

average CCRs to determine cost. We also do not believe that the use of hospital-specific

charges together with national average CCRs redistributes Medicare payments among

hospitals merely based on a mathematical calculation, as one commenter indicated. On

the contrary, a system that improves payment accuracy and moderates the influence of

individual hospital reporting practices on a *national* payment system is not one which

haphazardly redistributes payments. We note that, in a report issued in July 2006, the

GAO found that CMS's system of national CCRs shows promise to improve payment

accuracy because it reduces the impact that individual hospital-reporting practices has on

the DRG relative weights (GAO-06-880, "CMS's Proposed Approach to Set Hospital

Inpatient Payments Appears Promising"). With respect to the commenters' concerns

regarding inappropriate "equal weighting" of hospitals, under CMS' current methodology

for computing national CCRs, these concerns were addressed in last year's IPPS final

rule. The national CCRs are the sum of all costs divided by the sum of all charges. Thus,

all hospitals are not weighted equally. Larger hospitals will have more weight than

smaller hospitals in the final CCR calculation.

In response to the commenters' concerns that the data are outdated and do not

reflect the costs of new technology, there is an inevitable lag between the availability of

information from hospital claims or cost reports and the time it can be used to determine

relative weights. We always use the most recent data available to set relative weights.

Furthermore, as we noted in the FY 2007 IPPS final rule, CMS' current method of using

national average CCRs eliminates the need to match claims (for FY 2008, the 2006

MedPAR) to the time period of the CCRs (for FY 2008, FY 2005 HCRIS), which would

be necessary under an HSRV method that uses hospital-specific CCRs. Thus, we can use

claims data from one year later under our cost-based weighting methodology. We also

note that add-on payments made for the latest advancements in medical technologies may

not be included in the 2-year old hospital claims data that are used to set the relative

weights.

Regarding the comments stating that CMS mismatches revenues and costs by

omitting excessive costs from "high cost" hospitals in the cost base, while leaving in the

charges from those same "high cost" hospitals, we note that this is not actually the case.

If a hospital's costs are dropped from the national average CCR calculations, the

hospital's charges are also dropped from the national average CCR calculations. Lastly,

the commenters' assertion that the cost report data used for CCRs include only audited

data is incorrect. If the commenters are referring to the cost report data that CMS uses to

calculate the national average CCRs, we note that in accessing data for IPPS hospitals

from HCRIS, we select all IPPS hospitals, and do not only select hospitals whose cost

reports are audited.

Comment: MedPAC submited comments on the method we use to calculate the

national CCRs for the cost-based relative weights. The methodology to calculate the

national CCRs is described in section II.H. of the preamble of this final rule with

comment period. MedPAC suggested that we standardize the Medicare charges and costs

used to calculate the national CCRs from the Medicare cost reports to adjust for

differences in local wage levels, IME, and DSH. The standardization would be consistent

with the use of national standardized charges by revenue center also used in the

calculation of cost-based relative weights from the MedPAR.

Response: While we did not propose any changes to the cost-based relative

weights methodology, we appreciate the comment on maintaining consistency among our

data sources. Although we currently standardize charges from the MedPAR file when

calculating relative weights, we do not standardize costs and charges from hospital cost

reports, as MedPAC recommended. We may consider this recommendation as we

continue to refine our methodology for calculating relative weights. However, we note

that there would be no need to standarize costs and charges from hospital cost reports under an HSRV methodology.

b. Medium-Term Recommendations

RTI recommended that we expand the MedPAR file to include separate fields that disaggregate several existing charge departments. For compatibility with prior years' data, the new fields should partition the existing ones rather than recombine charges. RTI recommended including additional fields in the MedPAR file for the hospital departments that it statistically disaggregated in its report, as well as intermediate care, observation beds, other special nursing codes, therapeutic radiation and EEG, and possibly others. As with some of RTI's earlier recommendations with respect to cost reports, we will examine this suggestion in conjunction with other competing priorities CMS has been given for our information systems. We have limited information systems resources, and we will need to consider whether the time constraints we have to develop the IPPS final rule, in conjunction with the inconvenience of using the SAF and accounting for charge compression through regression, will justify the infrastructure cost to our information systems of incorporating these variables into the MedPAR.

Finally, RTI's medium-term recommendations include encouraging providers to use existing standard cost centers, particularly those for Blood and Blood Administration and for Therapeutic Radiology, in the current Medicare cost report. We believe this is closely related to the recommendation for improved cost reporting instructions. Therefore, we will consider this recommendation as part of any further effort we may undertake to revise cost reporting instructions or change the cost report.

Comment: Some commenters supported expanding the MedPAR file to include separate fields to disaggregate additional cost centers. One commenter supported this recommendation and suggested that the assignment of revenue codes and charges to revenue centers in MedPAR should be reviewed and changed to better reflect hospital accounting practices as reflected on the Medicare cost report.

Response: We will consider suggestions for modifying MedPAR in conjunction with other competing priorities we have for our information systems. Further, while we support the efforts of the national hospital associations to streamline hospital's reporting practices, we note that CMS does not instruct hospitals in the appropriate revenue codes to use because hospitals have discretion as to where and how they allocate charges based on their own financial system needs.

c. Long-Term Recommendations

RTI's long-term recommendations include adding new cost centers to the
Medicare cost report and/or undertaking the following activities:

● Add "Devices, Implants and Prosthetics" under the line for "Medical Supplies
Charged to Patients." Consider also adding a similar line for IV Solutions as a
subscripted line under the line for "Drugs Charged to Patients."

● Add CT Scanning and MRI as subscripted lines under the line for "Radiology-
Diagnostic." About one-third of hospitals that offer CT Scanning and/or MRI services
are already reporting these services on nonstandard line numbers. More consistent
reporting for both cost centers would eliminate the need for statistical estimation on the
radiology CCRs.

● In consultation with hospital industry representatives, determine the best way
to separate cardiology cost centers and add a new standard cost center for cardiac
catheterization and/or for all other cardiac diagnostic laboratory services. About 20
percent of hospitals already include a nonstandard line on their cost reports for
catheterization. Creating a new standard cost center could improve consistency in
reporting and substantially improve the program charge mismatching that now occurs.

● In consultation with hospital industry representatives, consider establishing a
new cost center to capture intermediate care units as distinct from routine or intensive
care.

● Establish expert study groups or other research vehicles to study options for
improving patient-level charging within nursing units. Nursing accounts for one-fourth of

IPPS charges and 41 percent of the computed costs from our claims analysis file.

Historically, nursing charges and costs have been assigned to patients without relying on

individual measures of service use. Consideration should be given to finding ways to

improve precision in nursing cost-finding that will improve relative resource weights

without adding substantial administrative costs to either the Medicare program or to

hospitals.

We agree with RTI that attention should be paid to these issues as we consider

changes to the Medicare cost report. The cost report has not been revised in nearly 10

years. During this time, there have been significant changes to the Medicare statute and

regulations that have affected the Medicare payment policies. Necessary incremental

changes have been made to the Medicare cost report over the years to accommodate the

Medicare wage index, disproportionate share payments, indirect and direct graduate

medical education payments, reporting of uncompensated care costs, among others. The

adoption of cost-based weights for the IPPS beginning in FY 2007 has brought further

attention to the importance of the Medicare cost report and how hospitals report costs and

charges. We recently began doing a comprehensive review of the Medicare cost report

and plan to make updates that will consider its many uses. As we update the cost report,

we will give strong consideration to RTI's recommendations and potential long-term

improvements that could be made to the IPPS cost-based relative weighting

methodology.

Comment: Several commenters made recommendations for how the relative

weights would be calculated under a 3-year transition from the current DRGs to the new

MS-DRGs. Some commenters suggested three options as follows:

(1) Use two GROUPERs (CMS DRGs and MS-DRGs) and then blend the

weights for each individual case.

(2) Blending current DRG weights with MS-DRG weights: To calculate a

blended cost-based weight, CMS could first calculate cost-based weights using the

current DRGs. CMS could then calculate cost-based weights using the MS-DRGs. The

blended weight for each MS-DRG would be based on the weighted average relative

weights (based on the current DRGs from which cases group into the new MS-DRGs)

and the MS-DRG weight. Under this approach, CMS would continue to calculate cost-

based weights for the current DRGs during the first 2 years of the transition period. This

approach recognizes that a case has different relative weights in the new system versus

the current DRG system.

(3) Blending MS-DRG base and severity level weights: CMS would blend the

actual MS-DRG weight with the weight of the base MS-DRG. The base MS-DRG

weight is determined by using expected case mix volume among severity levels. For

example, if an MS-DRG was subdivided into two subgroups: with the non-CC DRG

accounting for 90 percent of the cases and the other 10 percent in the CC DRG, these

ratios would be used to blend the base and the DRG-specific weight. Under this

approach, CMS would not have to calculate weights using two different DRG systems.

On the other hand, this approach does not use the current system when calculating the blended rates.

The commenters noted that while option 1 would provide the most accurate blended weights, it is the most burdensome to implement because it would require use of two GROUPERs, whereas under options 2 and 3, CMS would only use the blended relative weights, allowing hospitals and Medicare contractors to use only one grouping software.

MedPAC suggested that CMS adopt a 2-year transition period for MS-DRGs to coincide with the remainder of the current transition period for implementing cost-based weights, so as to "balance the payment impacts of implementing severity refinements and cost-based weights." MedPAC suggested that a 2-year transition might work as follows: CMS could group cases using the MS-DRG grouper beginning in FY 2008, but then use a blended weight for each category. The blended weight for an MS-DRG would reflect partly the weight that would have been assigned under an MS-DRG system with fully implemented cost-based weights. The weight for each MS-DRG in FY 2008 would be a blend of two parts:

● 50 percent of the average DRG weight that would have been attached to cases in the MS-DRG from the 2006 MedPAR file under a policy of 1/3 charge-based weights and 2/3 cost-based weights. These DRG weights are the ones that would have applied to the same cases under the FY 2008 policy if CMS simply continued the transition to cost-based weights without changing the DRG definitions.

● 50 percent of the CMS refined weights for the MS-DRG for FY 2008.

In FY 2009, cases would be grouped in the MS-DRGs and the weight for each MS-DRG

would be a 100 percent cost-based weight.

Response: We have carefully considered each comment in determining whether

there should be a transition period for the relative weights computed using MS-DRGs, the

length of the transition and how to compute weights during the transition. We also

considered how to accommodate a transition to MS-DRG relative weights with the

continuing transition to cost-based weights. Although we received strong general support

for adopting the MS-DRGs, we do believe that some transition is warranted to mitigate

the magnitude of potential changes in payment to hospitals that could occur in one year.

Furthermore, we agree with MedPAC that a two-year transition period that coincides

with the remainder of the transition period for implementing cost-based weights is

appropriate. By having these changes occur simultaneously over the same transition

period, we can avoid having large changes in payment that would occur with sequential

implementation. Further, we can also accomplish all of the payment reforms according

to the same schedule. Accordingly, we are implementing a 2-year transition to

MS-DRGs. For FY 2008, the first year of the transition, 50 percent of the relative weight

for each MS-DRG will be based on the CMS DRG relative weight and 50 percent will be

based on the MS-DRG relative weight. In FY 2009, the relative weights will be based

entirely on the MS-DRG relative weight. The blended relative weights for FY 2008 are

computed as follows:

First, using the Version 24.0 GROUPER, relative weights are calculated based on

100 percent costs and 100 percent charges, respectively (see section II.H. of the preamble

of this final rule with comment period for a description of the cost and charge based

calculations). Then these weights are blended using two-thirds of the cost-based weights

and one-third charge-based weights to establish the CMS DRG portion of the transition

weights.

Second, using the Version 25.0 GROUPER, relative weights are calculated based

on 100 percent costs and 100 percent charges, respectively (see section II.H. of the

preamble of this final rule with comment period for a description of how we compute

cost-based and charge-based weights). These weights are then blended using two-thirds

of the cost-based weights and one-third charge-based weights to establish the MS-DRG

portion of the transition weights.

Under the transition blend we are adopting in this final rule with comment period,

we group cases to MS-DRGs (using the Version 25.0 GROUPER), but the payment

weight for each DRG is a 50/50 blend of the MS-DRG weight and the CMS DRG weight.

Thus, we had to determine a blended weight for each DRG. Using the claims in the

FY 2006 MedPAR database that we used to compute cost-based weights under the

Version 24.0 GROUPER, we grouped each case to a CMS DRG (using the Version 24.0

GROUPER) and an MS-DRG (using the Version 25.0 GROUPER). Commonly, a set of

cases that grouped to a single MS-DRG grouped to two or more CMS DRGs. Therefore,

we determined an average CMS DRG weight for all cases that grouped to each MS-DRG.

Specifically, we summed the CMS DRG weights of all the cases that grouped to each

MS-DRG and then divided that number by the transfer-adjusted case count. To establish

the final blended weight for each DRG, we added 50 percent of the MS-DRG weight to

50 percent of the average CMS DRG weight for that MS-DRG. These final blended

relative weights are listed in Table 5 of this final rule with comment period.

Comment: Some commenters expressed concern about the continued transition

from charge-based weights to cost based weights, in light of RTI's recommendations to

alleviate charge compression on the relative weights and the proposal to introduce

MS-DRGs. For FY 2008, we proposed that the relative weights would be based on one-

third charges and two-third costs. Some commenters suggested that this transition should

be delayed until the public comments associated with cost reporting and charge

compression can be addressed. We have also received comments expressing concern on

the potential fluctuations in hospital payment if we were to implement both RTI's

recommendations on charge compression along with the MS-DRG system. In both cases,

commenters suggested delaying the transition from charge based to cost based weights by

maintaining the relative weights at two-third charges and one-third costs. MedPAC also

expressed concern about continuing the transition to cost-based weights. However,

unlike the commenter above, MedPAC suggested that CMS discontinue the transition

period to cost-based weights and implement 100 percent cost-based weights in FY 2008.

MedPAC's recommendation to discontinue the transition to cost-based weights presumed

full introduction of the MS-DRGs in FY 2008. The commenters believed the payment

fluctuations that will occur with full implementation of MS-DRGs can be mitigated by

fully adopting cost weights. However, as suggested above, MedPAC also suggested as

an alternative adopting MS-DRG weights according to the same schedule as the

cost-based weights.

Response: We appreciate the commenters' expressing concerns about the

continued transition to cost-based relative weights and the potential changes in payment

from the application of this methodology. In the FY 2007 IPPS final rule, we discussed

our rationale for implementing cost-based weights over a 3-year transition period. We

stated that the 3-year transition would mitigate the annual payment effects from the

changes to the relative weights while we further study whether to make adjustments to

account for charge compression. We believe that the cost-based methodology reduces

bias in the relative weights and makes Medicare's payments more accurate for both

medical and surgical DRGs. Therefore, any delays in the transition would not further our

goal of payment accuracy. We believe that current efforts to improve cost reporting and

our decision not to implement regression-based CCRs will alleviate concerns about

additional fluctuations in hospital payments from further changes to the relative weight

methodology. Furthermore, we believe that, for some types of hospitals (such as rural

hospitals), the payment changes from MS-DRGs are the opposite of those that will occur

from the transition to cost-based weights. For this reason, we believe a 2-year transition

of the MS-DRG system that coincides with the remaining two years of the transition to

cost-based weights will reduce the magnitude of annual payment changes and achieve our

long-term goal of improvements in payment accuracy. Therefore, we are continuing with

the 3-year transition to cost-based weights. For FY 2008, the DRG relative weights will

be a blend of 33 percent of charge-based weights and 67 percent of cost-based weights.

For the first year of the MS-DRG transition, the relative weights will be a blend of

50 percent of the CMS-DRG weight and 50 percent of the MS-DRG weight.

F. Hospital-Acquired Conditions, Including Infections

1. General

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 lead to higher Medicare 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 (for example, in FY 2007, the fixed-loss amount was $24,485 before a case qualified for outlier payments, and the hospital then only received 80 percent of its estimated costs above the fixed-loss cost threshold). Second, under the MS-DRGs we are adopting in this final rule with comment period, there are 258 sets of DRGs that are split into 2 or 3 subgroups based on the presence or absence of a major CC (MCC) or CC. If a condition acquired during the beneficiary's hospital stay is one of the conditions on the MCC or CC list, the result may be a higher payment to the hospital under the MS-DRGs. (We refer readers to section II.D. of this final rule with comment period for a detailed discussion of DRG reforms.)

2. Legislative Requirement

Section 5001(c) of Pub. L. 109-171 requires the Secretary to select, 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 will not receive additional payment for cases in which one of

the selected conditions was not present on admission. That is, the case will 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 the list 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.

3. Public Input

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought input from the

public regarding conditions with evidence-based guidelines that should be selected in

order to implement section 5001(c) of Pub. L. 109-171. The comments that we received

were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053). In the

FY 2008 IPPS proposed rule (72 FR 24716), we again sought formal public comment on

conditions that we proposed to select under section 5001(c). As discussed below, in this

final rule with comment period, we first summarize the comments we received on the FY

2007 IPPS proposed rule. We then explain our detailed proposals included in the FY

2008 proposed rule, followed by a summary of the public comments on each condition proposed and our responses to those public comments.

In summary, the majority of the comments that we received in response on the FY 2007 IPPS proposed rule addressed conceptual issues concerning the selection, measurement, and prevention of hospital-acquired infections. 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 the discussions.

Many commenters supported the statutory requirement for hospitals to submit information regarding secondary diagnoses present on admission beginning in FY 2008, 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 cautioned us about potential problems with relying on secondary diagnosis codes to identify hospital-acquired complications, and indicated that secondary diagnosis codes may be an inaccurate method for identifying true hospital-acquired complications.

A number of commenters expressed concerns about the data coding requirement for this payment change and asked for detailed guidance from CMS to help them identify and document hospital-acquired complications. Other commenters expressed concern

that not all hospital-acquired infections are preventable and noted that sicker and more

complex patients are at greater risk for hospital-acquired infections and complications.

Commenters suggested that CMS include standardized infection-prevention process

measures, in addition to outcome measures of hospital-acquired infections.

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. One commenter recommended that

CMS include appropriate consumer protections to prevent providers from billing patients

for the nonreimbursed costs of the hospital-acquired complications and to prevent

hospitals from selectively avoiding patients perceived at risk of complications.

In addition to the broad conceptual suggestions, some commenters recommended

specific conditions for possible inclusion in the payment changes, which we discussed in

detail in the preamble of the proposed rule and in section II.D.4. of this final rule with

comment period. We also discuss throughout section II.D. of the preamble of this final

rule with comment period other comments that we have considered in developing

hospital-acquired conditions that would be subject to reporting.

As it is not addressed elsewhere, we are responding here to the comment about

hospitals billing patients for costs of hospital-acquired complications that are not counted

as MCCs and CCs. Section 5001(c) does not make the additional cost of a

hospital-acquired complication a noncovered cost. The additional costs that a hospital

would incur as a result of a hospital-acquired complication remains a covered Medicare

cost that is included in the hospital's IPPS payment. Medicare's payment to the hospital

is for all inpatient hospital services provided during the stay. The hospital cannot bill the

beneficiary for any charges associated with the hospital-acquired complication. With

respect to the concern about a hospital avoiding patients that are at high risk of

complications, we note that the policy is selecting only those conditions that are

"reasonably preventable." Thus, we are only selecting those conditions where, if hospital

personnel are engaging in good medical practice, the additional costs of the

hospital-acquired condition will, in most cases, be avoided and the risk of selectively

avoiding patients at high risk of complications will be minimized. We further note

that Medicare's high cost outlier policy is unaffected by section 5001(c). The hospital's

total charges for all inpatient services provided during the stay will continue to be used to

determine whether the case qualifies for an outlier payment. Thus, there will continue to

be limitations on a hospital's financial risk of treating high cost cases even if, despite the

hospital maintaining good medical practice to avoid complications, a reasonably

preventable condition occurs after admission. Finally, as stated further below, we are

continuing to work to identify exclusions for situations where the policy should not apply

for the selected condition.

4. Collaborative Effort

CMS worked with public health and infectious disease experts from the Centers

for Disease Control and Prevention (CDC) to identify a list of hospital-acquired

conditions, including infections, as required by section 5001(c) of Pub. L. 109-171. As

previously stated, the selected conditions must meet the following three criteria: (a) high

cost or high volume or both; (b) result in the assignment of the 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. CMS and CDC

staff also collaborated on developing a process for hospitals to submit a Present on

Admission (POA) indicator with each secondary condition. The statute requires the

Secretary to begin collecting this information as of October 1, 2007. The POA indicator

is required in order for us to determine which of the selected conditions developed during

a hospital stay. The current electronic format used by hospitals to obtain this information

(ASC X12N 837, Version 4010) does not provide a field to obtain the POA information.

We issued instructions requiring acute care IPPS hospitals to submit the POA indicator

for all diagnosis codes, effective October 1, 2007, through Change Request No. 5499,

with a release date of May 11, 2007. The instructions specify how hospitals under the

IPPS submit this information in segment K3 in the 2300 loop, data element K301 on the

ASC X12N 837, Version 4010 claim. Specific instructions on how to select the correct

POA indicator for a diagnosis code are included in the ICD-9-CM Official Guidelines for

Coding and Reporting. These guidelines can be found at the following Web site:

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm

CMS and CDC staff also received input from a number of groups and organizations on hospital-acquired conditions, including infections. Many of these groups and organizations recommended the selection of conditions mentioned in the FY 2007 IPPS final rule, including the following because of the high cost or high volume (frequency) of the condition, or both, and because in some cases preventable guidelines already exist:

● Surgical site infections. The groups and organizations stated that there were evidence-based measures to prevent the occurrence of these infections which are currently measured and reported as part of the Surgical Care Improvement Program (SCIP).

● Ventilator-associated pneumonias. The groups and organizations indicated that these conditions are currently measured and reported through SCIP. However, other organizations counseled against selecting these conditions because they believed it was difficult to obtain good definitions and that it was not always clear which ones are hospital-acquired.

● Catheter associated bloodstream infections.

● Pressure ulcers.

● Hospital falls. The injury prevention groups included this condition among a group referred to as "serious preventable events," also commonly referred to as "never events" or "serious reportable events." A serious preventable event is defined as a condition which should not occur during an inpatient stay.

● Bloodstream infections/septicemia. Some commenters suggested that we focus on one specific organism, such as staph aureus septicemia.

● Pneumonia. Some commenters recommended the inclusion of a broader group of pneumonia patients, instead of restricting cases to ventilator-associated pneumonias. Some commenters mentioned that while prevention guidelines exist for pneumonia, it is not clear how effective these guidelines may be in preventing pneumonia.

● Vascular catheter associated infections. Commenters indicated that there are CDC guidelines for these infections. Other commenters stated that while this condition certainly deserves focused attention by health care providers, there is not a unique ICD-9-CM code that identifies vascular catheter-associated infections. Therefore, these commenters suggested that there would be difficulty separately identifying these conditions.

● Clostridium difficile-associated disease (CDAD). Several commenters identified this condition as a significant public health issue. Other commenters indicated that, while prevalence of this condition is emerging as a public health problem, there is not currently a strategy for reasonably preventing these infections.

● Methicillin-resistant staphylococcus aureus (MRSA). Several commenters indicated that MRSA has become a very common bacteria occurring both in and outside the hospital environment. However, other organizations stated that the code for MRSA (V09.0, Infection with microorganism resistant to penicillins Methicillin-resistant staphylococcus aureus) is not currently classified as a CC. Therefore, the commenters stated that MRSA does not lead to a higher reimbursement when the code is reported.

● Serious preventable events. As stated earlier, some commenters representing injury prevention groups suggested including a broader group of conditions than hospital falls which should not be expected to occur during a hospital admission. They noted that these conditions are referred to as "serious preventable events," and include events such as the following: (a) leaving an object in during surgery; (b) operating on the wrong body part or patient, or performing the wrong surgery; (c) air embolism as a result of surgery; and (d) providing incompatible blood or blood products. Other commenters indicated serious preventable events are so rare that they should not be selected as a hospital condition that cannot result in a case being assigned to a higher paying DRG.

5. Criteria for Selection of the Hospital-Acquired Conditions

CMS and CDC staff greatly appreciate the many comments and suggestions offered by organizations and groups that were interested in providing input into the selection of the initial hospital-acquired conditions.

CMS and CDC staff evaluated each recommended condition under the three criteria established by section 1886(d)(4)(D)(iv) of the Act. In order to meet the higher payment criterion, the condition selected must have an ICD-9-CM diagnosis code that clearly identifies the condition and is classified as a CC, or as an MCC (as proposed for the MS-DRGs in the proposed rule). Some conditions recommended for inclusion among the initial hospital-acquired conditions did not have codes that clearly identified the conditions. Because there has not been national reporting of a POA indicator for each diagnosis, there are no Medicare data to determine the incidence of the reported secondary diagnoses occurring after admission. To the extent possible, we used

information from the CDC on the incidence of these conditions. CDC's data reflect the

incidence of hospital-acquired conditions in 2002. We also examined FY 2006 Medicare

data on the frequency that these conditions were reported as secondary diagnoses. We

developed the following criteria to assist in our analysis of the conditions. The

conditions described were those recommended for inclusion in the initial hospital-

acquired infection provision.

● Coding – Under section 1886(d)(4)(D)(ii)(I) of the Act, a discharge is subject

to the payment adjustment if "the discharge includes a condition identified by a diagnosis

code" selected by the Secretary under section 1886(d)(4)(D)(iv) of the Act. We only

selected conditions that have (or could have) a unique ICD-9-CM code that clearly

describes the condition. Some conditions recommended by the commenters would

require the use of two or more ICD-9-CM codes to clearly identify the conditions.

Although we did not exclude these conditions from further consideration, the need to

utilize multiple ICD-9-CM codes to identify them may present operational issues. For

instance, the complexities associated with selecting septicemia as a hospital-acquired

condition subject to section 5001(c) of the DRA may present operational issues in

identifying whether or not the condition was present upon admission. The vast number

of clinical scenarios that we would have to account for could complicate implementation

of the provision.

● Burden (High Cost/High Volume) – Under section 1886(d)(4)(D)(iv)(I) of the

Act, we must select cases that have conditions that are high cost or high volume, or both.

● Prevention guidelines – Under section 1886(d)(4)(D)(iv)(II) of the Act, we

must select codes that describe conditions that could reasonably have been prevented

through application of evidence-based guidelines. We evaluated whether there is

information available for hospitals to follow to prevent the condition from occurring.

● MCC or CC – Under section 1886(d)(4)(D)(iv)(III) of the Act, we must select

codes that result in assignment of the case to a DRG that has a higher payment when the

code is present as a secondary diagnosis. The condition must be an MCC or a CC that

would, in the absence of this provision, result in assignment to a higher paying DRG.

● Considerations – We evaluated each condition above according to how it meets

the statutory criteria in light of the potential difficulties that we would face if the

condition were selected.

6. Selection of Hospital-Acquired Conditions

We discuss below our analysis of each of the conditions that were raised as

possible candidates for selection under section 5001(c) of Pub. L. 109-171 according to

the criteria described above in section II.D.5. of the preamble of this final rule with

comment period. We also discuss any considerations, which would include any

administrative issues surrounding the selection of a proposed condition. For example, the

condition may only be able to be identified by multiple codes, thereby requiring the

development of special GROUPER logic to also exclude similar or related ICD-9-CM

codes from being classified as a CC. Similarly, a condition acquired during a hospital

stay may arise from another condition that the patient had prior to admission, making it

difficult to determine whether the condition was reasonably preventable. Following a

discussion of each condition, we provide a summary that describes how each condition
was considered for the proposed rule, whether we are selecting it to be subject to the
provision in this FY 2008 IPPS final rule or if it will continue to be considered for the
future. In the proposed rule, we presented 13 conditions. The summary discussion and
table reflect changes to the order of the conditions. The summary presents the conditions
that best meet the statutory criteria and which conditions we are selecting to be subject to
the payment adjustment for hospital-acquired conditions beginning in FY 2009. In the
proposed rule, we encouraged comments on these conditions. We asked commenters to
recommend how many and which conditions should be selected in the FY 2008 IPPS
final rule along with justifications for these selections. We also encouraged additional
comments on clinical, coding, and prevention issues that may affect the conditions
selected. While, in this final rule with comment period, we present these 13 conditions in
the order they were proposed, we have re-ranked these conditions based on how well they
meet the statutory criteria according to compelling public health reasons in addition to
public comment and internal analysis.

       We received approximately 127 timely public comments on this section from
hospitals and health care systems, provider associations, consumer groups, purchasers,
medical device manufacturers, pharmaceutical companies, information technology
companies, and health care research organizations.

       Comment: Some commenters urged CMS to use discretion in selecting hospital-
acquired conditions that will be subject to the statutory provision and suggested that CMS
limit the number of conditions selected. A large majority of commenters strongly

supported the inclusion of three of the serious preventable events (object left in surgery, air embolism and blood incompatibility) and generally commented that the remaining conditions are not always preventable or may not have unique codes established.

A number of commenters both supported and opposed the conditions other than the three serious preventable events mentioned above. The commenters were generally optimistic about considering proposed conditions for the future upon resolution of suggested issues. A few commenters proposed that CMS initially begin with limited demonstrations to test CMS' methodology before nationwide implementation. These commenters specifically mentioned the Michigan Hospital Association Keystone Center.

The commenters who suggested not including conditions other than the three serious preventable events mentioned above noted that sicker and more complex patients are at greater risk for hospital-acquired infections and complications. In particular, the commenters believed some of the conditions proposed are a biological inevitability at a certain predictable rate regardless of safe practice. In addition, the commenters expressed concern about the difficulty of distinguishing between hospital-acquired and community-acquired infections. The commenters also believed that CMS should use incentives to allow hospitals to adopt innovative infection prevention technologies and provide necessary treatments for infections. Finally, a few commenters submitted additional conditions that were not included in the 13 conditions we considered in the proposed rule.

Response: In general, we discuss our responses to each of these comments below in the context of the specific conditions they reference. With respect to the general

comment that we should only select the three serious preventable events, we believe there

is a significant public health interest in selecting more than just these conditions.

According to the commenters, many of the other conditions we considered are not always

preventable and, therefore, should not be selected. The statute indicates that the

provision should apply to conditions that "could reasonably have been prevented through

the application of evidence-based guidelines." Therefore, for this reason, we are

selecting other conditions in addition to the serious preventable events to be subject to

this provision in this final rule with comment period. We discuss the application of the

statutory criteria to each of the conditions we considered below and why we believe the

condition is "reasonably preventable."

(a) Catheter-Associated Urinary Tract Infections

  Coding – ICD-9-CM code 996.64 (Infection and inflammatory reaction due to

indwelling urinary catheter) clearly identifies this condition. The hospital would also

report the code for the specific type of urinary infection. For instance, when a patient

develops a catheter associated urinary tract infection during the inpatient stay, the

hospital would report code 996.64 and 599.0 (Urinary tract infection, site not specified)

to clearly identify the condition. There are also a number of other more specific urinary

tract infection codes that could also be coded with code 996.64. These codes are

classified as CCs. If we were to select catheter-associated urinary tract infections, we

would implement the decision by not counting code 996.64 and any of the urinary tract

infection codes listed below when both codes are present and the condition was acquired

after admission. If only code 966.64 were coded on the claim as a secondary diagnosis,

we would not count it as a CC.

Burden (High Cost/High Volume) – CDC reports that there are 561,667

catheter-associated urinary tract infections per year. For FY 2006, there were 11,780

reported cases of Medicare patients who had a catheter associated urinary tract infection

as a secondary diagnosis. The cases had average charges of $40,347 for the entire

hospital stay. According to a study in the American Journal of Medicine, catheter-

associated urinary tract infection is the most common nosocomial infection, accounting

for more than 1 million cases in hospitals and nursing homes nationwide.[22]

Approximately 11.3 million women in the United States had at least one presumed acute

community-acquired urinary tract infection resulting in antimicrobial therapy in 1995,

with direct costs estimated at $659 million and indirect costs totaling $936 million.

Nosocomial urinary tract infection necessitates one extra hospital day per patient, or

nearly 1 million extra hospital days per year. It is estimated that each episode of

symptomatic urinary tract infection adds $676 to a hospital bill. In total, according to the

study, the estimated annual cost of nosocomial urinary tract infection in the United States

ranges between $424 and $451 million.

Prevention guidelines – There are widely recognized guidelines for the

prevention of catheter-associated urinary tract infections. Guidelines can be found at the

following Web site: http://www.cdc.gov/ncidod/dhqp/gl_catheter_assoc.html

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[22] Foxman, B.: "Epidemiology of urinary tract infections: incidence, morbidity, and economic costs," The American Journal of Medicine, 113 Suppl 1A, pp. 5s-13s, 2002.

CC - Codes 996.64 and 599.0 are classified as CCs in the CMS DRGs as well as in the MS-DRGs.

Considerations – The primary prevention intervention would be not using catheters or removing catheters as soon as possible, both of which are worthy goals because once catheters are in place for 3 to 4 days, most clinicians and infectious disease/infection control experts do not believe urinary tract infections are preventable. While there may be some concern about the selection of catheter associated urinary tract infections, it is an important public health goal to encourage practices that will reduce urinary tract infections. Approximately 40 percent of Medicare beneficiaries have a urinary catheter during hospitalization based on Medicare Patient Safety Monitoring System (MPSMS) data.

As stated above in the Coding section, this condition is clearly identified through ICD-9-CM code 996.64. Code 996.64 is classified as a CC. The hospital would also report the code for the specific type of urinary infection. For instance, when a patient develops a catheter associated urinary tract infection during the inpatient stay, the hospital would report codes 996.64 and 599.0 or another more specific code that clearly identifies the condition. These codes are classified as CCs under the CMS DRGs as well as the MS-DRGs. To select catheter-associated urinary tract infections as one of the hospital-acquired conditions that would not be counted as a CC, we would not classify code 996.64 as a CC if the condition occurred after admission. Furthermore, we would also not classify any of the codes listed below as CCs if present on the claim with code 996.64 because these additional codes identify the same condition. The following codes

represent specific types of urinary infections. We did not include codes for conditions

that could be considered chronic urinary infections, such as code 590.00 (Chronic

pyelonephritis, without lesion or renal medullary necrosis). Chronic conditions may

indicate that the condition was not acquired during the current stay. We would not count

code 996.64 or any of the following codes representing acute urinary infections if they

developed after admission and were coded together on the same claim.

- 112.2 (Candidiasis of other urogenital sites)

- 590.10 (Acute pyelonephritis, without lesion of renal medullary necrosis)

- 590.11 (Acute pyelonephritis, with lesion of renal medullary necrosis)

- 590.2 (Renal and perinephric abscess)

- 590.3 (Pyeloureteritis cystica)

- 590.80 (Pyelonephritis, unspecified)

- 590.81 (Pyelitis or pyelonephritis in diseases classified elsewhere)

- 590.9 (Infection of kidney, unspecified)

- 595.0 (Acute cystitis)

- 595.3 (Trigonitis)

- 595.4 (Cystitis in diseases classified elsewhere)

- 595.81 (Cystitis cystica)

- 595.89 (Other specified type of cystitis, other)

- 595.9 (Cystitis, unspecified)

- 597.0 (Urethral abscess)

- 597.80 (Urethritis, unspecified)

● 599.0 (Urinary tract infection, site not specified)

We believe the condition of catheter-associated urinary tract infection meets all of our criteria for selection as one of the initial hospital-acquired conditions. We can easily identify the cases with ICD-9-CM codes. The condition is a CC under both the CMS DRGs and the MS-DRGs. The condition meets our burden criterion with its high cost and high frequency. There are prevention guidelines on which the medical community agrees to avoid catheter-associated urinary tract infections. We believe this condition best meets the criteria discussed. Therefore, we proposed the selection of catheter-associated urinary tract infections as one of the initial hospital-acquired conditions.

We encouraged comments on both the selection of this condition and the related conditions that we proposed to exclude from being counted as CCs.

Comment: Most commenters suggested that a large number of physicians believe urinary tract infections may not be preventable after several days of catheter placement. A few commenters submitted the following statement from the proposed rule (72 FR 24719): "once catheters are in place for 3-4 days, most clinicians and infection control experts do not believe UTIs are preventable." The commenters also noted the potential difficulty in identifying this condition at admission.

Still other commenters believed this condition is difficult to code because the ICD-9-CM codes do not distinguish between catheter-associated inflammation and infection. The commenters asked CMS to consider a new code for "inflammatory

reaction from indwelling catheter" distinct from "catheter associated urinary tract infection."

In addition, the commenters noted that prevention guidelines are still being debated. The commenters referenced the prevention guideline published in 1981 and posted on the Web site at: http://www.cdc.gov/ncidod/dhqp/gl_catheter_assoc.html.

A few commenters also recommended exceptions for this condition, including patients with immunosuppression, patients who have a catheter placed for therapeutic installation of antimicrobial/chemotherapy agent, patients with sustained urinary tract trauma, and patients in need of permanent use of a catheter.

Commenters stated that Medicare reimbursement does not cover the increased cost of antibiotic-coated catheters which have been shown to reduce the incidence of catheter infections. These same commenters asked CMS to change Medicare payment policy to encourage the application of proven existing technology.

Commenters provided two potential examples of unintended consequences if this condition is to be implemented. First, the commenters believed that physicians and hospitals will increase urinalysis testing to identify urinary tract infections prior to admission. Second, the commenters suggested that physicians and hospitals will use more antibiotics to "clean" the urine of bacteria upon admission.

Response: CMS seeks to reduce the incidence of preventable catheter associated urinary tract infections by reducing unnecessary and inappropriate use of indwelling urinary catheters in hospitalized Medicare patients. There is widespread evidence that catheters may lead to an increased risk of infection if they are in place for several days.

In addition, there are prevention guidelines to assist physicians in determining how long a urinary catheter should be left in place that can prevent catheter-associated urinary tract infections. Therefore, we believe that catheter-associated urinary tract infections are reasonably preventable by following well-established prevention guidelines, and we are selecting this condition.

Concerning the request for the creation of a new code for "inflammatory reaction from indwelling catheter," we recommend the commenter contact the CDC. The CDC is responsible for maintaining the diagnosis part of the ICD-9-CM codes. We encourage commenters to send specific requests for new or revised ICD-9-CM diagnosis codes to Donna Pickett, CDC, at 3311 Toledo Road, Room 2402, Hyattsville, MD 20782, or via e-mail to dfp4@cdc.gov. Additional information on requesting a new ICD-9-CM diagnosis code may be obtained from the Web site at: http://www.cdc.gov/nchs/icd9.htm

The commenters are correct that prevention guidelines for avoiding catheter-associated urinary tract infections are scheduled to be updated by CDC's Healthcare Infection Control Practices Committee (HICPAC). The National Quality Forum (NQF) is currently working to update hospital-acquired infection definitions. The effort currently underway will update prevention guidelines that have been in place since 1981. We believe the ongoing effort to update prevention guidelines for avoiding catheter-associated urinary tract infections provides further evidence that this condition is a strong candidate to be selected because of how well it meets the statutory criteria.

We appreciate the many comments urging CMS to consider implementing exceptions for catheter-associated urinary tract infections when it is a hospital-acquired

condition but is not preventable. We will carefully consider these suggestions as we plan for the implementation of this new requirement in FY 2009.

With respect to the comment about encouraging the use antibiotic-coated catheters, we continue to work in cooperation with device companies and other associations to ensure that Medicare beneficiaries receive the most current therapeutic modalities. We annually update Medicare inpatient hospital payment rates to reflect hospital resource use for the latest medical technology and other innovations in how care is delivered.

We do not agree there will be significant unintended consequences of selecting catheter-associated urinary tract infections. As stated earlier, we believe this condition is generally avoidable if medical professionals carefully follow longstanding prevention guidelines. We believe hospitals, physicians, and others that treat Medicare patients will focus on taking medically appropriate steps to determine the length of time a catheter is in place. We do not believe it is inappropriate to perform a urinalysis upon admission to the hospital if clinically indicated. We would not consider doing so an unintended consequence.

We appreciate all the public comments on this condition, and have considered all of these points of view. We believe this condition meets the criteria of the DRA:

● There are unique codes that identify catheter-associated urinary tract infections that are currently considered to be a CC under the MS-DRGs;

● Prevention guidelines currently exist and will be updated prior to the October 1, 2008 implementation date of this provision; and

● As shown above, catheter-associated urinary tract infections are high cost/high volume conditions.

Therefore, in this final rule with comment period, we are selecting the condition of catheter-associated urinary tract infections to be subject to the provision beginning October 1, 2008.

(b) Pressure Ulcers

Coding – Pressure ulcers are also referred to as decubitus ulcers. The following codes clearly identify pressure ulcers.

● 707.00 (Decubitus ulcer, unspecified site)

● 707.01 (Decubitus ulcer, elbow)

● 707.02 (Decubitus ulcer, upper back)

● 707.03 (Decubitus ulcer, lower back)

● 707.04 (Decubitus ulcer, hip)

● 707.05 (Decubitus ulcer, buttock)

● 707.06 (Decubitus ulcer, ankle)

● 707.07 (Decubitus ulcer, heel)

● 707.09 (Decubitus ulcer, other site)

Burden (High Cost/High Volume) – This condition is both high-cost and high-volume. For FY 2006, there were 322,946 reported cases of Medicare patients who had a pressure ulcer as a secondary diagnosis. These cases had average charges for the hospital stay of $40,381.

Prevention guidelines – Prevention guidelines can be found at the following

Web sites: http://www.npuap.org/positn1.html and

http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409.

CC – Decubitus ulcer codes are classified as CCs under the CMS DRGs. Codes

707.00, 707.01, and 707.09 are CCs under the MS-DRGs. Codes 707.02 through 707.07

are considered MCCs under the MS-DRGs. As discussed earlier, MCCs result in even

larger payments than CCs.

Considerations – Pressure ulcers are an important hospital-acquired

complication. Prevention guidelines exist (non-CDC) and can be implemented by

hospitals. Clinicians may state that some pressure ulcers present on admission cannot be

identified (skin is not yet broken (Stage I) but damage to tissue is already done and skin

will eventually break down). However, by selecting this condition, we would provide

hospitals the incentive to perform careful examination of the skin of patients on

admission to identify decubitus ulcers. If the condition is present on admission, the

provision will not apply. In the proposed rule, we proposed to include pressure ulcers as

one of our initial hospital-acquired conditions. This condition can be clearly identified

through ICD-9-CM codes. These codes are classified as a CC under the CMS DRGs and

as a CC or MCC under the MS-DRGs. Pressure ulcers meet the burden criteria because

they are both high cost and high frequency cases. There are clear prevention guidelines.

While there is some question as to whether all cases with developing pressure ulcers can

be identified on admission, we believe the selection of this condition will result in a

closer examination of the patient's skin on admission and better quality of care. We welcomed comments on the proposed inclusion of this condition.

Comment: A majority of commenters supported the intent of selecting the condition of pressure ulcers, but had concerns about how the provision would be implemented in practice.   A large majority of commenters believed hospitals will more carefully examine the skin of patients if this condition is selected. However, many commenters cited difficulty in detecting stage 1 pressure ulcers on admission, particularly in certain patient populations.

The commenters cited the Guidance to Surveyors for Long-Term Care Facilities (CMS Manual System Pub. 100-07, State Operations Provider Certification issued November 2004, page 5), noting CMS' previous acknowledgment that some pressure ulcers are "unavoidable." The commenters cited evidence of an increased risk of pressure ulcer reoccurrence after a patient has had at least one stage IV ulcer.

The commenters expressed concern about how this condition will be coded upon admission. The commenters also suggested that present-on-admission coding of pressure ulcers will rely solely on physicians' notes and diagnoses, according to Medicare coding rules. The commenters were concerned that the current ICD-9-CM codes for pressure ulcers are not precise enough to delineate differences in wound depth, which is an important factor for determining the severity of an ulcer.

The commenters recommended that CMS supplement ICD-9-CM codes for pressure ulcers with severity adjustments for complications and comorbidities that are present on admission. Because patients with pressure ulcers often have other

complicating conditions, the commenters stated that it is unlikely that pressure ulcers

would potentially be the only secondary diagnosis that would change the DRG

assignment from one without a CC to one with a CC. Lastly, the commenters noted that

accurate identification of a pressure ulcer requires the education and expertise of a trained

physician.

The commenters suggested that CMS should exclude patients enrolled in the

Medicare hospice benefit and patients with certain diagnoses that make them more highly

prone to pressure ulcers such as hemiplegia, quadriplegia, wasting syndrome, with

advanced AIDS and/or protein malnutrition associated with a variety of serious end-stage

illnesses.

Response: We appreciate the overwhelming public support for the intent of

selecting this condition, provided we can address the concerns raised in the public

comments. We acknowledge the commenters' concern that CMS previously stated some

pressure ulcers are "unavoidable." However, we believe improved screening to identify

pressure ulcers upon admission for inpatient care will increase the quality of care. By

screening patients entering the hospital for pressure ulcers, the ulcers will be discovered

earlier and improve treatment of this preventable condition. We agree that the POA

coding of pressure ulcers will rely on the attending physician, who has primary

responsibility for documenting and diagnosing a patient's clinical conditions. Pressure

ulcers that are identified through screening upon admission that are documented properly

will continue to be assigned to a higher paying DRG.

With respect to the comment about patients with pressure ulcers having other complications and comorbidities, we note that many of the new MS-DRGs are subdivided into two or more severity levels. We will continue to evaluate the need for additional severity levels within base MS-DRGs. On the specific issue of the MS-DRGs that include pressure ulcers, we note that these MS-DRGs are already divided into three severity levels as follows:

● MS-DRG 573 (Skin Graft &/or Debridement for Skin Ulcer or Cellulitis with MCC)

● MS-DRG 574 (Skin Graft &/or Debridement for Skin Ulcer or Cellulitis with CC)

● MS-DRG 575 (Skin Graft &/or Debridement for Skin Ulcer or Cellulitis without CC/MCC)

We are aware that many patients with pressure ulcers may also have other comorbid and complicating conditions that will continue to assign the patient to a higher paying DRG. We do not believe this fact should preclude physicians and hospitals from screening patients for pressure ulcers upon admission. As we indicated in the proposed rule (72 FR 24726), we believe only a minority of cases will have one of the selected conditions as the only CC or MCC present on the claim. However, we believe it will continue to lead to improvements in the quality of care. We believe the selection of this condition will lead the physician and hospital to perform a proper skin exam upon admission, leading to earlier identification and treatment of pressure ulcers.

With respect to the comment that accurate identification of a pressure ulcer

requires the education and expertise of a trained physician, we agree. Hospitals should be

using properly educated and trained physicians to identify and treat pressure ulcers (as

well as all other medical conditions).

We appreciate all the public comment on this condition, and have considered all

of these points of view. We believe the condition of pressure ulcers meets the criteria of

the DRA:

● There are unique codes that identify pressure ulcers that are currently

considered to be a CC or an MCC under the MS-DRGs;

● Prevention guidelines to avoid pressure ulcers currently exist; and

● As shown above, pressure ulcers are high-cost/high-volume conditions.

Therefore, in this final rule with comment period, we are selecting the condition

of pressure ulcers to be subject to the payment adjustment for hospital-acquired

conditions beginning October 1, 2008. We referred the matter concerning the need for

additional, detailed ICD-9-CM codes to the CDC. We believe further specificity in the

ICD-9-CM codes will aid in distinguishing early from late stage pressure ulcers prior to

the implementation date of this provision on October 1, 2008.

Serious Preventable Events

Serious preventable events are events that should not occur in health care. The

injury prevention community has developed information on serious preventable events.

CMS reviewed the list of serious preventable events and identified those events for which

there was an ICD-9-CM code that would assist in identifying them. We identified four

types of serious preventable events to include in our evaluation. These include leaving an

object in a patient; performing the wrong surgery (surgery on the wrong body part, wrong

patient, or the wrong surgery); air embolism following surgery; and providing

incompatible blood or blood products. Three of these serious preventable events have

unique ICD-9-CM codes to identify them. There is not a clear and unique code for

surgery performed on the wrong body part, wrong patient, or the wrong surgery. Each of

these events is discussed separately.

(c) Serious Preventable Event – Object Left in during Surgery

      Coding –Retention of a foreign object in a patient after surgery is identified

through ICD-9-CM code 998.4 (Foreign body accidentally left during a procedure).

      Burden (High Cost/High Volume) – For FY 2006, there were 764 cases reported

of Medicare patients who had an object left in during surgery reported as a secondary

diagnosis. The average charges for the hospital stay were $61,962. This is a rare event.

Therefore, it is not high volume. However, an individual case will likely have high costs,

given that the patient will need additional surgery to remove the foreign body. Potential

adverse events stemming from the foreign body could further raise costs for an individual

case.

      Prevention guidelines – There are widely accepted and clear guidelines for the

prevention of this event. This event should not occur. Prevention guidelines for avoiding

leaving objects in during surgery are located at the following Web site:

http://www.qualityindicators.ahrq.gov/psi_download.htm.

      CC - This code is a CC under the CMS DRGs as well as under the MS-DRGs.

Considerations – There are no significant considerations for this condition.

There is a unique ICD-9-CM code and wide agreement on the prevention guidelines. We

proposed to include this condition as one of our initial hospital-acquired conditions. The

cases can be clearly identified through an ICD-9-CM code. This code is a CC under both

the CMS DRGs and the MS-DRGs. There are clear prevention guidelines. While the

cases may not meet the high frequency criterion, they do meet the high-cost criterion.

Individual cases can be high cost. In the proposed rule, we welcomed comments on

including this condition as one of our initial hospital-acquired conditions.

Comment: A large majority of commenters supported CMS' efforts to identify

the condition of "object left in surgery" as one that should not occur in the hospital

setting. The commenters supported selecting this condition in this year's IPPS rule.

The commenters applauded CMS for identifying a hospital-acquired condition

that has discrete ICD-9-CM codes and known methods of prevention. In addition, a few

commenters noted that prevention guidelines for this condition are fully identified and

endorsed by the NQF. MedPAC also complimented CMS for its efforts to identify

"object left in surgery" and stated that CMS should not allow a case to be classified as a

CC/MCC if this "never event" occurs during a patient's stay.

The commenters urged CMS to make exceptions for objects deliberately left in

place in surgery as opposed to accidental retained foreign objects. The commenters noted

that a patient may return to the hospital months or years after an object was left in during

surgery, and it is necessary to have POA codes to identify patients that return to a

different hospital to have the object removed. All of the commenters recognized that this event can cause great harm to patients.

Response: We believe exceptions for this condition are not necessary. The code that identifies this event, 998.4 (Foreign body accidentally left during a procedure) specifically states that the object was accidentally left in during the surgery. This code would not be assigned if a device or implant was deliberately implanted into a patient. In addition, as stated earlier, we recognize the important role of the attending physician in designating whether or not the serious preventable event occurred during the current admission. We agree with the commenters that a patient may return to the hospital months or years after the surgery to have the foreign object removed. In this circumstance, the hospital would code the condition as present on admission and the provision would not apply. By documenting the event early, the correct POA code can be applied. We agree with the commenters that this serious preventable event should be selected as a hospital-acquired condition in this final rule with comment period. Therefore, we are including this condition in the list of those to be implemented in FY 2009.

(d) Serious Preventable Event – Air Embolism

Coding - An air embolism is identified through ICD-9-CM code 999.1 (Complications of medical care, NOS, air embolism).

Burden (High Cost/High Volume) – This event is rare. For FY 2006, there were 45 reported cases of air embolism for Medicare patients. The average charges for the hospital stay were $66,007.

Prevention guidelines – There are clear prevention guidelines for air embolisms. This event should not occur. Serious preventable event guidelines can be found at the following Web site: http://www.qualityindicators.ahrq.gov/psi_download.htm.

CC - This code is a CC under the CMS DRGs and is an MCC under the MS-DRGs.

Considerations – There are no significant considerations for this condition. There is a unique ICD-9-CM code and wide agreement on the prevention guidelines. In addition, as stated earlier, the condition is a CC under the CMS DRGs and an MCC under the MS-DRGs. While the condition is rare, it does meet the cost burden criterion because individual cases can be expensive. Therefore, air embolism is a high-cost condition because average charges per case are high. In the proposed rule, we welcomed comments on the proposal to include this condition.

Comment: A large number of commenters supported CMS' efforts to select this condition as one that should not occur in the hospital setting. The commenters considered this an appropriate condition to include for the final rule. The commenters applauded CMS for identifying a hospital-acquired condition that has discrete ICD-9-CM codes and known methods of prevention.

In addition, the commenters noted that prevention guidelines for this condition are fully identified and endorsed by the NQF. MedPAC also complimented CMS for its efforts to identify "air embolism" and stated that CMS should not allow a case to be classified as a CC/MCC if this "never event" occurs during a patient's stay.

The commenters urged CMS to make exceptions for situations when air embolism

is technically unavoidable because of a special surgical procedure. All of the

commenters recognized that this event can cause great harm to patients.

Response: We appreciate the support for the selection of this condition. We also

welcome specific recommendations that would clearly define an appropriate exception to

this condition, including any appropriate ICD-9-CM diagnosis and procedure codes

which the commenter believes clearly define such an occurrence and the justification for

an exception. At this point, we do not believe such an exception is necessary.

We agree with commenters that this serious preventable event should be included

in the FY 2008 final rule. Therefore, we are including the condition of air embolism in

the list of those to be implemented in FY 2009.

(e) Serious Preventable Event – Blood Incompatibility

Coding - Delivering ABO-incompatible blood or blood products is identified by

ICM-9-CM code 999.6 (Complications of medical care, NOS, ABO incompatibility

reaction).

Burden (High Cost/High Volume) – This event is rare. Therefore, it is not high

volume. For FY 2006, there were 33 reported cases of blood incompatibility among

Medicare patients, with average charges of $46,492 for the hospital stay. Therefore,

individual cases have high costs.

Prevention guidelines – There are prevention guidelines for avoiding the

delivery of incompatible blood or blood products. The event should not occur. Serious

preventable event guidelines can be found at the following Web site:

http://www.qualityindicators.ahrq.gov/psi_download.htm

CC - This code is a CC under the CMS DRGs as well as the MS-DRGs.

Considerations – There are no significant considerations for this condition.

There is a unique ICD-9-CM code which is classified as a CC under the CMS DRGs as

well as the MS-DRGs. There is wide agreement on the prevention guidelines. While this

may not be a high-volume condition, average charges per case are high. Therefore, we

believe this condition is a high-cost condition and, therefore, meets our burden criterion.

We proposed to include this condition as one of our initial hospital-acquired conditions.

Comment: A large number of commenters supported CMS' efforts to identify

"blood incompatibility" as one condition that should not occur in the hospital setting.

The commenters considered this an appropriate condition to include for FY 2009. The

commenters applauded CMS for identifying a hospital-acquired condition that has

discrete ICD-9-CM codes and known methods of prevention. In addition, the

commenters noted that prevention guidelines for this condition are fully identified and

endorsed by the NQF. MedPAC also complimented CMS for its efforts to identify

"blood incompatibility" and stated that CMS should not allow a case to be classified as a

CC/MCC if this "never event" occurs during a patient's stay.

The commenters urged CMS to make exceptions for situations when blood

incompatibility is technically unavoidable in emergencies when patients deliberately

receive unmatched blood. All of the commenters recognized that this event can cause

great harm to patients.

Response: As suggested by commenters, hospitals should not be transfusing incompatible blood. The condition meets the criteria for being selected. It is a potential hospital-acquired condition that has discrete ICD-9-CM codes and known methods of prevention. Prevention guidelines for this condition are fully identified and endorsed by the NQF. We acknowledge that there may a rare emergency where a hospital does not have compatible blood available for transfusion. We welcome specific recommendations that would define circumstances where blood incompatibility is unavoidable, including any appropriate ICD-9-CM diagnosis and procedure codes, which the commenters believe clearly define such an occurrence. If providers can provide such a clinical scenario that can be identified by existing or new ICD-9-CM codes, we will consider excluding this situation from the provision. We agree with the commenters that this serious preventable event should be included in the FY 2008 final rule. Therefore, we are including the condition of blood incompatibility in the list of those to be implemented in FY 2009.

(f) Staphylococcus Aureus Bloodstream Infection/Septicemia

Coding – ICD-9-CM Code 038.11 (Staphylococcus aureus septicemia) identifies this condition. However, the codes selected to identify septicemia are somewhat complex. The following ICD-9-CM codes may also be reported to identify septicemia:

● 995.91 (Sepsis) and 995.92 (Severe sepsis). These codes are reported as secondary codes and further define cases with septicemia.

● 998.59 (Other postoperative infections). This code includes septicemia that develops postoperatively.

● 999.3 (Other infection). This code includes but is not limited to

sepsis/septicemia resulting from infusion, injection, transfusion, and vaccination

(ventilator-associated pneumonia is also included here).

Burden (High Cost/High Volume) – CDC reports that there are 290,000 cases of

staphylococcus aureus infection annually in hospitalized patients of which approximately

25 percent are bloodstream infections or sepsis. For FY 2006, there were 29,500 cases of

Medicare patients who had staphylococcus aureus infection reported as a secondary

diagnosis. The average charges for the hospital stay were $82,678. Inpatient

staphylococcus aureus result in an estimated 2.7 million days in excess length of stay,

$9.5 billion in excess charges, and approximately 12,000 inpatient deaths per year.

Prevention guidelines – CDC guidelines are located at the following Web site:

http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html.

CC – Codes 038.11, 995.91, 998.59, and 999.3 are classified as CCs under the

CMS DRGs and as MCCs under the MS-DRGs.

Considerations - Preventive health care associated bloodstream

infections/septicemia that are preventable are primarily those that are related to a central

venous/vascular catheter, a surgical procedure (postoperative sepsis) or those that are

secondary to another preventable infection (for example, sepsis due to catheter-associated

urinary tract infection). Otherwise, physicians and other public health experts may argue

whether septicemia is reasonably preventable. The septicemia may not be simply a

hospital-acquired infection. It may simply be a progression of an infection that occurred

prior to admission. Furthermore, physicians cannot always tell whether the condition was

hospital-acquired. We examined whether it might be better to limit the septicemia cases

to a specific organism (for example, code 038.11 (Staphylococcus aureus septicemia)).

CDC staff recommended that we focus on staphylococcus aureus septicemia because this

condition is a significant public health issue. As stated earlier, there is a specific code for

staphylococcus aureus septicemia, code 038.11. Therefore, the cases would be easy to

identify. However, as stated earlier, while this type of septicemia is identified through

code 038.11, coders may also provide sepsis code 995.91 or 995.92 to more fully

describe the staphylococcus aureus septicemia. Codes 995.91 and 995.92 are reported as

secondary codes and further define cases with septicemia. Codes 995.91 and 995.92 are

CCs under the CMS DRGs and MCCs under the MS-DRGs.

- 998.59 (Other postoperative infections). This code includes septicemia that

develops postoperatively.

- 999.3 (Other infection). This code includes but is not limited to

sepsis/septicemia resulting from infusion, injection, transfusion, and vaccination

(ventilator-associated pneumonia is also indexed here).

To implement this condition as one of our initial ones, we would have to exclude

the specific code for staphylococcus aureus septicemia, 038.11, and the additional

septicemia codes, 995.91, 995.92, 998.59, and 999.3.

We acknowledge that there are additional issues involved with the selection of

this condition that may involve developing an exclusion list of conditions present on

admission for which we would not apply a CC exclusion to staphylococcus aureus

septicemia. For example, a patient may come into the hospital with a staphylococcus

aureus infection such as pneumonia. The pneumonia might develop into staphylococcus

aureus septicemia during the admission. It may be appropriate to consider excluding

cases such as those of patients admitted with staphylococcus aureus pneumonia that

subsequently develop staphylococcus aureus septicemia from the provision. In order to

exclude cases that did not have a staphylococcus aureus infection prior to admission, we

would have to develop a list of specific codes that identified all types of staphylococcus

aureus infections such as code 482.41 (Pneumonia due to staphylococcus aureus). We

likely would not apply the new provision to cases of staphylococcus aureus septicemia if

a patient were admitted with staphylococcus aureus pneumonia. However, if the patient

had other types of infections, not classified as being staphylococcus aureus, and then

developed staphylococcus aureus septicemia during the admission, we would apply the

provision and exclude the staphylococcus aureus septicemia as a CC. We were not able

to identify any other specific ICD-9-CM codes that identify specific infections as being

due to staphylococcus aureus.

Other types of infections, such as urinary tract infections, would require the

reporting of an additional code, 041.11 (Staphylococcus aureus), to identify the

staphylococcus aureus infection. This additional coding presents administrative issues

because it will not always be clear which condition code 041.11 (Staphylococcus aureus)

is describing. We do not believe it would be appropriate to make code 041.11, in

combination with other codes, subject to the hospital-acquired conditions provision until

we better understand how to address the administrative issues that would be associated

with their selection. Therefore, we would exclude staphylococcus aureus septicemia

cases with code 482.41 reported as being subject to the hospital-acquired conditions

provision. Stated conversely, we would allow staphylococcus aureus septicemia to count

as a CC if the patient was admitted with staphylococcus aureus pneumonia.

We recognize that there may be other conditions which we should consider for

this type of exclusion. We proposed to include staphylococcus aureus bloodstream

infection/septicemia (code 038.11) as one of our initial hospital-acquired conditions. We

also proposed to exclude codes 995.91, 998.59, and 999.3 from counting as an MCC/CC

when they were reported with code 038.11. The condition can be clearly identified

through ICD-9-CM codes that are classified as CC under the CMS DRGs and MCCs

under the MS-DRGs. The condition meets our burden criterion by being both high cost

and high volume. There are prevention guidelines which we acknowledge are subject to

some debate among the medical community. We also acknowledge that we would have

to exclude this condition if a patient were admitted with a staphylococcus aureus

infection of a more limited location, such as pneumonia. In the proposed rule, we

encouraged commenters to make suggestions on this issue and to recommend any other

appropriate exclusion for staphylococcus aureus septicemia. We also encouraged

comments on the appropriateness of selecting staphylococcus aureus septicemia as one of

our proposed initial hospital-acquired conditions.

Comment: Many commenters opposed CMS' proposed selection of this condition

as part of the FY 2008 final rule. There were a minority of commenters who strongly

supported the selection of this condition. These commenters noted the existence of

technologies that allow the physician to determine the presence of Staphylococcus

Aureus upon admission. Many more commenters stated that accurately identifying

staphylococcus aureus septicemia on admission will be difficult, particularly in patients

who may have a staphylococcus aureus infection in a limited location. Several

commenters referenced the FY 2008 IPPS proposed rule, which stated "physicians cannot

always tell whether the condition was hospital acquired." Other commenters also noted

that there is still debate among physicians regarding the prevention guidelines for

staphylococcus aureus septicemia. The proliferation of changes in coding guidelines

presents coding problems for hospitals to accurately identify present-on-admission status

according to some comments. Specifically, the commenters noted that codes to identify

sepsis are very complex and have had recent changes. For instance, there is a code that

currently includes septicemia that develops postoperatively, but does not clearly

distinguish between intravascular and catheter-associated sources of septicemia. The

commenters also suggested that additional coding may be necessary to accurately identify

this condition in the many forms it often presents upon admission. Some commenters

suggested that the addition of codes may create a challenge for coding staff to identify the

correct code.

        A large majority of commenters urged CMS to narrow the category for

staphylococcus aureus septicemia to include only patients for whom it is reasonably clear

that the hospital was the source of the infection and that it could have been reasonably

prevented.

Response: We appreciate the plethora of comments regarding staphylococcus aureus septicemia. The commenters were very insightful and presented the challenges of selecting this condition in the FY 2008 final rule.

We agree that the recent proliferation of ICD-9-CM codes for this condition will make it difficult to code and could present an administrative burden on hospitals. In addition, we are sensitive to the difficulty of identifying when a disease has progressed to sepsis or septicemia. Given the course of progression to septicemia, it can be very difficult for a clinician to appropriately diagnose staphylococcus aureus septicemia as present on admission.

While we acknowledge the many concerns raised by the commenters, we continue to believe that hospital-acquired staphylococcus aureus septicemia remains a significant public health issue. We are aware of the continued need to prevent Staphylococcus Aureus septicemia in the hospital setting. Therefore, we plan to engage in a collaborative discussion with relevant experts to identify the circumstances when staphylococcus aureus septicemia is preventable. If we can identify when staphylococcus aureus septicemia is a reasonably preventable condition and have codes to distinguish those situations, we will consider this condition for future years. We appreciate the many comments and suggestions as we consider staphylococcus aureus septicemia for selection in the future, and look forward to receiving more public input to identify only instances when this condition is preventable.

Therefore, we are not selecting this condition in this final rule with comment period. We plan to collaborate with the public on this important public health issue and

continue to consider the condition for selection in the FY 2009 final rule. We encourage

and welcome public comment to further evaluate this condition.

(g) Ventilator Associated Pneumonia (VAP) and Other Types of Pneumonia

> **Coding** – Pneumonia is identified through the following codes:

- 073.0 (Ornithosis with pneumonia)

- 112.4 (Candidiasis of lung)

- 136.3 (Pneumocystosis)

- 480.0 (Pneumonia due to adenovirus)

- 480.1 (Pneumonia due to respiratory syncytial virus)

- 480.2 (Pneumonia due to parainfluenza virus)

- 480.3 (Pneumonia due to SARS-associated coronavirus)

- 480.8 (Pneumonia due to other virus not elsewhere classified)

- 480.9 (Viral pneumonia, unspecified)

- 481 (Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia])

- 482.0 (Pneumonia due to Klebsiella pneumoniae)

- 482.1 (Pneumonia due to Pseudomonas)

- 482.2 (Pneumonia due to Hemophilus influenzae [H. influenzae])

- 482.30 (Pneumonia due to Streptococcus, unspecified)

- 482.31 (Pneumonia due to Streptococcus, Group A)

- 482.32 (Pneumonia due to Streptococcus, Group B)

- 482.39 (Pneumonia due to other Streptococcus)

- 482.40 (Pneumonia due to Staphylococcus, unspecified)

- 482.41 (Pneumonia due to Staphylococcus aureus)

- 482.49 (Other Staphylococcus pneumonia)

- 482.81 (Pneumonia due to Anaerobes)

- 482.82 (Pneumonia due to Escherichia coli [E. coli])

- 482.83 (Pneumonia due to other gram-negative bacteria)

- 482.84 (Pneumonia due to Legionnaires' disease)

- 482.89 (Pneumonia due to other specified bacteria)

- 482.9 (Bacterial pneumonia unspecified)

- 483.0 (Pneumonia due to Mycoplasma pneumoniae)

There is not a unique code that identifies ventilator associated pneumonia. The

creation of a code for ventilator associated pneumonia was discussed at the

September 29, 2006 meeting of the ICD-9-CM Coordination and Maintenance

Committee meeting. Many issues and concerns were raised at the meeting concerning

the creation of this proposed new code. It has been difficult to define

ventilator-associated pneumonia. We plan to continue working closely with the CDC to

develop a code that can accurately describe this condition for implementation in

FY 2009. CDC will address the creation of a unique code for this condition at the

September 28-29, 2007 ICD-9-CM Coordination and Maintenance Committee meeting.

While we list 27 pneumonia codes above, our clinical advisors do not believe that

all of the codes mentioned could possibly be associated with ventilator-associated

pneumonia. Our clinical advisors specifically question whether the following codes

would ever represent cases of ventilator-associated pneumonia: 073.0, 480.0, 480.1,

480.2, 480.3, 480.8, 480.9, and 483.0. Therefore, we have a range of pneumonia codes,

all of which may not represent cases that could involve ventilator-associated pneumonia.

In addition, we do not have a specific code that uniquely identifies cases of

ventilator-associated pneumonia.

Burden (High Cost/High Volume) – CDC reports that there are 250,205

ventilator-associated pneumonias per year. Because there is not a unique ICD-9-CM

code for ventilator-associated pneumonia, there is not accurate data for FY 2006 on the

number of Medicare patients who had this condition as a secondary diagnosis. However,

we did examine data for FY 2006 on the number of Medicare patients who listed

pneumonia as a secondary diagnosis. There were 92,586 cases with a secondary

diagnosis of pneumonia, with average charges of $88,781. According to the journal

Critical Care Medicine, patients with ventilator-associated pneumonia have statistically

significantly longer intensive care lengths of stay (mean = 6.10 days) than those who do

not (mean = 5.32-6.87 days). In addition, patients who develop ventilator-associated

pneumonia incur, on average, greater than or equal to $10,019 in additional hospital costs

compared to those who do not.[23] Therefore, we believe that this is a high-volume

condition.

Prevention guidelines – Prevention guidelines are located at the following Web

site: http://www.cdc.gov/ncidod/dhqp/gl_hcpneumonia.html. However, it is not clear

how effective these guidelines are in preventing pneumonia. Ventilator-associated

pneumonia may be particularly difficult to prevent.

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[23] Safdar N.: Clinical and Economic Consequences of Ventilator-Associated Pneumonia: A Systematic
Review, Critical Care Medicine, 2005, 33(10), pp. 2184-2193.

CC – All of the pneumonia codes listed above are CCs under the CMS DRGs and under the MS-DRGs, except for the following pneumonia codes which are non-CCs: 073.0, 480.0, 480.1, 480.2, 480.3, 480.8, 480.9, 483.0. However, as mentioned earlier, there is not a unique ICD-9-CM code for ventilator-associated pneumonia. Therefore, this condition does not currently meet the statutory criteria for being selected.

Considerations – Hospital-acquired pneumonias, and specifically ventilator associated pneumonias, are an important problem. However, based on our work with the medical community to develop specific codes for this condition, we have learned that it is difficult to define what constitutes ventilator associated pneumonia. Although prevention guidelines exist, it is not clear how effective these are in preventing pneumonia. Clinicians cannot always tell which pneumonias are acquired in a hospital. In addition, as mentioned above, there is not a unique code that identifies ventilator-associated pneumonia. There are a number of codes that capture a range of pneumonia cases. It is not possible to specifically identify if these pneumonia cases are ventilator-associated or arose from other sources. Because we cannot identify cases with ventilator-associated pneumonia and there are questions about its preventability, we did not propose to select this condition as one of our initial hospital-acquired conditions. However, we welcomed public comments on how to create an ICD-9-CM code that identifies ventilator-associated pneumonia, and we encouraged participation in our September 28-29, 2007 ICD-9-CM Coordination and Maintenance Committee meeting where this issue will be discussed. We indicated that we would reevaluate the selection of this condition in FY 2009.

Comment: Some commenters urged CMS to select ventilator-associated

pneumonia at this time. Most commenters recommended that CMS delay selecting this

condition until a unique code is established.

Some commenters submitted an evidence-based peer-reviewed American

Association for Respiratory Care (AARC) Clinical Practice Guideline (CPG) on

strategies that should be disseminated and available to hospitals for the prevention of

ventilator associated pneumonia. The CPG can be found at

http://www.rcjournal.com/cpgs/09.03.0869.html. Concurrently, the AARC

acknowledges that more research needs to be done in this area.

A majority of commenters believed this condition can be reasonably prevented

through evidence-based medicine guidelines. These commenters noted that current

unique codes for this condition are absent. These commenters urged CMS to consider the

development of an explicit ICD-9-CM code for this ventilator-associated pneumonia and

to select it at a later date.

Response: At the time of publication of this final rule with comment period, there

is not a code associated with ventilator-associated pneumonia. Therefore, this condition

does not currently meet the statutory criteria for being selected. However, the ICD-9-CM

Coordination and Maintenance Committee will meet September 27–28, 2007, to discuss

the creation of a unique ICD-9-CM code for this condition. Further information of the

Committee's activities on diagnosis code issues can be found at the Web site:

http://www.cdc.gov/nchs/icd9.htm. We believe that once this condition has a unique

code, it should be further considered for selection beginning in FY 2009.

We believe that ventilator-associated pneumonia meets some of the criteria for being selected. There are guidelines for prevention of ventilator-associated pneumonia within CDC evidence based guidelines for healthcare associated pneumonia. More information can be found at: http://www.cdc.gov/ncidod/dhqp/gl_hcpneumonia.html. Furthermore, we are aware that the American Thoracic Society and the Infectious Disease Society of America collaborated to produce guidelines on the prevention of ventilator-associated pneumonia. As indicated above, most pneumonias are CCs. Therefore, it is reasonable to believe that ventilator-associated pneumonia will also be classified as a CC once a new code is created to identify it. At that time, we can further consider whether the condition is reasonably preventable and should be subject to this provision.

We appreciate all the public comment on this condition, and considered all of the respondents' point of view. While we acknowledge the clinical challenge of clearly identifying ventilator-associated pneumonia, we believe that once this condition has a unique ICD-9-CM code, coupled with well-known prevention guidelines that are the result of evidence-based medicine, we will give strong consideration for selecting this condition for FY 2009, and including it in the FY 2009 IPPS proposed rule.

(h) Vascular Catheter-Associated Infections

Coding – The proposed rule noted that the code used to identify vascular catheter associated infections is ICD-9-CM code 996.62 (Infection due to other vascular device, implant, and graft). This code includes infections associated with all vascular devices, implants, and grafts. It does not uniquely identify vascular catheter associated infections.

Therefore, there was not a unique ICD-9-CM code for this infection at the time of the

proposed rule. CDC and CMS staff requested that the ICD-9-CM Coordination and

Maintenance Committee discuss the creation of a unique ICD-9-CM code for vascular

catheter associated infections because the issue is important for public health. The

proposal to create a new ICD-9-CM was discussed at the March 22-23, 2007 meeting of

the ICD-9-CM Coordination and Maintenance Committee. A summary of this meeting

can be found at: http://www.cdc.gov/nchs/icd9.htm. In the proposed rule, we indicated

that coders would have to assign code 996.62 plus an additional code for the infection

such as septicemia to identify vascular catheter-associated infections. Therefore, a list of

specific infection codes would have to be developed to go along with code 996.62 if CDC

did not create a code for vascular catheter-associated infections. If the vascular catheter

associated infection was hospital-acquired, the DRG logic would have to be modified so

that neither the code for the vascular catheter associated infection along with the specific

infection code would count as a CC. However, even if these actions were taken, we were

concerned that code 996.62 is not specific to vascular catheter-associated infections.

Burden (High Cost/High Volume) – CDC reports that there are 248,678 central

line associated bloodstream infections per year. It appears to be both high cost and high

volume. However, we were not able to identify Medicare data on these cases because

there is no existing unique ICD-9-CM code.

Prevention guidelines – CDC guidelines are located at the following Web site:

http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html.

CC – Code 996.62 is a CC under the CMS DRGs and the MS-DRGs. However, as stated earlier, this code is broader than vascular catheter-associated infections. Therefore, at the time of the proposed rule, there was not a unique ICD-9-CM code to identify the condition, and it did not meet the statutory criteria to be selected. However, the proposed rule indicated that we will be seeking to create a code(s) to identify this condition and may select it as a condition under the provision beginning in FY 2009.

Considerations - There was not yet a unique ICD-9-CM code to identify this condition at the time of the proposed rule. In the proposed rule, we indicated that if a code were created prior to October 1, 2007, we would be able to specifically identify these cases. Some patients require long-term indwelling catheters, which are more prone to infections. Ideally catheters should be changed at certain time intervals. However, circumstances might prevent such practice (for example, the patient has a bleeding diathesis). In addition, a patient may acquire an infection from another source which can colonize the catheter. As mentioned earlier, coders would also assign an additional code for the infection, such as septicemia. Therefore, a list of specific infection codes would have to be developed to go along with code 996.62. If the vascular catheter-associated infection was hospital-acquired, the DRG logic would have to be modified so that neither the code for the vascular catheter-associated infection along with the specific infection code would count as a CC. Without a specific code for infections due to a catheter, it would be difficult to identify these patients. Given the current lack of an ICD-9-CM code for this condition, we did not propose to include it as one of our initial hospital-acquired conditions. However, we believed it showed merit for inclusion in future lists of

hospital-acquired conditions once we had resolved the coding issues and were able to

better identify the condition in the Medicare data. We indicated that we would reevaluate

the selection of this condition in FY 2009.

We encouraged comments on this condition which was identified as an important

public health issue by several organizations that provided recommendations on

hospital-acquired conditions. We indicated that we were particularly interested in

receiving comments on how we should handle additional associated infections that might

develop along with the vascular catheter-associated infection.

Comment: Some commenters stated there was not a unique ICD-9-CM code for

vascular catheter-associated infection. Therefore, the condition does not meet the criteria

for being selected. These commenters requested that CMS consider creating an explicit

code for catheter-associated infections and selecting the condition at that time. One

commenter recommended that CMS examine selecting vascular-catheter associated

infections and identify the condition using the CPT codes for insertion of a central venous

catheter. Other commenters recommend selecting the condition and rely on the use of

specific codes for the insertion of catheters to supplement the existing code 996.62

(Infection and inflammatory reaction due to other vascular device, implant, and graft).

The commenters believed that this alternative approach may reduce the need to rely on a

unique code for catheter associated blood stream infection (CA-BSI). Some commenters

noted that it is possible to screen for bloodstream infections upon admission. Other

commenters suggested that CMS exempt vascular surgery, implantable device codes, and

other obvious sources of existing conditions that cause blood stream infection prior to

catheter placement. Finally, the commenters suggested that CMS exclude long-term

catheter insertions such as the tunneled central venous catheter using codes 365.57

through 365.66.

Response: Since the publication of the FY 2008 IPPS proposed rule, CDC has

created a new code for vascular catheter-associated infection. The new code 999.31,

(Infection due to central venous catheter) will become effective on October 1, 2007. It is

available for public viewing along with other new codes listed on the CMS Web site at:

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/Downloads/new_diagnosis_cod

es_2007.pdf. This new code will address commenters concerns regarding coding for this

condition.

We appreciate all the public comment on this condition, and have considered all

of these points of view. For the proposed rule, our only barrier to selecting vascular

catheter-associated infections was the absence of a unique code to identify the condition.

As CDC has since created a code to identify vascular catheter-associated infections, we

believe the condition meets the criteria for being selected:

● There are unique codes that identify vascular catheter-associated infections as a

CC under the MS-DRGs;

● Prevention guidelines exist to avoid vascular catheter-associated infections;

and

● As shown above, vascular catheter-associated infections are high-volume

conditions.

At this time, we have not decided whether there are specific clinical situations where a vascular catheter associated infection would not be considered preventable. We will consider exceptions to the policy in the circumstances provided in the public comments. We will consider these suggestions before the provision becomes effective in FY 2009.

(i) Clostridium Difficile-Associated Disease (CDAD)

Coding –This condition is identified by ICD-9-CM code 008.45 (Clostridium difficile).

Burden (High Cost/High Volume) – CDC reports that there are 178,000 cases per year in U.S. hospitals. For FY 2006, there were 110,761 reported cases of Medicare patients with CDAD as a secondary diagnosis, with average charges for the hospital stay of $52,464. Therefore, this is a high-cost and high-volume condition.

Prevention guidelines– Prevention guidelines are not available. Therefore, we do not believe this condition can reasonably be prevented through the application of evidence-based guidelines.

CC – Code 008.45 is a CC under the CMS DRGs and the MS-DRGs.

Considerations – CDAD is an emerging problem with significant public health importance. If found early CDAD cases can easily be treated. However, cases not diagnosed early can be expensive and difficult to treat. CDAD occurs in patients on a variety of antibiotic regiments, many of which are unavoidable, and therefore preventability is an issue. We did not propose to include CDAD as one of our initial hospital-acquired conditions at this time, given the lack of prevention guidelines. We

welcomed public comments on CDAD, specifically on its preventability and whether

there is potential to develop guidelines to identify it early in the disease process and/or

diminish its incidence. We indicated that we would reevaluate the selection of this

condition in FY 2009.

Comment: Commenters noted the current clinical debate surrounding this

condition reveals that it is very difficult to prevent in all cases; it can be prevalent within

the hospital setting. In addition, some commenters noted this condition may be caused by

the treatment protocol prescribed for a principal diagnosis; it can also occur if the patient

is immune-compromised. Finally, some commenters stated that a significant percentage

of CDAD is unavoidable, and it is difficult to distinguish community acquired from

hospital acquired CDAD. Commenters also urged CMS to delay selection of this

condition because there is a lack of unique codes, complication codes, and guidelines for

prevention of this condition.

Response: This condition meets two of the three statutory criteria. There is an

ICD-9-CM code for CDAD. The code is 008.45 (Clostridium difficile). Therefore, the

condition can be clearly identified through the use of ICD-9-CM codes. Code 008.45 is

also a CC under the CMS DRGs and the MS-DRGs. Also, as shown above, CDAD

occurs with significant frequency in the Medicare population and is a high cost condition.

However, prevention guidelines for this condition are currently unavailable. As

suggested by the commenters, leading clinicians believe this condition may not be

reasonably preventable because it can occur as a result of broad spectrum antibiotic

administration, which is often unavoidable. Although we agree with these commenters,

we are also aware of the public interest in this issue and will continue to be interested in selecting this condition if treatment protocols evolve to the point where CDAD is a preventable condition and prevention guidelines are developed.

We are not selecting this condition for implementation in the FY 2008 final rule. It does not currently meet the statutory guidelines for being selected because there are no prevention guidelines. Nevertheless, we will consider adopting this condition in the future if prevention guidelines to avoid CDAD are developed.

(j) Methicillin-Resistant Staphylococcus Aureus (MRSA)

Coding – MRSA is identified by ICD-9-CM code V09.0 (Infection with microorganisms resistant to penicillins). One would also assign a code(s) to describe the exact nature of the infection.

Burden (High Cost/High Volume) – For FY 2006, there were 95,103 reported cases of Medicare patients who had MRSA as a secondary diagnosis. The average charges for these cases were $31,088. This condition is a high-cost and high-volume infection. MRSA has become a very common bacterium occurring both in and outside of the hospital environment.

Prevention guidelines – CDC guidelines are located at the following Web site: http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf.

CC – Code V09.0 is not a CC under the CMS DRGs and the MS-DRGs. The specific infection would be identified in a code describing the exact nature of the infection, which may be a CC.

Considerations – As stated earlier, preventability may be hard to ascertain since the bacteria have become so common both inside and outside the hospital. There are also considerations in identifying MRSA infections because hospitals would report the code for MRSA along with additional codes that would describe the exact nature of the infection. We would have to develop a list of specific infections that could be the result of MRSA. We did not propose to include MRSA as one of our initial hospital-acquired conditions because the condition is not a CC. We recognize that associated conditions may be a CC. In the proposed rule, we welcomed comments on the proposal not to include this condition. Should there be support for including this condition, we requested recommendations on what codes might be selected to identify the specific types of infections associated with MRSA.

Comment: Commenters displayed a high level of interest in this condition, not only as a hospital-acquired condition, but also as a broader public health problem that continues to affect Medicare beneficiaries. Commenters noted that MRSA is both high volume and high cost, referring to the language in the proposed rule. For this reason, many commenters believed this condition should be given a unique ICD-9-CM code to be tracked in FY 2008. Furthermore, the commenters urged CMS to include it on the list of conditions for FY 2009 for which reimbursement may be withheld. Medical device companies that provide products to screen for MRSA commented in support of selecting the condition.

However, a large number of commenters had reservations about selecting this condition because MRSA is not a CC or MCC under the new MS-DRGs. Most

commenters acknowledged the clear prevention guidelines for MRSA. However, they

contend that there remains debate on whether MRSA is reasonably preventable. These

commenters indicated MRSA is ubiquitous and may be colonizing in so many potential

patients that it is difficult to determine if it is acquired in a hospital. The commenters

also noted current literature reveals a strain of community acquired MRSA that may be

difficult to detect upon admission to the hospital.

Response: We acknowledge the strong public health interest in reducing the

number of MRSA related infections. However, MRSA does not currently meet the

statutory criteria to be selected. Although there is an ICD-9-CM code to identify MRSA

and CDC has prevention guidelines to reduce its incidence, we do not believe that there is

a consensus among public health experts that MRSA is preventable. The public

comments and the literature on this condition reveal a vigorous debate over whether

MRSA is really community-acquired rather than hospital-acquired given the significant

potential number of patients that can be colonized with MRSA prior to admission. While

this concern may be possible to address through screening patients for MRSA upon

admission, the condition is not currently identified as a CC or MCC under the MS-DRGs.

If present as a secondary diagnosis, the presence of MRSA alone does not lead to higher

Medicare payment. Our data do not suggest that presence of MRSA alone will lead to

higher hospital costs that would justify classifying it as a CC or MCC. Therefore, as the

condition is not an MCC or CC, it does not meet the statutory criteria for being selected

at this time.

Although we are not selecting MRSA at this time, we believe it is a precursor to several other conditions that we have selected. MRSA may be a precursor to catheter associated urinary tract infections, vascular catheter-associated infections, and mediastinitis after coronary artery bypass graft (CABG) surgery—a surgical site infection that we have selected and is discussed in more detail below.

(k) Surgical Site Infections

Coding – Surgical site infections are identified by ICD-9-CM code 998.59 (Other postoperative infection). The code does not tell the exact location or nature of the postoperative wound infection. The code includes wound infections and additional types of postoperative infections such as septicemia. The coding guidelines instruct the coder to add an additional code to identify the type of infection. To implement this condition we would have to remove both code 998.59 and the specific infection from counting as a CC if they occurred after the admission. We would have to develop an extensive list of possible infections that would be subject to the provision. We may also need to recommend the creation of a series of new ICD-9-CM codes to identify various types of surgical site infections, should this condition merit inclusion among those that are subject to the proposed hospital-acquired conditions provision.

Burden (High Cost/High Volume) – CDC reports that there are 290,485 surgical site infections each year. As stated earlier, there is not a unique code for surgical site infection. Therefore, we examined Medicare data on patients with any type of postoperative infection. For FY 2006, there were 38,763 reported cases of Medicare patients who had a postoperative infection. These patients had average charges for the

hospital stay of $79,504. We are unable to determine how many of these patients had

surgical site infections.

Prevention guidelines – CDC guidelines are available at the following Web site:

http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html

CC – Code 998.59 is a CC under the CMS DRGs and the MS-DRGs.

Considerations – As mentioned earlier, code 998.59 is not exclusive to surgical

site infections. It includes other types of postoperative infections. Therefore, code

998.59 does not currently meet the statutory criteria for being subject to the provision

because it does not uniquely identify surgical site infections. To identify surgical site

infections, we would need new codes that provide more detail about the type of

postoperative infection as well as the site of the infection. In addition, one would report

both code 998.59 as well a more specific code for the specific type of infection, making

implementation difficult. While there are prevention guidelines, it is not always possible

to identify the specific types of surgical infections that are preventable. Therefore, we

did not propose to select surgical site infections as one of our proposed hospital-acquired

conditions at this time. However, we welcomed public comments on whether we can

develop criteria and codes to identify preventable surgical site infections that would assist

us in reducing their incidence. We indicated that we were exploring ways to identify

surgical site infections and would reevaluate this condition in FY 2009.

Comment: A number of commenters specifically requested that CMS consider

selecting mediastinitis after coronary artery bypass graft (CABG) surgery. Commenters

noted that mediastinitis is a postoperative infection that can arise after CABG.

Commenters stated that the condition meets the criteria set forth in the DRA. According

to the comments, mediastinitis is a frequently occurring and costly infection that will develop

after CABG surgery. The commenters noted that there are unique codes to identify mediastinitis

and prevention guidelines that are backed by evidence-based medicine have been developed.

Response: We agree that mediastinitis meets the statutory criteria for being

selected.

Coding—There are unique ICD-9-CM codes to identify the condition. The

ICD-9-CM code for mediastinitis is 519.2.

Burden (High Cost/High Volume)—We examined Medicare data on patients

who received a CABG operation (with codes 36.10 - 36.19) and also had mediastinitis

(ICD-9-CM code 519.2) as a secondary diagnosis. For FY 2006, there were 108 reported

cases of Medicare patients who had this postoperative infection after CABG. These

patients had average charges for the hospital stay of $304,747. Therefore, mediastinitis is

a high-cost condition.

Prevention guidelines— The CDC surgical site infection prevention guidelines

are backed by evidence based medicine. Further information can be found at:

http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html.

We are selecting this condition because it meets the statutory criteria and was

suggested in the public comments. We would identify the coronary artery bypass graft

procedures through procedure codes 36.10 through 36.19. Therefore, when a patient has

a coronary artery bypass graft performed (code 36.10 through 36.19), and a secondary

diagnosis of mediastinitis (code 519.2) is reported that was not present on admission, we

will not count mediastinitis as an MCC beginning October 1, 2009.

"Surgical site infections" is a broad category, and we were looking for assistance

from the public for ways to identify specific surgical site infections. We appreciate the

suggestion to select mediastinitis after CABG surgery when it is a hospital acquired

condition. We are selecting this condition for implementation in this FY 2008 final rule.

We welcome additional recommendations for other types of surgical site infections that

could also be selected and look forward to working with stakeholders and the public as

we consider additional surgical site infections in the future.

(l) Serious Preventable Event – Surgery on Wrong Body Part, Patient, or Wrong Surgery

Coding - Surgery performed on the wrong body part, wrong patient, or the wrong surgery would be identified by ICD-9-CM code E876.5 (Performance of inappropriate operation). This diagnosis code does not specifically identify which of these events has occurred.

Burden (High Cost/High Volume) – As stated earlier, there are not unique ICD-9-CM codes which capture surgery performed on the wrong body part or the wrong patient, or the wrong surgery. Therefore, we examined Medicare data on the code for performance of an inappropriate operation. For FY 2006, there was one Medicare case reported with this code, and the patient had average charges for the hospital stay of $24,962. This event is rare. Therefore, it is not high volume. Individual cases could have high costs. However, we were unable to determine the impact with our limited data.

Prevention guidelines – There are guidelines to ensure that the correct surgery was performed on the correct patient or correct patient's body part. This event should not occur. Further information and prevention guidelines can be found at: http://www.ahrq.gov/clinic/ptsafety/.

CC - This code is not a CC under the CMS DRGs and the MS-DRGs. Therefore, it does not meet the criteria for selection under section 1886(d)(4)(D)(iv) of the Act. However, Medicare does not pay for performing surgery on the wrong body part or patient, or performing the wrong surgery. These services are not considered to be reasonable and necessary and are excluded from Medicare coverage.

Considerations – There are significant considerations for the selection of this condition. There is not a unique ICD-9-CM code that would describe the nature of the inappropriate operation. All types of inappropriate operations are included in code E876.5. Unlike other conditions, performance of an inappropriate operation is not a complication of a prior medical event that was medically necessary. Rather, in this case, there was a needed intervention but it was done to either the wrong body part or the wrong patient, or was not the correct operation. Thus, a service was completed that was not reasonable and necessary and Medicare does not pay for any inpatient service associated with the wrong surgery. It is not necessary for us to select this condition because Medicare does not pay for it under any circumstances.

Comment: A majority of commenters agreed that there are not unique codes to identify wrong surgery. In addition, these commenters pointed out that there are guidelines to ensure that the correct surgery is being performed on the correct patient or correct patient's body part. These commenters stated that wrong surgery is a serious preventable event that should not occur.

One commenter urged CMS to rank the condition - surgery on wrong body part, wrong patient, or wrong surgery (wrong site surgery) - higher in our list of hospital-acquired conditions. This commenter stated that wrong site surgery may not be rare, but rather may be quite prevalent. The commenter disagreed with CMS' belief that wrong site surgery should not be considered as a complication because it is a risk of being in a hospital. The commenter recommended the development of specific codes for wrong site surgery.

Response: With respect to this latter comment, the commenter may have

misunderstood our discussion of this issue in the proposed rule. We never asserted

wrong site surgery is not a complication because it is a risk of being in a hospital. Rather,

we stated the event itself is wrong and should never occur. Unlike CCs and MCCs,

wrong surgery is not a complication of a prior medical event that was medically

necessary. Wrong surgery is not a CC or an MCC because the entire event itself should

never occur, is not reasonable and necessary and should not result in any payment to the

hospital or physician. We are not selecting wrong surgery because it is not an event for

which Medicare should pay less; it is an event for which Medicare should pay nothing at

all.

As stated in the proposed rule, there is not a unique ICD-9-CM code that

identifies surgery performed on the wrong body part or the wrong patient, or the wrong

surgery. Code E876.5 (Performance of inappropriate operation) does not describe what

specifically was wrong with the surgery, such as whether it was performed on the wrong

side, the wrong patient, or if the wrong surgery were performed. In examining Medicare

data on the code for performance of an inappropriate operation, we found only one case

reported in FY 2006. We agree this is a serious issue that requires close examination and

monitoring.

The proposed rule indicated that wrong surgery (right patient, wrong surgery,

right surgery, wrong patient, etc.) is not a reasonable and necessary service. Therefore, it

is not covered by Medicare and should not be paid. Wrong surgery is not a CC and does

not meet the criteria of the statute. As stated above, there are generally recognized

guidelines hospitals and physicians must follow to ensure that the correct surgery was

performed on the correct patient or correct patient's body part. This event should not

occur. If hospitals fail to ensure the correct surgery is performed, there are other

provisions in the regulations to address this alarming event. For instance, a hospital must

meet the CoPs in order to participate in Medicare. If wrong surgery was performed, the

hospital could be out of compliance with the Surgical Services CoP, the Quality

Assessment and Performance Improvement CoP, or potentially others. Performance of

wrong surgery may suggest a systems failure or systems that do not comply with the

CoPs that should be further investigated. We are interested in promoting a culture of

safety and are interested in helping hospitals improve their performance. The hospital

would have an opportunity to develop and present a plan of correction to avoid

termination of its participation in Medicare by addressing the deficiencies that resulted in

an incorrect surgery being performed. The final action that would be taken would depend

on the individual circumstances and whether the hospital has addressed the problem to

reduce the chance of a similar occurrence in the future. In any event, we reiterate that the

way for Medicare to address wrong surgery is not through this provision that does not

pay extra for preventable hospital complications when we should be paying nothing at all,

but instead through Medicare's regulations that ensure that every Medicare provider

meets basic quality of care standards.

(m) Falls and Fractures, Dislocations, Intracranial Injury, Crushing Injury, and

Burns

Coding – There is no single code that shows that a patient has suffered a fall in the hospital. Codes would be assigned to identify the nature of any resulting injury from the fall such as a fracture, contusion, concussion, etc. There is a code to indicate that a patient fell from bed, code E884.4 (Fall from bed). One would then assign a code that identifies the external cause of the injury (the fall from the bed) and an additional code(s) for any resulting injury (a fractured bone).

Burden (High Cost/High Volume) – As stated earlier, there is not a code to identify all types of falls. Therefore, in the FY 2008 IPPS proposed rule, we examined Medicare data on the number of Medicare beneficiaries who fell out of bed. For FY 2006, there were 2,591 cases reported of Medicare patients who fell out of bed. These patients had average charges of the hospital stay of $24,962. However, depending on the nature of the injury, costs may vary in specific cases.

Prevention guidelines – Falls may or may not be preventable. Serious preventable event guidelines can be found at the following Web site:

http://www.qualityindicators.ahrq.gov/psi_download.htm

CC – Code E884.4 is not a CC under the CMS DRGs or the MS-DRGs.

Considerations – There are not clear codes that identify all types of falls. Hospitals would also have to use additional codes for fractures and other injuries that result from the fall. In addition, depending on the circumstances, the falls may or may not be preventable. We did not propose the inclusion of falls as one of our initial hospital-acquired conditions because we could only identify a limited number of these cases, and they were not classified as CCs. However, we welcomed public comments on

how to develop codes or coding logic that would allow us to identify injuries that result

from falls in the hospital so that Medicare would not recognize the higher costs

associated with treating patients who acquire these conditions in the hospital.

Comment: Several commenters stated that the category of falls is not appropriate

for inclusion as one of the hospital-acquired conditions. Specifically, the commenters

noted that it is impossible to prevent all falls, and the definition of what constitutes a

"preventable fall" is not well-defined. Several commenters strongly recommended the

inclusion of falls for the final rule because falls and their resulting injuries are an

important public health safety issue. However, these commenters did not give further

details or recommendations to CMS regarding how to identify falls and related injuries as

a hospital-acquired condition that would be subject to this provision.

Response: With respect to the comment that not all falls are preventable, we

reiterate that the statutory provision authorizes the Secretary to select conditions that

"could reasonably have been prevented through the application of evidence based

guidelines." We believe that injuries that occur in the hospital due to falls are

preventable. As discussed earlier, we received a couple of comments urging us to include

falls as one of our hospital acquired conditions. We recognize that preventable injuries

are an important patient safety issue. Therefore, we considered additional ways to

identify patients who had preventable injuries that occurred in the hospital. We examined

the use of a combination of External cause of injury codes and the specific injury to

identify these cases. We identified five external causes of injury codes that would

identify falls in a hospital. These include:

- E884.2 Fall from chair

- E884.3 Fall from wheelchair

- E884.4 Fall from bed

- E 884.5 Fall from other furniture

- E884.6 Fall from commode

These codes clearly identify certain types of falls. If coded for an inpatient, they could identify that the fall occurred in the hospital. If these codes appeared on a claim along with a fracture or trauma code that did not reflect that the condition was present on admission, we could conclude that the injury was a result of a fall in the hospital that should not be counted as an MCC or CC. However, we identified potential problems in using the external cause of injury codes. There is a separate field on the electronic claim to report one external cause of injury code. However, hospitals do not report the POA indicator with this field. Therefore, we will not be able to tell if the external cause of injury code is identifying an event that occurred before or after admission.

Hospitals can also report external cause of injury codes as a secondary diagnosis. If the hospital lists the external cause of injury code among the secondary diagnoses, the hospital would be assigning a Present on Admission indicator to the external cause of injury code. In these cases, we would be able to identify that one of the five types of falls indicated above occurred after admission. We could use this information along with the ICD-9-CM diagnosis code for the specific type of injury, such as a fracture, to not allow the specific injury to count as a MCC or CC, since it would be the result of a preventable injury. In our analysis of the use of an external cause of injury code, we believe this

approach is too complicated to identify preventable injuries. Therefore, we focused on

simply identifying injuries that should not occur during a hospitalization. If a preventable

injury occurs during a hospitalization, it should be included on our list of hospital

acquired conditions.

We reviewed diagnosis codes contained in the Injury and Poisoning Chapter of

ICD-9-CM and attempted to develop a list of codes that could identify potential adverse

events that may or may not have been the result of a fall occurring in the hospital setting.

After reviewing each category of diagnosis codes, we identified the following injuries

that should not occur during a patient's hospitalization. The generic categories of injuries

are as follows:

- Fractures – ICD-9-CM code range 800 through 829

- Dislocations – ICD-9-CM code range 830 through 839

- Intracranial injury – ICD-9-CM code range 850 through 854

- Crushing injury – ICD-9-CM code range 925 through 929

- Burns – ICD-9-CM code range 940 through 949

- Other and unspecified effects of external causes – ICD-9-CM code range 991

through 994

In our view, the above conditions should not occur after admission to the hospital.

That is, if the patient is admitted to the hospital without a crushing injury, a burn,

fracture, dislocation, among others, we can see no reason why such an event would not be

preventable while the patient is in the hospital. None of these injuries should occur after

admission. We believe this range of conditions offers a relatively uncomplicated method

to determine if an injury or trauma is acquired in the hospital. This range of conditions

meets the statutory criteria for being selected when they are MCCs or CCs. First, they

are identifiable with ICD-9-CM codes. Second, injuries that occur as a result of a fall in

the hospital complicate the care and treatment of the patient. Fractures and dislocations

and other injuries are common in the Medicare population. There were more than

175,000 fractures and other traumatic injuries in the above range of codes for FY 2006.

Third, hospital-acquired injuries included in this range of codes should not occur and are

preventable. Although we have not identified specific prevention guidelines for the

conditions described by the above range of codes, we believe these types of injuries and

trauma should not occur in the hospital, and we look forward to working with CDC and

the public in identifying research that has or will occur that will assist hospitals in

following the appropriate steps to prevent these conditions from occurring after

admission.

       We welcome public comments on additions and deletions to this injury list as well

as our findings on the use of a combination of external cause of injury codes and injury

codes to identify patients that acquired an injury in the hospital due to a fall. We also

welcome any additional suggestions to identify cases where preventable injuries, such as

falls, occur during hospitalization. We will review all recommendations in the FY 2009

IPPS rule in order to further refine our policy to identify preventable injuries and ensure

that Medicare does not pay extra by counting them as MCC or CCs.

**(n) Other Conditions Suggested through Comment: Deep Vein Thrombosis (DVT)/
Pulmonary Embolism (PE)**

Comment: A number of commenters encouraged CMS to select Venous

Thromboembolism (VTE), which includes both Deep Vein Thrombosis (DVT) and

Pulmonary Embolism (PE), as a preventable condition. The commenters noted that

prophylactic measures exist to avoid these conditions and they are preventable if these

steps are followed.

The commenters asserted that this condition meets the DRA criteria requirements

for a condition eligible for a payment adjustment in that it involves high cost and high

volume (according to the 2006 MedPAR data, DVT resulted in more than 180,000

discharges with a mean standardization cost of $17,410 and PE in more than 100,000

discharges with a mean standardization cost of $20,742), and results in assignment to a

higher paying DRG if present as a secondary diagnosis. The commenters also noted that

both DVT and PE have ICD-9-CM codes that are on the MCC and CC lists. In addition,

this condition can be prevented in accordance with evidence-based guidelines. These

commenters cited Geerts, et al., *Prevention of Venous Thromboembolism: The Seventh*

ACCP Conference on Antithrombotic and Thrombolytic Therapy, Chest, 126: 338S-400S

(2004). The commenters acknowledged DVT and PE are identified by multiple codes,

but asserted that administrative issues surrounding the selection of this condition could be

resolved. They requested that CMS consider selecting DVT and PE as preventable

complications for which hospitals will not receive additional payments.

Response: We appreciate these comments suggesting that we add DVT and PE to

our list of conditions that would be subject to the hospital acquired conditions provision.

A DVT is a blood clot that forms in a vein, most commonly in the lower extremity. It

can arise secondary to a number of clinical circumstances, including prolonged inactivity

or bedrest, or from extended periods of time with the lower extremity in a bent position.

It can also arise in the setting of a hypercoagulable state such as that which occurs with a

number of malignancies, where the blood has an increased propensity to form clots, and it

is also more common in patients taking oral contraceptives, particularly in conjunction

with regular tobacco use. A PE is a clot that occurs in one of the pulmonary arteries that

supplies a portion of the lung, most commonly when part or all of a DVT migrates to the

pulmonary vessels from its original location, although it can also occur in the absence of

a DVT, and it is a particularly serious event that is often life threatening. We refer

readers to the current medical literature to further define DVT and PE.

We agree that there are circumstances where these conditions are preventable, and

where the condition meets the statutory criteria to be selected. These conditions can be

identified by unique ICD-9-CM codes. DVT can be identified through codes 453.40

(Venous embolism and thrombosis of unspecified deep vessels of lower extremity),

453.41 (Venous embolism and thrombosis of deep vessels of proximal lower

extremity), and 453.42 (Venous embolism and thrombosis of deep vessels of distal lower

extremity). All three codes are on the CC list. PE is identified through codes 415.10

(Iatrogenic pulmonary embolism and infarction) and 415.19 (Other pulmonary embolism

and infarction). Both of these codes are on the MCC list.   The commenters provided

Medicare data showing that these conditions are both frequent and high cost in the

Medicare population. Finally, the commenters have identified prevention guidelines

backed by evidence-based medicine to avoid DVTs and PEs. Therefore, at least in some

circumstances, these conditions meet the statutory criteria for being selected.

We appreciate the collaborative efforts of other organizations to further define the

prevention guidelines for this condition. We recognize that routine admission physical

examinations should include efforts to detect a DVT. Although we believe DVTs and

PEs may be preventable in certain circumstances (such as when an otherwise healthy

patient is having elective surgery on a lower extremity), it is possible that a patient may

have a DVT upon admission that goes unidentified, and it is also possible that DVT may

occur because of other circumstances, such as an occult malignancy. If a DVT is

clinically suspected upon admission to the hospital, the definitive diagnosis of a DVT can

be made with a Doppler ultrasound examination or intravenous venogram, or both. We

anticipate that it is not feasible to perform these studies on every hospitalized patient. In

the case of a patient who is admitted with a clinically unapparent DVT that is not

detected, the hospital will have followed all typical patient care protocols yet the DVT

went undiagnosed upon admission. It may remain undetected until the patient exhibits

symptoms of either the DVT or a PE that is unrelated to the patient's principal diagnosis.

In these circumstances, we believe the DVT or PE should continue to be counted as an

MCC or CC because, in our view, the condition either was unidentifiable prior to

admission or did not likely occur as a result of poor management of the patient while they

were in the hospital. We believe it is very important to select DVTs and PEs only when

they are preventable through following standard prevention guidelines. We will seek to

identify clearly defined instances of preventable DVT and PE that should not occur in the

hospital setting which will help to further increase hospital quality of care.

We appreciate suggestions on how to identify DVTs and PEs that are preventable

hospital acquired conditions. If we can identify only those circumstances where DVTs

and PEs are preventable and meet the statutory criteria for being selected, we likely

would make them subject to the provision in the FY 2009 IPPS final rule. We welcome

comments on this issue and look forward to working with stakeholders to identify

instances of preventable DVTs and PEs prior to implementation of this provision on

October 1, 2008.

(o) Other Conditions Suggested through Public Comment: Legionnaires' Disease

Comment: One commenter suggested that CMS select Legionnaire's disease.

The commenter asserted that this condition is high cost/high volume: CDC estimates

between 8,000 and 18,000 cases per year. Due to underreporting and underdiagnosis,

only 2 to 10 percent of cases are reported. Death occurs in 10 to 15 percent of cases. In

addition, the commenter cited established prevention guidelines: CDC prevention

guidelines are available and widely distributed. Finally, the commenter stated that

Legionnaires' disease is identified by ICD-9-CM code 482.84.

Response: While there may be a discrete ICD-9-CM code to identify

Legionnaires' disease, it is not typically a hospital-acquired condition. Legionnaires'

disease is usually acquired outside of a hospital from a contaminated water supply that

may or may not have any relation to a particular institution. Any outbreak of

Legionnaires' disease suggests a significant public health emergency that should be

addressed by public health resources rather than by a particular Medicare payment policy.

(p) CMS Response to Additional Comments

We welcomed any comments on the clinical aspects of the conditions and on which conditions should be selected for implementation on October 1, 2008. We also solicited comments on any problematic issues for specific conditions that may support not selecting them as one of the initial conditions. We encouraged comments on how some of the administrative problems can be overcome if there is support for a particular condition.

Commenters did not raise any general administrative concerns. Rather, a number of commenters addressed the potential for an appeals process and POA coding issues. We have included the comment and response for each issue below:

● **Appeals Process:**

Comment: A large number of commenters requested clarification from CMS on how hospitals appeal CMS decisions that a particular patient may fall under the hospital-acquired conditions policy and, therefore, is not eligible for higher payment through assignment to the higher CC/MCC level of the MS-DRG. They asked CMS to provide specific instructions for hospitals to follow for appealing a decision.

Response: We do not believe a separate appeals process is necessary for the payment adjustment for hospital-acquired conditions because existing procedures provide adequate opportunity for review. Under 42 CFR §412.60(d), a hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request. A hospital that believes a discharge was assigned to the incorrect DRG as a

result of the payment adjustment for hospital-acquired conditions may request review of

the DRG assignment by its fiscal intermediary or MAC.

However, we note that section 1886(d)(7)(B) of the Act, as amended by section

5001(c)(2) of the DRA, provides that there shall be no administrative or judicial review

of the establishment of DRGs, including the selection and revision of codes under the

payment adjustment for hospital-acquired conditions. Therefore, although a hospital may

request review of a DRG assignment in a particular case, the statute does not provide for

review of the codes we select to be subject to the payment adjustment for

hospital-acquired conditions.

● **POA Coding**

Comment: Commenters suggested that all secondary diagnoses coded as present

on admission be used to support the development of new complication rate measures and

other quality indicators in the future. They suggested that CMS should develop special

Grouper logic to exclude similar ICD-9-CM codes. The commenters stated that reducing

hospital payments for a condition present upon admission, but not documented, is too

punitive.

Many commenters submitted the experiences of two States that already use

present-on-admission coding. They believed it takes several years and intense

educational efforts to achieve reliable data and therefore there must be a strong clinical

training component.

The commenters recommended that CMS implement the collection of the POA

indicator but delay the implementation of any conditions that are dependent on its use

until physicians and hospitals have an appropriate level of experience.

Response: We refer commenters to the Change Request No. 5499 released on

May 11, 2007, for answers to additional questions regarding present-on-admission

coding. We remind commenters that the DRG payment adjustment based on the POA

indicator is not applicable until October 1, 2008. It is important to note that hospitals will

gain experience in reporting POA information during FY 2008 prior to it having a

payment impact in FY 2009.

● **Prevention Guidelines**

Comment: A small number of commenters questioned the feasibility and

reliability of current prevention guidelines. The commenters supported CMS' goal of

encouraging improvements in health care and reducing the number of preventable

infections, but believed that hospitals must be reimbursed appropriately for providing the

care patients need. The commenters believed that CMS should be sure that hospitals are

not penalized for infections that originated outside the hospital or that are caused by

factors beyond the hospital's control.

The commenters suggested that CMS should recognize that, even with the best

infection control practices, some infections will occur anyway. They added that reducing

payments for all cases in which those infections occur could harm hospitals' ability to

purchase and provide advanced drugs and treatment modalities or invest in other

infection control technologies.

Response: We address each concern regarding prevention guidelines in the respective response for each condition. We are committed to improving quality and decreasing the number of hospital-acquired conditions. In that goal, we have chosen these specific conditions because they fulfill the criteria outlined in the DRA: the conditions have unique codes that are MCCs or CCs; the conditions are high volume, high cost or both; and the conditions can be reasonably prevented through the application of evidence-based guidelines.

● **Academic Centers/Hospitals with high risk patients:**

Comment: Commenters representing academic centers and hospitals with high risk patient populations urged CMS to consider excluding patients considered to be high risk such as those that are more susceptible to infections.

Response: As indicated above, we are selecting conditions that are "reasonably preventable" through application of evidence-based guidelines and meet the other statutory criteria. In response to comments on each of the conditions considered, we indicated that we are researching whether to establish exceptions to the conditions for specific clinical circumstances where the condition may not be preventable. The determination of whether a patient is "high risk" will depend on the specific circumstances of the patient and the condition under consideration. We do not believe it is possible to classify a patient generally as "high risk" in all the circumstances where the provision could potentially apply. As we indicated above, we welcome public comments on clinical scenarios where a specific condition may not be reasonably preventable in the

hospital and how to identify and distinguish those circumstances from other situations where the condition is preventable.

7. Other Issues

Under section 1886(d)(4)(D)(vi) of the Act, "[a]ny change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii)." Subparagraph (C)(i) refers to DRG classifications and relative weights. Therefore, the statute requires the Secretary to continue counting the conditions selected under section 5001(c) of the DRA as MCCs or CCs when updating the relative weights annually. Thus, the higher costs associated with a case with a hospital-acquired MCC or CC will continue to be assigned to the MCC or CC DRG when calculating the relative weight but payment will not be made to the hospital at one of these higher-paying DRGs. Further, subparagraph (C)(iii) refers to the budget neutrality calculations that are done so aggregate payments do not increase as a result of changes to DRG classifications and relative weights. Again, the higher costs associated with the cases that have a hospital-acquired MCC or CC will be included in the budget neutrality calculation but Medicare will make a lower payment to the hospital for the specific cases that includes a hospital-acquired MCC or CC. Thus, to the extent that the provision applies and cases with an MCC or CC are assigned to a lower-paying DRG, section 5001(c) of the DRA will result in cost savings to the Medicare program. We note that the provision will only apply when the selected conditions are the only MCCs and CCs present on the claim. Therefore, if a nonselected MCC or CC is on the claim, the case will continue to be

assigned to the higher paying MCC or CC DRG, and there will be no savings to Medicare from the case. We believe the provision will apply in a small minority of cases because it is rare that one of the selected conditions will be the only MCC or CC present on the claim.

To summarize, we appreciate all of the comments on hospital-acquired conditions and look forward to continued input as we plan to implement these hospital-acquired conditions. Below is the list of conditions that we are selecting in this FY 2008 final rule. These conditions will be made subject to the provision beginning on October 1, 2008 (FY 2009).

- Serious Preventable Event- Object Left in Surgery

- Serious Preventable Event- Air Embolism

- Serious Preventable Event- Blood incompatibility

- Catheter-Associated Urinary Tract Infections

- Pressure Ulcers (Decubitus Ulcers)

- Vascular Catheter-Associated Infection

- Surgical Site Infection - Mediastinitis After Coronary Artery Bypass Graft (CABG) Surgery

- Hospital-Acquired Injuries - Fractures, Dislocations, Intracranial Injury, Crushing Injury, Burn, and Other Unspecified Effects of External Causes

We will also propose the following conditions for consideration in the FY 2009 IPPS proposed rule. We will work diligently to address issues surrounding these conditions and propose to select these conditions in the FY 2009 IPPS final rule.

● Ventilator Associated Pneumonia (VAP)

● Staphylococcus Aureus Septicemia

● Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)

Finally, we list below the set of conditions that signal further analysis for future

implementation.

● Methicillin Resistant Staphylococcus Aureus (MRSA)

● Clostridium Difficile-Associated Disease (CDAD)

● Wrong Surgery - Provision not applicable because Medicare should not pay

less; it should not pay at all.

Table 1: Hospital-Acquired Conditions (in rank order)

Condition	Considered in NPRM	Proposed in NPRM	Selected in FY 2008 Final Rule	May Be Considered in Future Rulemaking
1. Serious Preventable Event- Object left in surgery	Yes	Yes	Yes	N/A
2. Serious Preventable Event- Air embolism	Yes	Yes	Yes	N/A
3. Serious Preventable Event- Blood incompatibility	Yes	Yes	Yes	N/A
4. Catheter Associated Urinary Tract Infections	Yes	Yes	Yes	N/A
5. Pressure Ulcers (Decubitus Ulcers)	Yes	Yes	Yes	N/A
6. Vascular Catheter Associated Infection	Yes	No (No FY 2008 code)	Yes (Code Created for FY 2008)	N/A

Condition	Considered in NPRM	Proposed in NPRM	Selected in FY 2008 Final Rule	May Be Considered in Future Rulemaking
7. Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG) surgery	Yes (All surgical site infections, not just Mediastinitis)	No (No unique codes)	Yes (Comments suggested Mediastinitis which has unique code)	N/A
8. Falls	Yes	No (Coding not unique)	Yes (Operational difficulties will be overcome by FY 2009)	Expand to all hospital acquired injuries, adverse events
9. Ventilator Associated Pneumonia (VAP)	Yes	No (Coding not unique)	No (Coding not unique)	Yes- FY 2009 IPPS final rule (Pursuing code with CDC)
10. Staphylococcus Aureus Septicemia	Yes	Yes	No (Must identify subset where preventable)	Yes- FY 2009 IPPS final rule
11. Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)	No	No	No	Yes- FY 2009 IPPS final rule (Work to identify situations where it should be preventable)
12. Methicillin Resistant Staphylococcus Aureus (MRSA)	Yes	No	No	Yes
13. Clostridium Difficile-Associated Disease (CDAD)	Yes	No	No	Yes
Other: Medicare Does not Pay For:				

Condition	Considered in NPRM	Proposed in NPRM	Selected in FY 2008 Final Rule	May Be Considered in Future Rulemaking
14. Wrong Surgery	Yes	No	No	Provision not Applicable. Medicare should not pay at all.

G. Changes to Specific DRG Classifications

1. Pre-MDCs: Intestinal Transplantation

In the FY 2005 IPPS final rule (69 FR 48976), we reassigned intestinal transplant cases from CMS DRG 148 (Major Small and Large Bowel Procedures with CC) and CMS DRG 149 (Major Small and Large Bowel Procedures without CC) to CMS DRG 480 (Liver Transplant and/or Intestinal Transplantation). In the FY 2006 IPPS final rule (70 FR 47286), we continued to evaluate these cases to see if a further DRG change was warranted. While we found that intestinal only transplants and combination liver-intestine transplants have higher average charges than other cases in CMS DRG 480, these cases are extremely rare (there were only 4 cases in FY 2004) and the insufficient number of cases did not warrant creating a separate DRG.

For FY 2008, we examined the September 2006 update of the FY 2006 MedPAR file and found 1,208 cases assigned to CMS DRG 480. In section II.C. of the preamble of the FY 2008 IPPS proposed rule, we proposed to split CMS DRG 480 into two severity levels: MS-DRG 005 (Liver Transplant and/or Intestinal Transplant with MCC) and MS-DRG 006 (Liver Transplant and/or Intestinal Transplant without MCC). The following table displays our results:

MS-DRG	Number of Cases	Average Length	Average Charges

		of Stay	
MS-DRG 006 – All cases	446	10.05	$129,519
MS-DRG 006 – Intestinal transplant cases only	3	34	$354,793
MS-DRG 005 – All cases	762	22.25	$243,271
MS-DRG 005 – Intestinal transplant cases only	9	40.22	$460,089
MS-DRG 005 – Intestinal and liver transplant	1	56	$1,179,425

Under the MS-DRGs, 10 of 13 intestinal transplant cases are assigned to proposed

MS-DRG 005 based on the secondary diagnosis of the patient. The three remaining

intestinal transplant cases do not have an MCC and would be assigned to MS-DRG 006,

absent further changes to the DRG logic. These three intestinal transplants have average

charges of approximately $354,793 and an average length of stay of 34 days. Average

charges and length of stay for these three cases are more comparable to the average

charges of approximately $243,271 and average length of stay of 22.25 days for all cases

assigned to proposed MS-DRG 005. For this reason, we proposed to move all intestinal

transplant cases to MS-DRG 005. As part of the proposal, we proposed to redefine

proposed MS-DRG 005 as "Liver Transplant with MCC or Intestinal Transplant." The

presence of a liver transplant with MCC or an intestinal transplant would assign a case to

the higher severity level. We also proposed to redefine proposed MS-DRG 006 as "Liver

Transplant without MCC".

Comment: Two commenters supported the proposed reassignment of intestinal

transplants to MS-DRG 005. One commenter stated that CMS should continue to

evaluate the frequency of this procedure and reassign it to an appropriate DRG reflective

of its high resource utilization.

Response: We appreciate the support of the commenters and agree that when we

receive sufficient data, we will again consider a separate intestinal transplant DRG.

Comment: One commenter supported separate MS-DRGs for intestinal

transplants and combination liver-intestine transplants. The commenter cited that the data

from the Milliman 2005 US Organ and Tissue Transplant Cost Estimates and Discussion

Research Report supports separate MS-DRGs. This report provided data for 58 intestine

only transplants with estimated first year billed charges of $813, 600 and 47 liver-

intestine transplants with estimated first year billed charges of $830,200.

Response: The report submitted by the commenter does not indicate whether the

patients cited in the study were Medicare. Further, it is not clear whether the identified

costs were hospital inpatient only or total. For these reasons, we are not using these data

to make an MS-DRG assignment. However, we are open to considering, to the extent

feasible, reliable, validated data other than MedPAR data in annually recalibrating and

reclassifying the DRGs.

In this final rule with comment period, we are adopting as final our proposal to

reassign intestinal transplantation cases to MS-DRG 005. We are also redefining MS-

DRG 005 as "Liver Transplant with MCC or Intestinal Transplant" and MS-DRG 006 as

"Liver Transplant without CC".

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

a. Implantable Neurostimulators

We received a joint request from three manufacturers to review the DRG

assignment for cases involving neurostimulators. The commenters are concerned that:

● Neurostimulator cases may be assigned to 30 different DRGs in 12 different MDCs depending upon the patient's principal diagnosis.

● Neurostimulator cases represent a small proportion of the total cases in their assigned DRG and have higher costs.

● The 11 new ICD-9-CM codes created beginning in FY 2007 that identify pain are assigned to MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services) rather than MDC 1 (Diseases and Disorders of the Nervous System). The manufacturers were concerned that these pain codes will be a common principal diagnosis for patients who receive a neurostimulator and will be assigned to MDC 23, which contains a wide variety of dissimilar diagnoses. The new ICD-9-CM codes are: 338.0 (Central pain syndrome), 338.11 (Acute pain due to trauma), 338.12 (Acute post-thoracotomy pain), 338.18 (Other acute postoperative pain), 338.19 (Other acute pain), 338.21 (Chronic pain due to trauma), 338.22 (Chronic post-thoracotomy pain), 338.28 (Other chronic postoperative pain), 338.29 (Other chronic pain), 338.3 (Neoplasm related pain (acute)(chronic)), and 338.4 (Chronic pain syndrome).

The manufacturers recommended that we:

● Reroute all spinal and peripheral neurostimulator cases into a common set of base DRGs.

● Reclassify ICD-9-CM pain codes 338.0 through 338.4 currently assigned to MDC 23 into MDC 1 when reported as the principal diagnosis.

● Revise surgical CMS DRGs in MDC 1 based on whether the patient received a major device.

● Split the single surgical CMS DRG in MDC 19 (Mental Diseases and

Disorders) and MDC 23 into two CMS DRGs: one CMS DRG for minor procedures as

defined by CMS DRGs 477 (Non-Extensive O.R. Procedure Unrelated to Principal

Diagnosis) and CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal

Diagnosis) and one CMS DRG for major procedures.

● Create a new CMS DRG in MDC 1 for major devices.

The manufacturers recognized that implementing a re-routing feature in the

CMS DRG system would be a major undertaking and, alternatively, suggested

reassigning the pain codes to MDC 1 as an interim step. In the FY 2008 IPPS proposed

rule, we noted that we agreed with this suggestion. With respect to the suggestion to split

the single surgical CMS DRG in MDCs 19 and 23 into two CMS DRGs and create a

major device CMS DRG within MDC 1, in the FY 2008 IPPS proposed rule, we

encouraged commenters to examine the assignment of neurostimulator cases under the

MS-DRGs to determine whether the changes we proposed to adopt to better recognize

severity in the CMS DRG system would address these concerns.

The implantation of a neurostimulator requires two types of procedures. First, the

surgeons implant leads containing electrodes into the targeted section of the brain, spine,

or peripheral nervous system. Second, a neurostimulator pulse generator is implanted

into the pectoral region and extensions from the neurostimulator pulse generator are

tunneled under the skin and connected with the proximal ends of the leads. Hospitals

stage the two procedures required for a full system neurostimulator implant.

There are separate ICD-9-CM procedure codes that identify the implant of the leads and the insertion of the pulse generator. The three codes for the leads insertion are: 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)); 03.93(Implantation or replacement of spinal neurostimulator lead(s)); and code 04.92 (Implantation or replacement of peripheral neurostimulator lead(s). The five codes for the insertion of the pulse generator 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 rechargeable neurostimulator pulse generator); and 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

The patient's principal diagnosis determines the MDC assignment. Implant of a cranial, spinal or peripheral neurostimulator will result in assignment of the case to a surgical DRG within that MDC. Although the manufacturers are correct that neurostimulator cases can potentially be assigned to many different CMS DRGs based on the patient's principal diagnosis, they also provided data that showed that nearly 90 percent are assigned to 6 different CMS DRGs that cross two MDCs. In MDC 1, neurostimulator cases are assigned to four CMS DRGs: CMS DRG 7 (Peripheral and Cranial Nerve and Other Nervous System Procedures with CC); CMS DRG 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures without CC); CMS DRG 531 (Spinal Procedures with CC); and CMS DRG 532 (Spinal Procedures without CC). In

MDC 8 (Disease and Disorders of the Musculoskeletal System and Connective Tissue),

neurostimulator cases are assigned to two CMS DRGs: CMS DRG 499 (Back and Neck

Procedures Except Spinal Fusion with CC); and CMS DRG 500 (Back and Neck

Procedures Except Spinal Fusion without CC).

        With very limited exceptions, such as tracheostomies and certain types of

transplants, the principal diagnosis is fundamental to the assignment of a case to an MDC

within the DRG system. By relying on the patient's principal diagnosis, the DRG system

will group together patients who are clinically similar. As indicated in the proposed rule,

for this reason, we were concerned about adopting the suggestion that all neurostimulator

cases be rerouted to a common DRG irrespective of the patient's principal diagnosis. We

believe such a step would be fundamentally inconsistent with the idea of creating

common groups of patients who are clinically similar based on diagnosis and procedures.

For this reason, we do not believe that a rerouting step should be adopted that would

group together all neurostimulator cases.

        However, in the FY 2008 IPPS proposed rule, we agreed with the manufacturers'

suggestion that the new ICD-9-CM codes created in FY 2007 for central and chronic pain

syndrome and chronic pain (codes 338.0, 338.21 through 338.29, and 338.4) should be

assigned to MDC 1 when present as the principal diagnosis. The manufacturers

requested that we reclassify the pain codes (338.0 through 338.4) from MDC 23 to MDC

1. Our medical consultants advised that the acute pain codes (codes 338.11 through

338.19) should remain in MDC 23 because the acute pain is not a neurological condition.

According to the manufacturers, the National Center for Health Statistics' (NCHS) choice

in locating the pain codes within ICD-9-CM's Nervous System chapter has much clinical

validity, particularly for chronic pain. The manufacturers further noted that acute pain is

typically self-limited, a symptomatic response to an immediate insult that serves the body

as a warning sign. However, chronic pain is unrelenting and serves no warning or

protective function. It is a disease process of its own accord, according to the

commenters.

The manufacturers described pain as follows. Broadly, there are two main

categories of pain: nociceptive and neuropathic. Nociceptive pain is caused by sensory

neurons, called nociceptors, responding to tissue damage. This type of pain is the body's

normal response to injury. The pain is usually localized and time-limited. That is, when

the tissue damage heals, the pain typically resolves. Acute pain is typically nociceptive.

In general, nociceptive pain is typically treated with anti-inflammatories and, in more

severe cases, with opioids via a morphine pump for example.

In contrast, neuropathic pain is caused by malfunctioning or pathologically altered

nervous pathways stemming from injury to the nervous system, either as a direct result of

trauma to a nerve (phantom limb syndrome, reflex sympathetic dystrophy/complex

regional pain syndrome after injury) or due to other medical conditions that cause

damage to the nerve such as herpes (postherpetic neuralgia), diabetes (diabetic

neuropathy), and peripheral vascular disease (critical limb ischemia). Failed back

surgery syndrome (FBSS) is another common source of neuropathic pain. Typically,

neuropathic pain is chronic and may persist for months or years beyond the healing of

damaged tissue. Because the nerves themselves have been damaged, neuropathic pain

can be considered its own disease process. Neuropathic pain may be more difficult to

treat than nociceptive pain and has been shown to be more responsive to

neurostimulation.

The pain codes, created effective October 1, 2006, are currently assigned to

MDC 23. The neurostimulator cases with a principal diagnosis using the pain codes were

assigned to CMS DRG 461 (O.R. Procedure with Diagnoses of Other Contact with

Health Services) for the first time in FY 2007. As explained above, prior to our adoption

of the new pain codes in FY 2007, these cases had historically been assigned to

CMS DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure

with and without CC, respectively) in MDC 1. Adopting the commenters'

recommendation would result in the neurostimulator cases being assigned to their historic

CMS DRGs.

Our medical officers agreed that cases that use the new pain diagnosis codes for

central and chronic pain syndrome and chronic pain (codes 338.0, 338.21 through 338.29,

and 338.4) as a principal diagnosis should be assigned to MDC 1. For this reason, in the

FY 2008 IPPS proposed rule, we proposed to assign cases with a principal diagnosis of

central pain syndrome (code 338.0), chronic pain due to trauma (code 338.21), chronic

post-thoracotomy pain (code 338.22), other chronic postoperative pain (code 338.28),

other chronic pain (code 338.29), or chronic pain syndrome (code 338.4) to MDC 1,

although we explained that we planned to monitor their use and may reassign them if

needed.

Comment: Several commenters supported our proposal to assign diagnosis codes for central and chronic pain syndrome and chronic pain as a principal diagnosis to MDC 1. One commenter stated that this proposal recognizes the fundamentally neurologic nature of these cases.

Response: We appreciate the support of the commenters. Accordingly, in this final rule with comment period, we are adding diagnosis codes 338.0, 338.21, 338.22, 338.28, 338.29, and 338.4 when assigned as a principal diagnosis to MDC 1.

b. Intracranial Stents

Effective October 1, 2004, the ICD-9-CM Coordination and Maintenance Committee created procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)). At the same time, we created code 00.65 (Percutaneous insertion of intracranial vascular stent(s)). It is our customary practice to assign new codes to the same DRG as their predecessor codes. The service described by code 00.62 was removed from code 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)), which is assigned to CMS DRG 533 (Extracranial Procedures with CC) and CMS DRG 534 (Extracranial Procedures without CC) (MS-DRGs 37, 38, and 39 (Extracranial Procedures with MCC, with CC, and without CC/MCC, respectively, in this final rule with comment period) when the patient has a principal diagnosis in MDC 1. Therefore, we assigned code 00.62 to CMS DRGs 533 and 534 in MDC 1 beginning in FY 2005. In addition, we made code 00.65 a non-O.R. procedure for DRG assignment. We also assigned code 00.62 to the Non-Covered Procedure edit of the MCE, as Medicare had a

national non-coverage determination for intracranial angioplasty and atherectomy with

stenting.

Effective November 6, 2006, Medicare covers percutaneous transluminal

angioplasty (PTA) and stenting of intracranial arteries for the treatment of cerebral artery

stenosis in cases in which stenosis is 50 percent or greater in patients with intracranial

atherosclerotic disease when furnished in accordance with FDA-approved protocols

governing Category B Investigational Device Exemption (IDE) clinical trials. CMS

determined that coverage of intracranial PTA and stenting is reasonable and necessary

under these circumstances. All other indications for PTA without stenting to treat

obstructive lesions of the vertebral and cerebral arteries remain noncovered. This

decision can be found online in the CMS Coverage Manual (Publication 100.3):

http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp at section 20.7.B.5.

A manufacturer recently met with CMS to request that code 00.62 be reassigned

to CMS DRGs 1 and 2 (Craniotomy Age > 17 with and without CC, respectively)

(MS-DRGs 025 (Craniotomy and Endovascular Intracranial Procedures with MCC), 026

(Craniotomy and Endovascular Intracranial Procedures with CC), and 027 (Craniotomy

and Endovascular Intracranial Procedures without CC/MCC) in this final rule with

comment period) and CMS DRG 543 (Craniotomy with Major Device Implant or Acute

Complex Central Nervous System Principal Diagnosis) (MS-DRGs 023 and 024

(Craniotomy with Major Device Implant or Acute Complex Central Nervous System

Principal Diagnosis with MCC and without MCC, respectively, in this final rule with

comment period). The manufacturer noted that other similar endovascular intracranial

procedures that treat a cerebrovascular blockage are currently assigned to the craniotomy

CMS DRGs. These endovascular-approach cases already assigned to the craniotomy

CMS DRGs are identified by procedure codes 39.72 (Endovascular repair or occlusion of

head and neck vessels), 39.74 (Endovascular removal of obstruction from head and neck

vessel(s)), and 39.79 (Other endovascular repair (of aneurysm) of other vessels). Under

the MS-DRGs in the FY 2008 IPPS proposed rule, we proposed the assignment of

procedure codes 39.72, 39.74, and 39.79 to MS-DRGs 025, 026, and 027 and MS-DRGs

023 and 024. Although we have concerns about the assignment of additional

endovascular procedures to an open surgical DRG, we agreed that there is clinical

consistency between procedure codes 39.72, 39.74, and 39.79 and procedure code 00.62.

For this reason, we agreed that procedure code 00.62 should be assigned to MS-DRGs

025, 026, and 027, and MS-DRGs 023 and 024, which are divided by the presence or

absence of specific CCs.

    In order to assure appropriate DRG assignment as described above, we proposed

to make conforming changes to the MCE by removing code 00.62 from the Non-Covered

Procedure edit. However, as intracranial PTA is only covered when performed in

conjunction with insertion of a stent, we proposed to redefine the edit by specifying that

code 00.62 must be accompanied by code 00.65 (Percutaneous insertion of intracranial

vascular stent(s)). Should code 00.65 not be reported on the claim, the case would fail

the MCE edit. For a full discussion of this change, we refer readers to the MCE

discussion in section II.F.6. of the preamble of this final rule with comment period.

Although we proposed to assign endovascular intracranial procedures to the same MS-DRGs as craniotomy, we remained concerned that endovascular intracranial procedures are clinically different than open craniotomy surgical procedures and may have very different resource requirements. At the current time, there are an insufficient number of cases to warrant creation of a separate base DRG for endovascular intracranial procedures. However, as we indicated in the proposed rule, we intend to revisit the assignment of intracranial endovascular procedures at a later date when more data are available to analyze these cases.

Comment: Several commenters supported the proposal to assign endovascular procedure codes to open surgical DRGs. One commenter commended CMS for the proposal and stated that the reassignment places these cases in DRGs of more appropriate clinical and resource homogeneity (than their previous assignments to the extracranial procedure DRGs).

Response: We continue to have reservations about the classification of open craniotomy surgeries and endovascular cranial procedures within the same DRGs. However, we note that there is clinical consistency between procedure codes 39.72, 39.74, 39.79 (endovascular procedures on the head and neck), which are assigned to open surgical DRGs, and code 00.62 (an intracranial endovascular procedure). We will continue to monitor these DRGs for uniformity both from a clinical as well as a resource-consumption standpoint as more data become available.

In this final rule with comment period, for FY 2008, we are assigning code 00.62 to MS-DRGs 25, 26, and 27 as well as MS-DRGs 23 and 24, as we proposed and

describe above. We note that the claims containing code 00.62 must be accompanied by

code 00.65 in order to qualify as a covered procedure. As previously stated, the lack of

code 00.65 on the claim will cause the claim to fail the MCE edit, and the claim will be

denied.

3. MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat) - Cochlear
Implants

Cochlear implants were first covered by Medicare in 1986 and were assigned to

CMS DRG 49 (Major Head and Neck Procedures) in MDC 3 (Diseases and Disorders of

the Ear, Nose, Mouth, and Throat). CMS DRG 49 is the highest weighted DRG in that

MDC. However, two manufacturers of cochlear implants contend that this DRG

assignment is clinically and economically inappropriate and have requested that cochlear

implant cases be reassigned from CMS DRG 49 to CMS DRG 543 (Craniotomy with

Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis).

The manufacturers stated that procedures assigned to CMS DRG 49 are

performed mostly for diseases such as head and neck cancers, while procedures in

CMS DRG 543 include operations on and inside the skull and implantation of complex

devices, including intracranial neurostimulators. The manufacturers described the

cochlear implant procedure as requiring incisions behind the ear to remove a section of

the temporal bone, followed by microscopic neurotologic surgery under general

anesthesia, and is typically completed in 2 to 4 hours to restore hearing to the profoundly

deaf. For these reasons, these manufacturers believe cochlear implant procedures are

similar to open craniotomies.

Based on their analysis of the FY 2005 MedPAR data, the manufacturers identified a total of 139 cochlear implant cases using ICD-9-CM procedure codes 20.96 (Implantation or replacement of cochlear prosthetic device NOS), 20.97 (Implantation or replacement of cochlear prosthetic device, single channel), and 20.98 (Implantation or replacement of cochlear prosthetic device, multiple channel). The manufacturers reported 121 out of 139 cochlear implant cases were assigned to CMS DRG 49 with average standardized charges of approximately $58,078.

When we reviewed the FY 2006 MedPAR data, we identified 104 cochlear implant cases assigned to CMS DRG 49. In the MS-DRGs in the FY 2008 IPPS proposed rule, CMS DRG 49 is subdivided into two severity levels: MS-DRG 129 (Major Head and Neck Procedures with CC or MCC) and MS-DRG 130 (Major Head and Neck Procedures without CC). The following table displays our results:

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 130 - All cases	1,095	3.04	$23,928
MS-DRG 130 - Code 20.96 cases only	38	1.63	$51,740
MS-DRG 130 - Code 20.97 cases only	2	1.50	$38,855
MS-DRG 130 - Code 20.98 cases only	45	1.24	$50,219
MS-DRG 129 – All cases	1,244	5.35	$34,169
MS-DRG 129 – Code 20.96 cases only	10	2.70	$81,351
MS-DRG 129 – Code 20.97 cases only	1	5.00	$95,441
MS-DRG 129 – Code 20.98 cases only	8	3.13	$53.510

Under the proposed MS-DRGs, 19 out of 104 cochlear implant cases are assigned to MS-DRG 129 based on the secondary diagnosis of the patient. The 85 remaining cochlear implant cases do not have a CC or MCC and were proposed to be assigned to MS-DRG 130, absent further changes to the DRG logic.

The average charges of approximately $54,238 for cochlear implant cases are

higher than the average charges of approximately $29,375 for the other cases in

CMS DRG 49. However, the average charges are not as high as the average charges of

approximately $78,118 for cases assigned to CMS DRG 543. Further, our medical

advisors do not believe that surgery to implant a cochlear implant is clinically similar to

an open craniotomy in MDC 1 because typically a craniotomy involves removing and

then replacing a section of the skull in order to perform a procedure on or within the

brain, whereas a cochlear implant involves drilling a hole in the mastoid bone in order to

insert the implant into the inner ear.

We have been unable to address this issue under the current DRGs because there

are not enough inpatient cochlear implant cases to warrant creation of a separate DRG.

Although these cases will continue to have higher charges than other cases in their

assigned DRG, in the FY 2008 proposed rule, we proposed to move the cochlear implant

cases to the higher DRG severity level within CMS DRG 49. As part of this proposal, we

indicated that we would redefine MS-DRG 129 as "Major Head and Neck Procedures

with CC or MCC or Major Device." The presence of a major head and neck procedure

with a CC or MCC or major device would assign the case to the higher severity level

within CMS DRG 49.

Comment: Some commenters supported the proposed reassignment of cochlear

implant cases to MS-DRG 129.

Response: We appreciate the commenters' support for the proposed MS-DRG

assignment for these cases.

Comment: Two commenters expressed appreciation for CMS's recognition of the

payment issues facing cochlear implants by proposing to classify these cases to

MS-DRG 129. However, one of the commenters stated that, even with the proposed

reassignment, the costs of these cases are nearly 60 percent higher than all cases within

MS-DRG 129.

The commenters contended that these procedures should be assigned to MS-DRG

24 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System

Principal Diagnosis with MCC). They pointed out that cases that have been assigned to

DRG 543 in the CMS DRGs are assigned to MS-DRGs 23 and 24 (Craniotomy with

Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis

with and without MCC) in the MS-DRGs. The commenters stated that cochlear implant

procedures are clinically and resource coherent with other craniotomy procedures such as

Kinetra® dual array deep brain stimulator and should be assigned to MS-DRG 024. One

of the commenters indicated that the principal diagnosis codes for hearing loss are

currently assigned to MDC 3, not MDC 1. They believed that this MDC assignment

prevents cochlear implants from being assigned to MS-DRG 024. The commenters

suggested that sensorineural hearing loss (codes 389.10-389.18) is a nervous system

disorder that should be assigned to MDC 1. One commenter stated that cochlear

implantation cases should be assigned as a pre-MDC based on complexity and should be

assigned to a separate or different DRG that involves implantation of a complex neural

stimulation device. Another commenter recommended that CMS develop a third level of

complexity for major head and neck procedures and assign cochlear implants to the

highest severity level.

Response: Our medical advisors do not believe that surgery to implant a cochlear

implant is clinically similar to an open craniotomy in MDC 1. Typically, a craniotomy

involves removing and then replacing a section of the skull in order to perform a

procedure on or within the brain, whereas a cochlear implant involves entering the

mastoid bone, not the intracranial space.

With regard to the MDC assignment, we believe that sensorineural hearing loss is

due to a defect in the inner ear or the acoustic nerve and is a disorder of the ear that is

appropriately assigned to MDC 3.

As the low volume of cochlear implant cases does not justify a new MS-DRG, the

current base DRG assignment for cochlear implants is appropriate. In addition, MS-DRG

129 does not meet the criteria for a three-level split. Therefore, we do not believe there is

a better alternative to the policy we proposed. Accordingly, in this final rule with

comment period, we are assigning all cochlear implant cases to MS-DRG 129.

MS-DRG 129 is redefined as "Major Head and Neck Procedures with CC or MCC or

Major Device."

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

Tissue)

a. Hip and Knee Replacements

In the FY 2006 IPPS final rule (70 FR 47303), we deleted DRG 209 (Major Joint

and Limb Reattachment Procedures of Lower Extremity) and created two new

DRGs: 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545

(Revision of Hip or Knee Replacement). The two new DRGs were created because

revisions of joint replacement procedures are significantly more resource intensive than

original hip and knee replacements procedures. DRG 544 includes the following

procedure code assignments:

- 81.51, Total hip replacement

- 81.52, Partial hip replacement

- 81.54, Total knee replacement

- 81.56, Total ankle replacement

- 84.26, Foot reattachment

- 84.27, Lower leg or ankle reattachment

- 84.28, Thigh reattachment

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

Further, we created a number of new ICD-9-CM procedure codes effective

October 1, 2005, that better distinguish the many different types of joint replacement

procedures that are currently being performed. In the FY 2006 IPPS final rule

(70 FR 47305), we indicated a commenter had requested that, once we receive claims

data using the new procedure codes, we closely examine data from the use of the codes

under the two new DRGs to determine if future additional DRG modifications are

needed.

Further, the American Association of Hip & Knee Surgeons (AAHKS)

recommended that we make further refinements to the DRGs for knee and hip

arthroplasty procedures. AAHKS previously presented data to CMS on the important

differences in clinical characteristics and resource utilization between primary and

revision total joint arthroplasty procedures. AAHKS stated that CMS' decision to create

a separate DRG for revision of total joint arthroplasty (TJA) in October 2005 resulted in

more equitable reimbursement for hospitals that perform a disproportionate share of

complex revision of TJA procedures, recognizing the higher resource utilization

associated with these cases. AAHKS stated that this important payment policy change

led to increased access to care for patients with failed total joint arthroplasties, and

ensured that high volume TJA centers could continue to provide a high standard of care

for these challenging patients.

AAHKS further stated that the addition of new, more descriptive ICD-9-CM

diagnosis and procedure codes for TJA in October 2005 gave it the opportunity to further

analyze differences in clinical characteristics and resource intensity among TJA patients

and procedures. Inclusive of the preparatory work to submit its recommendations, the

AAHKS compiled, analyzed, and reviewed detailed clinical and resource utilization data

from over 6,000 primary and revision TJA procedure codes from 4 high volume joint

arthroplasty centers located within different geographic regions of the United States:

University of California, San Francisco, CA; Mayo Clinic, Rochester, MN;

Massachusetts General Hospital, Boston, MA; and the Hospital for Special Surgery, New

York, NY. Based on its analysis, AAHKS recommended that CMS examine Medicare

claims data and consider the creation of separate DRGs for total hip and total knee

arthroplasty procedures. CMS DRG 545 currently contains revisions of both hip and

knee replacement procedures. AAHKS stated that based on the differences between

patient characteristics, procedure characteristics, resource utilization, and procedure code

payment rates between total hip and total knee replacements, separate DRGs were

warranted. Furthermore, AAHKS recommended that CMS create separate base DRGs

for routine versus complex joint revision or replacement procedures as shown below.

Routine Hip Replacements

- 00.73, Revision of hip replacement, acetabular liner and/or femoral heal only

- 00.85, Resurfacing hip, total, acetabulum and femoral head

- 00.86, Resurfacing hip, partial, femoral head

- 00.87, Resurfacing hip, partial, acetabulum

- 81.51, Total hip replacement

- 81.52, Partial hip replacement

- 81.53, Revision of hip replacement, not otherwise specified

Complex Hip Replacements

- 00.70, Revision of hip replacement, both acetabular and femoral components

- 00.71, Revision of hip replacement, acetabular component

- 00.72, Revision of hip replacement, femoral component

Routine Knee Replacements and Ankle Procedures

- 00.83, Revision of knee replacement, patellar component

- 00.84, Revision of knee replacement, tibial insert (liner)

- 81.54, Revision of knee replacement, not otherwise specified

- 81.55, Revision of knee replacement, not otherwise specified

- 81.56, Total ankle replacement

Complex Knee Replacements and other reattachments

- 00.80, Revision of knee replacement, total (all components)

- 00.81, Revision of knee replacement, tibial component

- 00.82, Revision of knee replacement, femoral component

- 84.26, Foot reattachment

- 84.27, Lower leg or ankle reattachment

- 84.28, Thigh reattachment

AAHKS also recommended the continuation of CMS DRG 471 (Bilateral or

Multiple Major Joint Procedures of Lower Extremity) without modifications. CMS DRG

471 includes any combination of two or more of the following procedure codes:

- 00.70, Revision of hip replacement, both acetabular and femoral components

- 00.80, Revision of knee replacement, total (all components)

- 00.85, Resurfacing hip, total, acetabulum and femoral head

- 00.86, Resurfacing hip, partial, femoral head

- 00.87, Resurfacing hip, partial, acetabulum

- 81.51, Total hip replacement

● 81.52, Partial hip replacement

● 81.54, Total knee replacement

● 81.56, Total ankle replacement

As discussed in section II.C. of the preamble of this final rule with comment

period, we proposed, and are adopting in this final rule with comment period, MS-DRGs

to better recognize severity of illness for FY 2008. The MS-DRGs include two new

severity of illness levels under the current base DRG 544. We also proposed to add three

new severity of illness levels to the base DRG for Revision of Hip or Knee Replacement

(currently DRG 545). The new MS-DRGs are as follows:

● MS-DRG 466 (Revision of Hip or Knee Replacement with MCC)

● MS-DRG 467 (Revision of Hip or Knee Replacement with CC)

● MS-DRG 468 (Revision of Hip or Knee Replacement without CC/MCC)

● MS-DRG 469 (Major Joint Replacement or Reattachment of Lower Extremity

with MCC)

● MS-DRG 470 (Major Joint Replacement or Reattachment of Lower Extremity

without MCC)

We found that the MS-DRGs greatly improved our ability to identify joint

procedures with higher resource costs. The following table indicates the average charges

for each new MS-DRG for the joint procedures.

MS-DRGs That Replace DRGs 544 and 535 with New Severity Levels			
MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 466	3,886	9.55	$69,649.08
MS-DRG 467	10,078	6.06	$48,575.01

MS-DRGs That Replace DRGs 544 and 535 with New Severity Levels			
MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 468	26,718	4.06	$38,720.28
MS-DRG 483	28,211	8.46	$53,676.09
MS-DRG 484	390,344	4.03	$33,465.85

AAHKS analyzed Medicare data under the CMS DRG system and was unaware of how its analysis would change under the proposed MS-DRGs. Under the CMS DRGs, the AAHKS recommendation would replace 2 DRGs with 4 new ones. However, under the proposed MS-DRGs, the AAHKS recommendation would result in 5 DRGs becoming 12. Because AAHKS is recommending four new joint replacement DRGs (two for knees and two for hips), each would need to be subdivided into severity levels under our proposed MS-DRG system. Therefore, the four new joint DRGs could be subdivided into three levels each, leading to 12 new DRGs. For the proposed rule, we indicated that the changes we proposed to adopt are sufficiently better for recognizing severity of illness among the hip and knee replacement cases. We did not believe that there would be significant improvements in the proposed MS-DRGs recognition of severity of illness from creating an additional 7 DRGs. However, we acknowledged the valuable assistance the AAHKS had provided to CMS in creating the new joint replacement procedure codes and modifying the joint replacement DRGs beginning in FY 2006. These efforts greatly improved our ability to categorize significantly different groups of patients according to severity of illness. In the proposed rule, we welcomed comments from AAHKS on whether the proposed MS-DRGs recognize patient complexity and severity of illness in the hip and knee replacement DRGs consistent with the concerns it expressed to us in

previous comments. We also welcomed public comments from others on whether the proposed changes to the hip and knee replacement DRGs better recognize severity of illness and complexity of these operations in the Medicare patient population.

Comment: Two commenters supported CMS' efforts to refine the DRG system to better identify costs associated with different joint procedures. The commenters encouraged CMS to continue working with the orthopedic community, including AAHKS, to monitor the need for additional new DRGs. The commenters stated that proposed MS-DRGs 466 through 470 are a good first step. However, they stated that CMS should continue to evaluate the data for these procedures and consider additional refinements to the MS-DRGs, including the need for additional severity levels.

Response: We agree that MS-DRGs better identify resource costs for joint procedures than do the CMS DRGs. The AAHKS and others are welcome to suggest additional refinements to us if they believe further improvements are needed.

Comment: One commenter (AAHKS) stated that it was pleased that CMS decided to recognize both surgical complexity and medical severity of illness in the MS-DRGs. The commenter stated that MS-DRGs are more reflective of procedural complexity than the CS-DRGs proposed last year. In addition, the commenter believed that the process is fairly straight forward, making it easier to understand, with the grouping logic available in the public domain. However, the commenter raised several concerns about the proposed joint replacement and revision MS-DRGs. AAHKS stated that its data suggest that all three base DRGs (primary replacement, revision of major joint replacement, and bilateral joint replacement) should be separated into three severity

levels (that is, MCC, CC, and non-CC). We proposed three severity levels for revision of hip and knee replacement (MS-DRGs 466, 467, and 468). The commenter agreed with this 3-level subdivision.

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

● Is the per-case underpayment amount significant enough to affect admission vs. referral decisions on a case-by-case basis?

● Is the total level of underpayments sufficient to encourage systematic admission vs. referral policies, procedures, and marketing strategies?

The commenter also recommended refining the five existing criteria for

MCC/CC/without subgroups as follows:

● Create subgroups if they meet the five existing criteria, with cost difference

between subgroups ($1,350) substituted for charge difference between subgroups

($4,000);

● If a proposed subgroup meets criteria number 2 and 3 (at least 5 percent and at

least 500 cases) but fails one of the others, then create the subgroup if either of the

following criteria are met:

▫ At least $1,000 cost difference per case between subgroups; or

▫ At least $1 million overall cost should be shifted to cases with a CC (or MCC)

within the base DRG for payment weight calculations.

Response: In section II.B.3. of this preamble, we respond to the recommendation

that we modify our five criteria for creating severity subgroups and state we do not

believe it is appropriate to do so at this time. At this time, we believe the criteria we

established to create subdivisions within a base DRG are reasonable and establish the

appropriate balance between better recognition of severity of illness, sufficient

differences between the groups, and a reasonable number of cases in each subgroup.

However, we may consider further modifications to the criteria at a later date once we

have had some experience with MS-DRGs created using the proposed criteria. We

examined data for the base DRGs for MS-DRGs 461 and 462 (Bilateral or Multiple

Major Joint Procedures of Lower Extremity with MCC and without MCC, respectively)

as well as the base DRGs for MS-DRGs 469 and 470 (Major Joint Replacement or

Reattachment of Lower Extremity with CC and without CC, respectively) for the

proposed rule.

Our data did not support creating additional subdivisions based on the criteria we

proposed.

Comment: Another commenter (AAHKS) continued to support the separation of

routine and complex joint procedures. The commenter believed that certain joint

replacement procedures have significantly lower average charges than do other joint

replacements. The commenter's data suggest that more routine joint replacements are

associated with substantially less resource utilization than other more complex revision

procedures. The commenter stated that leaving these procedures in the revision

MS-DRGs results in substantial overpayment for these relatively simple, less costly

revision procedures, which in turn results in a relative underpayment for the more

complex revision procedures.

Response: We examined data on this issue and identified two procedure codes for

partial knee revisions that had significantly lower average charges than did other joint

revisions. The two codes are as follows:

● 00.83 Revision of knee replacement, patellar component

● 00.84 Revision of total knee replacement, tibial insert (liner)

The following table illustrates our findings for MS-DRG 466 (Revision of Hip or

Knee Replacement with MCC), MS-DRG 467 (Revision of Hip or Knee replacement

with CC), and MS-DRG 468 (Revision of Hip or Knee Replacement without CC/MCC):

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 466 – All cases	3,886	9.55	$69,649.08
MS-DRG 466 with code 00.83 or 00.84 only	258	10.53	$54,141.72
MS-DRG 467 – All cases	10,078	6.06	$48,575.01
MS-DRG 467 with code 00.83 or 00.84 only	955	5.47	$31,191.04
MS-DRG 468 – All cases	26,718	4.06	$38,720.28
MS-DRG 468 with code 00.83 or 00.84 only	2,718	3.45	$22,799.31

Cases with codes 00.83 and 00.84 have significantly lower charges than do other cases in these DRGs. For cases in MS-DRG 466, those with codes 00.83 or 00.84 have average charges of $54,141.72 compared to average charges of $69,646.08 for all cases within the DRG, a difference of $15,504.36. There is a difference of $17,383.97 for MS-DRG 467 and $15,920.97 for MS-DRG 468. The data suggest that these less complex partial knee revisions are less resource intensive than other cases assigned to MS-DRGs 466, 467, or 468. We examined other orthopedic DRGs to which these two codes could be assigned. As can be seen in the table below, these cases have very similar average charges to those in MS-DRG 485 (Knee Procedures with Principal Diagnosis of Infection with MCC), MS-DRG 486 (Knee Procedures with Principal Diagnosis of Infection with CC), MS-DRG 487 (Knee Procedures with Principal Diagnosis of Infection without CC), MS-DRG 488 (Knee Procedures without Principal Diagnosis of Infection with CC or MCC), and MS-DRG 489 (Knee Procedures without Principal Diagnosis of Infection without CC).

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 485 – All cases	916	12.69	$59,722.69
MS-DRG 485 with code 00.83 or 00.84 only	174	11.71	$57,649.86

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 486 – All cases	1,461	8.39	$37,730.19
MS-DRG 486 with code 00.83 or 00.84 only	336	7.73	$37,315.10
MS-DRG 487 – All cases	1,139	5.84	$27,184.41
MS-DRG 487 with code 00.83 or 00.84 only	262	7.73	$29,142.35
MS-DRG 488 – All cases	1,462	5.66	$30,073.21
MS-DRG 488 with code 00.83 or 00.84 only	703	4.24	$30,138.06
MS-DRG 489 – All cases	3,687	3.11	$18,865.79
MS-DRG 489 with code 00.83 or 00.84 only	2,456	3.18	$22,122.64

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

Comment: One commenter expressed concern about the grouper logic for assigning cases to MS-DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity (current CMS DRG 471). Specifically, the commenter stated that the following bilateral joint replacements should be, but are not, assigned to MS-DRGs 461 and 462.

- A patient receives identical acetabular revisions of both hips (00.71 and 00.71).

- A patient receives a total revision of one hip (00.70) and a acetabular revision of the other hip (00.71).

● A patient receives both a total hip replacement (81.51) and a total knee

replacement (81.54).

● A patient receives both a total revision of one hip (00.70) and a total

replacement of the other hip (81.51).

Response: We addressed this issue in the FY 2007 final rule and do not believe

additional modifications are needed. We are providing the following summary of the

previous action. After publication of the FY 2006 IPPS final rule, a number of hospitals

and coding personnel advised us that the DRG logic for CMS DRG 471 (Bilateral or

Multiple Major Joint Procedures of Lower Extremity), which utilizes the new and revised

hip and knee procedure codes under CMS DRGs 544 and 545, also includes codes that

describe procedures that are not bilateral or that do not involve multiple major joints.

CMS 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 CMS DRG 471 in FY 2006 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 CMS DRG 471, we were assigning cases to CMS DRG 471 that did not

have bilateral or multiple joint procedures. For example, when a hospital reported a code

for revision of the tibial component (code 00.81) and patellar component of the right knee

(code 00.83), the FY 2006 DRG logic assigned the case to CMS DRG 471. The

commenters indicated that this code assignment was incorrect because only one joint has

undergone surgery, but two components were used. One commenter indicated that

ICD-9-CM did not identify left/right laterality. Therefore, it was difficult to use the

current coding structure to determine if procedures were performed on the same leg or on

both legs. The commenters raised concern about whether CMS intended to pay hospitals

using CMS 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 CMS DRG 471 that

do not specifically identify bilateral or multiple joint procedures so that it would only

include cases involving the more resource intensive cases of bilateral or multiple total

joint replacements and revisions.

We agreed that the new and revised joint procedure codes should not be assigned

to CMS DRG 471 unless they include bilateral and multiple joints. Therefore, in the

FY 2007 IPPS final rule, we removed the following codes from CMS DRG 471 that did

not identify bilateral and multiple joint revisions or replacements:

- 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

DRG 471 contains the following codes:

- 00.70, Revision of hip replacement, both acetabular and femoral components

- 00.80, Revision of knee replacement, total (all components)

- 00.85, Resurfacing hip, total, acetabulum and femoral head

- 00.86, Resurfacing hip, partial, femoral head

- 00.87, Resurfacing hip, partial, acetabulum

- 81.51, Total hip replacement

- 81.52, Partial hip replacement

- 81.54, Total knee replacement

- 81.56, Total ankle replacement

As a result of the removal of the identified codes from CMS DRG 471 in

FY 2007, the reporting of one or more of the following hip or knee revision codes would

be assigned to DRG 545: 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and

81.55. This list included partial revisions of the knee and hip as well as unspecified joint

procedures such as code 81.55 where it was not clear if the revision is total or partial.

Given this historical information of the changes we made in FY 2007, we will

address the current commenter's concerns. The commenter's first scenario in which a

patient received identical acetabular revisions of both hips 00.71 and 00.71 would not be

assigned to CMS DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower

Extremity), which becomes MS-DRGs 461 and 462. Even though this scenario identified

revisions to two joints, they were both partial revisions that were less resource intensive

than full bilateral or multiple joint revisions or replacements. In our view, the decision

not to assign these cases to CMS DRG 471 was consistent with the public comments we

received on the FY 2007 IPPS rule to ensure that CMS DRG 471 includes only full

bilateral or multiple joint replacements or revisions. Similarly, the second scenario in

which a patient receives a total revision of one hip (00.70) and a partial acetabular

revision of the other hip (00.71) would not lead to the assignment of CMS DRG 471 for

the same reason. As with the first scenario, code 00.71 was not included in

CMS DRG 471. There was only one total and one partial joint revision in this scenario.

Again, we believe that our decision not to assign these cases to CMS DRG 471 was

consistent with the public comments to only include bilateral or multiple full revisions or

replacements in this DRG. The third and fourth scenarios in which a patient received

both a total hip replacement (81.51) and a total knee replacement (81.54) and another

patient received both a total revision of one hip (00.70) and a total replacement of the

other hip (81.51) would be assigned to CMS DRG 471. These are either full

replacements or revisions on multiple joints. As we adopted the same logic to assign

cases under the MS-DRGs as under the CMS DRGs, only full replacements or revisions

of multiple joints will be included in MS-DRGs 461 and 462 (the MS-DRG analog to

CMS DRG 471). Therefore, we are not making any revisions to the bilateral or multiple

major joint procedures of lower extremity DRGs, MS-DRG 461 and 462. The same

procedure code DRG logic used in CMS DRG 471 will be applied to MS-DRGs 461 and

462.

b. Spinal Fusions

In the FY 2007 IPPS final rule (71 FR 47947), we discussed a request that urged

CMS to consider applying a severity concept to all of the back and spine surgical cases,

similar to the approach that was used in the FY 2006 final rule in refining the cardiac

DRGs with an MCV. Specifically, the commenter recommended that the use of spinal

devices be uniquely identified within the spine DRGs. The commenter's suggestion

involved the development of 10 new spine DRGs as well as additional modifications.

One of these modifications included revising CMS DRG 546 (Spinal Fusions Except

Cervical with Curvature of the Spine or Malignancy). The commenter stated CMS DRG

546 did not adequately recognize clinical severity or the resource differences among

spinal fusion patients whose surgeries include fusing multiple levels of their spinal

vertebrae.

We agreed with the commenter that it was important to recognize severity when

classifying groups of patients into specific DRGs. In addition, in response to

recommendations from MedPAC's March 2005 Report to Congress, we stated that we

were conducting a comprehensive analysis of the entire DRG system to determine if we

could better identify severity of illness. We further stated that until results from our

analysis were available, it would be premature to implement a severity concept for the

spine DRGs. Therefore, we did not make any adjustments to those DRGs at that time.

Under the MS-DRGs described in section II.D. of the preamble of the proposed

rule, we proposed a number of refinements that would better recognize severity for

FY 2008. The proposed MS-DRGs, which we are adopting in this final rule with

comment period, included several refinements to the spine DRGs. These refinements are

described in detail below.

In the FY 2006 IPPS final rule, we noted that there are numerous innovations

occurring in spinal surgery such as artificial spinal disc prostheses, kyphoplasty,

vertebroplasty and the use of spine decompression devices. As part of our analysis of the

DRG system for the proposed rule, we did a comprehensive review of the DRGs for

spinal fusion and other back and neck procedures to determine whether additional

refinements beyond the proposed MS-DRGs were necessary. We studied data from the

FY 2006 MedPAR file for the entire group of spine DRGs. This group included

DRG 496 (Combined Anterior/Posterior Spinal Fusion), DRGs 497 and 498 (Spinal

Fusion Except Cervical with and without CC, respectively), DRGs 499 and 500 (Back

and Neck Procedures Except Spinal Fusion with and without CC, respectively),

DRGs 519 and 520 (Cervical Spinal Fusion with and without CC, respectively), and

DRG 546 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy).

As indicated earlier, we proposed a two or three-way split for each of these spine

DRGs to better recognize severity of illness, complexity of service, and resource

utilization. In addition, we examined the procedure codes that identify multiple fusion or

refusion of the vertebrae (codes 81.62 through 81.64) to determine if the data supported

further refinement when a greater number of vertebrae are fused.

In applying the proposed MS-DRG logic, CMS DRG 497 and 498 were collapsed

and the result was a split with two severity levels: proposed MS-DRG 459 (Spinal Fusion

Except Cervical with MCC) and proposed MS-DRG 460 (Spinal Fusion Except Cervical

without MCC). There were a total of 51,667 cases in proposed MS-DRGs 459 and 460.

We identified 288 cases where nine or more (T1-S1) vertebrae were fused (code 81.64)

that we proposed to assign to MS-DRGs 459 and 460.   The average charges and length

of stay for cases in these MS-DRGs were closer to the average charges and length of stay

for cases in proposed MS-DRGs 456 through 458 (Spinal Fusion Except Cervical with

Curvature of the Spine or Malignancy with MCC, with CC, and without CC,

respectively). For example, in proposed MS-DRG 460, there were 238 cases with an

average length of stay of 6.20 days and average charges of $110,908 when nine or more

noncervical (T1-S1) vertebrae are fused. There were an additional 50 cases in which nine

or more vertebrae were fused in proposed MS-DRG 459 with average charges of

$171,839. Without any further modification to the proposed MS-DRGs, these cases

would be assigned to proposed MS-DRGs 459 and 460 that have average charges of

$59,698 and $99,298, respectively. However, we believe that the average charges for

these cases ($142,871, $95,489, and $77,528, respectively) are more comparable to the

average charges for cases in proposed MS-DRGs 456 through 458. We believe these

data support assigning cases where nine or more noncervical (T1-S1) vertebrae are fused

from MS-DRG 459 and 460 into MS-DRG 456 through 458. The table below represents

our findings.

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 459 (Spinal Fusion Except Cervical with MCC) - All Cases	3,186	10.10	$99,298
MS-DRG 459 (Spinal Fusion Except Cervical with MCC) - Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	50	13.00	$171.839
MS-DRG 460 (Spinal Fusion Except Cervical without MCC) - All Cases	48,481	4.36	$59,698
MS-DRG 460 (Spinal Fusion Except Cervical without MCC) - Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	238	6.20	$110,908
MS-DRG 456 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy with MCC) - All Cases	548	14.79	$142,871
MS-DRG 456 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy with MCC) - Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	61	13.34	$170,655
MS-DRG 457 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy with CC) - All Cases	1,500	8.14	$95,489
MS-DRG 457 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy with CC) - Cases With Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	146	8.88	$125,722
MS-DRG 458 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy without CC - All Cases	1,340	4.58	$77,528
MS-DRG 458 (Spinal Fusion Except Cervical with Curvature of the Spine or Malignancy without CC) - Cases with Procedure Code 81.64 (Fusion or refusion of 9 or more vertebrae)	81	6.21	$123,823

Therefore, we proposed to move those cases that include fusing or refusing nine

or more noncervical (T1-S1) vertebrae from MS-DRGs 459 and 460 into MS-DRGs 456

though 458. This modification would include revising the MS-DRG title to reflect the

fusion or refusion of nine or more noncervical (T1-S1) vertebrae. The revised titles for

proposed MS-DRGs 456 through 458 would be as follows:

● MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions with MCC)

● MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions with CC)

● MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions without CC/MCC)

In the FY 2008 IPPS proposed rule, we invited public comment on this topic as

well as on the additional changes we proposed to the spine MS-DRGs discussed below.

Further analysis demonstrated that spinal fusion cases with a principal diagnosis

of tuberculosis or osteomyelitis also have higher average charges than other cases in

CMS DRG 497 (MS-DRGs 459 and 460 in this final rule with comment period) that were

more similar to the cases assigned to CMS DRG 546 (MS-DRGs 456 through 458 in this

final rule with comment period). Although the volume of cases is relatively low, the data

show very high average charges for these patients. The following tables display our

results:

MS-DRGs	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 459 (Spinal Fusion Except Cervical with MCC)	3,186	10.10	$99,298
MS-DRG 460 (Spinal Fusion Except Cervical without MCC)	48,481	4.36	$59,698

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions with MCC)	548	14.79	$142,870
MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions with CC)	1,500	8.14	$95,489
MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or 9+ Fusions without CC/MCC)	1,340	4.58	$77,528

Tuberculosis and Osteomyelitis			
Principal Diagnosis	Number of Cases	Average Length of Stay	Average Charges
Codes 015.02, 015.04, 015.05, 730.08, 730.18 and 730.28	194	24.8	$128,073

For this reason, we proposed to add the following diagnoses to the principal

diagnosis list for MS-DRGs 456 through 458:

● 015.02, Tuberculosis of bones and joints, vertebral column, bacteriological or

histological examination unknown (at present)

● 015.04, Tuberculosis of bones and joints, vertebral column, tubercle bacilli not

found (in sputum) by microscopy, but found by bacterial culture

● 015.05, Tuberculosis of bones and joints, vertebral column, tubercle bacilli not

found by bacteriological examination, but tuberculosis confirmed histologically

● 730.08, Acute osteomyelitis of other specified sites

● 730.18, Chronic osteomyelitis of other specified sites

● 730.28, Unspecified osteomyelitis of other specified sites

For the complete list of principal diagnosis codes that lead to assignment of

CMS DRG 546 (MS-DRGs 496 through 498 in this final rule with comment period), we

refer readers to section II.D.4.b. of the preamble of the FY 2007 IPPS final rule (71 FR

47947).

Comment: One commenter expressed support of CMS' refinement of the DRGs

for spinal procedures, and noted that it had made several recommendations in the past.

Specifically, this commenter was pleased with the refinements to address multiple level

procedures such as those in proposed MS-DRGs 456-458 (Spinal Fusion Except Cervical

with Spinal Curvature or Malignancy or 9+ Fusions with MCC/with CC/and without

CC/MCC, respectively), as well as the proposal to add specified diagnoses of tuberculosis

and osteomyelitis to the list of principal diagnoses for MS-DRGs 456-458. The

commenter also supported the proposal to move cases involving the use of motion-

preserving spine devices into the higher severity level of MS-DRG 490.

This commenter suggested that MS-DRG 460 (Spinal Fusion Except Cervical

without MCC) should include severity levels that distinguish with CC and without CC

cases. The commenter urged CMS to create a CC split for this MS-DRG.

Response: We appreciate the commenter's support for the refinements proposed

to the spine DRGs. The data analysis conducted in developing the MS-DRGs did not

support a CC split for proposed MS-DRG 460. As stated in the FY 2008 proposed rule,

in order to warrant creation of a CC or major CC subgroup within a base MS-DRG, the

subgroup had to meet all five criteria. We refer readers to the FY 2008 proposed rule

(72 FR 24705) and section II.D.3 of this final rule with comment period for a complete

listing of the criteria. As stated in the proposed rule, the data did support a split for

proposed MS-DRG 460 with two severity levels of with MCC and without MCC.

Therefore, in this final rule with comment period we are implementing MS-DRG 460 as

final policy.

Comment: One manufacturer requested that CMS reassign newly created

procedure code 84.82 (Insertion or replacement of pedicle-based dynamic stabilization

device(s)), effective October 1, 2007, from proposed MS-DRG 490 to MS-DRG 460.

The commenter stated the surgical procedure requirements for code 84.82 are very

similar to other procedures that were proposed for assignment to MS-DRG 460 as a result

of the complexity and resources utilized. The commenter further noted that in the

FY 2008 proposed rule (72 FR 24734) CMS reported a total of 83 cases identified by

code 84.59 (Insertion of other spinal devices)—a predecessor code to 84.82—and it is

unknown whether the cases reported with code 84.59 truly reflect dynamic stabilization

procedures.

Response: In developing the MS-DRGs, we conducted a comprehensive review

of the entire group of spine DRGs and proposed a number of revisions to account for

differences in level of severity, complexity, and resource utilization. We believe the

proposed spinal MS-DRGs more appropriately classify the variety of emerging spinal

technologies. In response to the uncertainty of correct coding and accurate charge

information for the reporting of pedicle-based dynamic stabilization devices by code

84.59, we refer the commenter to the ICD-9-CM Coordination and Maintenance

Committee Meeting's September 28-29, 2006 and March 22-23, 2007 interim coding

advice regarding these devices, which was to continue using code 84.59 to describe this

technology.

Effective October 1, 2007, new code 84.82 will be available to identify and

describe procedures using pedicle-based dynamic stabilization devices more accurately.

Our practice has been to assign a new code to the same MS-DRG as its predecessor code

unless we have clinical information or cost data that demonstrates a different MS-DRG

assignment is warranted. At this time, we have no information to suggest that ICD-9-CM

code 84.82 should be reassigned from MS-DRG 490. As final policy for FY 2008, code

84.82 will be assigned to MS-DRG 490.

Comment: Two commenters indicated that they supported the reassignment of

spinal fusion cases with a principal diagnosis of tuberculosis or osteomyelitis to MS-

DRGs 456-458 (Spinal Fusion Except Cervical with Spinal Curvature or Malignancy or

9+ Fusions with MCC/with CC/and Without CC/MCC, respectively) to better recognize

the utilization of resources involved with these cases, however they recommended that

the MS-DRG titles be modified to reflect these conditions. One of the commenters

suggested the following title modifications:

● MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature,

Malignancy, Tuberculosis, or Osteomyelitis or 9+ Fusions with MCC)

● MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature,

Malignancy, Tuberculosis, or Osteomyelitis or 9+ Fusions with CC)

● MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature,

Malignancy, Tuberculosis, or Osteomyelitis or 9+ Fusions without CC/MCC)

Response: We appreciate the commenter's support of the proposal to reassign

cases with a principal diagnosis of tuberculosis or osteomyelitis to MS-DRGs 456-458.

We also appreciate the suggestion for revising the DRG titles to better classify these

patients. While we recognize the creative approach to modifying the code titles, we must

limit the DRG titles to 68 characters.

We have reviewed the MS-DRG titles and are revising them as follows:

● MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions with MCC)

● MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions with CC)

● MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature or

Malignancy or 9+ Fusions without CC/MCC)

Therefore, effective October 1, 2007, the new titles for MS-DRGs 456-458 will

be implemented as above.

c. Spinal Disc Devices

Over the past several years, manufacturers of spinal disc devices have requested

reassignment of DRGs for their products and applied for new technology add-on

payment. CHARITE™ is one of these devices. 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

CMS 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 CMS DRG 499

(Back and Neck Procedures Except Spinal Fusion with CC) and CMS DRG 500 (Back

and Neck Procedures Except Spinal Fusion without CC) to the CMS DRGs for spinal

fusion, CMS DRG 497 (Spinal Fusion Except Cervical with CC) and CMS DRG 498

(Spinal Fusion Except Cervical without CC), for procedures on the lumbar spine and to

CMS DRGs 519 and 520 for procedures on the cervical spine. In the FY 2005 IPPS final

rule (69 FR 48938), we indicated that CMS DRGs 497 and 498 are limited to spinal

fusion procedures. Because the surgery involving the CHARITE^{TM} Artificial Disc is not

a spinal fusion, we decided not to include this procedure in these CMS 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), 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^{TM} 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.

We did evaluate whether to reassign the CHARITE^{TM} Artificial Disc to different

CMS DRGs using the Secretary's authority under section 1886(d)(4) of the Act

(70 FR 47308). We indicated that we did not have Medicare charge information to

evaluate CMS DRG changes for cases involving an implant of a prosthetic intervertebral

disc like the CHARITE^{TM} and did not make a change in its CMS DRG assignments. We

stated that we would consider whether changes to the CMS DRG assignments for the

CHARITE^{TM} 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 CMS DRG assignments for the CHARITE^{TM} Artificial

Disc, code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral). The commenter

had previously submitted an application for the CHARITE^{TM} Artificial Disc for new

technology add-on payments for FY 2006 and had requested a reassignment of cases

involving CHARITE^{TM} implantation to CMS DRGs 497 and 498. The commenter asked

that we examine claims data for FY 2005 and reassign procedure code 84.65 from

CMS DRGs 499 and 500 into CMS DRGs 497 and 498. The commenter again stated the

view that cases with the CHARITE^{TM} Artificial Disc reflect comparable resource use and

similar clinical indications as do those in CMS DRGs 497 and 498. If CMS were to

reject reassignment of the CHARITE^{TM} Artificial Disc to CMS 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[TM] Artificial Disc is reasonable and necessary. The proposed NCD stated that

lumbar artificial disc replacement with the CHARITE[TM] 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[TM] 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 CMS DRGs 499 and 500 to CMS 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[TM]

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[TM] Artificial Disc. The final NCD can be found on the CMS Web site at:

http://www.cms.hhs.gov/mcd/viewncd.asp:ncd_id-150.10&ncd_version1&basket=ncd%3
A150%2E10%3A1%3ALumbar+Artificial+Disc+Replacement%280ADR%29.

We agreed with a commenter on the FY 2007 IPPS proposed rule that it was not

appropriate to consider a DRG revision at that time for the CHARITE[TM] Artificial Disc,

given the recent decision to limit coverage for surgical procedures involving this device.

Although we had reviewed the Medicare charge data, we were concerned that there were

a very small number of cases for patients under 60 years of age who had received the

CHARITE^{TM} Artificial Disc. We believed it appropriate to base the decision of a DRG

change on charge data only on the population for which the procedure is covered. We

had an extremely small number of cases for Medicare beneficiaries under 60 on which to

base such a decision. For this reason, we did not believe it was appropriate to modify the

CMS DRGs in FY 2007 for CHARITE^{TM} cases.

For FY 2008, we proposed to collapse CMS DRGs 499 and 500 (Back and Neck

Procedures Except Spinal Fusion With and Without CC, respectively) and identified a

total of 74,989 cases. Under the proposed MS-DRGs (which we are adopting in this final

rule with comment period), the result of the analysis of the data supports that these CMS

DRGs split into two severity levels: MS-DRG 490 (Back and Neck Procedures Except

Spinal Fusion with CC or MCC) and MS-DRG 491 (Back and Neck Procedures Except

Spinal Fusion Without CC or MCC).   We found a total of 53 cases that used the

CHARITE™ Artificial Disc. Without any further modification to the proposed MS-

DRGs, average charges are $26,481 for 6 cases with a CC or MCC and $37,324 for 47

CHARITE™ cases without a CC or MCC. (We find it counterintuitive that average

charges for cases in the higher severity level are lower but checked our data and found it

to be correct).

We also analyzed data for other spinal disc devices. Average charges for the

X Stop Interspinous Process Decompression Device (code 84.58) are $31,400 for cases

with a CC or MCC and $28,821 for cases without a CC or MCC. Average charges for

other specified spinal devices described by code 84.59 (Coflex, Dynesys, M-Brace) are

$34,002 for 18 cases with a CC or MCC and $33,873 for 65 cases without a CC or MCC.

We compared these average charges to data in the proposed spinal fusion MS-DRGs 453

(Combined Anterior/Posterior Spinal Fusion With MCC), 454 (Combined

Anterior/Posterior Spinal Fusion with CC), 455 (Combined Anterior/Posterior Spinal

Fusion without CC/MCC), 459 (Spinal Fusion Except Cervical with MCC), and 460

(Spinal Fusion Except Cervical without MCC). These cases have lower average charges

than the spinal fusion MS-DRGs. The following tables display the results:

MS-DRGs 490 and 491	**Number of Cases**	**Average Length of Stay**	**Average Charges**
MS-DRG 490 - All Cases	17,493	5.13	$29,656
MS-DRG 490 - Cases with Procedure Code 84.65 (CHARITE™)	6	3.33	$26,481
MS-DRG 491 - All Cases	57,496	2.27	$17,789
MS-DRG 491 - Cases with Procedure Code 84.65 (CHARITE™)	47	2.43	$37,324
MS-DRG 491 - Cases without Procedure Code 84.65 (CHARITE™)	57,449	2.27	$17,773

MS-DRGs 490 and 491	**Number of Cases**	**Average Length of Stay**	**Average Charges**
MS-DRG 490 - All Cases	17,493	5.13	$29,656
MS-DRG 490 - Cases with Procedure Code 84.58 (X Stop)	179	2.65	$31,400
MS-DRG 490 - Cases without Procedure Code 84.58 (X Stop)	17,314	5.15	$29,638
MS-DRG 491 - All Cases	57,496	2.27	$17,789
MS-DRG 491 - Cases with Procedure Code 84.58 (X Stop)	1,174	1.34	$28,821

MS-DRG 491 - Cases without Procedure Code 84.58 (X-Stop)	56,322	2.29	$17,559

MS-DRGs 490 and 491	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 490 - All Cases	17,493	5.13	$29,656
MS-DRG 490 - Cases with Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	18	5.56	$34,002
MS-DRG 490 - Cases without Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	17,475	5.13	$29,651
MS-DRG 491 - All Cases	57,496	2.27	$17,789
MS-DRG 491 - Cases with Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	65	2.35	$33,873
MS-DRG 491 - Cases without Procedure Code 84.59 (Coflex/Dynesys/M-Brace)	57,431	2.27	$17,770

MS-DRGs 453, 454, 455, 459 and 460	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 453 - Combined Anterior/Posterior Spinal Fusion With MCC	792	15.84	$180,658
MS-DRG 454 - Combined Anterior/Posterior Spinal Fusion With CC	1,411	8.69	$116,402
MS-DRG 455 - Combined Anterior/Posterior Spinal Fusion Without CC/MCC	1,794	4.84	$85,927
MS-DRG 459 - Spinal Fusion Except Cervical with MCC	3,186	10.10	$99,298
MS-DRG 460 - Spinal Fusion Except Cervical without MCC	48,481	4.36	$59,698

The data demonstrate that the average charges for CHARITE™ and the other

devices are higher than other cases in proposed MS-DRGs 490 and 491 but lower than

proposed MS-DRGs 453 through 455 and 459 and 460. For this reason, we do not

believe that any of the cases that use these spine devices should be assigned to the spinal

fusion MS-DRGs. However, we do believe that the average charges for cases using these

spine devices are more similar to the higher severity level in MS-DRG 490.

As such, in the FY 2008 IPPS proposed rule, we proposed to move cases with

procedure codes 84.58, 84.59, and 84.65 into proposed MS-DRG 490 and revise the title

to reflect disc devices. The proposed modified MS-DRG title would be: MS-DRG 490

(Back and Neck Procedures Except Spinal Fusion with CC or MCC or Disc Devices).

We believe these proposed changes to the spine DRGs are appropriate to

recognize the similar utilization of resources, differences in levels of severity, and

complexity of the services performed for various types of spinal procedures described

above. We encouraged commenters to provide input on this approach to better recognize

the types of patients these procedures are being performed upon and their outcomes.

Comment: Several commenters supported our proposal to recognize utilization of

resources, differences in levels of severity, and the complexity of spinal procedures in

proposed MS-DRGs 490 and 491. The commenters were pleased with the proposal to

reassign cases identified by procedure codes 84.58[24], 84.59 and 84.65 to proposed

MS-DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC or MCC or

Disc Devices). One commenter stated that the proposed refinements to MS-DRG 490

result in Medicare payment that better recognizes patient conditions and procedural

complexity. Another commenter believed that the proposals will provide more

appropriate payment and ensure patient access to spine technologies. This commenter

commended CMS for its responsiveness in considering resource use associated with new

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[24] Effective October 1, 2007, procedure code 84.58 (Implantation of interspinous process decompression device) has been deleted and replaced by new procedure code 84.80 (Insertion or replacement of interspinous process device(s)).

technologies, such as spine motion preservation devices, and stated the proposal to assign

higher payment rates will enable hospitals to provide Medicare patients with access to

these technologies.

Two commenters suggested CMS also consider moving cases with procedure

code 84.62 (Insertion of total spinal disc prosthesis, cervical) into MS-DRG 490. The

commenters stated that this procedure is clinically coherent with the other cases proposed

for reassignment to this DRG. Many commenters also recommended that CMS continue

analyzing claims data in the future to ensure appropriate DRG assignment for all spinal

related procedures.

Response: We greatly appreciate the commenters' support of our proposal. We

analyzed data for procedure code 84.62 and found 23 cases with an average length of stay

of 1.48 days and average charges of $30,114 in MS-DRG 491. We also identified 4 cases

in MS-DRG 490 with an average length of stay of 10.5 days and average charges of

$104,313. The table below displays our results.

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 490 – All cases	17,493	5.13	$29,655
MS-DRG 490 – Cases with code 84.62	4	10.50	$104,313
MS-DRG 490 – Cases without code 84.62	17,484	5.13	$29,633
MS-DRG 491 – All cases	57,496	2.27	$17,788
MS-DRG 491 – Cases with code 84.62	23	1.48	$30,114
MS-DRG 491 – Cases without code 84.62	57,470	2.27	$17,783

We agree that cases with procedure code 84.62 appear to require greater

utilization of resources than other cases in MS-DRG 491 and they are clinically similar to

other spine disc prostheses cases we are assigning to MS-DRG 490. Therefore, in this

FY 2008 final rule, we are moving cases identified by procedure code 84.62 from MS-DRG 491 to MS-DRG 490.

Comment: One commenter urged CMS to reconsider the placement of procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) into MS-DRG 490. The commenter indicated this code represents technology that is a significant alternative to spinal fusion for a number of patients diagnosed with degenerative disc disease. The commenter noted that a total disc replacement is different from the other procedures included in MS-DRG 490 and is more complex. For example, excision of an intervertebral disc (code 80.51) represents only one component of a total disc replacement surgery; however, both procedures are assigned to the same DRG and receive the same payment. The commenter further noted that other procedures included in MS-DRG 490 do not involve the removal of a disc and including all of these procedures together is not an accurate reflection of clinical coherence.

According to the commenter, a variety of new artificial discs are leading to improvements in the area of total disc replacement procedures, including the ProDisc-L™ Total Disc Arthroplasty. In addition, the commenter stated, "appropriate Medicare payment is essential to ensure access to this alternative treatment and the diffusion of an innovative new technology." The commenter believed that the most appropriate MS-DRG assignment for code 84.65 is MS-DRG 460 (Spinal Fusion Except Cervical without MCC) and requested that CMS reassign procedure code 84.65 to MS-DRG 460 and modify the title to "Spinal Fusion Except Cervical without MCC and Artificial Disc Replacement."

Response: We disagree with the commenter that cases identified by procedure

code 84.65 should be reassigned to MS-DRG 460 with a revised title. We provided the

analysis in the FY 2008 IPPS proposed rule that demonstrated the average charges for

code 84.65 were substantially lower than the average charges for the spinal fusion MS-

DRGs but higher than the average charges for other cases in proposed MS-DRGs 490 and

491. As a result, we proposed to move cases identified by procedure code 84.65 into the

higher severity level and modify the proposed title to reflect disc devices. We agree with

the above statement, "appropriate Medicare payment is essential to ensure access to this

alternative treatment and the diffusion of an innovative new technology" made by the

commenter. The charge data do not support moving cases with procedure code 84.65

into the spinal fusion DRGs at this time. As a result, effective October 1, 2007, cases

identified by procedure code 84.65 will remain assigned to MS-DRG 490 (Back and

Neck Procedures Except Spinal Fusion with CC or MCC or Disc Devices) with the

modified title as proposed.

d. Other Spinal DRGs

We did not identify any data to support moving cases in or out of CMS DRGs 496

(Combined Anterior/Posterior Spinal Fusion), 519 (Cervical Spinal Fusion with CC), or

520 (Cervical Spinal Fusion without CC)). Under the proposed MS-DRG system, we

proposed to split CMS DRG 496 into three severity levels: MS-DRG 453 (Combined

Anterior/Posterior Spinal Fusion with MCC), MS-DRG 454 (Combined

Anterior/Posterior Spinal Fusion with CC), and proposed MS-DRG 455 (Combined

Anterior/Posterior Spinal Fusion without CC). We also proposed to split CMS DRG 519

into three severity levels: MS-DRG 471 (Cervical Fusion with MCC), MS-DRG 472

(Cervical Fusion with CC), and MS-DRG 473 (Cervical Fusion without CC). In the

FY 2008 IPPS proposed rule, we did not propose changes to these DRGs.

We did not receive any public comments on the above proposals to refine the

remaining spinal DRGs. Therefore, in this final rule with comment period, we are

adopting as final MS-DRGs 453, 454, 455, 471, 472, and 473.

5. MDC 17 (Myeloproliferative Diseases and Disorders, Poorly Differentiated

Neoplasm): Endoscopic Procedures

Between last year's final rule and this year's proposed rule, we received a request

from a manufacturer to review the DRG assignment of codes 33.71 (Endoscopic insertion

or replacement of bronchial valve(s)), 33.78 (Endoscopic removal of bronchial device(s)

or substances), and 33.79 (Endoscopic insertion of other bronchial device or substances)

with the intent of moving these three codes out of CMS DRG 412 (History of

Malignancy With Endoscopy) (MS-DRGs 843, 844, and 845 in this final rule with

comment period). The requestor noted that CMS DRG 412 is titled to be a DRG for

cases with a history of malignancy, and none of the three codes (33.71, 33.78, or 33.79)

necessarily involve treatment for malignancies. In addition, the requestor believed the

integrity of the DRG is compromised because the other endoscopy codes assigned to

CMS DRG 412 are all diagnostic in nature, while codes 33.71, 33.78, and 33.79 represent

therapeutic procedures.

The requestor also stated that while the diagnostic endoscopies in CMS DRG 412

do not have significant costs for equipment or pharmaceutical agents beyond the basic

endoscopy, the therapeutic procedures described by codes 33.71, 33.78, and 33.79

involve substantial costs for devices or substances in relation to the cost of the

endoscopic procedure itself. The requestor was concerned that, if these three codes

continue to be assigned to CMS DRG 412, payment will be so inadequate as to constitute

a substantial barrier to Medicare beneficiaries for these treatments.

ICD-9-CM procedure codes 33.71, 33.78, and 33.79 were all created for use

beginning October 1, 2006. In the proposed rule, we stated that these codes have been in

use only for a few months, and we had no data to make a different DRG assignment. We

assigned these codes based on the advice of our medical officers to a DRG that included

similar clinical procedures.

On the matter of codes 33.71, 33.78, and 33.79 being therapeutic in nature while

all other endoscopies assigned to CMS DRG 412 are diagnostic, we disagreed with the

commenter in the proposed rule. CMS DRG 412 includes procedure codes for

therapeutic endoscopic destruction of lesions of the bronchus, lung, stomach, anus, and

duodenum, as well as codes for polypectomy of the intestine and rectum. In addition, we

note that there are codes for insertion of therapeutic devices currently located in this

DRG.

In the proposed rule, we stated that it would be premature to assign these codes to

another DRG without any supporting data. We indicated that we would reconsider our

decision for these codes if we had data suggesting that a DRG reassignment was

warranted. Therefore, aside from the proposed changes to the MS-DRGs, in the FY 2008

IPPS proposed rule, we did not propose to change the current DRG assignment for codes

33.71, 33.78, and 33.79.

Comment: We did not receive any specific comments addressing the published

proposal. We did receive comments asking CMS to use external data to make DRG

assignments until Medicare data are available.

Response: We reiterate that the new codes under discussion were created for use

beginning October 1, 2006. Commenters did not provide any external data for us to

evaluate. We have no data that would support a different DRG assignment for these

codes. Therefore, codes 33.71 (Endoscopic insertion or replacement of bronchial

valve(s)), 33.78 (Endoscopic removal of bronchial device(s) or substances), and 33.79

(Endoscopic insertion of other bronchial device or substances) will remain assigned to

MS-DRGs 843, 844, and 845 (Other Myeloproliferative Disease or Poorly Differentiated

Neoplasm Diagnosis w/ MCC, w/CC or w/o CC/MCC respectively) until we have data

that suggest a different DRG assignment would be warranted.

6. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this final rule with comment

period, the Medicare Code Editor (MCE) is a software program that detects and reports

errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and

demographic information are entered into the Medicare claims processing systems and

are subjected to a series of automated screens. The MCE screens are designed to identify

cases that require further review before classification into a DRG. For FY 2008, we

proposed to make the following changes to the MCE edits.

a. Non-Covered Procedure Edit: Code 00.62 (Percutaneous angioplasty or atherectomy

of intracranial vessel(s))

As discussed in II.G.2. of the preamble of this final rule with comment period,

under MDC 1, code 00.62 is a covered service when performed in conjunction with code

00.65 (Percutaneous insertion of intracranial vascular stent(s)). Effective November 6,

2006, Medicare covers PTA and stenting of intracranial arteries for the treatment of

cerebral artery stenosis in cases in which stenosis is 50 percent or greater in patients with

intracranial atherosclerotic disease when furnished in accordance with the FDA-approved

protocols governing Category B Investigational Device Exemption (IDE) clinical trials.

CMS determined that coverage of intracranial PTA and stenting is reasonable and

necessary under these circumstances. Therefore, we proposed to make a conforming

change and to add the following language to this edit: Procedure code 00.62 (PTA of

intracranial vessel(s)) is identified as a noncovered procedure except when it is

accompanied by procedure code 00.65 (Intracranial stent).

We did not receive any public comments on this proposal. Therefore, for

FY 2008, we are adopting as final our proposed revision of the coverage edit, recognizing

procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s))

as a covered procedure when reported in conjunction with procedure code 00.65

(Intracranial stent).

b. Non-Specific Principal Diagnosis Edit 7 and Non-Specific O.R. Procedures Edit 10

When MCE Non-Specific Principal Diagnosis Edit 7 and Non-Specific O.R.

Procedures Edit 10 were created at the beginning of the IPPS, it was with the intent that

they were to encourage hospitals to code as specifically as possible. While the codes on

both edits are valid according to the ICD-9-CM coding scheme, more precise codes are

preferable to give a more complete understanding of the services provided on the

Medicare claims. When the MCE was created, we had intended that these specific edits

would allow educational contact between the provider and the contractor. It was never

the intention that these edits would be used to deny/reject or return-to-provider those

claims submitted with non-specific codes. However, we found these two edits to be

misunderstood, and found that claims were erroneously being denied, rejected, or

returned. On November 11, 2006, CMS issued a Joint Signature Memorandum that

instructed all fiscal intermediaries and all Part A and Part B Medicare Administrative

Contractors (A/B MACs) to deactivate the Fiscal Intermediary Shared System Edits

W1436 through W1439 and W1489 through W1491 which edited for Non-Specific

Diagnoses and the Non-Specific Procedures.

Therefore, in the FY 2008 IPPS proposed rule, we proposed to make a

conforming change to the MCE by removing the following codes from Edit 7:

00320	07070	13100
01590	07071	1319
01591	0728	1329
01592	0738	1369
01593	07420	1370
01594	08240	1371
01596	0979	1372
0369	09810	1373
0399	09830	1374
0528	09950	138
05310	0999	1390
0538	1009	1391
05440	1109	1398
0548	1129	1409
0558	1149	1419
05600	1279	1429
0568	129	1439
06640	1309	1449

1469	2299	3349
1479	2306	3359
1509	2319	34120
1519	2329	3419
1529	2349	3439
1539	23690	3449
1543	23770	34690
1579	23875	34691
1589	2390	3489
1590	2391	3499
1609	2392	3509
1619	2393	3519
1629	2394	3529
1639	2396	3539
1649	2397	3569
1709	2398	3579
1719	2399	3589
1729	2469	3599
1739	2519	3609
1749	25200	3619
1769	2529	3629
179	2539	3639
1809	2549	3649
1839	25510	3659
1874	2569	3669
1879	2579	3679
1889	2589	3689
1899	2681	36900
1909	2709	36901
1929	2719	36902
1949	2729	36903
1969	2739	36904
1991	27540	36905
20490	2759	36906
20491	27650	36907
20590	27730	36908
20591	2779	36910
20690	2793	36911
20691	2799	
20890	28730	36912
20891	28800	36913
2129	28850	36914
2139	28860	36915
2149	28950	36916
2159	3239	36917
2169	3249	36918
2189	326	36920
2199	32700	36921
2229	32710	36922
2239	32720	36923
2249	32730	36924
2259	32740	36925
2279	3309	3693
22800	3319	3694

36960	4275	5269
36961	4279	5279
36962	42820	52800
36963	42830	5299
36964	42840	5309
36965	4289	53640
36966	4299	5379
36967	4329	5539
36968	43390	56400
36969	43490	5649
36970	4379	5679
36971	4389	5689
36972	4419	56960
36973	4429	5699
36974	4449	5739
36975	44620	57510
36976	4479	5759
3698	4519	5769
3699	45340	5779
3709	4539	5799
3719	4579	5859
3729	4599	5889
3739	4619	5890
3749	46450	5891
3759	46451	5899
3769	4749	5909
3779	4919	5959
3789	5169	5969
37960	51900	5989
3809	5199	59960
3819	5209	5999
3829	52100	60090
3839	52110	60091
3849		6019
3859	52120	6029
3879	52130	60820
38800	52140	6089
38810	5219	6109
38830	52320	6169
38840	52330	6179
38860	52340	61800
38870	5239	6184
3889	52400	6189
38900	52420	6199
38910	52430	6209
3897	52450	62130
3899	52460	6219
41090	52470	62210
41091	5249	6229
41092	52520	6239
412	52540	6249
4149	52550	6269
4179	52560	6279
42650	5259	62920

63390	64810	65430
63391	64820	65440
64090	64830	65450
64091	64840	65460
64093	64850	65470
64100	64860	65480
64110	64870	65490
64120	64880	65491
64130	64890	65492
64180	64900	65493
64190	64910	65494
64191	64920	65500
64193	64930	65510
64200	64940	65520
64210	64950	65530
64220	64960	65540
64230	65100	65550
64240	65110	65560
64250	65120	65570
64260	65130	65580
64270	65140	65590
64290	65150	65591
64300	65160	65593
64310	65180	65600
64320	65190	65610
64380	65191	65620
64390	65193	65630
64400	65200	65640
64410	65210	65650
64420	65220	65660
64600	65230	65670
64610	65240	65680
64620	65250	65690
64630	65260	65700
64640	65270	65800
64650	65280	65810
64660	65290	65820
64670	65291	65830
64680	65293	65840
64690	65300	65880
64700	65310	65890
64710	65320	65891
64720	65330	65893
64730	65340	65900
64740	65350	65910
64750	65360	65920
64760	65370	65930
64780	65380	65940
64790	65390	65950
64791	65391	65960
64792	65393	65980
64793	65400	65990
64794	65410	65991
64800	65420	65993

66000	66590	67410
66010	66591	67420
66020	66592	67430
66030	66593	67440
66040	66594	67450
66050	66600	67480
66060	66610	67490
66070	66620	67492
66080	66630	67494
66090	66700	67500
66100	66710	67510
66110	66800	67520
66120	66810	67580
66130	66820	67590
66140	66880	67600
66190	66890	67610
66191	66891	67620
66193	66892	67630
66200	66893	67640
66210	66894	67650
66220	66900	67660
66230	66910	67680
66300	66920	67690
66310	66930	67691
66320	66940	67692
66330	66950	67693
66340	66960	67694
66350	66970	677
66360	66980	6809
66380	66990	6819
66390	66991	6829
66391	66992	68600
66393	66993	6869
66400	66994	6949
66410	67000	7019
66420	67100	7049
66430	67110	7059
66440	67120	7069
66441	67130	70700
66444	67140	70710
66450	67150	7079
66480	67180	7149
66490	67190	71590
66491	67191	7179
66494	67192	71849
66500	67193	71850
66510	67194	71870
66520	67200	72230
66530	67300	72270
66540	67310	72280
66550	67320	72290
66560	67330	7239
66570	67380	7244
66580	67400	7289

73000	76070	78900
73010	76072	78930
73020	76073	78940
73030	76074	78960
73090	76079	79009
73091	7608	7901
73092	7609	7904
73093	7610	7905
73094	7611	7906
73095	7612	79091
73096	7613	79092
73097	7614	79099
73098	7615	7929
73099	7616	79380
73310	7617	79500
73340	7618	7954
73390	7619	7964
7359	7629	7969
73600	7630	7993
73620	7631	79989
73630	7632	7999
73670	7633	8290
7369	7634	
73810	7635	8291
7389	7636	8398
74100	7637	8399
74190	76383	8409
7429	7639	8419
7439	76520	8439
7449	7679	8469
7459	7689	8479
7469	77010	8489
74760	7709	8678
7489	77210	8679
74900	7729	86800
74910	7759	86810
7509	7769	9009
7519	7779	9019
7529	7789	9029
75310	7799	9039
75312	78031	9048
75320	78051	9049
7539	78052	9050
7559	78053	9051
75670	78054	9052
7579	78055	9053
7599	78057	9054
7600	78058	9055
7601	78079	9056
7602	7825	9057
7603	78261	9058
7604	78262	9059
7605	78340	9060
7606	78830	9061

9062	94105	9519
9063	94106	9529
9064	94107	9539
9065	94108	9549
9066	94109	9559
9067	94200	9569
9068	94201	9579
9069	94202	95890
9070	94203	9599
9071	94204	9609
9072	94205	9639
9073	94209	9649
9074	94300	9659
9075	94301	9679
9079	94302	9699
9080	94303	9709
9081	94304	9739
9082	94305	9769
9083	94306	9779
9084	94309	9809
9085	94400	9849
9086	94401	9859
9089	94402	9889
9090	94403	9899
9091	94404	9929
9092	94405	9939
9093	94406	99520
9094	94407	99522
9095	94408	99523
9099	94500	99529
9219	94501	99550
9229	94502	99580
9239	94503	99590
9249	94504	99600
9269	94505	99630
9279	94506	99640
9289	94509	99660
9299	9460	99670
9349	9479	99680
9399	9490	99690
94100	9491	99700
94101	9492	99760
94102	9493	9989
94103	9494	
94104	9495	

In addition, we proposed to make a conforming change to the MCE by removing

the following codes from Edit 10:

0650	0763	0780
0700	0769	2630

3500	4610	7910
3510	4620	7920
3520	4640	7930
3550	4650	7940
3560	4660	7950
3570	4680	7960
3610	5300	7980
3710	5310	7990
3770	5640	8000
3800	7550	8010
3810	7670	8020
3830	7700	8040
3840	7720	8070
3850	7760	8080
3860	7770	8090
3880	7780	8100
4040	7790	8120
4050	7800	8130
4100	7810	8153
4210	7820	8155
4240	7830	8400
	7840	8440
4400	7850	8460
4440	7870	8469
4500	7880	8660
4590	7890	8670

Comment: Several commenters commended CMS for simplifying what they considered to be a burdensome edit that has ceased to serve its intended purpose.

Response: We appreciate the commenters' support for the removal of the specified codes from Edit 7 and Edit 10.

Comment: One commenter pointed out that code 015.95 (Tuberculosis of unspecified bones and joints, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically) was included on the list of nonspecific principal diagnoses in the MCE, but was not included in the list of codes to be deleted in the proposed rule.

Response: The commenter is correct; code 015.95 should have been included in the list of codes to be deleted from Edit 7. We have modified the list to include deletion of this code as part of the deletion of the edit in the MCE software.

After consideration of the public comments received, in this final rule with comment period, we are finalizing our deletion of the specified listed codes in Edit 7 (Non-Specific Principal Diagnosis) (including code 015.95) and in Edit 10 (Non-Specific O.R. Procedures) of the MCE.

c. Limited Coverage Edit 17

Edit 17 in the MCE contains ICD-9-CM procedure codes describing medically complex procedures, including lung volume reduction surgery, organ transplants, and implantable heart assist devices which are to be performed only in certain pre-approved medical centers. CMS has established, through regulation (CMS-3835-F: Medicare Conditions of Participation: Requirements for Approval and Reapproval of Transplant Centers to Perform Organ Transplants, published in the **Federal Register** on March 30, 2007 (72 FR 15198)), a survey and certification process for organ transplant programs. The organs covered in this transplant regulation are heart, heart and lung combined, intestine, kidney, liver, lung, pancreas, and multivisceral. Historically, kidney transplants have been regulated under the End-Stage Renal Disease (ESRD) conditions for coverage. Other types of organ transplant facilities have been regulated under various NCDs.

The regulation becomes effective on June 28, 2007. Organ transplant programs will have 180 days from the June 28, 2007 effective date of the regulation to apply for

participation in the Medicare program under the new survey and certification process.

After these programs apply, we will survey and approve programs that meet the new

Medicare conditions of participation. Until transplant facilities are surveyed and

approved, kidney transplant facilities will continue to be regulated under the ESRD

conditions for coverage, and other types of organ transplant facilities will continue to be

regulated under the NCDs.

In the FY 2008 IPPS proposed rule, we proposed to add conforming Medicare

Part A payment edits to the MCE, consistent with the requirements of the organ

transplant regulation (CMS-3835-F), to ensure that Medicare covers only those organ

transplants performed in Medicare-approved facilities. We proposed to add the following

procedure codes to the existing list of limited coverage procedures under Edit 17:

- 55.69, Other kidney transplantation

- 52.80, Pancreatic transplant, not otherwise specified

- 52.82, Homotransplant of pancreas

We did not receive any public comments on this portion of the proposed MCE

revisions. Therefore, we will implement the changes as stated above by adding

procedure codes 55.69, 52.80, and 52.82 to the list of limited coverage procedures in the

MCE.

d. Revision to Part 1, Pancreas Transplant Edit A

Effective for services performed on or after April 26, 2006, we published an NCD

for Pancreas Transplants in section 260.3 of the Coverage Manual, stating that pancreas

alone transplants are reasonable and necessary for Medicare beneficiaries in facilities that

are Medicare-approved for kidney transplantation. In addition, patients must have a

diagnosis of Type I diabetes mellitus. The complete NCD can be found at the following

CMS Web site:

http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=260.3&ncd_version=3&basket=ncd%

3A260%2E3%3A3%3APancreas+Transplants

Edit A in the MCE currently includes the following language and codes.

"Procedure codes 52.80 (Pancreatic transplant, not otherwise specified) and

52.82 (Homotransplant of pancreas) are identified as non-covered procedures except for

the following two conditions:

When either 52.80 or 52.82 are combined with the procedure code in Procedure

list 2 and there is at least one principal or secondary diagnosis code present from both

Diagnosis List 1 and Diagnosis List 2.

Procedure List 1:

Code 52.80

Code 52.82

Procedure List 2:

Code 55.69

Diagnosis List 1:

Codes 250.00 through 250.93

Diagnosis List 2:

Code 403.01

Code 403.11

Code 403.91

Code 404.02

Code 404.03

Code 404.12

Code 404.13

Code 404.92

Code 404.93

Codes 585.1 through 585.6

Code 585.9

Code V42.0

Code V43.89"

This technical correction was not included in the FY 2008 IPPS proposed rule

because of the timing of the release of the NCD. However, we need to make a revision to

Edit A in the MCE to conform to the changes in our national coverage of the pancreas

alone (PA) procedure. This NCD was implemented on July 3, 2006, which prevented us

from addressing the MCE edit in the FY 2007 IPPS final rule. However, because the

MCE changes for FY 2007 are retroactive to April 26, 2006, both procedure codes 52.80

and 52.82 will still trigger a limited coverage edit when coverage criteria have been met.

Therefore, we are removing Edit A in its entirety from the MCE.

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.

        For FY 2008, we did not propose any revisions of the surgical hierarchy for any

MDC. In general, the MS-DRGs that we proposed (and are adopting in this final rule

with comment period) for use in FY 2008 and discussed in section II.D. of the preamble

of this final rule with comment period follow the same hierarchical order as the

CMS DRGs they are replacing, except for DRGs that were deleted and consolidated.

        Comment: Two commenters supported no changes in the surgical hierarchy for

FY 2008. However, one commenter stated that CMS should continue to revisit this issue

on an annual basis.

        Response: We will continue to conduct annual analysis of the surgical hierarchy

in the MS-DRGs as we have with the CMS-DRGs and propose revisions when necessary.

For FY 2008, there will no changes to the surgical hierarchy.

8. CC Exclusions List

a. Background

        As indicated earlier in the preamble of this final rule with comment period, under

the IPPS DRG classification system, we have developed a standard list of diagnoses that

are considered CCs. Historically, we developed this list using physician panels that

classified each diagnosis code based on whether the diagnosis, when present as a

secondary condition, would be considered a substantial complication or comorbidity. A

substantial complication or comorbidity was defined as a condition that, because of its

presence with a specific principal diagnosis, would cause an increase in the length of stay

by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2.

and 3. of the preamble of this final rule with comment period for a discussion of the

refinement of CCs in relation to the MS-DRGs we proposed and are adopting in this final

rule with comment period for FY 2008.

b. CC Exclusions List for FY 2008

        In the September 1, 1987 final notice (52 FR 33143) concerning changes to the

DRG classification system, we modified the GROUPER logic so that certain diagnoses

included on the standard list of CCs would not be considered valid CCs in combination

with a particular principal diagnosis. We created the CC Exclusions List for the

following reasons: (1) to preclude coding of CCs for closely related conditions; (2) to

preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure

that cases are appropriately classified between the complicated and uncomplicated DRGs

in a pair. As we indicated above, we developed a list of diagnoses, using physician

panels, to include those diagnoses that, when present as a secondary condition, would be

considered a substantial complication or comorbidity. In previous years, we have made

changes to the list of CCs, either by adding new CCs or deleting CCs already on the list.

        In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987

final notice (52 FR 33154), we explained that the excluded secondary diagnoses were

established using the following five principles:

        ● Chronic and acute manifestations of the same condition should not be

considered CCs for one another.

●   Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis

codes for the same condition should not be considered CCs for one another.

●   Codes for the same condition that cannot coexist, such as partial/total,

unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be

considered CCs for one another.

●   Codes for the same condition in anatomically proximal sites should not be

considered CCs for one another.

●   Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of

codes. We have continued to review the remaining CCs to identify additional exclusions

and to remove diagnoses from the master list that have been shown not to meet the

definition of a CC.[25]

For FY 2008, 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, 2007. (See section II.G.10. of the preamble

of this final rule with comment period for a discussion of ICD-9-CM changes.) We are

making these changes in accordance with the principles established when we created the

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[25] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; and the FY 2007 final rule (71 FR 47870) for the FY 2007 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.

CC Exclusions List in 1987. In addition, as discussed in section II.D.3. of the preamble

of this final rule with comment period, we are indicating on the CC exclusion list some

updates to reflect the exclusion of a few codes from being an MCC under the MS-DRG

system that we are adopting for FY 2008.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List,

respectively, which are included in the Addendum to this final rule with comment period,

will be effective for discharges occurring on or after October 1, 2007. Each of these

principal diagnoses for which there is a CC exclusion is shown with an asterisk, and the

conditions that will not count as a CC, are provided in an indented column immediately

following the affected principal diagnosis.

A complete updated MCC, CC, and Non-CC Exclusions List is available through the

Internet on the CMS Web site at: http:/www.cms.hhs.gov/AcuteInpatientPPS.

Beginning with discharges on or after October 1, 2007, the indented diagnoses will not be

recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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 24.0, is available

for $225.00, which includes $15.00 for shipping and handling. Version 25.0 of this

manual, which will include the final FY 2008 DRG changes, will be available in hard

copy for $250.00. Version 25.0 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 CMS DRGs 468, 476, and 477

Each year, we review cases assigned to CMS DRG 468 (Extensive O.R.

Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure

Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure

Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change

the procedures assigned among these CMS DRGs. Under the MS-DRGs that we are

adopting for FY 2008, discussed in section II.D. of the preamble of this final rule with

comment period, CMS DRG 468 has a three-way split and becomes MS-DRGs 981, 982,

and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with

CC, and without CC/MCC). CMS DRG 476 becomes proposed MS-DRGs 984, 985, and

986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and

without CC/MCC). CMS DRG 477 becomes MS-DRGs 987, 988, and 989

(Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and

without CC/MCC).

MS-DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly

CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none

of the O.R. procedures performed are related to the principal diagnosis. These CMS

DRGs are intended to capture atypical cases, that is, those cases not occurring with

sufficient frequency to represent a distinct, recognizable clinical group. MS-DRGs 984

through 986 (previously CMS DRG 476) are assigned to those discharges in which one or

more of the following prostatic procedures are performed and are unrelated to the

principal diagnosis:

- 60.0, Incision of prostate

- 60.12, Open biopsy of prostate

- 60.15, Biopsy of periprostatic tissue

- 60.18, Other diagnostic procedures on prostate and periprostatic tissue

- 60.21, Transurethral prostatectomy

- 60.29, Other transurethral prostatectomy

- 60.61, Local excision of lesion of prostate

- 60.69, Prostatectomy, not elsewhere classified

- 60.81, Incision of periprostatic tissue

- 60.82, Excision of periprostatic tissue

- 60.93, Repair of prostate

- 60.94, Control of (postoperative) hemorrhage of prostate

- 60.95, Transurethral balloon dilation of the prostatic urethra

- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy

- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy

- 60.99, Other operations on prostate

All remaining O.R. procedures are assigned to MS-DRGs 981 through 983 and

987 through 989 (previously CMS DRGs 468 and 477), with MS-DRGs 987 through 989

(previously CMS DRG 477) assigned to those discharges in which the only procedures

performed are nonextensive procedures that are unrelated to the principal diagnosis.[26]

In the FY 2008 IPPS proposed rule, we did not propose to change the procedures

assigned among these DRGs. We did not receive any public comments on this subject.

Therefore, for FY 2008, we are not changing the procedures assigned among these

DRGs.

a. Moving Procedure Codes from CMS DRG 468 (MS-DRGs 981 through 983) or CMS

DRG 477 (MS-DRGs 987 through 989) to MDCs

We annually conduct a review of procedures producing assignment to CMS DRG

468 (MS-DRGs 981 through 983 in this final rule with comment period) or CMS DRG

477 (MS-DRGs 987 through 989 in this final rule with comment period) on the basis of

volume, by procedure, to see if it would be appropriate to move procedure codes out of

these DRGs into one of the surgical DRGs for the MDC into which the principal

diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a

frequency count of each major operative procedure code. We also compare procedures

across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal

diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs

for the MDC in which the diagnosis falls. In the FY 2008 IPPS proposed rule, we did not

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[26]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.

propose to remove any procedures from CMS DRG 468 (MS-DRGs 981 through 983 in

this final rule with comment period) or CMS DRG 477 (MS-DRGs 987 through 989).

We did not receive any public comments on this subject. Therefore, based on this year's

review, we are not removing any procedures from these DRGs.

b. Reassignment of Procedures among CMS DRGs 468, 476, and 477 (MS-DRGs 981

through 983, 984 through 986, and 987 through 989)

We also annually review the list of ICD-9-CM procedures that, when in

combination with their principal diagnosis code, result in assignment to CMS DRGs 468,

476, and 477 (MS-DRGs 981 through 983, 984 through 986, and 987 through 989,

respectively, in this final rule with comment period), to ascertain whether any of those

procedures should be reassigned from one of these three DRGs to another of the three

DRGs based on average charges and the length of stay. We look at the data for trends

such as shifts in treatment practice or reporting practice that would make the resulting

DRG assignment illogical. If we find these shifts, we would propose to move cases to

keep the DRGs clinically similar or to provide payment for the cases in a similar manner.

Generally, we move only those procedures for which we have an adequate number of

discharges to analyze the data.

We did not propose to move any procedure codes among these DRGs. We did

not receive any public comments on this subject. Therefore, we are not moving any

procedure codes from CMS DRG 476 (MS-DRGs 984, 985, and 986 in this final rule

with comment period) to CMS DRG 468 (MS-DRGs 981, 982, and 983 in this final rule

with comment period) or to CMS DRG 477 (MS-DRGs 987, 988, and 989 in this final

rule with comment period), or from CMS DRG 477 (MS-DRGs 987, 988, and 989 in this

final rule with comment period) to CMS DRGs 468 (MS-DRGs 981, 982, and 983 in this

final rule with comment period) or to CMS DRG 476 (MS-DRGs 984, 985, and 986 in

this final rule with comment period) for FY 2008.

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 2008. We did not receive any public comments on this subject.

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

As described in section II.B.1. of the preamble of this final rule with comment

period, 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 2008 at a public meeting held on September 28-29, 2006, and finalized the coding

changes after consideration of comments received at the meetings and in writing by

December 4, 2006. Those coding changes are announced in Tables 6A through 6F in the

Addendum to this proposed rule. The Committee held its 2007 meeting on

March 22-23, 2007. 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 2007

will be included in the October 1, 2007 update to ICD-9-CM. Code revisions that were

discussed at the March 22-23, 2007 Committee meeting could not be finalized in time to

include them in the Addendum to the proposed rule. These additional codes are included

in Tables 6A through 6F of this final rule with comment period and are marked with an

asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's

September 28-29, 2006 meeting can be obtained from the CMS Web site at:

http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. The minutes of the

diagnosis codes discussions at the September 28-29, 2006 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, 2007. The new ICD-9-CM codes are listed, along with their DRG

classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes,

respectively) in the Addendum to this final rule with comment period. 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 2008 IPPS

proposed rule, we only solicited comments on the proposed classification of these new

codes.

       Comment: One commenter expressed concern that the 2-month timeframe

between adoption of new ICD-9-CM codes and the effective date of new codes creates a

disadvantage for the coding community because updating of facility-specific and industry

information, such as education/training materials and code books, is based on the final

codes. The commenter noted that ICD-9-CM code changes discussed at the

March 22-23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting were

not listed in the FY 2008 IPPS proposed rule, so the coding community has 2 months,

rather than 5 months, to update its coding products. The commenter recommended that

CMS consider implementation of codes discussed at the spring meeting in April of the

following year, rather than forcing the new codes into the October release.

Response: We are sympathetic to the commenter's concern that the short

timeframe between adoption of new codes and the effective date of new codes may make

it challenging to update coding products. However, this short time period has proven to

be invaluable for collecting MedPAR data on new technologies as soon as possible.

Therefore, we will continue our current process of attempting to expedite the creation of

new ICD-9-CM codes.

For codes that have been replaced by new or expanded codes, and the

corresponding new or expanded diagnosis codes are included in Table 6A. New

procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by

expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis

Codes). These invalid diagnosis codes will not be recognized by the GROUPER

beginning with discharges occurring on or after October 1, 2007. 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, 2007. 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 2008.

In the September 7, 2001 final rule implementing the IPPS new technology

add-on payments (66 FR 46906), we indicated we would attempt to include proposals for

procedure codes that would describe new technology discussed and approved at the

Spring meeting as part of the code revisions effective the following October. As stated

previously, ICD-9-CM codes discussed at the March 22-23, 2007 Committee meeting

that received consensus and that were finalized by May 2007, are included in Tables 6A through 6F of the Addendum to this final rule with comment period.

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 on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) . . . until the fiscal year that begins after such date." This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to identify the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to identify and report the new codes.

The ICD-9-CM Coordination and Maintenance Committee holds its meetings in

the spring and fall in order to update the codes and the applicable payment and reporting

systems by October 1 of each year. Items are placed on the agenda for the ICD-9-CM

Coordination and Maintenance Committee meeting if the request is received at least

2 months prior to the meeting. This requirement allows time for staff to review and

research the coding issues and prepare material for discussion at the meeting. It also

allows time for the topic to be publicized in meeting announcements in the **Federal**

Register as well as on the CMS Web site. The public decides whether or not to attend

the meeting based on the topics listed on the agenda. Final decisions on code title

revisions are currently made by March 1 so that these titles can be included in the IPPS

proposed rule. A complete addendum describing details of all changes to ICD-9-CM,

both tabular and index, is published on the CMS and NCHS Web sites in May of each

year. Publishers of coding books and software use this information to modify their

products that are used by health care providers. This 5-month time period has proved to

be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the

December 4-5, 2005 ICD-9-CM Coordination and Maintenance Committee minutes. The

public agreed that there was a need to hold the fall meetings earlier, in September or

October, in order to meet the new implementation dates. The public provided comment

that additional time would be needed to update hospital systems and obtain new code

books and coding software. There was considerable concern expressed about the impact

this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the

Act, as added by section 503(a) of 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, 2007 implementation of an ICD-9-CM code at the

September 28-29, 2006 Committee meeting. Therefore, there were no new ICD-9-CM

codes implemented on April 1, 2007.

We believe that this process captures the intent of section 1886(d)(5)(K)(vii) of

the Act. This requirement was included in the provision revising the standards and

process for recognizing new technology under the IPPS. In addition, the need for

approval of new codes outside the existing cycle (October 1) arises most frequently and

most acutely where the new codes will identify new technologies that are (or will be)

under consideration for new technology add-on payments. Thus, we believe this

provision was intended to expedite data collection through the assignment of new

ICD-9-CM codes for new technologies seeking higher payments.

        Current addendum and code title information is published on the CMS Web site

at: www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01_overview.asp#TopofPage.

Information on ICD-9-CM diagnosis codes, along with the Official ICD-9-CM Coding

Guidelines, can be found on the Web site at: www.cdc.gov/nchs/icd9.htm. Information

on new, revised, and deleted ICD-9-CM codes is also provided to the AHA for

publication in the Coding Clinic for ICD-9-CM. AHA also distributes information to

publishers and software vendors.

        CMS also sends copies of all ICD-9-CM coding changes to its contractors for use

in updating their systems and providing education to providers.

        These same means of disseminating information on new, revised, and deleted

ICD-9-CM codes will be used to notify providers, publishers, software vendors,

contractors, and others of any changes to the ICD-9-CM codes that are implemented in

April. The code titles are adopted as part of the ICD-9-CM Coordination and

Maintenance Committee process. Thus, although we publish the code titles in the IPPS

proposed and final rules, they are not subject to comment in the proposed or final rules.

We will continue to publish the October code updates in this manner within the IPPS

proposed and final rules. For codes that are implemented in April, we will assign the new

procedure code to the same DRG in which its predecessor code was assigned so there

will be no DRG impact as far as DRG assignment. Any midyear coding updates will be

available through the Web sites indicated above and through the Coding Clinic for

ICD-9-CM. Publishers and software vendors currently obtain code changes through

these sources in order to update their code books and software systems. We will strive to

have the April 1 updates available through these Web sites 5 months prior to

implementation (that is, early November of the previous year), as is the case for the

October 1 updates.

11. Other DRG Issues Addressed in the FY 2008 IPPS Proposed Rule

a. Seizures and Headaches

       After publication of the FY 2007 IPPS final rule (71 FR 47928), we received

correspondence expressing concerns about the revisions we made to the seizure and

headache DRGs effective on October 1, 2006. We created new DRGs 562 (Seizure

Age >17 With CC), DRG 563 (Seizure Age >17 Without CC), and DRG 564 (Headaches

Age >17) as an interim step to better recognize severity of illness among seizure and

headache patients for FY 2007. Although national Medicare utilization data supported

the revised DRGs, the commenter indicated that the change did not appropriately

recognize hospital resources associated with the patients treated in the hospital's inpatient

headache program. The commenter stated that patients who are admitted to the hospital's

inpatient headache program suffer from chronic headache pain and require inpatient

treatment that can last up to 12 days. The commenter noted that these patients are

referred from around the country after several months of unsuccessful pain relief and

treatment. The commenter indicated that the majority of patients treated at the hospital's

inpatient headache program are drug dependent from being administered increasing

dosages of pain relievers that have been unsuccessful in resolving chronic headache pain.

Further, the commenter noted that the patients require detoxification before any headache

treatment begins. The commenter urged CMS to subdivide the headache DRG to better

recognize the higher level of severity associated with treating chronic headache patients

in the hospital's program.

Although we are sympathetic to the commenter, it is not feasible to design a DRG

system that addresses concerns that may be unique to one facility. Other than this one

commenter, we did not receive any concern about our decision to create separate DRGs

for seizures and headaches. However, we agreed to review this issue as part of our effort

to redesign the DRG system to better recognize severity of illness for FY 2008.

As discussed in section II.C. of the preamble of this final rule with comment

period, we are adopting MS-DRGs for FY 2008. While the CMS DRG structure did not

support splitting the headache DRG based on the presence or absence of a CC, the MS-

DRGs support the creation of a split for the headache DRGs based on whether the patient

has an MCC as shown below:

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 102 (Headaches with MCC)	1,268	5.04	$19,077
MS-DRG 103 (Headaches without MCC)	14,277	3.22	$11,989

(The criteria for determining whether to subdivide a DRG are described in detail

earlier in section II.D. of the preamble of this final rule with comment period.) Thus, we

proposed to create two MS-DRGs for headaches under the MS-DRGs as shown below:

- MS-DRG 102 (Headaches with MCC)

● MS-DRG 103 (Headaches without MCC)

We believe this proposed structure would better recognize those headache patients who are severely ill and require more resources as described by the commenter. We refer the readers to section II.D. of the preamble of this final rule with comment period for a detailed discussion of the MS-DRGs.

Comment: Three commenters supported a DRG system that accounts for the severity of illness, intensity of service, and differences in the cost of care in treating headache patients. They strongly support CMS' proposal to revise its current headache classification, CMS DRG 564 (Headaches Age > 17), that was effective as of October 1, 2006 (FY 2007). One of the commenters stated that CMS DRG 564 does not adequately classify headache cases based on the presence or absence of complicating conditions and assumes a relatively short length of stay, resulting in inadequate payments to cover the costs of treating severely complex chronic headache patients that are referred to specialized treatment centers such as theirs. The commenters also agreed with the use of secondary diagnoses to improve payments and better account for severity within a DRG that is defined by the diagnosis of headache. However, the commenters indicated that certain secondary diagnoses related to medication overuse and dependency are not considered MCCs for headache cases. According to one of the commenters, the common secondary diagnosis codes used for patients with medication overuse and dependency are identified by the following ICD-9-CM codes (a fifth digit representing the drug dependence as unspecified (0), continuous (1), episodic (2), or in remission (3) would be applied according to the physician documentation):

- 304.0x, Opioid type dependence

- 304.1x, Sedative, hypnotic or anxiolytic dependence

- 304.2x, Cocaine dependence

- 304.3x, Cannabis dependence

- 304.4x, Amphetamine and other psychostimulant dependence

- 304.5x, Hallucinogen dependence

- 304.6x, Other specified drug dependence

- 304.7x, Combinations of opioid type drug with any other

- 304.8x, Combinations of drug dependence excluding opioid type drug

- 304.9x, Unspecified drug dependence

The commenters recognize that most of the above listed conditions were included

on the proposed CC list; however, none of them were included on the proposed MCC list.

Therefore, the majority of patients treated in the commenter's specialized headache

program will not qualify to be assigned to proposed MS-DRG 102 (Headache with MCC)

and will be paid using proposed MS-DRG 103 (Headache without MCC)--the lower

severity level. The commenter further noted that, in contrast to patients who primarily

exhibit substance abuse, the headache patient does not primarily exhibit addictive

disease, but is a desperate individual who takes increasing amounts of medication to

control pain that has not successfully been controlled. In addition, the patient

experiences withdrawal phenomena (sweating, shaking, crawling skin, sleeplessness,

changes to blood pressure and pulse) as he or she attempts to reduce the drugs at the

recommendation of the physician. The commenter noted that a chronic headache patient

with a narcotics addiction is more costly to treat because, to ensure a successful treatment outcome, the patient must be effectively withdrawn from the offending medication, while simultaneously addressing the escalating pain and controlling it which requires inpatient hospitalization that can last up to 2 weeks.

Another commenter suggested that according to the MCCs identified, there appeared to be a significant variance in cost for headache patients whose stay involved an additional two days. This commenter encouraged CMS to examine the creation of a CC split under the current CMS DRG classification if the adoption of the MS-DRG system does not take place. The commenter stated the determination should consider whether the MCCs used in the MS-DRG analysis are on the current CMS DRG CC list.

One of the commenters provided several suggestions for how the proposed MS-DRG classification could more accurately identify case complexity for inpatient headache cases. The suggestions are described below.

1. Include the ICD-9-CM codes (304.00-304.93) on the list of MCCs. These conditions are true indicators of case complexity and patients with these complications should be paid at the higher severity level if there are only these two adult headache DRGs.

2. If the above suggestion of moving those codes to the MCC list has unintended consequences for a large number of the other (non-headache) DRGs, another approach would be to add a modifier to the CC list recognizing these codes as MCCs for cases in which the principal diagnosis is headache.

3. Add a third headache MS-DRG specifically for the opioid and other

medication overuse codes.

The commenter indicated a preference for the third option stating that based on

the data available and medical judgment, this MS-DRG would be the most clinically

appropriate method to better recognize severity among headache cases. In addition, the

commenter noted it is most consistent with efforts already underway in the ICD-10

classification system to identify medication overuse in patients with a principal diagnosis

of headache, although ICD-10 is not yet available.

Response: We appreciate the commenter's support of the proposed MS-DRG

classification system to better recognize severity of illness, intensity of service, and

differences in the cost of care in treating headache patients. The commenters are correct

that the drug dependency diagnosis codes (304.0x – 304.9x) are not considered MCCs in

the proposed MS-DRG system. As we discussed in the proposed rule (72 FR 24702), we

categorized diagnoses as MCCs, CCs, and non-CC based on an iterative approach in

which each diagnosis was evaluated to determine the extent to which its presence as a

secondary diagnosis resulted in increased hospital resources.

We examined the MedPAR data for headache patients with drug dependency

(codes 304.00 – 304.93). Our medical advisors also analyzed clinical issues surrounding

patients who have these codes reported as a secondary diagnosis. After evaluation of the

data and clinical issues, our medical advisors recommend that we not change the CC

status for the drug dependency codes. Our analysis demonstrated approximately 254

cases in MS-DRG 103 with an average length of stay of 4.9 days and average charges

approximately $2,500 higher than without drug dependency. There were 25 cases in

MS-DRG 102 with an average length of stay of 7 days and average charges

approximately $5,000 higher than all cases in MS-DRG 102. The results are shown in

the table below.

Headaches			
DRG	**Number of cases**	**Average length of stay**	**Average Charges**
MS-DRG 102 with MCC – All cases	1,268	5.04	$19,077
MS-DRG 102 with MCC - With secondary diagnosis of drug dependency codes 304.00-304.93	25	7	$24,061
MS-DRG 103 without MCC – all cases	14,277	3.22	$11,989
MS-DRG 103 with MCC – With secondary diagnosis of drug dependency codes 304.00-304.93	254	4.9	$14,447

The process used to subdivide a MS-DRG into severity levels based upon the

presence of a CC or MCC included five criteria. All five criteria had to be met to satisfy

the requirement of creating severity levels. We refer readers to section II.D.3. of the

preamble to this final rule with comment period for a complete discussion of these

criteria.

In studying the data for headaches, the number of cases that include secondary

diagnoses of drug dependency does not meet the minimum requirement of 500 cases to

create another subdivision. Therefore, only the "with MCC" and "without MCC"

severity levels were established and proposed for headache cases.

We agree with the commenter that headache patients who suffer from medication overuse are not identical to substance abuse patients. However, if a headache patient presents to the hospital with withdrawal phenomena and it is the drug withdrawal symptoms that require attention and resolution prior to directing treatment towards the headache symptoms, the reason for the patient's admission (or principal diagnosis) appears to be the drug withdrawal. The Official ICD-9-CM Guidelines for Coding and Reporting instruct that the principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "*that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.*" Therefore, these headache patients are being admitted to address their drug dependency and drug withdrawal before any headache treatment can begin.

As discussed above, at this time, analysis of the data does not support assigning the drug dependency codes as MCCs. Secondly, there is not justification to warrant adding modifiers to the drug dependency codes that are currently on the CC list to consider those diagnoses as MCCs for headache cases only. (Further, modifiers are not used in ICD-9-CM.) Lastly, the data does not support subdividing the proposed MS-DRGs for headaches into another severity level.

In this FY 2008 final rule, we are adopting the MS-DRGs. Therefore, effective October 1, 2007, the MS-DRGs for headache cases will be as follows:

- MS-DRG 102 (Headaches with MCC)

- MS-DRG 103 (Headaches without MCC).

Comment: One commenter applauded CMS for the changes in the DRG structure

to better recognize differences in patient severity.   This commenter recommended

further refinements to proposed MS-DRG 100 (Seizures with MCC) and MS-DRG 101

(Seizures without MCC). According to the commenter, most Medicare patients who are

assigned to the seizure DRGs are admitted to receive acute treatment that is typically

provided in the general medical setting.   Alternatively, the commenter stated that

patients who suffer from uncontrolled seizures or intractable epilepsy are admitted to an

epilepsy center for a comprehensive evaluation to identify the epilepsy seizure type, the

cause of the seizure, and the location of the seizure. The commenter added that these

patients are admitted to the hospital for 4 to 6 days with 24-hour monitoring that includes

the use of EEG video monitoring along with cognitive testing and brain imaging

procedures. The commenter noted that patients treated in an epilepsy center receive

highly technical care that is comparable to the care received in a hospital's intensive care

unit, and these patients are more costly to treat.

With the assistance of an outside reviewer, the commenter analyzed cost data for

proposed MS-DRGs 100 and 101, which focused on a target group of patients identified

with a diagnosis of epilepsy (diagnosis codes 345.0 through 345.9) or convulsions

(diagnosis code 780.39) and the presence of EEG video monitoring (vEEG) (procedure

code 89.10) or a Wada test (procedure code 89.19). The commenter stated that the

patients identified with those codes are treated in specialized epilepsy centers. The

commenter recommended that CMS further refine proposed MS-DRGs 100 and 101 by

subdividing cases with the combination of a diagnosis of epilepsy and one of the

diagnostic tests performed into separate DRGs defined as follows:

- MS-DRG XXX (Epilepsy Evaluation with MCC)

- MS-DRG XXX (Epilepsy Evaluation without MCC)

The commenter acknowledged that the target group of cases constitutes a small

portion of the total cases found in MS-DRGs 100 and 101. However, the commenter

noted that the diagnostic procedures described above (codes 89.10 and 89.19) are

performed by a small minority of hospitals in the United States. The commenter believed

that the recommendation to refine these DRGs would result in a minimal impact on other

hospitals, while substantially improving the accuracy of payment to those hospitals

specializing in epilepsy treatment.

Response: We appreciate the commenter's support of our efforts to better

recognize severity in the DRG system and its recommendation to further refine the

proposed seizure DRGs. Epilepsy is currently identified by ICD-9-CM diagnosis codes

345.0x through 345.9x. There are two fifth-digits that may be assigned to a subset of the

epilepsy codes, depending on the physician documentation:

- 0 - without mention of intractable epilepsy

- 1 - with intractable epilepsy

According to the commenter, the specialized epilepsy centers focus on treating

patients who suffer from intractable epilepsy. The data that the commenter reviewed

included the range of epilepsy codes (345.0 through 345.9), the code for convulsions

(780.39) and the codes for the diagnostic tests (89.10 and 89.19). The data that were

submitted by the commenter did not clearly identify the specific epilepsy codes reviewed or the combination of the diagnostic procedures performed along with specified epilepsy codes. It was also unclear what secondary codes were reviewed in the analysis. As a result, we were unable to conduct our own analysis to evaluate the commenter's recommendation. In addition, we do not believe that we should make further changes to the MS-DRG assignments based on combinations of selected diagnoses. These types of analyses could be done with virtually any MS-DRG and would add significant complexity to the DRG system that we do not believe is warranted at this time. We encourage the commenter to provide the specific codes used in its analysis so we can examine this issue as we continue to make further refinements to the DRGs for FY 2009.

We also note that the topic of epilepsy has been discussed over the last couple of years at the ICD-9-CM Coordination and Maintenance Committee meetings due to confusion with physician documentation and the implications of coding a patient as having a one-time seizure versus "labeling" the patient as having the diagnosis of epilepsy. It is unclear if the data identifying these conditions are accurate and reliable as a result of this confusion.

In conclusion, as final policy for FY 2008, effective October 1, 2007, the following seizure DRGs are adopted as proposed:

- MS-DRG 100 (Seizures with MCC)
- MS-DRG 101 (Seizures without MCC).

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

(1) Background

We addressed the topic of Medicare payment for devices that are replaced without

costs or where credit for a replaced device is furnished to the hospital in the FY 2007

IPPS final rule (71 FR 47962). In that final rule, we included the following background

information:

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. Nonetheless, 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 who

would be potentially 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 corrective action to care

for patients. 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 are addressed as early as possible so that patients' quality of

health care is protected and high quality medical care, equipment, and technologies are

provided. We are taking several steps to assist in the early recognition and analysis of

patterns of device problems to minimize the potential for harm from device-related

defects to Medicare beneficiaries 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, we issued an 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 medical care received by Medicare beneficiaries was reasonable

and necessary and, therefore, that the provider or supplier would be appropriately paid.

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, registry data can facilitate public response to the quality of

health care issues in the event of future device recalls. Analysis of registry data may

uncover patterns of device malfunction, device-related infection, or early battery

depletion that would trigger a more specific investigation. Patterns found in registry data

may identify problems in patient outcomes earlier than the currently available

mechanisms, which do not systematically collect detailed information about each patient

who receives an ICD.

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 patients' quality of health care status and medical

outcomes. While participation in an ICD registry is required as a Medicare condition of

coverage for ICD implantation for certain clinical conditions, we believe that the

potential benefits of other data collection extend well beyond their application in

Medicare's specific NCDs. As medical technology continues to advance swiftly, data

collection regarding the short-term and long-term medical outcomes of new technologies,

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 device-related

problems, patterns of complications, and health-related outcomes. This information will

facilitate early interventions to mitigate any harm potentially imposed upon Medicare

beneficiaries and the public, and to improve the quality and efficiency of health care

services provided.

        Moreover, published data from registries may further help the development of

high quality, evidence-based clinical practice guidelines for the care of patients who may

receive device implants. In turn, widespread use of evidence-based guidelines may

reduce variation in medical practice, leading to improved personal care and overall public

health. Registry information may also contribute to the development of more

comprehensive and refined quality metrics that may be used to systematically assess the

collected data, and then improve the safety and quality of health care provided to

Medicare beneficiaries. 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 to progressively work towards that goal, and to ensure excellent and

open communication and rapid system wide responses.

One strategy for this data collection involves adding information to the claims forms. CMS has a long history of collecting hemoglobin or hematocrit data from ESRD patients on the claims form. Modification of claims forms was necessary to do that. CMS is exploring the use of claims data to collect other types of clinical or technical data such as device manufacturer and model number. The systematic recording of model numbers can enhance knowledge of device-related outcomes and complications. We look forward to further discussions with the public about new strategies to both recognize device-related problems early as well as recognize health-related outcomes of new technologies.

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-related problems, potentially leading to more timely improvements in medical device technologies. This systematic approach, which enables hospitals to identify and then appropriately report selected services when devices are replaced without cost to the hospital, or with full or partial credit to the hospital for the cost of the replaced device, should provide comprehensive information regarding the hospitals' experiences with Medicare beneficiaries who have specific medical devices that are being replaced. Because Medicare beneficiaries are common recipients of implanted devices, the claims information may be particularly helpful in identifying patterns of device-related problems early in their natural history, so that appropriate strategies to reduce future problems may be developed. One possible strategy would be for the Medicare program to use

information obtained through the use of bar coding of medical devices. The FDA issued

a final rule in the **Federal Register** on February 26, 2004 (69 FR 9119), that required bar

codes for human drugs and biological product labels effective April 26, 2006. In the final

rule, FDA deferred action on requiring bar codes for medical devices, noting the

difficulty in standardizing medical devices, as compared to drugs and biologicals, which

have the unique NDC numbering system. This rule can be reviewed on the **Federal**

Register's Web site at: http://www.docket.access.gpo.gov/2004/04-4249.htm

        We intend to monitor FDA's work in this area to determine how this technology

could help CMS promote higher quality through better clinical decision making and, as

discussed below, assist in improving the accuracy of the Medicare payment system.

        In addition to our concern for overall public health, we also have a fiduciary

responsibility to the Medicare Trust Fund to ensure that Medicare pays only for covered

services. Therefore, in the FY 2007 IPPS final rule, we indicated that we believe we

need to consider whether it is appropriate to reduce the Medicare payment in cases in

which an implanted device is replaced at reduced or no cost to the hospital or with partial

or full credit for the removed device. Such consideration could cover certain devices for

which credit for the replaced medical device is given, or medical devices that are

replaced as a result of or pursuant to a warranty, field action, voluntary recall, or

involuntary recall, and medical devices that are provided free of charge. We indicated

that conveying this information to the Medicare beneficiary could provide for a reduction

in the IPPS payment if 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.

In FY 2007 IPPS final rule, we indicated a need to develop a methodology to determine the amount of the reduction to the otherwise payable IPPS payment for medical devices furnished to Medicare beneficiaries. We believe that this policy is appropriate because, in these cases, the full cost of the replaced device is not incurred and, therefore, an adjustment to the payment is necessary to remove the cost of the device.

(2) Current and Proposed Policies

In the CY 2007 OPPS final rule (71 FR 68071 through 68077), we adopted a policy that requires a reduced payment to a hospital or ambulatory surgical center when a device is provided to them at no cost. From our experience with the OPPS, we understand that a manufacturer will often provide a credit or partial credit for the recalled device rather than a free replacement. In other situations, a manufacturer will provide either a full or partial credit for a device that needs to be replaced only during the manufacturer's warranty period. In either of these situations, the original implantation of the device was paid for either by Medicare, another third party on behalf of the beneficiary by making payment directly to the hospital, or the implantation was paid for directly by the beneficiary. Therefore, we believe that Medicare should not pay the hospital for the full cost of the replacement if the hospital is receiving a partial or full credit, either due to a recall or service during the warranty period. The device was

already paid for at the time of initial implantation, and Medicare should retain the credit

that is being provided to the hospital for service to a Medicare beneficiary.

Moreover, we also believe that a proposed adjustment is consistent with section

1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for

which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay.

Payment of the full IPPS payment amount in cases in which the device was replaced

under warranty or in which there was a full or partial credit for the price of the recalled or

failed device effectively results in Medicare payment for a noncovered item. Therefore,

in the FY 2008 IPPS proposed rule, we proposed to adjust the IPPS payment amount in

these circumstances under the authority of section 1886(d)(5)(I) of the Act, which

permits the Secretary to make "exceptions and adjustments to such payment amounts…as

the Secretary deems appropriate."

Under the OPPS, we currently only apply the reduced payment amount in

situations where the hospital received a replacement device at no cost or at full credit for

the replacement device. Unlike the current OPPS policy, we proposed for purposes of the

IPPS to apply the policy for partial as well as full credit for a replacement device. As we

indicated above, our experience with the OPPS suggests that the policy should be applied

beyond full replacement of a recalled device. We proposed to reduce the amount of the

Medicare IPPS payment when a full or partial credit towards a replacement device is

made or the device is replaced without cost to the hospital or with full credit for the

removed device. However, we do not believe that the IPPS policy should apply to all

DRGs and all situations in which a device is replaced without cost to the hospital for the

device or with full or partial credit for the removed device.   We recognize that, in many

cases, the cost of the device is a relatively modest part of the IPPS payment. In other

situations, we believe the amount of the credit will also be nominal. In these cases, we

believe that the averaging nature of payments under the IPPS would incorporate any

significant savings from a warranty replacement, field action, or recall into the payment

rate for the associated DRG, and that no specific adjustment would be necessary or

appropriate. For this reason, we proposed to apply the policy only to those DRGs under

the IPPS where the implantation of the device determines the base DRG assignment and

situations where the hospital received a credit equal to 20 percent or more of the cost of

the device. We believe a credit that is equal to or more than this percentage is

substantial, and Medicare should not pay for the full cost of these replacement devices

because hospitals have received significant savings from the manufacturer for its

replacement costs. In the proposed rule, we sought comment on the application of this

percentage amount. We further believe that it is appropriate to limit application of the

policy only to those DRGs where implantation of the device determines the DRG

assignment. In making a decision to assign a case based on whether a device was

implanted, we recognized that the device cost was a significant portion of the overall

costs faced by the hospital that treats the case. Therefore, we believe that Medicare

should not make full payment for those DRGs where the assignment of the case is made

based on implantation of the device when the hospital is receiving either a full or

significant partial credit for the device. In the proposed rule, we included a listing of the

CMS DRGs (including the proposed new MS-DRG title) that would be subject to this policy.

CMS has requested and received new condition codes from the National Uniform Billing Committee (NUBC) to describe claims where a provider has received a device or product without cost. We will use these condition codes to reduce payment when the hospital used a device for which full or partial credit is given, or the item was replaced as a result of or under a warranty, field action, voluntary recall, involuntary recall, or otherwise provided free of charge. On November 4, 2005, we issued Change Request 4058, Transmittal 741, in the Medicare Claims Processing Manual. The effective date of this transmittal was April 1, 2006, and the implementation date was April 3, 2006. This transmittal specifies that the following two new condition codes have been created. They are defined below:

● Condition Code 49 – Product Replacement within Product Lifecycle. Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

● Condition Code 50 – Product Replacement for Known Recall of a Product. The manufacturer or the FDA has identified the product for recall and therefore replacement.

This transmittal can be accessed at the following Web site: http://www.cms.hhs.gov/Transmittals/downloads/R741CP.pdf.

Hospitals must report these codes on any claim for IPPS services that includes a replacement device or product for which they received full or partial credit. Hospital

billing offices would report one of these condition codes in addition to the specific code

for the type of procedure performed (for example, replacement of a defibrillator). We

proposed to require the hospital to provide invoices or other information indicating its

normal cost of the device and the amount of the credit it received.

Under our policy, the fiscal intermediary (or, if applicable, the MAC) would

process claims involving DRGs that are subject to this policy that include a device that is

replaced without cost to the hospital for the device or with full or partial credit for the

removed device as identified by condition codes 49 or 50. For a device provided to the

hospital without cost, the fiscal intermediary (or, if applicable, the MAC) would subtract

the cost of the device from the DRG payment. For a device for which the hospital

received a full or partial credit, the fiscal intermediary (or, if applicable, the MAC) would

subtract the amount credited from the DRG payment. CMS will issue specific claims

processing instructions to Medicare contractors and hospitals on implementing this

policy. We proposed to require the hospital to provide invoices or other information

indicating the cost of the device and the amount of credit it received. In the proposed

rule, we sought comment on the best approach to making this payment adjustment and

what types of documentation hospitals should provide to the fiscal intermediary or MAC.

We proposed to invoke our special exceptions and adjustment authority under

section 1886(d)(5)(I)(i) of the Act to make this adjustment. 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 would

be appropriate to adjust payments for surgical procedures to replace certain devices by

providing payments to hospitals only for the non-device-related procedural costs when such a device is replaced without cost to the hospital for the device or with full credit for the removed device.

Comment: Many commenters addressed this proposal. Some commenters suggested that CMS rescind the implementation of the proposed policy. Other commenters supported "the goal of accurate payment for services provided and…the concept of a payment offset for devices that are replaced without cost or where a credit is furnished to the hospital for a replaced device." However, most commenters also suggested that, if CMS were to implement the policy, CMS reconsider the process.

The commenters believed that blanket implementation of the proposal ignores the underlying concept of the DRG payment system. They stated that DRG payments are fundamentally based on averages of historical costs and charges. They added that to reduce the payment for cases involving replacement of a medical device assumes that either these types of cases have not occurred in the past or are occurring at such a dramatic increase as to materially skew the averages used to develop the DRG weights. The commenters reiterated that CMS has stated that we believe device failures that are covered by manufacturers' warranties occur routinely. The commenter noted that this statement acknowledges that incidental device failure has occurred in the past and was likely covered by the manufacturer warranty. The commenter stated that, if so, this practice is part of the historical cost and charge data used to develop the current DRG weights for cases involving implantation, and that reduction of payment of certain cases

involving a reimplantation would ignore the average DRG weight for those cases that already implicitly include this reduction.

Another commenter suggested that CMS develop a proxy to the full cost of the device by using a percentage of the DRG, based on historical data because Medicare does not reimburse providers at full cost. One commenter recommended that, if adopted, CMS include in this policy that these claims will not be included in the calculation of relative weights, as this will reduce payment of services for procedures with non-replacement devices.

Several commenters suggested that CMS should consider raising the proposed threshold from 20 percent to greater than 50 percent of the cost of the device. Given the administrative burden of manually processing these claims, the commenters believed that it is not worth the burden on the hospitals' or fiscal intermediaries' part if only a nominal portion of the cost of the device is at issue. Commenters further suggested that if CMS implements this policy, estimated costs should be calculated from the charges on the claims and the DRG payment only reduced by the device cost if the payment is greater than the cost of the case less the cost of the device.

Several commenters cited the administrative burden that would result with implementation of this policy. One commenter stated that the proposal would result in significant operational burden and would essentially delay payment for otherwise clean claims. The commenter encouraged CMS to obtain invoice cost information from hospitals by having the hospitals report returned devices with a specific code similar to the use of HCPCS code C9399 (outpatient reporting for new drugs without HCPCS

codes). The commenter indicated that hospitals are able to report the HCPCS code and

the NCD number for drugs in the remarks section of the claim form in form locator field

84. The commenter believed a similar approach can be used in the inpatient setting when

either Condition Code 49 or 50 is present on the claim. This would trigger the hospital to

report the percentage of the device credit in the remarks field. The commenter suggested

that this approach would provide CMS with the data it needs while eliminating the need

for hard copy invoices, which will significantly reduce the hospital reporting burden.

Another commenter suggested using a similar approach--applying an average adjustment

based on the previous year's experience with credits to arrive at an aggregate method for

making payment adjustments rather than a claim-by-claim approach.

Some commenters raised concerns about the use of condition code 49 with

devices that are returned within the warranty period. These commenters explained that

the time from explant of a device, receipt of the device by the manufacturer, subsequent

device analysis and issuance of the warranty results can often be eight weeks or longer.

According to the commenters, a hospital will be unaware during this time whether a full,

partial, or even zero credit will be made. The commenter suggested that hospitals be

either: (1) allowed to submit the claims immediately without condition code 49 and

submit a claim adjustment with condition code 49 at a later date once the credit

determination is made; or (2) allow hospitals to hold the claim until a determination is

made on the level of the credit. Another commenter who suggested that CMS adopt this

approach raised a concern about "unintended consequences." The commenter expressed

a concern that hospitals may not return a nonworking device to avoid the payment offset

resulting in the manufacturer being unable to identify defects that need to be corrected.

This commenter suggested that "discouraging device return from hospitals" would be

"detrimental to industry efforts at identifying trends and improving the long-term

reliability of current and future products." The commenter suggested that allowing

hospitals to submit a bill without Condition Code 49 and later submitting an adjustment

claim with the code could avoid discouraging hospitals from returning devices that are

replaced.

Other commenters raised concerns about the nomenclature that is used to describe

Condition Code 49. These commenters were concerned that Condition Code 49

describes "replacement of a product earlier than the anticipated lifecycle due to an

indication that the product is not functioning properly." One commenter was concerned

that submitting a bill immediately with Condition Code 49 would indicate a premature

determination that a device was replaced due to improper functioning. Like the

commenter above, this commenter was concerned that the manufacturer may make a later

determination that the device was functioning properly or the warranty period had

expired and hospital will have already billed using Condition Code 49. Another

commenter suggested that a device may be replaced during a warranty period even

though it is functioning properly (for example, the patient depleted a battery prematurely

because of higher than normal energy needs). In this case, the commenter was concerned

that Condition Code 49 will label the replacement as being due to a malfunction when it

actually results from higher than normal use but proper functioning of the device. The

commenter suggested alternative nomenclature for Condition Code 49 that focuses on the

product being replaced earlier than its anticipated lifecycle as a result of either a product malfunction or higher than normal use.

Finally, some commenters raised concerns about the use of invoices to determine the level of the reduction in Medicare's payment. One commenter indicated that credits are derived using the original and current contract prices for the device being explained and the product price for the replacement device. According to this commenter, manufacturers can provide hospitals with the credit dollar amount and the percentage the credit represents of the full cost of the device. Based on that information, hospitals will easily be able to determine whether they need to submit a claim with Condition Code 49 (that is, the credit is equal to or greater than the threshold reduction where the policy applies) and can furnish Medicare without the dollar amount of the credit that is due.

Response: We disagree with the commenters who suggested that our proposal assumes that either device recalls or replacements have not occurred in the past or are occurring at such a dramatic increase as to materially skew the averages used to develop the DRG weights. Our policy assumes that hospital charges include the full cost of the device. Although the relative weights are based on estimated costs, charges are an important element of the relative weight methodology. We apply hospital cost-to-charge ratios to hospital charges to determine the DRG relative weight. If hospitals have uniform charging practices for all cases irrespective of whether they receive a device at no cost or with a partial credit, the CCR will be applied to a hospital charge that does not reflect that the hospital did not pay the full cost of the device. Under these circumstances, we believe it is appropriate that Medicare's payment should recognize a

hospital's reduced cost for a device that it receives either at no or a substantially reduced cost.

We agree with the commenters who suggested that the proposed threshold should be raised from 20 percent to 50 percent or greater of the cost of the device. The commenters have raised valid issues about potential administrative burden and delays that could occur when determining whether a device was replaced due to a malfunction or due to higher than normal use. We agree that the policy should not apply if only a nominal portion of the cost of the device is at issue.

With respect to the suggestion that the policy should only apply if Medicare's payment is greater than estimated costs of the case (less the device) calculated from the charges on the claims, we believe the policy we have adopted to recognize the lower costs of replaced devices that are either replaced at no cost or partial cost is reasonable. However, we may consider this idea in the future as we continue to make refinements to our policy for full or partial credit devices.

We understand the commenters' concerns about potential delays that could occur while a returned device is being evaluated during a warranty service period. Of the suggestions we received to address this concern, we agree that hospitals should have the options of either: (1) submitting the claims immediately without Condition Code 49 and a claim adjustment with Condition Code 49 at a later date once the credit determination is made or (2) holding the claim until a determination is made on the level of the credit. We believe that giving hospitals these options would address the concern of the commenter that hospitals may not return a non-working device for a replacement. Further, these

ideas would facilitate more efficient administration of the policy by allowing the hospital

to be provided with all of the information it needs to be paid correctly by Medicare

without the need to suspend claims or delay payment. However, hospitals should note

that if choosing option 1 above, the rules for submitting adjustment claims still apply and

can be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf,

section 130.2.

       The commenters raise a valid point concerning the nomenclature for Condition

Code 49 that only describes device malfunctions when the policy may apply to other

situations. We will bring the concerns of the commenter to the National Uniform Billing

Committee (NUBC) for further consideration. The NUBC is a committee brought

together by the American Hospital Association and includes the participation of all major

national provider and payer organizations. Their major role is to maintain the integrity of

the UB 92 and (now UB 04) data set and to be a forum for discussions that lead to

mutually agreed data elements for the claim as well as the data elements for other claim-

related transactions.

       With respect to the comments about using invoice information as documentation

for the credit due to Medicare, we provided invoices as an example of the type of

documentation a fiscal intermediary or MAC may require to determine the percentage

credit. Our fiscal intermediaries (or MAC if applicable) are in the best position to

evaluate and determine matters regarding the adequacy of documentation to determine

Medicare payment. In this final rule with comment period, we are not requiring any

specific documentation to determine whether the percentage credit will apply. Invoices

or the documentation (including those suggested in the public comments) would be at the

discretion of the fiscal intermediary or MAC.

Therefore, after consideration of the public comments received, for FY 2008, we

are implementing the following decisions regarding returned devices. We are applying

the policy to the MS-DRGs listed in the chart below; those cases being MS-DRGs where

the implantation of the device determines the base DRG assignment. Further, we are

applying the policy in situations where the hospital received a credit equal to 50 percent

or more of the cost of the device. Hospitals have the option of either: (1) submitting the

claims immediately without condition code 49 and a claim adjustment with condition

code 49 at a later date once the credit determination is made or (2) holding the claim until

a determination is made on the level of the credit. Should hospitals choose option 1, we

note that the rules for submitting adjustment claims do apply, and can be found at the

Web site noted above. CMS will issue specific claims processing instructions to

Medicare contractors and hospitals on implementing this policy.

DRGs Subject to Final Policy		
MDC	**MS- DRG**	**Narrative Description of DRG**
PRE	1 and 2	Heart Transplant or Implant of Heart Assist System with and without MCC, respectively (former CMS-DRG 103, Heart Transplant or Implant of Heart Assist System)
1	25 and 26	Craniotomy and Endovascular Intracranial Procedure with MCC or with CC, respectively (former CMS-DRG 1, Craniotomy Age > 17 With CC)
1	26 and 27	Craniotomy and Endovascular Intracranial Procedure with CC or without CC/MCC, respectively (former CMS-DRGs 2,

		DRGs Subject to Final Policy
MDC	**MS- DRG**	**Narrative Description of DRG**
		Craniotomy Age > 17 Without CC)
1	40 and 41	Peripheral & Cranial Nerve & Other Nervous System Procedure with MCC; or with CC or Peripheral Neurostimulator, respectively (former CMS-DRG, 7 Peripheral & Cranial Nerve & Other Nervous System Procedures With CC)
1	42	Peripheral & Cranial Nerve & Other Nervous System Procedure without CC/MCC (former CMS-DRG 8, Peripheral & Cranial Nerve & Other Nervous System Procedures without CC)
1	23 and 24	Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant; and without MCC [or Chemotherapy Implant], respectively (former CMS-DRG 543, Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis)
3	129 and 130	Major Head & Neck Procedures with CC/MCC or Major Device; or without CC/MCC, respectively (former CMS-DRG 49, Major Head & Neck Procedures)
5	216, 217, and 218	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization With MCC; or with CC; or without CC/MCC, respectively (former CMS-DRG 104, Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization)
5	219, 220, and 221	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC; or with CC, or without CC/MCC, respectively (former CMS-DRG 105, Cardiac Valve & Other Major Cardiothoracic Procedures Without Cardiac Catheterization)

DRGs Subject to Final Policy		
MDC	**MS- DRG**	**Narrative Description of DRG**
5	237	Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair (former CMS-DRG 110, Major Cardiovascular Procedures With CC)
5	238	Major Cardiovascular Procedures without MCC (former CMS-DRG 111, Major Cardiovascular Procedures without CC)
5	260, 261, and 262	Cardiac Pacemaker Revision Except Device Replacement with MCC, or with CC, or without CC/MCC, respectively (former CMS-DRGs117, Cardiac Pacemaker Revision Except Device Replacement)
5	258 and 259	Cardiac Pacemaker Device Replacement With MCC, and Without MCC, respectively (former CMS-DRG 118, Cardiac Pacemaker Device Replacement)
5	226 and 227	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC and without MCC, respectively (former CMS-DRG 515, Cardiac Defibrillator Implant without Cardiac Catheterization)
5	215	Other Heart Assist System Implant (former CMS-DRG 525, Other Heart Assist System Implant)
5	222 and 223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock with MCC and without MCC, respectively (former CMS-DRGs 535, Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock)
5	224 and 225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock with MCC and without MCC, respectively (former CMS-DRG 536, Cardiac Defibrillator Implant with Cardiac Catheterization

MDC	MS- DRG	Narrative Description of DRG
		without Acute Myocardial Infarction/Heart Failure/Shock)
5	242, 243, and 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (MS-DRG 551, Permanent Cardiac Pacemaker Implant with Major Cardiovascular Diagnosis or AICD Lead or Generator
5	242, 243, and 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (former CMS-DRG 552, Other Permanent Cardiac Pacemaker Implant without Major Cardiovascular Diagnosis)
8	461 and 462	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC, or without MCC, respectively (former CMS-DRG 471, Bilateral or Multiple Major Joint Procedures of Lower Extremity)
8	469 and 470	Major Joint Replacement or Reattachment of Lower Extremity with MCC or without MCC, respectively (former CMS-DRG 544, Major Joint Replacement or Reattachment of Lower Extremity)
8	466, 467, and 468	Revision of Hip or Knee Replacement with MCC, with CC, or without CC/MCC, respectively (former CMS-DRG 545, Revision of Hip or Knee Replacement)

DRGs Subject to Final Policy

To codify in regulations the policies for the IPPS discussed above, we are adding

a new paragraph (g) to §412.2 and a new §412.89 to 42 CFR Part 412, Subpart F. We are

also making a technical, conforming change to the heading of Subpart F and adding an

uncoded center heading before the proposed new §412.89.

12. Other MS-DRG Issues Raised in the Public Comments on the Proposed Rule

a. Heart Transplants or Implants of Heart Assist System and Liver Transplants

(Pre-MDC)

In our analysis of heart transplant or implant of heart assist system base DRGs

and liver transplant base DRGs, we found that each warranted two subdivisions based

on our five criteria for establishing the MS-DRGs discussed in section II.D. of this final

rule with comment period. We proposed two MS-DRGs for heart transplant or implant

of heart assist system: MS-DRG 001 (Heart Transplant or Implant of Heart Assist

System with MCC) and MS-DRG 002 (Heart Transplant or Implant of Heart Assist

System without MCC). We also proposed two MS-DRGs for liver transplant:

MS-DRG 005 (Liver Transplant with MCC or Intestinal Transplant) and MS-DRG 006

(Liver Transplant without MCC).

Comment: Two commenters responded to our proposal on the subdivision of

heart transplant or implant of heart assist system. One commenter representing one of the

manufacturers of left ventricular assist devices (LVAD) stated that this change seems to

appropriately identify severity of illness based upon mean length of stay days and charges

associated with implantable LVADs as long as hospitals accurately report and document

complications.

Another commenter representing transplant surgeons recommended that CMS

defer implementation of separate severity levels for heart transplant and liver transplants

pending further study. The commenter stated that payment for the uncomplicated

procedures--the without MCC group--are too low, resulting in financial instability for

many centers and the creation of inappropriate patient selection incentives. The

commenter submitted an analysis showing that of the 37 heart transplant centers for

which data were available, 10 (27 percent) would undergo DRG payment reductions of

more than 10 percent while, of the 52 liver transplant centers, 11 (19 percent) would

experience reductions of more than 10 percent, with many experiencing reductions over

20 percent. The commenter indicated that transplant cases are relatively low volume

which makes these DRGs more vulnerable to fluctuations.

The commenter stated that while the concept of dividing DRGs based on severity

is conceptually sound in the context of admissions for many medical conditions and

perhaps for certain surgical admissions, transplantation as a whole is an extremely

complex process that generally involves patients with life threatening conditions. The

commenter stated that the presence or absence of a condition on the MCC list is not a

good predictor of inpatient hospital costs for liver and heart transplants. The commenter

stated that one factor that influences hospital costs and lengths of stay is the

characteristics of the donor organ. The commenter stated that the donor risk index and

the model for end-stage liver disease (MELD) system which prioritizes patients waiting

for liver transplants by severity of illness are two important factors for any severity index

for transplant DRGs. This information is not identified in the MedPAR data.

Several commenters also stated that the use of certain donor organs increase

in-hospital costs for transplantation. A category of donor called DCD (donor after

cardiac death) generally represents a donor with a severe brain injury who is taken to the

operating room, removed from the ventilator, and who dies a cardiac, rather than a brain,

death. Another category of donor called ECD (extended or expanded criteria donor) is

generally older and sicker than a standard donor. Use of organs from DCD or ECD

donors permits transplantations that may be more expensive, as the organs may not be

optimal. The commenters suggested that we take these issues into consideration when

making DRG assignments.

In addition, two commenters stated that a separate DRG may be needed to address

the significantly higher costs associated with combined liver/kidney transplants. One of

the commenters stated that the recent increases in volume justify creation of a separate

DRG. Another commenter stated that the Milliman 2005 US Organ and Tissue

Transplant Cost Estimates and Discussion Research Report indicates a separate MS-DRG

is warranted at a higher level. However, the commenter did not provide data on

combined liver/kidney transplants from the report.

Response: We cannot use the factors suggested in the commenters to subdivide

the transplant DRGs because they are not distinctly identified in the current ICD-9-CM

coding system. The National Center for Health Statistics is responsible for the

maintenance of the diagnosis codes. We have advised representatives from the transplant

industry to approach the National Center for Health Statistics in order to request unique

codes to identify cases that include factors such as a DCD or ECD donor or the patient's

MELD score. Without specific data that show how these factors affect patient costs, we

cannot use them to subdivide the transplant DRGs. Suggestions on coding issues

involving diagnosis codes should be directed 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.

The table below illustrates our findings on heart and liver transplant MS-DRGs:

MS-DRG	Number of Cases	Average Length of Stay	Average Charges
MS-DRG 001 (Heart transplant or implant of heart assist system with MCC)	572	41.03	$442, 339
MS-DRG 002 (Heart transplant or implant of heart assist system without MCC)	304	22.81	$250,693
MS-DRG 005 (Liver transplant with MCC or intestinal transplant)	762	22.25	$243, 271
MS-DRG 006 (Liver transplant without MCC)	446	10.05	$129,519

The data support the current MCC split for heart and liver transplants. Therefore,

we disagree with the commenter who suggested that diagnosis codes do not explain

patient resource cost for these DRGs. In addition, the MCC split was supported by

another commenter that manufactures LVADs. In response to the comments about the

impact on transplant centers, we note that the change to the MS-DRGs is redistributive

within each base DRG. Payment for the high severity cases will increase, and it will

decrease for other cases. In total, Medicare payments for transplants likely will be

unchanged. Rather, Medicare's payment will be better directed to reflect patient severity

of illness. In response to the comment about combined liver/kidney transplants, we

believe these patients would have a secondary diagnosis that is an MCC that would result

in the patient being assigned to MS-DRG 005. For instance, a common cause of

combined liver and kidney failure is hepatorenal syndrome, in which the liver failure

actually causes the kidney failure. In this case, the principal diagnosis is liver failure.

The second diagnosis--kidney failure--is an MCC. Patients with combined liver/kidney

failure are very sick patients, and we believe it is highly likely that if they are properly

coded, all patients would be assigned to MS-DRG 005 and be paid the maximum amount

for a patient receiving a liver transplant. At this time, we do not believe that a separate

MS-DRG is needed for combined liver-kidney transplants.

With respect to the Milliman 2005 US Organ and Tissue Transplant Cost

Estimates and Discussion Research Report discussed by the commenter, we are open to

considering, to the extent feasible, reliable, validated data other than MedPAR data in

annually recalibrating and reclassifying the DRGs. Because the commenter did not

provide data on combined liver/kidney transplants from the report, we could not fully

evaluate the commenter's claims.

b. Gliadel® Wafer (MDC 1)

Gliadel® Wafer is the only implantable chemotherapy agent approved by FDA

for the treatment of malignant brain tumors. This treatment is approved for newly

diagnosed patients with high-grade malignant glioma and for patients with recurrent

glioblastoma multiforme, which is the most fatal form of primary brain tumor.

ICD-9-CM procedure code 00.10 (Implantation of chemotherapeutic agent) was created

October 1, 2002 to uniquely identify this technology. In the FY 2008 IPPS proposed

rule, we proposed to assign the technology to MS-DRG 23 (Craniotomy with Major

Device Implant or Acute Complex Central Nervous System Principal Diagnosis with

MCC) and MS-DRG 24 (Craniotomy with Major Device Implant or Acute Complex

Central Nervous System Principal Diagnosis without MCC).

Comment: One commenter, the manufacturer of the Gliadel® Wafer technology,

recommended that CMS recognize the complexity and costs associated with implantation

of Gliadel® Wafer and reassign all cases that use it to MS-DRG 23. The commenter also

recommended that the MS-DRG titles for MS-DRG 23 and 24 be revised to:

● MS-DRG 023, "Craniotomy with Acute Complex Central Nervous System

Principal Diagnosis with MCC or Major Device Implant"; and

● MS-DRG 024, "Craniotomy with Acute Complex Central Nervous System

Principal Diagnosis without MCC."

The commenter provided data showing a total of 502 cases receiving the Gliadel®

Wafer. The majority of the patients, 84 percent (423 cases), were assigned to MS-DRG

24. For MS-DRG 24, the commenter reported that the standardized average charges for

Gliadel® cases were approximately $74,069, which is 27 percent greater than the average

charges for non-Gliadel cases in MS-DRG 24 of approximately $58,181. Many

commenters encouraged CMS to reassign these cases to MS-DRG 23.

Response: Based on our review on the FY 2006 MedPAR data, we found 73

Gliadel® cases assigned to MS-DRG 23 and 398 cases assigned to MS-DRG 24. The

following table displays our results:

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 23 – All cases	2,950	13.63	$91,518
MS-DRG 23 – Gliadel cases	73	12.44	$104,975
MS-DRG 24 – All cases	2,432	8.63	$61,865
MS-DRG 24 – Gliadel cases	398	7.03	$75, 482

Under the MS-DRGs, 73 out of 471 Gliadel® cases are assigned to

MS-DRG 023. The 398 remaining Gliadel® cases do not have an MCC and would be

assigned to MS-DRG 024, absent further changes to the DRG logic.

The average charges of approximately $75,482 for Gliadel® cases are higher than

the average charges of approximately $61,865 for the overall cases in MS-DRG 024 and

are approximately midway between the with and without MCC severity levels. In this

final rule with comment period, we are assigning all Gliadel® cases to MS-DRG 23. The

title for MS-DRG 023 is changed to "Craniotomy with Major Device Implant or Acute

Complex Central Nervous System Principal Diagnosis with MCC or Chemo Agent

Implant". The presence of craniotomy with major device implant or acute complex

central nervous system principal diagnosis with MCC or implantation of

chemotherapeutic agent would assign a case to the higher severity level.

c. Myasthenia Gravis and Acute and Chronic Inflammatory Demyelinating Neuropathies

(AIDP-CIDP) (MDC 1)

Comment: One comment, a national association that represents neurologists and

neuroscience professionals, was concerned that there are no separate DRGs for

Myasthenia Gravis and Acute and Chronic Inflammatory Demyelinating Neuropathies

(AIDP-CIDP). Myasthenia gravis is an autoimmune disease caused by antibodies that

block receptors at the neuromuscular junction resulting in decreased activation of

muscles by nerves, leading to varying degrees of muscle weakness. Acute inflammatory

demyelinating neuropathy, also known as Guillain-Barre Syndrome, is caused by an

autoimmune process that attacks the myelin sheaths around nerves, causing defective

nerve transmission that leads to sensory loss and muscle weakness. Chronic inflammatory

demyelinating neuropathy is a chronic, relapsing form of the acute syndrome.

We proposed to assign these conditions to MS-DRGs 56 and 57 (Degenerative

Nervous System Disorders With and Without MCC, respectively). According to the

commenter, cases with these conditions should not be assigned to an MS-DRG for

degenerative nervous system disorders.

The commenter stated that a separate DRG needs to be established to recognize

the substantially higher costs of treating patients with an acute exacerbation of

myasthenia gravis. There are two ICD-9-CM diagnosis codes for myasthenia gravis:

code 358.00 (Myasthenia gravis without (acute) exacerbation) and code 358.01

(Myasthenia gravis with exacerbation). According to the commenter, in addition to

plasmapheresis, acute myasthenia gravis patients often require respiratory support,

intensive care unit stays, and IVIG administration. The commenter requested that CMS

review cost data for admissions under this diagnosis and determine whether these cases

had costs that were substantially higher than other cases assigned to the same DRG.

The commenter stated that, similar to myasthenia gravis, AIDP and CIDP are

highly likely to require respiratory support and intensive care unit stays with

plasmapheresis or IVIG administration, or both, when presenting acutely or in acute

exacerbation. The ICD-9-CM diagnosis code that is reported for AIDP is code 357.0

(Acute infective polyneuritis), and the appropriate diagnosis code for CIDP is code

357.81 (Chronic inflammatory demyelinatng polyneuritis). The commenter stated that

the data on AIDP and CIDP are unavailable at this time. Therefore, the commenter

requested that CMS track these cases in consideration of a separate DRG for AIDP/CIDP

for next year.

Response: The commenter raised a concern that myasthenia gravis cases are

being assigned to the degenerative nervous system disorders DRG, and did not believe

that the condition should be assigned to that DRG. However, we would point out that

myasthenia gravis cases are currently assigned to CMS DRG 12 (Degenerative Nervous

System Disorders). Moving to the MS-DRGs did not alter this DRG logic. We simply

subdivided this DRG into two severity levels. Given the extensive changes we are

making in moving to MS-DRGs we believe it is premature to consider refinements to this

base DRG for myasthenia gravis cases. Rather, we will wait to gain experience under the

MS-DRGs and determine whether further refinements are needed to the base DRGs.

d. Peripheral and Spinal Neurostimulators (MDC 1 and MDC 8)

In our analysis of spinal procedures and peripheral and cranial nerve and other

nervous system procedures based DRGs in MDC 1, we found that each warranted three

subdivisions based on our five criteria. There are three MS-DRGs for spinal procedures:

MS-DRG 28 (Spinal Procedures with MCC), MS-DRG 29 (Spinal Procedures with CC),

and MS-DRG 30 (Spinal Procedures without CC). There are three MS-DRGs for

peripheral and cranial nerve and other nervous system procedures: MS-DRG 40

(Peripheral and Cranial Nerve and Other Nervous System Procedures with MCC),

MS-DRG 41 (Peripheral and Cranial Nerve and Other Nervous System Procedures with CC),

and MS-DRG 42 (Peripheral and Cranial Nerve and Other Nervous System Procedures without

CC).

For back and neck procedures based DRGs in MDC 8, we found that the base DRG

warranted two subdivisions based on our five criteria. There are two MS-DRGs for back and

neck procedures except spinal fusion: MS-DRG 490 (Back and Neck Procedures Except Spinal

Fusion with CC/MCC or Disc Devices) and MS-DRG 491 (Back and Neck Procedures Except

Spinal Fusion without CC/MCC).

Comment: Several commenters analyzed the effects of the MS-DRGs and

contended that the payment levels for cases with implantable neurostimulator devices are,

in many instances, inadequate to cover the cost of the device and the hospital procedure

to implant it. The commenters stated that most neurostimulator cases are assigned to the

lowest severity level in these DRGs and concluded that the average charges of these cases

are more similar to the higher severity levels. The commenters recommended that CMS:

● For spinal cord nonrechargeable stimulator cases in MDC 1: Reassign all

full-system implants which includes cases reported with ICD-9-CM procedure codes

03.93 (Implantation or replacement of spinal neurostimulator lead(s)) and 86.94

(Insertion or replacement of single array neurostimulator pulse generator, not specified as

rechargeable), or 86.95 (Insertion or replacement of dual array neurostimulator pulse

generator, not specified as rechargeable), to MS-DRG 29 and revise the title to "Spinal

Procedure with CC or Major Device Implant."

● For spinal cord rechargeable neurostimulator cases in MDC 1: Reassign all full-system implant cases reported with ICD-9-CM procedure codes 03.93 and 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator) or 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) to MS-DRG 28, and revise the title to "Spinal Procedure with MCC or Major Device Implant."

● For spinal cord rechargeable neurostimulator cases in MDC 8: Reassign all full-system implant cases reported with ICD-9-CM procedure codes 03.93 and 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator) or 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) to MS-DRG 490.

● For peripheral nonrechargeable neurostimulator cases in MDC 1: Reassign all full-system implant cases reported with ICD-9-CM procedure codes 04.92 (Implantation or replacement of peripheral neurostimulator lead(s)) and 86.94 or 86.95 to MS-DRG 041 and revise the title to "Peripheral and Cranial Nerve and Other Nervous System Procedures with CC or Major Device Implant."

● For peripheral rechargeable neurostimulator cases in MDC 01: Reassign all full-system implant cases reported with ICD-9-CM procedure codes 04.92 and 86.97 or 86.98 to MS-DRG 040 and revise the title to "Peripheral and Cranial Nerve and Other Nervous System Procedures with MCC or Major Device Implant."

Two commenters recommended device-dependent surgical DRGs for these cases.

Several commenters also provided an alternative option to the recommendations listed

above:

● Assign all full-system spinal cord stimulator cases (rechargeable and non-

rechargeable) in MDC 1 to MS-DRG 029.

● Assign all full-system Spinal cord stimulator cases (rechargeable and non-

rechargeable) in MDC 8 to MS-DRG 490.

● Assign all full-system peripheral neurostimulator cases (rechargeable and non-

rechargeable) in MDC 1 to MS-DRG 041.

● Maintain the new-technology add-on payment for rechargeable

neurostimulators for one additional year because of limited data.

Response: We analyzed the FY 2006 MedPAR data for full system spinal and

peripheral neurostimulators, both nonrechargeable and rechargeable, using the procedure

codes listed above. We found that the majority of spinal neurostimulator cases in MDC 1

(113 cases) were assigned to MS-DRG 030. The majority of the peripheral

neurostimulator cases (44 cases) were assigned to MS-DRG 042. The majority of the

spinal neurostimulator cases (253 cases) in MDC 8 were assigned to MS-DRG 491. The

following table displays our results:

MS-DRG	Number of cases	Average length of stay	Average charges
Spinal Procedures			
MS-DRG 028 – With MCC	1,531	14.67	$88,392.05
MS-DRG 029 – With CC	2,699	7.63	$46,223.20
MS-DRG 030 – Without MCC or CC	3,540	3.67	$27,081.14
Spinal Neurostimulators			

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 028 - With MCC	7	2.57	$81,208.14
MS-DRG 029 With CC	29	3.10	$68,090.03
MS-DRG 030 - Without MCC/CC	113	1.81	$57,399.84

The average charges for the 113 spinal neurostimulator cases assigned to

MS-DRG 030 of approximately $57,400 are much higher than the average charges of

approximately $27,081 for the overall charges in MS-DRG 030. The charges for these

cases more closely approximate the charges for the other cases in the CC level,

MS-DRG 029.

MS-DRG	Number of cases	Average length of stay	Average charges
Peripheral and Cranial Nerve Procedures			
MS-DRG 040 – With MCC	4,300	13.59	$64,354.13
MS-DRG 041 - With CC	7,388	7.53	$37,421.99
MS-DRG 042 – Without MCC/CC	5,112	3.65	$30,600.18
Peripheral Neurostimulators			
MS-DRG 040 - With MCC	12	8.92	$63,170.42
MS-DRG 041 - With CC	24	4.96	$45,118.04
MS-DRG 042 – Without MCC/CC	44	1.71	$50,716.25

The average charges for the 44 peripheral neurostimulator cases assigned to

MS-DRG 042 of approximately $50,716 are much higher than the average charges of

approximately $30,600 for the overall charges in MS-DRG 042. Further, they are even

higher than the 24 MS-DRG 041 cases with a peripheral neurostimulator and a CC. The

relationship between average charges for neurostimulator cases and the MS-DRG where

they are assigned does not appear to be monotonic in this case. We believe the low

volume of cases for this technology may explain this unusual pattern in average charges.

One or a few cases with aberrant charges could potentially be skewing the data.

Nevertheless, we do believe the data for the MS-DRG 042 peripheral neurostimulator

cases does illustrate that their average charges should be reassigned to a higher severity

level. Although average charges for peripheral neurostimulator cases without an MCC or

CC appear to be midway between average charges for cases in MS-DRGs 040 and 041,

we do not believe these cases should be assigned to the "with MCC" MS-DRG at this

time. Before deciding whether further MS-DRG assignment is warranted, we prefer to

have more data that demonstrates monotonicity in the average charges.

MS-DRG in MDC 8	Number of cases	Average length of stay	Average charges
MS-DRG 490 – All cases	17,493	5.13	$29,656.66
MS-DRG 490 – Spinal neurostimulator cases	49	3.69	$62,385.33
MS-DRG 491 – All cases	57,496	2.27	$17,788.59
MS-DRG 491 - Spinal neurostimulator cases	253	1.62	$56,238.72

The average charges for the 253 spinal neurostimulator cases assigned to

MS-DRG 491 in MDC 8 of approximately $56,239 are much higher than the average

charges of approximately $17,789 for the overall charges in MS-DRG 491. The charges

for these cases are also higher than the average charges of $29,656 for MS-DRG 490.

We believe these cases should be assigned to MS-DRG 490 at this time.

In this final rule with comment period, we are assigning full system spinal cord

nonrechargeable and rechargeable neurostimulator cases in MS-DRG 030 to MS-DRG

029 in MDC 1. ICD-9-CM procedure codes 03.93 and 86.94 or 86.95 or 86.97 or 86.98

must be reported in order for the spinal neurostimulator cases to be assigned to MS-DRG

029. We are defining MS-DRG 029 as "Spinal Procedures with CC or Neurostimulator."

The presence of a spinal procedure with CC or neurostimulator would assign the case to

the second severity level.

We are also assigning full system peripheral nonrechargeable and rechargeable

neurostimulator cases in MS-DRG 042 to MS-DRG 041 in MDC 1. ICD-9-CM

procedure codes 04.92 and 86.94 or 86.95 or 86.97 or 86.98 must be reported in order for

the peripheral neurostimulator cases to be assigned to MS-DRG 041. We are defining

MS-DRG 041 as "Peripheral and Cranial Nerve and Other Nervous System Procedures

with CC or Neurostimulator." The presence of a peripheral and cranial nerve procedure

with CC or neurostimulator would assign the case to the second severity level.

The full system spinal cord nonrechargeable and rechargeable neurostimulator

cases in MS-DRG 491 are being assigned to MS-DRG 490. ICD-9-CM procedure codes

03.93 and 86.94 or 86.95 or 86.97 or 86.98 must be reported in order for the spinal

neurostimulator cases to be assigned to MS-DRG 490. We are defining MS-DRG 490 as

"Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Devices or

Neurostimulator." The presence of a back and neck except spinal fusion procedure with

CC/MCC or disc devices or neurostimulator would assign the case to the second severity

level.

We refer readers to section II.J. of the preamble to this final rule with comment

period for new technology discussions about rechargeable neurostimulators. We will

continue to monitor these low volume full system neurostimulator cases for further

refinements if warranted.

e. Stroke and Administration of Tissue Plasminogen Activator (tPA) (MDC 1)

In FY 2006, CMS created CMS DRG 559 (Acute Ischemic Stroke with Use of

Thrombolytic Agent) by assigning diagnosis codes for embolic stroke codes plus

procedure code 99.10 (Injection or infusion of thrombolytic agent) to this new CMS

DRG. The coding content of CMS DRGs 14 (Intracranial Hemorrhage or Cerebral

Infarction) was not modified—cases that included a diagnosis code for embolic stroke but

the patient was not administered a thrombolytic agent continued to be assigned to this

DRG. CMS DRG 15 (Nonspecific CVA and Precerebral Occlusion without Infarct) also

remained unchanged. Under the new MS-DRGs, the former CMS DRG 559 will have

three severity levels: MS-DRG 061 (Acute Ischemic Stroke with Use of Thrombolytic

Agent with MCC), MS-DRG 062 (Acute Ischemic Stroke with Use of Thrombolytic

Agent with CC), and MS-DRG 063 (Acute Ischemic Stroke with Use of Thrombolytic

Agent w/o CC/MCC).

Comment: One commenter agreed with CMS' proposal to take the severity of a

patient's illness into account when establishing payment rates. The commenter noted that

severely ill or complex patients require more intensive evaluation, treatment, and

monitoring, resulting in higher costs. The commenter added that it is logical to reimburse

hospitals at a higher rate for those patients who require more care.

However, the commenter expressed some concerns with the proposed payment

rates for stroke patients with a CC or without a CC/MCC who are treated with tPA,

noting that according to its calculations, reimbursement rates for MS-DRGs 062 and 063

will decrease. The commenter believed that this decrease could create a financial

disincentive for hospitals if payment for MS-DRGs 062 and 063 fails to provide adequate

reimbursement for those costs incurred by facilities that administer tPA.

Response: The cost of treating patients with tPA continues to be represented in

MS-DRGs 061, 062, and 063, but the cases have been distributed according to the

presence of an MCC, or a CC, or the lack of either an MCC or CC in MS-DRG 063

according to the historical data represented by MedPAR. Medicare likely will continue

to pay the same amount for all patients treated with tPA. However, our payments will

better reflect patient severity of illness by paying higher amounts for those cases where

the patient has an MCC or CC than if they do not.

Comment: One commenter urged CMS to create a process that allows for

periodic evaluation and updating of the MCC and CC lists, noting that CMS must

institute a process that allows for the addition of other conditions that create a special

concern for one set of patients, including stroke patients, to the MCC and CC lists.

Response: As described in section II.D.3.of this preamble, we reviewed more

than 13,000 diagnosis codes in order to establish the MCC and CC lists. This review

activity is an ongoing, annual process, as CMS has reviewed portions of the diagnosis

codes every year with regard to placement on the CC list. The difference is that this year,

more than 13,000 diagnosis codes were reviewed, and the designation has changed from

simply "CC" to major comorbidity or complication (MCC) or comorbidity or

complication (CC). We believe these lists to be comprehensive and we will continue to evaluate their content with regard to all patients.

Comment: One commenter expressed concern about the so-called "drip and ship" cases where tPA is administered in the emergency department at Hospital A, but the patient is immediately transferred to Hospital B, which has a stroke center. The commenter pointed out that many community hospitals do not have the necessary resources, including neurology expertise, to care for the critically ill stroke patient. However, the commenter added, with the support of a nearby stroke center, they are able to diagnose ischemic stroke and institute reperfusion (tPA) treatment within the critical three hour window. The commenter stated that transfer after administration of tPA is required by the need to closely monitor patients after reperfusion treatment. Given the critical need to minimize brain damage by immediately administering the tPA when indicated, the commenter stated that the original hospital where the patient presented with stroke symptoms must not delay treatment until after the patient is transferred.

When a patient is treated with reperfusion therapy in a local emergency department, but transferred and admitted to another hospital with the necessary stroke services, it is the understanding of the commenter that CMS' current policy, as implemented through the DRG GROUPER, requires that those cases be assigned to a stroke DRG that does not recognize the reperfusion therapy. The hospital to which the patient was ultimately admitted did not administer the reperfusion therapy, and the hospital which administered the thrombolytic drug did not admit the patient. The commenter noted that these patients are in the severely ill category and require the same

high level of resources as any other patient who receives reperfusion therapy and who

would normally be assigned to CMS DRG 559.

The commenter made the following suggestion: "when a patient has been started

on reperfusion therapy [tPA] at another hospital, as an outpatient, and is transferred to a

hospital with a stroke center, the case should be assigned to one of the "stroke-with-

thrombolytic agent DRGs" (MS-DRGs 061, 062, or 063).

Response: We previously considered this situation in 2005 when we created

DRG 559 that separately distinguished stroke patients administered a thrombolytic agent.

The commenter is suggesting that it is not the thrombolytic agent itself that raises the

hospital's costs (although in our view, it is certainly an element of higher costs) but all of

the other services that are provided by the receiving hospital to such a patient. Although

we recognize the concerns of the commenter, the emergency room is already being

compensated for the administration of the tPA. Therefore, we do not believe it would be

appropriate for Medicare to pay for the same service at another facility.

f. Gliasite® Radiation Therapy System (RTS) (MDC 1)

Comment: One commenter, the manufacturer of Gliasite® Radiation Therapy

System (RTS), wrote that this technology is used in the treatment of malignant brain

cancer. The commenter indicated that patients who undergo this treatment require two

admissions. The first admission includes tumor debulking and a special catheter is

implanted. The following ICD-9-CM procedures are assigned to report the procedures

performed: code 01.59 (Other excision or destruction of lesion or tissue of brain) and

code 01.27 (Insertion of catheter(s) into cranial cavity or tissue). Under the proposed

MS-DRGs, the case for this admission with a principal diagnosis of glioblastoma and

procedure codes 01.59 and 01.27 would be assigned to MS-DRGs 26 and 27 (Craniotomy

and Endovascular Intracranial Procedures with and without MCC/CC, respectively).

The commenter added that the second admission usually occurs in a week or 10

days and entails liquid radioisotope infused into the special catheter. The patient is

monitored for a few days and then the radioisotope is removed. ICD-9-CM procedure

code 92.20 (Infusion of liquid brachytherapy radioisotope) and code 01.27 (Removal of

catheter(s) from cranial cavity or tissue) would be assigned to identify the procedures

performed in the second admission. Under the proposed MS-DRGs, for the second

admission, the case with a principal diagnosis of glioblastoma and procedure codes 92.20

and 01.27 would be assigned to medical MS-DRGs 54 and 55 (Nervous System

Neoplasm with and without MCC, respectively).

The commenter requested that CMS recognize the resources associated with

infusion of radioisotope and establish two new surgical MS-DRGs for these

admissions/treatments:

● Liquid radiotherapy infusion for glioblastoma without tumor debulking

● Liquid radiotherapy infusion for glioblastoma with craniotomy, tumor

debulking, and implantation of infusion catheter

The commenter stated that the costs of the implant can be considered equivalent

to the cost of an MCC and should be recognized in a surgical MS-DRG descriptor.

Response: The refinement of the DRGs is not based on the creation of any new

logic under the MS-DRGs. We believe that it is not appropriate to make DRG revisions

of this nature as part of the final rule since the base DRG has not changed for these cases.

However, we will examine the need for further DRG refinements as we gain experience

under the MS-DRGs.

g. Noninvasive Ventilation (MDC 4)

Comment: One commenter representing a national association requested the

creation of a new DRG for noninvasive positive pressure ventilation (NPPV). According

to the commenter, NPPV is an effective and preferred treatment in the management of

patients with acute exacerbations of chronic obstructive pulmonary disease and other

forms of respiratory failure.

Currently, this treatment is identified in ICD-9-CM by procedure code 93.90

(Continuous positive airway pressure (CPAP)) and does not require the use of mechanical

ventilation via an endotracheal tube or tracheotomy. The commenter indicated that

NPPV is a valuable and clinically appropriate option for patients who may require

short-term (<96 hours) ventilatory support when presenting with an acute respiratory

failure condition. The commenter noted that results have demonstrated improved

outcomes and less risk associated with less invasive devices. Therefore, the commenter

stated, the selection of treatment for ventilatory support does not solely rely on patient

acuity. To better recognize NPPV as an appropriate treatment in acute respiratory

conditions and ensure proper reimbursement, the commenter also proposed that CMS

consider including NPPV (code 93.90) in proposed MS-DRG 207 (Respiratory System

Diagnosis with Ventilatory Support 96+ hours) if the creation of a new MS-DRG was not

a viable option.

Response: We met with the commenter on June 13, 2007, regarding the above

requests to create a new MS-DRG for patients who receive NPPV or reassign cases to a

different MS-DRG. After discussing the clinical and coding issues surrounding NPPV,

we advised the commenter to request a new procedure code to distinguish between the

various treatments that are currently included in code 93.90. We informed the

commenter about the ICD-9-CM Coordination and Maintenance Committee and the

process for requesting a new procedure code.

h. Heart Assist Devices (MDC 5)

Comment: One commenter requested that CMS create an additional severity

level in MS-DRG 215 that would be titled "Other Heart Assist Implant without Major

Complications." The commenter indicated that CMS should have a consistent number of

severity levels between this MS-DRG and MS-DRGs 001 or 002 (Heart Transplant or

Implant of Heart Assist System with MCC or without MCC, respectively). In the

proposed rule, MS-DRG 215 (formerly CMS DRG 525, and still titled "Other Heart

Assist System Implant") had no severity levels. The commenter stated that, by capturing

the severity of the cases with devices coded to 37.65 (Implant of external heart assist

system), hospitals will be more appropriately reimbursed and CMS will be consistent in

its policy.

The commenter added that without a severity breakdown in MS-DRG 215, it

feared the integrity of the MS-DRG will be distorted, causing an unwarranted financial

windfall for some cases. The commenter indicated that Medicare will be overpaying less

severe cases and underpaying cases with major complications if MS-DRG 215 is not

subdivided into with MCC and without MCC severity levels.

Response: We reviewed the following data specifically in light of this comment.

Our findings are represented in the table below.

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 215 – All cases	142	11.32	$204,885.12
MS-DRG 215 – Cases with insertion of nonimplantable heart assist system (code 37.62)	63	10.95	$134,669.43
MS-DRG 215 – Cases with repaid heart assist and system (code 37.63)	29	14.07	$225,962.07
MS-DRG 215 – Cases with implant of external heart assist (VAD) (code 37.65)	59	11.80	$286,953.90

In the proposed rule (72 FR 24705), we explained that we developed a set of

criteria to facilitate the decision-making process surrounding the subdivision of a DRG

into subgroups based on the presence of a CC or MCC. We specified that in order to

warrant creation of a CC or MCC subgroup within a base MS-DRG, the subgroup had to

meet all of the five criteria listed. One of the criteria was that the subgroup contained at

least 500 cases. In this instance, there are only 142 cases in the MedPAR data.

Therefore, there are too few cases to warrant a subdivision of the base DRG into severity

levels. We will continue to monitor this DRG, and should future data prove that a

subdivision of MS-DRG 215 is warranted, we will consider revision of its structure.

i. Automatic Implantable Cardioverter-Defibrillators (ACID) Lead and Generator

Procedures (MDC 5)

Comment: One commenter commended CMS for creating a separate, stand alone

DRG for automatic implantable cardioverter-defibrillator (AICD) generator replacements

and defibrillator lead replacements. The new DRG is MS-DRG 245 (AICD lead and

generator procedures). The MS-DRG contains the following codes:

● 00.52, Implantation or replacement of transvenous lead [electrode] into left

ventricular coronary venous system

● 00.54, Implantation or replacement of cardiac resynchronization defibrillator

pulse generator device only [CRT-D]

● 37.95, Implantation of automatic cardioverter/defibrillator leads(s) only

● 37.96, Implantation of automatic cardioverter/defibrillator pulse generator only

● 37.97, Replacement of automatic cardioverter/defibrillator leads(s) only

● 37.98, Replacement of automatic cardioverter/defibrillator pulse generator only

The commenter indicated that under the current CMS DRGs, the defibrillator

generator and defibrillator lead replacements were included in DRG 551 with pacemaker

implants. The commenter supported this new MS-DRG, which recognizes the distinct

differences in resource utilization between pacemaker and defibrillator generators and

leads. The commenter stated that CMS should consider additional refinements for the

defibrillator generator and leads. In reviewing the standardized charges for the AICD

leads, the commenter believed that the leads may be more appropriately assigned to

another DRG such as MS-DRG 243 (Permanent Cardiac Pacemaker Implant with CC) or

MS-DRG 258 (Cardiac Pacemaker Device Replacement with MCC). The commenter

recommended that CMS consider moving the defibrillator leads back into a pacemaker

DRG, either MS-DRG 243 or MS-DRG 258.

Response: We appreciate the commenter's support for the refinements made

through the MS-DRGs to better identify differences in patient care costs associated with

pacemakers and defibrillators. In our view, the data support separate DRGs for these

very different devices. The commenter supported the proposed DRG change we made

that removed both the defibrillator generators and leads from the pacemaker MS-DRG

and then recommended that we move the defibrillator leads only back into a pacemaker

DRG. The commenter, as stated, had supported this change because the commenter

believed that it better identified devices that were quite different. We proposed

separating defibrillator and pacemaker devices because they are such different devices.

Moving the defibrillator leads back into a pacemaker MS-DRG defeats the purpose of

creating separate MS-DRGs for defibrillators and pacemakers. Therefore, we are

finalizing MS-DRG 245 as proposed with the leads and generator codes listed above.

j. Artificial Heart (MDC 5)

Comment: One commenter requested that ICD-9-CM code 37.52 (Implantation

of total replacement heart system) [which includes artificial heart] be moved from

CMS DRG 525 (Other Heart Assist System Implant) to CMS DRG 103 (Heart Transplant

or Implant of Heart Assist System). These CMS DRGs would be renumbered and

renamed in the proposed MS-DRG system, with CMS DRG 525 becoming MS-DRG 215

(Other Heart Assist System Implant) and CMS DRG 103 becoming MS-DRGs 001

(Heart Transplant or Implant of Heart Assist System with MCC) and 002 (Heart

Transplant or Implant of Heart Assist System without MCC). The commenter stated that

the change of MS-DRG assignment from MS-DRG 215 to MS-DRGs 001 or 002 will

more accurately reflect the grouping of procedures for the implantation of a total

replacement heart system with heart transplantation and other heart assist systems

intended as destination therapy to more accurately recognize hospital resources for the

treatment of end-stage heart failure. We received a similar comment from another

manufacturer.

Response: Medicare does not currently cover artificial heart implants.

ICD-9-CM procedure code 37.52 (Implantation of total replacement heart system) was

created for potential use for discharges on or after October 1, 2003. However, code 37.52

was immediately put on the noncovered procedure list of the MCE as no device then

existed that was deemed safe and effective as an artificial heart. The technology remains

noncovered by Medicare. For this reason, we currently have no data to suggest that the

DRG assignment for procedure code 37.52 needs to be changed.

Our review of the second manufacturer's product shows it to be a bi-ventricular

device, not an artificial heart as described in their marketing literature. This commenter

also is currently in the process of requesting coverage for its device. We recommend that

the manufacturer of this device request to be added to the agenda of the ICD-9-CM

Coordination and Maintenance Committee meeting of September 27, 2007. An

ICD-9-CM procedure code will help us to determine whether a Medicare patient treated

with this new technology should be assigned to a DRG other than the one that includes

the predecessor code used to describe the service.

Comment: One commenter suggested that CMS reevaluate the appropriateness of including ICD-9-CM procedure code 37.62 (Insertion of nonimplantable heart assist system) in CMS DRG 525 (Other Heart Assist System Implant), which will become MS-DRG 215 (Other Heart Assist System Implant), and reassign code 37.62 to more accurately reflect hospital resource consumption of services involving mechanical support for cardiovascular failure. The commenter suggested that patients treated with a nonimplantable heart assist system are less costly than other patients in MS-DRG 215 and should be reassigned to a different DRG that would reflect its lower costs. Further, the commenter suggested that hospitals may not be using code 37.62 consistent with its intended purpose.

Response: The commenter has not provided a compelling justification for changing the placement of code 37.62. Our understanding is that this code describes use of a nonimplantable heart assist system to temporarily replace the heart's function. The function of the device to replace the heart means that there are only three potential MS-DRGs where code 37.62 could be assigned: MS-DRG 215 (Other Heart Assist System Implant) and MS-DRGs 001 and 002 (Heart Transplant or Implant of Heart Assist System with and without MCC, respectively). The commenter suggested that the code should be assigned to a lower paying MS-DRG than MS-DRG 215. However, the only other MS-DRGs to which the code could be assigned have even higher payment weights. Therefore, we are making no changes to the DRG assignment for code 37.62 for FY 2008. Although the commenter suggested potential problems with use of the code, the commenter did not suggest any potential solutions for how to address this problem.

Therefore, we have no information upon which to take further action to address the

commenter's concern.

k. Vascular Procedures (MDC 5)

We proposed three MS-DRGs for vascular procedures: MS-DRG 252 (Other Vascular

Procedures with MCC), MS-DRG 253 (Other Vascular Procedures with CC) and MS-DRG 254

(Other Vascular Procedures without CC/MCC).

Comment: One commenter evaluated the diagnoses associated with MS-DRGs 252, 253,

and 254 to assess whether patients with diagnoses not on the CC or MCC lists were more costly

to treat. The commenter selected the following 30 diagnosis codes:

250.70, Diabetes with peripheral circulatory disorders, type II or unspecified type, not state uncontrolled
263.9, Unspecified protein-calorie malnutrition
276.1, Hyposmolality and/or hyponatremia
276.2, Acidosis
276.51, Dehydration
276.7, Hyperpotassemia
276.8, Hypopotassemia
280.0, Secondary to blood loss (chronic)
285.1, Acute posthemorrhagic anemia
287.5, Thrombocytopenia, unspecified
410.71, Subendocardial infarction, initial episode of care
427.1, Paroxysmal ventricular tachycardia
427.31, Atrial fibrillation
440.1, Atherosclerosis of renal artery
440.24, Atherosclerosis of the extremities with gangrene
444.22, Arterial embolism and thrombosis, lower extremity
458.9, Hypotension, unspecified
491.21, Obstructive chronic bronchitis with (acute) exacerbation
496, Chronic airway obstruction, not elsewhere classified
511.9, Unspecified pleural effusion
518.0, Pulmonary collapse
599.0, Urinary tract infection, site not specified
682.6, Other cellulitis and abscess, leg, except foot
682.7, Other cellulitis and abscess, foot, except toes
707.15, Ulcer of other part of foot

785.4, Gangrene
790.7, Bacteremia
996.62, Infection and inflammatory reaction due to vascular device, implant and graft
997.1, Cardiac complications
998.11, Hemorrhage complicating a procedure

The commenter recommended that CMS should:

● Reassign vascular procedure cases containing two or more of the identified diagnosis codes from MS-DRG 253 to MS-DRG 252.

● Reassign vascular procedure cases containing two or more of the identified diagnosis codes from MS-DRG 254 to MS-DRG 253.

Response: In our proposed rule analysis, we found that the vascular procedures DRG warranted three subdivisions according to our five criteria. Nineteen of the 30 diagnosis codes suggested by the commenter already appear on the CC or MCC list and will result in a patient being assigned to either MS-DRG 252 or MS-DRG 253. The remaining 11 diagnosis codes do not appear on either list. These codes are: 250.70, 276.51, 276.7, 276.8, 280.0, 287.5, 427.31, 440.1, 458.9, 496, and 707.15.

Although the commenter has identified common diagnoses in this patient population, our medical advisors reviewed the clinical issues and claims data for cases reporting each of the conditions not on the MCC or CC list as a secondary diagnosis. After evaluating the claims data and analyzing the clinical issues, our medical advisors recommend that we not change the CC status for the codes mentioned above. They do not believe there is sufficient justification for making these codes CCs. We do not believe that we should make further changes to the MS-DRG assignments based on combinations of selected diagnoses. These types of analyses could be done with virtually

any MS-DRG and would add significant complexity to the DRG system that we do not

believe is warranted at this time. We reiterate that the MS-DRGs—like the predecessor

CMS-DRGs—are intended to establish an average payment based on groups of patients

that are similar in costs and clinical characteristics. Over time, we found that the

CMS DRGs did not sufficiently recognize differences in patient severity of illness, and

we proposed to adopt the MS-DRGs as an alternative to achieve this objective. While we

acknowledge that further potential improvements may be warranted as we have more

experience with the new system, we have significant concerns about selectively analyzing

specific diagnoses within a given MS-DRG to change their DRG assignment. Although

we have increased the assigned severity level for a limited number of cases, these

decisions recognize that the patient was more complex than was suggested by their

secondary diagnosis either because of a specific procedure (in the case of intestinal

transplants) or the type of technology used to treat their condition (in the case of cochlear

implants and spinal stabilization devices).

We refer readers to section II.D.2.a. of this preamble for complete information on

the CC list.

l. Coronary Artery Stents (MDC 5)

Effective for cases discharged on or after October 1, 2005 (FY 2006), the

ICD-9-CM Coordination and Maintenance Committee created a series of adjunct codes

further describing procedures on the vascular system. These codes were at the 00.4

subcategory (Adjunct vascular system procedures), with codes 00.40 through 00.43

describing the number of vessels upon which a procedure was performed, and codes

00.45 through 00.48 describing the number of stents which were inserted. As these codes

were deemed to be adjunct codes that supplemented the information describing a

patient's hospital treatment, they were not considered procedure codes that would affect

DRG assignment. However, coders were encouraged to thoroughly and completely code

all hospital stays, in case this information would be used for future DRG determination.

We received comments on the proposed MS-DRGs concerning the DRG assignment for

procedures on multiple coronary vessels and insertion of multiple stents in coronary

arteries.

Comment: Commenters have analyzed standardized charges in the FY 2006

MedPAR data for percutaneous transluminal coronary angioplasty (PTCA) in

conjunction with codes indicating insertion of drug-eluting or non-drug-eluting coronary

artery stent(s) and the use of codes indicating procedures on multiple vessels and/or

insertion of multiple stents. These commenters believe that mean standardized charges

for these combination codes vary substantially from the mean standardized charges

associated with the DRGs to which they are proposed to be assigned. The DRGs under

consideration in this section for drug-eluting stents are MS-DRG 246 (Percutaneous

Cardiovascular Procedure with Drug-Eluting Stent with MCC) (formerly CMS DRG 557

(Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with Major

Cardiovascular Diagnosis)) and MS-DRG 247 (Percutaneous Cardiovascular Procedure

with Drug-Eluting Stent without MCC) (formerly CMS DRG 558 (Percutaneous

Cardiovascular Procedure with Drug-Eluting Stent without Major Cardiovascular

Diagnosis)). The DRGs under consideration in this section for non-drug-eluting stents

are MS-DRG 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent

with MCC) and MS-DRG 249 (Percutaneous Cardiovascular Procedure with Non-Drug-

Eluting Stent with MCC). (These were either formerly CMS DRG 555 (Percutaneous

Cardiovascular Procedures with Major Cardiovascular Diagnosis) or CMS DRG 556

(Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without Major

Cardiovascular Diagnosis), respectively.)

The commenters recommended that PTCA code 00.66 (Percutaneous transluminal

coronary angioplasty [PTCA] or coronary atherectomy) in combination with a code for

insertion of a drug-eluting or non-drug-eluting stent, plus adjunct codes indicating

procedures on multiple vessels and insertion of multiple stents be assigned to MS-DRGs

246 and 248 as described above. They stated that their analysis of standardized charges

for PTCA with insertion of a drug-eluting or non-drug-eluting stent(s) in multiple vessels

or with insertion of multiple stents vary substantially from the mean standardized charges

associated with the DRGs to which they are proposed to be assigned. The commenters

found that the variation in charges between the subgroups and the overall DRG average

meet CMS' criteria for moving cases between DRGs, and suggested that cases with

multiple vessels and multiple stents be moved up to the first DRG in the series. That is,

cases with insertion of drug-eluting stents in MS-DRG 247 would be assigned to

MS-DRG 246, and cases with non-drug-eluting stents in MS-DRG 249 would be

assigned to MS-DRG 248. In each of the MS-DRGs, cases where multiple vessels are

treated or multiple stents are placed would be assigned to the "with MCC" MS-DRG

rather than the "without MCC" MS-DRG.

Response: We reviewed the MedPAR data in response to these comment and

found that PTCAs with four or more vessels or four or more stents were more

comparable in average charges to the higher weighted DRG in the group. These data are

summarized in the following tables.

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 246 - All cases	31,204	6.34	$64,009.36
MS-DRG 246 - Cases with codes 00.66 and 36.07 with 4 or more vessels (code 00.43) and 4 or more stents (code 000.48)	1,425	5.68	$78,02.93
MS-DRG 247 - All cases	267,684	2.24	$40,857.34
MS-DRG 247 - Cases with codes 00.66 and 36.07 with 4 or more vessels (code 00.43) and 4 or more stents (code 000.48)	8,095	2.33	$61,666.34

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 248 - All cases	4,710	6.53	$56,671.61
MS-DRG 248 - Cases with codes 00.66 and 36.06 with 4 or more vessels (code 00.43) and 4 or more stents (code 000.48)	112	6.38	$69,431.81
MS-DRG 249 - All cases	27,914	2.55	$35,577.22
MS-DRG 249 - Cases with codes 00.66 and 36.06 with 4 or more vessels (code 00.43) and 4 or more stents (code 000.48)	232	3.76	$54,203.87

In both cases, we believe that the average charges for cases where four or more

vessels are treated or four or more stents are placed more closely approximate average

charges in the higher weighted MS-DRG. Therefore, we are assigning these cases to the

higher weighted MS-DRG according to the following logic.

Claims containing code 00.66 for PTCA, and code 36.07 (Insertion of drug-eluting coronary artery stent(s)), and code 00.43 (Procedure on four or more vessels) or code 00.48 (Insertion of four or more vascular stents) are assigned to MS-DRG 246. In addition, claims containing code 00.66 for PTCA, and code 36.06 (Insertion of non-drug-eluting coronary artery stent(s)), and code 00.43 or code 00.48 are assigned to MS-DRG 248.

We are also making conforming changes to the MS-DRG titles as follows: MS-DRG 246 is titled "Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4 or more Vessels/Stents". The title for MS-DRG 247 will remain unchanged. MS-DRG 248 is titled "Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4 or more Vessels/Stents". The title for MS-DRG 249 will remain unchanged. This DRG modification is based on newly created codes that were developed to provide additional detail on the number of vessels treated and the number of stents inserted. The DRG combines two distinct concepts: the insertion of four or more stents or the performance of a vascular procedure on four or more vessels, in order to determine the DRG assignment. Although we are adopting this DRG change for FY 2008, we plan to continue examining whether this revision of the DRG definition captures a relatively homogeneous group of cases. We currently only have one year of data on these new codes. Therefore, we plan to revisit this issue further in next year's proposed rule when we have a second year of data to better distinguish the different types of cases that are treated with this technology.

m. Endovascular Repair of Aortic and Thoracic Aneurysms (MDC 5)

Comment: Several commenters expressed concern that the relative weights for

MS-DRGs 237 and 238 (Major Cardiovascular Procedures with MCC and without MCC,

respectively), formerly CMS-DRGs 110 and 111 (Major Cardiovascular Procedures with

CC and without CC, respectively) do not reflect the severity of illness and the resource

use required for such complex care. One commenter noted that regardless of the DRG

assignment, the cost of the endovascular graft or device does not change, nor is it

insignificant. The commenter further stated that MS-DRGs 237 and 238 do not

adequately factor into the relative weights that the device is not incidental to treatment; it

is a major component of the treatment.

Response: New MS-DRGs 237 and 238 are exactly the same as their predecessor

CMS DRGs 110 and 111 in content. Using historic Medicare charges and hospital cost

report data submitted to us by hospitals, we have included the cost of the device into the

MS-DRG relative weights.

Comment: Several commenters suggested that MS-DRGs 237 and 238 should be

divided into three levels of severity: "with MCC", "with CC", and "without CC/MCC"

and noted that it is important that CMS be consistent and not create inequities with regard

to major surgical procedures. One commenter stated that patients with aortic aneurysm

fall naturally into three clinical categories, with patients who are genetically predisposed

to an aneurysm are likely to be younger (between 50 and 60 years of age, not between 70

and 80 years of age) and are more likely to be healthier than the typical aneurysm patient.

Those cases are suggested for an MS-DRG without CC/MCC. The commenter added

that the other cases would fall into the "with MCC" or "with CC" MS-DRGs based on the

severity of their CCs.

Response: When we consolidated all existing DRGs into the base DRGs, we

removed all demarcations that had been added over the years, including considerations

for age, gender, and discharge disposition, as well as elimination of the current split

based on the presence or absence of a CC, burns, trauma, AMI, major cardiovascular

condition, among others. We then applied the severity criteria described elsewhere in

this preamble, and stated that in order to warrant creation of a CC or major CC subgroup

within a base MS-DRG, the subgroup had to meet all five criteria. The commenter states

that genetically predisposed patients tend to be younger. Although age is a variable that

would be available in the Medicare claims data, genetic predisposition to a certain class

of diseases generally cannot be identified in the ICD-9-CM coding system. Therefore, as

we are not able to identify those patients, we cannot subdivide these MS-DRGs using

genetic predisposition as criterion.

We considered subdividing MS-DRGs 237 and 238 into three DRGs for the

proposed rule. However, MS-DRGs 237 and 238 did not meet the criteria for a 3-way

split.

Comment: Two commenters suggested that instead of "with MCC" in the

surgical DRGs, CMS should establish a list of devices that would be equivalent to the

MCC categorization and further subdivide the MS-DRGs based on the presence of "with

Major Device." Specifically, they suggested that endovascular devices or grafts used

during cardiovascular procedures should be considered major devices. Therefore, they

added, when a major device or implantable graft is used in a cardiovascular repair

procedure, such as those performed to repair an abdominal or thoracic aortic aneurysm,

CMS should assign those cases to MS-DRGs where the DRG title has been changed to

reflect that the costs of the device are similar to the costs of an MCC.

Response: We believe the commenter is suggesting that we establish a list of

major devices and use them as a proxy for MCCs. We will take this suggestion under

consideration in future reviews of the MS-DRGs.

We looked at data to review the differences between endovascular graft repair of

abdominal aortic aneurysm (code 39.71) and endovascular graft repair of thoracic aortic

aneurysm (code 39.73). Our findings are represented in the table below.

MS-DRG	Number of cases	Average length of stay	Average Charges
MS-DRG 237 – All cases	20,789	11.47	$93,824.52
MS-DRG 237 – Cases with code 39.71 (abdominal)	1,484	8.95	$89,929.39
MS-DRG 237 – Cases with code 39.73 (thoracic)	277	10.98	$119,120.51
MS-DRG 238 – All cases	42,797	4.88	$51,410.12
MS-DRG 238 – Cases with code 39.71 (abdominal)	14,091	2.58	$55,798.25
MS-DRG 238 – Cases with code 39.73 (thoracic)	877	4.95	$72,426.29

Review of these data shows that the 887 thoracic cases in MS-DRG 238 have

average charges that are between both groups. We believe that the data indicate that

endovascular repair of the thoracic aorta cases should be assigned to MS-DRG 237.

Therefore, we are assigning procedure code 39.73 (Endovascular implantation of

graft in thoracic aorta) to MS-DRG 237 in FY 2008.

n. O.R. Procedures for Obesity (MDC 10)

Comment: One commenter was concerned with the conditions that are classified

as MCCs and CCs for MS-DRGs 619, 620, 621 (O.R. Procedures for Obesity with MCC,

with CC, and without CC/MCC, respectively), previously CMS DRG 288. The

commenter fully supported efforts to base payments on patient severity, but states that

some of the proposed changes do not appear to achieve that goal. The commenter

acknowledged the three severity levels added to former CMS DRG 288 (O.R. Procedures

for Obesity). However, the commenter stated that all of the morbidly obese Medicare

patients will have one or more serious comorbidities. The commenter was concerned

about the application of the complete MCC and CC list to MS-DRGs 619, 620, and 621.

The commenter stated that the following codes, which are on the MCC and CC lists,

should not be considered MCCs or CCs for these bariatric DRGs because these

conditions are "contraindications" to performing bariatric surgery:

● Diabetes codes 250.10 through 250.13; 250.20 through 250.23; and 250.30

through 250.33 (all MCCs)

● Coronary atherosclerosis codes 414.02 through 414.04; and 414.06 and 414.07

(all CCs)

● Aneurysm and dissection of heart codes 414.10 (CC), 414.12 (MCC), and

414.19 (CC)

The commenter also requested that the following codes be classified as CCs for

these bariatric DRGs:

● Diabetes codes - 250.00 through 250.93

- Obstructive sleep apnea – 327.23

- Hypertensive disease – 401.0 through 405.99

- Cirrhosis of liver without mention of alcohol – 571.5

- Biliary cirrhosis – 571.6

- Other chronic nonalcoholic liver disease – 571.8

- Unspecified chronic liver disease without mention of alcohol – 571.9

Response: Our clinical advisors disagree with the recommendations to change the

diabetes, coronary atherosclerosis, and aneurysm and dissection codes from MCCs and

CCs to non-CCs for the bariatric MS-DRGs. They believe these conditions represent

significant CCs in the general patient population and the data we used to perform this

analysis support their judgment. Although we do have secondary diagnosis codes that are

"exclusions" (not counted as an MCC or a CC if they are related to the principal

diagnosis), we have not analyzed whether to classify a particular diagnosis as an MCC or

a CC for purposes of determining if a particular type of surgery should be performed.

However, we believe the commenter indicates that our decision to classify these

conditions as MCCs or CCs is correct by suggesting that the presence of these conditions

is so significant in increasing severity of illness that it is a contraindication to surgery.

We expect that physicians will not order surgical procedures that are contraindicated

merely because the case would be assigned to a higher-paying DRG.

Our medical advisors evaluated the request to make the codes specified above

CCs. Our medical advisors reviewed claims data and clinical issues for cases reporting

codes 250.00 through 250.93; 327.23; 401.0 through 405.99; and 571.5 as secondary

diagnoses. After evaluating the claims data and analyzing the clinical issues, our medical

advisors recommend that we not change the CC status for codes 250.00 through 250.93;

327.23; 401.0 through 405.99; and 571.5. They do not believe there is sufficient

justification for making these codes CCs at this time.

o. Penile Restorative Procedures (MDC 12)

       Comment: One commenter, a national organization representing the prosthetic

urology community applauded CMS for moving forward to ensure that Medicare

payments for inpatient services are appropriate and accurately reflect the severity and

resources required for patient care. The commenter supported the proposal to implement

MS-DRGs on October 1, 2007. However, the commenter indicated that the cost of

implants and prosthetics used in penile implant procedures are comparable to the

resources utilized in a patient with a MCC or CC diagnosis. Generally, the commenter

suggested that in surgical MS-DRGs where implants and prostheses are part of the

ICD-9-CM procedure code title that CMS should consider revising the MS-DRG titles to

account for the costs associated with surgical procedures that use an implant or

prosthesis. As an example, the commenter expressed support for the proposed

modification to MS-DRG 129 (Major Head and Neck Procedure with CC/MCC or Major

Device). The commenter believed that, when a major implant/prosthesis/device

demonstrates costs that are greater than or similar to the difference between the relative

weights of a CC/MCC DRG versus a without CC/MCC DRG pair, CMS should

recognize the device or implant in the MS-DRG titles and reassign these cases.

Specifically, the commenter recommended that the title for proposed MS-DRG 709

(Penis Procedures with CC or MCC) be revised to add the phrase "or major device or

implant" and include all cases where an implantable prosthesis is used in a penile

restorative procedure.

Response: We appreciate the commenter's support for MS-DRGs and its general

suggestions for future refinements. The commenter did not provide specific examples of

types of implants and prosthesis which they want to have evaluated for possible DRG

reassignment. We are not clear as to whether or not there will be ICD-9-CM procedure

codes for these specific implants. It is premature to modify the MS-DRG titles at this

time without more specific information and analysis.

Comment: This same commenter also urged CMS to review clinically significant

conditions for penile restorative procedures on the proposed MCC and CC lists.

Response: We refer readers to section II.D.3. of this final rule with comment

period for a complete discussion on the public comments received on the MCC and CC

lists. We welcome any specific recommendations for future revisions and refinements to

the MCC and CC lists.

p. Female Reproductive System Reconstruction Procedures (MDC 13)

Comment: Two commenters requested that CMS establish levels within

MS-DRG 748 (Female Reproductive System Reconstruction Procedures). The

commenters noted that all of the other proposed MS-DRGs for surgical male and female

reproductive system procedures have either "MCC or CC" subdivisions. The

commenters believed that CMS may have made an oversight by not establishing severity

levels within this MS-DRG.

Response: As stated in the FY 2008 proposed rule, in order to warrant creation of a CC or MCC subgroup within a base MS-DRG, the subgroup has to meet all five criteria. In developing the proposed MS-DRGs, this base DRG did not meet three of the five criteria required to subdivide a DRG into additional severity subgroups. MS-DRG 748 failed the following three criteria:

● At least 5 percent of the patients in the MS-DRG fall within the MCC or CC subgroup.

● At least 500 cases are in the MCC or CC subgroup.

● There is a $4,000 difference in average charge between subgroups.

We refer readers to section II.D.3 of the FY 2008 proposed rule (72 FR 24705) for a complete listing of the criteria.

As such, effective October 1, 2007, we are adopting the MS-DRGs as final policy and MS-DRG 748 will remain as proposed with the following title: MS-DRG 748 (Female Reproductive System Reconstruction Procedures)

q. Urological and Gynecological Disorders with Grafts or Prosthesis (MDCs 13 and 14)

Comment: We received comments commending CMS for the creation of new ICD-9-CM procedure codes that identify the use of grafts or prosthetics in female pelvic prolapse repair procedures. The commenters acknowledged that the use of these new codes will result in better data collection, outcomes research, and improve the quality of health care for women. However, the commenters indicated that the cost of implants and prosthetics used in treating various urological and gynecological conditions are comparable to the resources utilized in a patient with an MCC or CC diagnosis.

Specifically, the commenters recommended that the titles for the following proposed

MS-DRGs be revised to add the term, "or major device" to account for cases where a

graft or prosthesis is used.

- MS-DRG 333 (Rectal Resection with CC)

- MS-DRG 662 (Minor Bladder Procedures with Major CC)

- MS-DRG 707 (Major Male Pelvic Procedures with CC or Major CC)

- MS-DRG 709 (Penis Procedures with CC or Major CC)

- MS-DRG 746 (Vagina, Cervix & Vulva Procedures with CC or Major CC)

Response: We appreciate the commenter's support of the new procedure codes

and the suggestion to revise the proposed MS-DRG titles. The newly created codes

describing the use of grafts or prosthetics are restricted to female pelvic prolapse repair

procedures and are not effective until October 1, 2007. As a result, there is no data

available for analysis at this time. We will evaluate these recommendations as we obtain

additional data using the MS-DRGs to determine if future changes to the above

mentioned MS-DRGs are warranted.

r. High Dose Interleukin-2 (HD-IL-2) (MDC 17)

We received comments concerning the appropriate assignment within the

MS-DRGs of patients receiving High-dose Interleukin-2 (IL-2).

In the FY 2004 final rule (68 FR 45360, August 1, 2003), we discussed the

creation of a specific code to identify IL-2 (procedure code 00.15, High-dose infusion of

Interleukin-2 (IL-2)) and the subsequent modification of existing CMS DRG 492

(Chemotherapy with Acute Leukemia as Secondary Diagnosis) by adding code 00.15 to

the DRG logic and changing the title to "Chemotherapy with Acute Leukemia or with use

of High Dose Chemotherapy Agent". This drug is marketed as Proleukin©. Under the

proposed MS-DRGs, CMS DRG 492 would be replaced by MS-DRG 837

(Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose

Chemotherapeutic Agent with MCC), MS-DRG 838 (Chemotherapy with Acute

Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapeutic Agent), or

MS-DRG 839 (Chemotherapy with Acute Leukemia as Secondary Diagnosis without

CC/MCC).

        Administration of high-dose Interleukin-2 (HD-IL-2) is a hospital inpatient-based

regimen that can produce durable remissions of metastatic renal cell cancer and

metastatic melanoma in a subset of patients. In contrast to traditional cytotoxic

chemotherapies which target cancer cells directly, HD-IL-2 enhances the body's natural

cancer defenses by stimulating the growth and activity of cancer-killing white blood

cells. HD-IL-2 therapy is associated with severe complications that can

include: hypotension, metabolic acidosis, acute renal failure, arrhythmia, myocardial

inflammation, coagulation defects, hyperthyroidism, psychosis, respiratory distress

syndrome, catheter related septicemia, hyperbilirubinemia and thrombocytopenia.

        To safely administer HD-IL-2, the FDA-approved label states that HD-IL-2

"should be administered in a hospital setting under the supervision of a qualified

physician experienced in the use of anticancer agents. An intensive care facility and

specialists skilled in cardiopulmonary or intensive care medicine must be available."

Strict nursing protocols must be followed in order to minimize adverse events such as cardiac arrhythmias as well as severe hypotension.

Because it is associated with such severe side effects, HD-IL-2 therapy requires substantially greater resource utilization, including longer hospital stays and additional nursing support, than conventional chemotherapy. Conventional chemotherapy may be administered to patients either on an outpatient basis or through a series of short (that is, 1 to 3 day) inpatient stays. By contrast, FDA approval for high-dose IL-2 refers specifically to the following protocol:

"Each course of high-dose IL-2 therapy is administered during two separate hospital admissions, with an average length of stay of six to seven days each. For the first cycle, Interleukin-2 is administered every 8 hours over a 5-day period. Patients are then discharged to rest at home for several days, and then readmitted for a second cycle consisting of an identical dosing regimen. These two cycles comprise the first course of high-dose IL-2 therapy, which may be repeated after 8 to 12 weeks if the patient is responding."

Based on data from peer reviewed publications, some centers may administer IL-2 "off-label" in low- or intermediate-dose regimens. For such off-label uses, IL-2 is either not administered as a bolus, or in a much lower-dose bolus. Because low- or intermediate-dose IL-2 therapy poses a lower risk of serious side effects, its administration is less resource intensive in terms of patient monitoring, nursing support, and length of stay.

A specific code was created for the administration of High-dose Interleukin-2

beginning with cases discharged on or after October 1, 2003. Code 00.15 (High-dose

infusion interleukin-2 (IL-2)) came from existing code 99.28 (Injection or infusion of

biological response modified [BMR] as an antineoplastic agent), which had been created

for use on or after October 1, 1994. However, as there may be some confusion in the

industry concerning the differentiation and correct coding of "high-dose" IL-2 therapy

from less resource intensive uses, some non-high-dose cases have probably been

incorrectly billed under 00.15 as high-dose cases when they should have been classified

to code 99.28. Code 00.15 is specifically titled "High-dose infusion Interleukin-2" and

contains inclusion terms specifying "Infusion (IV Bolus, CIV) interleukin." A

specifically written "excludes note" in the Tabular section of the Procedure Manual sends

Coders to code 99.28 to correctly describe the administration of low-dose infusion

Interleukin-2. This confusion has possibly caused Medicare to overpay for some non-

high-dose cases as if they were high-dose cases, and may have reduced the reported

average charges and costs of true high-dose IL-2 therapy [in the MedPAR data files]. If

reported average charges do not reflect true high-dose IL-2 therapy, the result of this

coding inaccuracy may be causing the IPPS relative weight to reflect a blend of the costs

of patient treated with high-dose and low-dose administration of IL-2.

To address this incorrect coding issue, CMS will clarify the ICD-9-CM coding

system by making additional entries in both the Index and Tabular portions of the

Procedure section of the code book. Procedure code 00.15 should only be billed for

"bolus, high-dose IL-2." Cases must satisfy the following four criteria, as documented in

the medical record, to qualify for use of code 00.15 as "bolus, high-dose IL-2":

● Bolus infusions given over no more than 30-minutes at a dose of no less than

600,000 IU/kg (weight-adjusted);

● Placement and utilization of a central line;

● Administration in a hospital setting under the supervision of a qualified

physician experienced in the use of anticancer agent with an intensive care facility and

specialists skilled in cardiopulmonary or intensive care medicine available, and

● A planned 5-day treatment protocol.

Comment: Commenters indicated that the administration of High-dose IL-2 is an

extremely complicated and advanced therapy, requiring much stricter nursing protocols

to prevent or manage the expected complications which accompany this type of cytotoxic

therapy. The commenters also noted that HD-IL-2 cases are assigned to a CMS DRG for

chemotherapy that, in their view, is clinically inappropriate. The commenters stated that

technologies should be assigned to clinically consistent DRGs. Therefore, the

commenters added, when a therapy differs clinically and in resource allocation from the

other cases assigned to the same base DRG, adoption of a new DRG for that technology

is warranted. Commenters urged CMS to reassess whether cases using HD-IL-2 and

other treatments involving advanced technologies are assigned to appropriate DRGs and

to create new, clinically appropriate DRGs for all advanced therapies.

Response: The cost of treating patients with HD-IL-2 continues to be represented

in MS-DRGs 837, 838, and 839, but the cases have been distributed according to the

presence or absence of an MCC, a CC, or the lack of either a comorbidity or complication

according to the historical data represented by MedPAR. Medicare likely will continue

to pay the same amount for all patients in these MS-DRGs. However, our payments will

better reflect patient severity of illness by paying higher amounts for those cases where

the patient has an MCC or CC than if they do not. The data suggest that it is appropriate

to divide CMS DRG 492 based on severity levels, so for the MS-DRG system, new MS-

DRGs 837, 838, and 839 were created, as described above. Our findings are represented

in the following table.

MS-DRG	Number of cases	Average length of stay	Average charges
MS-DRG 837 – All cases	1,525	22.62	$107,269.93
MS-DRG 837 – Cases with IL-2 Infusion (Code 00.15)	56	8.11	$73,104.34
MS-DRG 837 – Cases without IL-2 Infusion (Code 00.15)	1,469	23.17	$108,600.39
MS-DRG 838 – All cases	855	9.15	$46,596.45
MS-DRG 838 – Cases with IL-2 Infusion (Code 00.15)	555	4.78	$44,008.54
MS-DRG 838 – Cases without IL-2 Infusion (Code 00.15)	522	11.94	$48,247.36
MS-DRG 839 – All cases	1,307	6.04	$22,693.30
MS-DRG 839 – Cases with IL-2 Infusion (Code 00.15)	20	4.40	$38,002.15
MS-DRG 839 – Cases without IL-2 Infusion (Code 00.15)	1,287	6.07	$22,455.40

These data suggest that average charges for patients receiving HD-IL-2 are either comparable or lower than other patients within assigned MS-DRGs 837 and 838. For this reason, we believe most cases treated with HD-IL-2 will be paid adequately under the MS-DRGs. The remaining 20 cases in MS-DRG 839 have average charges that are more than $15,000 higher than other cases within this MS-DRG. The average charges for these cases are closer to those for MS-DRG 838.

In spite of the possibility of erroneous coding of low-dose IL-2 cases to procedure code 00.15 instead of the more appropriate code 99.28 as discussed above, the data do not currently suggest a problem with Medicare payment for most of the HD-IL-2 cases assigned to MS-DRGs 837, 838, and 839. However, the data do suggest that the costs of cases of IL-2 coded with 00.15 currently assigned to MS-DRG 839 are closer to MS-DRG 838. Therefore, for FY 2008, we are assigning procedure code 00.15 (High-dose infusion of Interleukin-2 (IL-2)) to MS-DRG 837 (Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapeutic Agent with MCC) and MS-DRG 838 (Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapeutic Agent).

s. Computer Assisted Surgery

Comment: We received one comment from a manufacturer requesting that CMS recognize improved clinical outcomes resulting from computer assisted surgery and develop new MS-DRGs to group patients together who receive this technology. The commenter noted that effective October 1, 2004, CMS created codes to describe specific forms of computer assisted surgery. The commenter further noted that clinical outcomes

are superior when computer assisted surgery is utilized; however, assigning the computer

assisted surgery codes does not affect the DRG assignment. The commenter encouraged

CMS to consider this issue as it continues to refine the DRG system.

> Response: We appreciate the commenter's recommendation that CMS evaluate

how to better recognize the clinical outcomes associated with computer-assisted surgical

procedures. It is unclear which procedures the commenter is proposing we specifically

examine at this time. Currently, the procedure codes that identify the use of computer

assisted surgery are as follows:

- 00.31, Computer assisted surgery with CT/CTA

- 00.32, Computer assisted surgery with MR/MRA

- 00.33, Computer assisted surgery with fluoroscopy

- 00.34, Imageless computer assisted

- 00.35, Computer assisted surgery with multiple datasets

- 00.39, Other computer assisted surgery

> We will continue to study this issue as we obtain additional data under the

MS-DRGs and determine if it is appropriate to make further modifications.

13. Changes to MS-DRG Logic As a Result of Public Comments

> To assist the readers in identifying all changes that were made to the MS-DRGs as

a result of public comments received on the FY 2008 IPPS proposed rule, we have

developed the following summary chart of those changes.

MS-DRG Summary Chart

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
Pre-MDC			
Intestinal Transplant			
MS-DRG 005	Liver transplant and/or intestinal transplant w MCC	Liver transplant w MCC or intestinal transplant	Cases with procedure code 46.97 (Transplant of intestine) are reassigned from MS-DRG 006 to MS-DRG 005.
MS-DRG 006	Liver transplant and/or Intestinal Transplant w/o MCC	Liver transplant w/o MCC	
MDC 1 (Diseases and Disorders of the Nervous System)			
Implantation of Chemotherapeutic Agent **Intracranial Stents**			
MS-DRG 023	Craniotomy with major device implant or acute complex central nervous system principal diagnosis with MCC	Cranio w major dev iImpl/acute complex CNS PDX with MCC or chemo implant	Cases with procedure code 00.10 (Implantation of chemotherapeutic agent) are reassigned from MS-DRG 024 to MS-DRG 023.
MS-DRG 024	Craniotomy with major device implant or acute complex central nervous system principal diagnosis without MCC	Cranio w major dev impl/acute complex CNS PDX w/o MCC	Cases with procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)) are reassigned from MS-DRGs 037-039 to MS-DRGs 023-024.
Intracranial Stents			
MS-DRG 025	Craniotomy & endovascular intracranial procedures w MCC	Craniotomy & endovascular intracranial procedures w MCC	Cases with procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)) are reassigned from MS-DRGs 037-039 to MS-DRGS 025-027.
MS-DRG 026	Craniotomy & endovascular intracranial procedures w CC	Craniotomy &endovascular intracranial procedures w CC	
MS-DRG 027	Craniotomy & endovascular intracranial procedures w/o CC/MCC	Craniotomy & endovascular intracranial procedures w/o CC/MCC	

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
Spinal Neurostimulators			
MS-DRG 028	Spinal procedures w MCC	Spinal procedures w MCC	Full system spinal cord non-rechargeable and rechargeable neurostimulator cases in MS-DRG 030 are reassigned to MS-DRG 029 in MDC 1. ICD-9-CM procedure codes 03.93 (Implantation or replacement of spinal neurostimulator lead(s)), and 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable), or 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable), or 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator), or 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) must be reported in order for the spinal neurostimulator cases to be assigned to MS-DRG 029.
MS-DRG 029	Spinal procedures w CC	Spinal procedures w CC or spinal neurostimulators	
MS-DRG 030	Spinal procedures w/o CC/MCC	Spinal procedures w/o CC/MCC	
Intracranial Stents			
MS-DRG 037	Extracranial procedures w MCC	Extracranial procedures w MCC	Cases with procedure code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)) are reassigned from MS-DRGs 037 to MS-DRGs 023-027.
MS-DRG 038	Extracranial procedures w CC	Extracranial procedures w CC	
MS-DRG 039	Extracranial procedures w/o CC/MCC	Extracranial procedures w/o CC/MCC	
Peripheral Neurostimulators			
MS-DRG 040	Periph & cranial nerve & other nerv	Periph & cranial nerve & other nerv	Full system peripheral non-rechargeable and

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
	syst proc w MCC	Syst proc with MCC	rechargeable neurostimulator cases in MS-DRG 042 are reassigned to MS-DRG 041. ICD-9-CM procedure codes 04.92 (Implantation or replacement of peripheral neurostimulator lead(s)), and 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable), or 86.95 (Insertion or replacement of dual array neurostimlator pulse generator, not specified as rechargeable), or 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator), or 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) must be reported in order for the peripheral neurostimulator cases to be assigned to MS-DRG 041.
MS-DRG 041	Peripheral/Cranial nerve & other nerv syst proc with CC	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	
MS-DRG 042	Peripheral/cranial Nerve & other nerv syst proc w/o CC/MCC	Periph/cranial nerve & other nerv Syst proc w/o CC/MCC	
Pain Codes			
MS-DRG 091	Other disorders of nervous system w MCC	Other disorders of nervous system w MCC	Cases with a principal diagnosis of code 338.0 (Central pain syndrome) or code 338.21 (Chronic pain due to trauma) or code 338.22 (Chronic post-thoracotomy pain) or code 338.28 (Other chronic postoperative pain) or code 338.29 (Other chronic pain) or code 338.4 (Chronic pain syndrome) are reassigned from MDC 23, MS-DRGs 947-948 to MS-DRGs 091-093.
MS-DRG 092	Other disorders of nervous system w CC	Other disorders of nervous system w CC	
MS-DRG 093	Other disorders of nervous system w/o CC/MCC	Other disorders of nervous system w/o CC/MCC	
MDC 3 (Disease and Disorders of the Ear, Nose, Mouth, and Throat)			
Cochlear Implants			
MS-DRG 129	Major head & neck procedures w	Major head & neck procedures w	Cochlear implant cases are reassigned from

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
MS-DRG 130	CC/MCC Major head & neck procedures w/o CC/MCC	CC/MCC or Major Device Major head & neck procedures w/o CC/MCC	MS-DRG 130 to MS-DRG 129. The ICD-9-CM procedure codes for cochlear implants are: 20.96 (Implantation or replacement of cochlear prosthetic device, not otherwise specified), or 20.97 (Implantation or replacement of cochlear prosthetic device, single channel), or 20.98 (Implantation or replacement of cochlear prosthetic device, multiple channel).
MDC 5 (Disease and Disorders of the Circulatory System)			
Endovascular Implantation of Graft in Thoracic Aorta			
MS-DRG 237	Major cardiovascular procedures w MCC	Major cardiovasc procedures w MCC or thoracic aortic aneurysm repair	Cases with procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) are reassigned from MS-DRG 238 to MS-DRG 237.
MS-DRG 238	Major cardiovascular procedures w/o MCC	Major cardiovascular procedures w/o MCC	
Multiple Vessels, Multiple Coronary Stents			
MS-DRG 246	Percutaneous cardiovascular pro w drug-eluting stent w Major CC	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ Vessels/Stents	Cases in MS-DRG 247 with procedure code 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy), and code 36.07 (Insertion of drug-eluting coronary artery stent(s)), and code 00.43 (Procedure on four or more vessels), or code 00.48 (Insertion of four or more vascular stents) are reassigned to MS-DRG 246.
MS-DRG 247	Percutaneous cardiovascular proc w drug-eluting stent w/ot Major CC	Perc cardiovasc proc w drug-eluting stent w/o MCC	
MS-DRG 248	Percutaneous cardiovascular proc w non-drug-eluting stent w Major CC	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ Ves/stents	Cases in MS-DRG 249 with procedure codes 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy), and code 36.06 (Insertion of non-drug-eluting coronary artery stent(s)), and code 00.43
MS-DRG 249	Percutaneous cardiovascular proc w non-drug-eluting stent w/o Major CC	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
			(Procedure on four or more vessels), or code 00.48 (Insertion of four or more vascular stents) are reassigned to MS-DRG 248.
MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)			
Spinal Fusion			
MS-DRG 456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC	Spinal fusion exc cerv w spinal curv/malig/infec or 9+ fusions w MCC	The following diagnoses are added to the principal diagnosis list for MS-DRGs 456-458: 015.02 (Tuberculosis of bones and joints, vertebral column, bacteriological or histological examination unknown (at present)); 015.04 (Tuberculosis of bones and joints, vertebral column, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture); 015.05 (Tuberculosis of bones and joints, vertebral column, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically); 730.08 (Acute osteomyelitis of other specified sites); 730.18 (Chronic osteomyelitis of other specified sites); and 730.28 (Unspecified oteomyelitis of other specified sites).

Procedure code 81.64 (Fusion or refusion of 9 or more vertebrae) is added to the list of procedures for MS-DRGs 456-458. |
MS-DRG 457	Spinal fusion exc w spinal curv, malig or 9 + fusions w CC	Spinal fusion exc cerv w spinal curv/malig/infec or 9+ fusions w CC	
MS-DRG 458	Spinal fusion exc w spinal curv, malig or 9+fusions w/o CC/MCC	Spinal fusion exc cerv w spinal curv/malig/infec or 9+ fusions w/o CC/MCC	
Hip and Knee Replacements			
MS-DRG 466	Revision of hip or knee	Revision of hip or knee replacement w	Cases with procedure code 00.83 (Revision of

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
	replacement w MCC	MCC	knee replacement, patellar component), or code 00.84 (Revision of total knee replacement, tibial insert (liner)) are reassigned from MS-DRGs 466-468 to MS-DRGs 485-489.
MS-DRG 467	Revision of hip or knee replacement w CC	Revision of hip or knee replacement w CC	
MS-DRG 468	Revision of hip or knee replacement w/o CC/MCC	Revision of hip or knee replacement w/o CC/MCC	
MS-DRG 485	Knee procedures w pdx of infection w MCC	Knee procedures w pdx of infection w MCC	
MS-DRG 486	Knee procedures w pdx of infection w CC	Knee procedures w pdx of infection w CC	
MS-DRG 487	Knee procedures w pdx of infection w/o CC/MCC	Knee procedures w pdx of infection w/o CC/MCC	
MS-DRG 488	Knee procedures w/o pdx of infection w CC/MCC	Knee Procedures without Principal Diagnosis of Infection with CC/MCC	
MS-DRG 489	Knee procedures w/o pdx of infection w/o CC/MCC	Knee Procedures without Principal Diagnosis of Infection without CC/MCC	
Spinal Procedures **Spinal Neurostimulators**			
MS-DRG 490	Back & neck procedures except spinal fusion w CC/MCC or disc devices	Back & neck proc exc spinal fusion with CC/MCC or disc device/neurostim	Cases with procedure codes 84.59 (Insertion of other spinal devices), or 84.62 (Insertion of total spinal disc prosthesis, cervical),or 84.65

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
MS-DRG 491	Back & neck procedures except spinal fusion w/o CC/MCC	Back & neck proc exc spinal fusion w/o CC/MCC	(Insertion of total spinal disc prosthesis, lumbosacral), or 84.80 (Insertion or replacement of interspinous process device(s)), or 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), or 84.84 (Insertion or replacement of facet replacement devices) are reassigned from MS-DRG 491 to MS –DRG 490. Reassign full system spinal cord non-rechargeable and rechargeable neurostimulator cases in MS-DRG 491 to MS-DRG 490 in MDC 8. ICD-9-CM procedure codes 03.93 (Implantation or replacement of spinal neurostimulator lead(s)), and 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable), or 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable), or 86.97 (Insertion or replacement of single array rechargeable neurostimulator pulse generator), or 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator) must be reported in order for the spinal neurostimulator cases to be assigned to MS-DRG 490.
MDC 17 (MYELOPROLIFERATIVE DISEASES AND DISORDERS, POORLY DIFFERENTIATED NEOPLASM

MDC/MS-DRG	Proposed Title	Final Title	Procedure Code Reassignments
High-dose infusion interleukin-2 [IL-2])			
MS-DRG 837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	Cases with procedure code 00.15 (High-Dose Infusion Interleukin-2 [IL-2]) are reassigned from MS-DRG 839 to MS-DRG 838.
MS-DRG 838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	Chemo w acute leukemia as sdx w CC or high dose chemo agent	
MS-DRG 839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	Chemo w acute leukemia as sdx w/o CC/MCC	
MDC 23 (Factors Influencing Health Status and Other Contacts with Health Status)			
MS-DRG 947	Signs & symptoms w MCC	Signs & symptoms w MCC	Cases with a principal diagnosis of code 338.0 (Central pain syndrome), 338.21 (Chronic pain due to trauma),or 338.22 (Chronic post-thoracotomy pain),or 338.28 (Other chronic postoperative pain), or 338.29 (Other chronic pain), or 338.4 (Chronic pain syndrome) are reassigned from MDC 23, MS-DRGs 947-948 to MS-DRGs 091-093 in MDC 1.
MS-DRG 948	Signs & symptoms w/o MCC	Signs & symptoms w/o MCC	

H. Recalibration of DRG Weights

In section II.E. of the preamble of this final rule with comment period, we stated

that we are continuing to implement the cost-based DRG relative weights under a 3-year

transition period such that, in FY 2008 (year two of the transition), the relative weights

will be recalibrated using a blend of 67 percent of the cost-based relative weight and

33 percent of the charge-based relative weight. For FY 2009, the relative weights will be

100 percent cost-based. We are making a few minor changes to the cost-based relative

weighting methodology that we adopted in the FY 2007 IPPS final rule (71 FR 47962

through 47971). However, in section II.E.2. of the preamble of the FY 2008 IPPS

proposed rule, we requested public comments about whether to adopt any of the short-

term recommendations to the cost-based relative weighting methodology for FY 2008

made by RTI. In response to those comments, we state in section II.E.2. of the preamble

of this final rule with comment period that we are not adopting RTI's recommended

regression-based CCRs for medical supplies and devices, IV drugs, and CT Scans and

MRIs for FY 2008. However, as recommended by RTI, for FY 2008, we are adding two

new CCRs for a total of 15 CCRs: one for "Emergency Room" and one for "Blood and

Blood Products," both of which can be derived directly from the Medicare cost report.

As we proposed, in developing the FY 2008 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 2006 MedPAR data used in this final rule with

comment period include discharges occurring on October 1, 2005, through September 30,

2006, based on bills received by CMS through March 2007, 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 2006 MedPAR file used in

calculating the relative weights includes data for approximately 11,782,098 Medicare

discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a

Medicare Advantage managed care plan are excluded from this analysis. The data

exclude CAHs, including hospitals that subsequently became CAHs after the period from

which the data were taken. The second data source used in the cost-based relative

weighting methodology is the FY 2005 Medicare cost report data files from HCRIS,

which represents the most recent full set of cost report data available. We used the

March 31, 2007 update of the HCRIS cost report files for FY 2005 in setting the 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 FY 2007 and was

applied as follows:

● To the extent possible, all the claims were regrouped using the MS-DRGs

being adopted for FY 2008, as discussed in section II.D. of the preamble of this final rule

with comment period.

● The transplant cases that were used to establish the relative weights for heart

and heart-lung, liver and/or intestinal, and lung transplants (MS-DRGs 001, 002, 005,

006, and 007, respectively; previously CMS DRGs 103, 480, and 495) were limited to

those Medicare-approved transplant centers that have cases in the FY 2006 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 IPPS rates, 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, IME and DSH payments, and, for hospitals in Alaska and Hawaii, the

cost-of-living adjustment was applied. Beginning with FY 2008, because hospital

charges include charges for both operating and capital costs, we are standardizing total

charges to remove the effects of differences in geographic adjustment factors, large urban

add-on payments, cost-of-living adjustments, DSH payments, and IME adjustments under

the capital IPPS as well.

● 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 standardized

charges per case and the standardized charges per day for each DRG.

● The average charge for each DRG was then recomputed (excluding the

statistical outliers). To compute the average DRG charge, we sum the standardized

charges by DRG and divide by the transfer adjusted case count. A transfer case is

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 nontransfer cases. That is, a

transfer case receiving payment under the transfer methodology equal to half of what the

case would receive as a nontransfer would be counted as 0.5 of a total case.   The average

charge per DRG is then 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

1.50850 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.

The methodology we used to calculate the DRG cost-based relative weights from

the FY 2006 MedPAR claims data and FY 2005 Medicare cost report data is as follows:

● To the extent possible, all the claims were regrouped using the FY 2008

MS-DRG classifications discussed in section II.D. of the preamble of this final rule with

comment period.

● The transplant cases that were used to establish the relative weights for heart

and heart-lung, liver and/or intestinal, and lung transplants (MS-DRGs 001, 002, 005,

006, and 007, respectively; previously CMS DRGs 103, 480, and 495) were limited to

those Medicare-approved transplant centers that have cases in the FY 2006 MedPAR file.

(Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)

● Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each DRG and before eliminating statistical outliers.

● Claims with total charges or total length of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, and anesthesia charges were also deleted.

● At least 96.1 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.

● Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each DRG.

Once the MedPAR data were trimmed and the statistical outliers were removed,

the charges for each of the 15 cost groups for each claim were standardized to remove the

effects of differences in area wage levels, IME and DSH payments, and for hospitals in

Alaska and Hawaii, the applicable cost-of-living adjustment. Beginning with FY 2008,

because hospital charges include charges for both operating and capital costs, we are

standardizing total charges to remove the effects of differences in geographic adjustment

factors, large urban add-on payments, cost-of-living adjustments, DSH payments, and

IME adjustments under the capital IPPS as well. Charges were then summed by DRG for

each of the 15 cost groups so that each DRG had 15 standardized charge totals. These

charges were then adjusted to cost by applying the national average CCRs developed

from the FY 2005 cost report data.

The 15 cost centers that we used in the relative weight calculation are shown in

the following table. Included in the 15 CCRs are two distinct CCRs for FY 2008 for

"Emergency Room" and "Blood and Blood Products." The costs and charges for these

two additional CCRs are removed from the "Other Services" CCR. The table shows the

lines on the cost report that we used to create the 15 national cost center CCRs that we

used to adjust the DRG charges to cost. For FY 2008, we are making minor revisions to

the Cardiology, Laboratory, Radiology, and Other Services CCRs we are using to

calculate the DRG relative weights, as follows:

● The costs for cases involving Electroencephalography (EEG), cost report line

54, are currently in the Cardiology cost center group. However, MedPAR categorizes the

claims data for EEG under Laboratory Charges (revenue codes 0740 and 0749). In order

to maintain consistency with matching costs on the cost report to charges on MedPAR

claims, we are moving cost report line 54 for EEG out of the Cardiology cost center

group into the Laboratory cost center group.

● In the FY 2007 IPPS proposed rule, we originally included the costs for

Radioisotopes, cost report line 43, in the Radiology cost center group. However, in

response to comments, we moved Radioisotopes to the Other Services cost center group.

After researching this issue further over the past year, we believe that Radioisotopes is a

radiology-related service that more appropriately belongs in the Radiology cost center

group. Accordingly, for FY 2008, as we proposed, we are moving the cost report line

item for line 43, Radioisotopes, out of the Other Services cost center group and into the

Radiology cost center group. The version of the 15 cost center groupings are in the table

below:

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Routine Days	Private Room Charges	011X and 014X		Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X				C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X					
Intensive Days	Intensive Care Charges	020X		Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
	Coronary Care Charges	021X		Coronary Care Unit	C_1_C5_27	C_1_C7_26 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

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
	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
	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 &	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

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Delivery				Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_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 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X		Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X		Anesthesi-ology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X		Electro-cardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X		Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
				PBP Clinic Laboratory Services	C_1_C5_45	C_1_C7_44 C_1_C6_45	D4_HOS_C2_45
				Electro-encep halography	C_1_C5_54	C_1_C7_45 C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X		Radiology - Di agnostic	C_1_C5_41	C_1_C6_41 C_1_C7_41	D4_HOS_C2_41
	MRI Charges	061X		Radiology - Th erapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
				Radioisotope	C_1_C5_43	C_1_C6_43 C_1_C7_43	D4_HOS_C2_43
Emergency Room	Emergency Room Charges	045x		Emergency	C_1_C5_61	C_1_C6_61 C_1_C7_61	D4_HOS_C2_61
Blood and Blood Products	Blood Charges	038x		Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46 C_1_C7_46	D4_HOS_C2_46

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Other Services	Blood Storage / Processing	039x		Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47 C_1_C7_47	D4_HOS_C2_47
	Lithotripsy Charge	079X					
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X					
				ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58 C_1_C7_58	D4_HOS_C2_58
	Outpatient Service Charges	049X and 050X		Other Ancillary	C_1_C5_59	C_1_C6_59 C_1_C7_59	D4_HOS_C2_59
				Clinic	C_1_C5_60	C_1_C6_60 C_1_C7_60	D4_HOS_C2_60
	Ambulance Charges	054X					
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62 C_1_C7_62	D4_HOS_C2_62

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
	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
						C_1_C7_65	
				Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
						C_1_C7_68	

We developed the national average CCRs as follows:

Taking the FY 2005 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D, 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.

After we multiplied the total charges for each DRG in each of the 15 cost centers by the corresponding national average CCR, we summed the 15 "costs" across each DRG to produce a total standardized cost for the DRG. The average standardized cost for each DRG was then computed as the total standardized cost for the DRG divided by the

transfer-adjusted case count for the DRG. The average cost for each DRG was then

divided by the national average standardized cost per case to determine the relative

weight.

The new cost-based relative weights were then normalized by an adjustment

factor of 1.50957 so that the average case weight after recalibration was equal to the

average case weight before recalibration. Since more trims were applied to the data

under the cost-based weighting methodology than under the charge-based methodology, a

smaller universe of claims was used in the cost-based weighting methodology. In this

instance, the different universe of claims also resulted in a slightly higher cost-based

normalization factor than the normalization factor derived for charge-based weights. The

normalization adjustment is intended to ensure that recalibration by itself neither

increases nor decreases total payments under the IPPS, as required by section

1886(d)(4)(C)(iii) of the Act.

The 15 national average CCRs for FY 2008 are as follows:

Group	CCR
Routine Days	0.553
Intensive Days	0.490
Drugs	0.209
Supplies & Equipment	0.345
Therapy Services	0.428
Laboratory	0.177
Operating Room	0.303
Cardiology	0.196
Radiology	0.181
Emergency Room	0.309
Blood and Blood Products	0.455
Other Services	0.451
Labor & Delivery	0.501
Inhalation Therapy	0.198
Anesthesia	0.146

As we explained in section II.D. of the preamble of this final rule with comment

period, in response to comments, we are implementing the MS-DRGs with a 2-year

transition period beginning in FY 2008. For FY 2008, the first year of the transition, 50

percent of the relative weight for a DRG is based on the two-thirds cost-based

weight/one-third charge-based weight calculated using FY 2006 MedPAR data grouped

to the Version 24.0 (FY 2007) DRGs. The remaining 50 percent of the FY 2008 relative

weight for a DRG is based on the two-thirds cost-based weight/one-third charge-based

weight calculated using FY 2006 MedPAR grouped to the Version 25.0 (FY 2008) MS-

DRGs. In FY 2009, the relative weights will be based on 100 percent cost weights

computed using the Version 26.0 (FY 2009) MS-DRGs. Specifically, the blended

relative weights for FY 2008 are computed as follows:

First, using the Version 24.0 GROUPER, relative weights are calculated based on

100 percent cost-based and 100 percent charge-based, respectively. These weights are

then blended using two-thirds of the cost-based weights and one-third of the charge-based

weights to establish the CMS DRG portion of the transition weights.

Second, using the Version 25.0 FY 2008 (MS-DRG) GROUPER, relative weights

are calculated based on 100 percent cost-based weights and 100 percent charge-based

weights, respectively. These weights are then blended using two-thirds of the cost-based

weights and one-third of the charge-based weights to establish the MS-DRG portion of

the transition weights.

Under the transition blend we are adopting in this final rule with comment period, we will group cases to MS-DRGs (using the Version 25.0 GROUPER), but the payment weight for each DRG will be a 50/50 blend of the MS-DRG weight and CMS DRG weight. Thus, we had to determine a blended weight for each DRG. Using the claims in the FY 2006 MedPAR database that we used to compute cost-based weights under the Version 24.0 GROUPER, we grouped each case to a CMS DRG (using the Version 24.0 GROUPER) and an MS-DRG (using the Version 25.0 GROUPER). Commonly, a set of cases that grouped to a single MS-DRG grouped to two or more CMS DRGs. Therefore, we determined an average CMS DRG weight for all cases that grouped to each MS-DRG. Specifically, we summed the CMS DRG weights of all the cases that grouped to each MS-DRG and then divided that number by the transfer-adjusted case count. To establish the final blended weight for each DRG, we added 50 percent of the MS-DRG weight to 50 percent of the average CMS DRG weight for that MS-DRG. These final blended relative weights are listed in Table 5 of this final rule with comment period.

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 2008. Using the FY 2006 MedPAR data set, there are 7 MS-DRGs that contain fewer than 10 cases. Under the MS-DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases

grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally

have very low volumes because children are typically ineligible for Medicare. In the

past, we have found that the low volume of cases for the pediatric DRGs could lead to

significant year-to-year instability in their relative weights. Although we have always

encouraged non-Medicare payers to develop weights applicable to their own patient

populations, we have heard frequent complaints from providers about the use of the

Medicare relative weights in the pediatric population. We believe that eliminating this

age split in the MS-DRGs will provide more stable payment for pediatric cases by

determining their payment using adult cases that are much higher in total volume. All of

the low-volume DRGs listed below are for newborns. Newborns are unique and require

separate DRGs that are not mirrored in the adult population. Therefore, it remains

necessary to retain separate DRGs for newborns. In FY 2008, because we do not have

sufficient MedPAR data to set accurate and stable cost weights for these low-volume

DRGs, we are computing weights for the low-volume DRGs by adjusting their FY 2007

weights by the percentage change in the average weight of the cases in other DRGs. The

crosswalk table is shown below:

Low-Volume DRG	DRG Title	Crosswalk to DRG
789	Neonates, Died or Transferred to Another Acute Care Facility	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
791	Prematurity With Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
792	Prematurity Without Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
793	Full-Term Neonate With Major Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
794	Neonate With Other Significant Problems	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)
795	Normal Newborn	FY 2007 FR weight (adjusted by percent change in average weight of the cases in other DRGs)

I. MS-LTC-DRG Reclassifications and Relative Weights for LTCHs for FY 2008

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 CMS 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 CMS DRGs used under the IPPS. Therefore, we specified that we

will continue to update the LTC-DRG classifications and relative weights to be effective

for discharges occurring on or after October 1 through September 30 each year. We

further stated that we will publish the annual proposed and final update of the LTC-DRGs

in same notice as the proposed and final update for the IPPS (69 FR 34125).

Comment: Several commenters strongly recommended that we establish one

rulemaking cycle that would encompass the update of the LTCH PPS payment rates

(July 1) as well as the development of the LTC-DRG weights (October 1). One

commenter also suggests that this change should begin for RY 2009 and, for that year,

CMS should implement a 3-month update to the standardized amount (July 1, 2008

through September 30, 2008 with no other policy changes. The commenters also have

stated that there should only be one rulemaking cycle because of interactive effects of

adjustments made at two different times.

Response: In the RY 2008 LTCH PPS final rule (72 FR 26874), we responded to

a similar comment by stating that we would "evaluate whether such a consolidation is a

workable alternative to the present schedule."   While we appreciate the continued

interest of commenters on this issue, we note that we did not propose a change to the

LTCH PPS update cycle in the FY 2008 IPPS proposed rule. Therefore, we do not

believe that the IPPS final rule is the appropriate vehicle for addressing these concerns.

Rather, we believe that exploring the possibility of the consolidation of the LTCH PPS

rulemaking cycles would be better addressed in the LTCH PPS rate year regulations since

those rules are the primary vehicle for proposing and finalizing policy changes to the

LTCH PPS. Therefore, we will continue our evaluation of this suggestion for the time

being.

In the FY 2008 IPPS proposed rule, we did not address the issue concerning

changing the present update cycle for the LTCH PPS, and therefore, we are not making

any changes to the LTCH PPS update cycle in this final rule with comment period.

However, we will take all comments and suggestions concerning the RY 2009 update

into consideration when preparing the RY 2009 LTCH PPS proposed rule. Commenters'

concerns regarding any changes to the present rulemaking cycle will be considered when

we evaluate the possibility of making changes to the present update cycle as well as any

options that may be available. To this end, any proposed changes to the present update

cycle would be included in the RY 2009 LTCH PPS proposed rule for public comment.

In the past, the annual update to the IPPS CMS 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 2008 IPPS proposed rule (72 FR 24755 through 24757), 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 earlier than the agency had accounted for new technology in

the past. In implementing the statutory change, the agency has provided that ICD-9-CM

diagnosis and procedure codes for new medical technology may be created and assigned

to existing DRGs in the middle of the Federal fiscal year, on April 1. However, this

policy change will not impact the DRG relative weights in effect for that year, which will

continue to be updated only once a year (October 1), nor will it have any impact on

Medicare payments in that year. 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 noted above, the patient classification system used under the LTCH PPS is the

same patient classification system that is used under the IPPS. Therefore, the ICD-9-CM

codes currently used under both the IPPS and 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.

Because we do not publish a midyear IPPS rule, any April 1 ICD-9-CM coding

update will not be published midyear. Rather, we will assign any new diagnosis or

procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.G.10. of the preamble of this final rule with comment period). Any coding updates will be available through the Web sites provided in section II.G.10. of the preamble of this final rule with comment period and through the Coding Clinic for ICD-9-CM, a product of the American Hospital Association. 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 under the LTCH PPS, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of 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 is an open process through the ICD-9-CM Coordination and Maintenance Committee. Requestors will be given the opportunity to present the merits for a new code and to make a clear and convincing case for the need to update ICD-9-CM codes for purposes of the IPPS new

technology add-on payment process through an April 1 update (as also discussed in

section II.G.10. of the preamble of this final rule with comment period).

As we discussed in the FY 2008 IPPS proposed rule (72 FR 24755), at the

September 28, 2006 ICD-9-CM Coordination and Maintenance Committee meeting,

there were no requests for an April 1, 2007 implementation of ICD-9-CM codes.

Therefore, the next update to the ICD-9-CM coding system will not occur until

October 1, 2007 (FY 2008). Because there were no coding changes suggested for an

April 1, 2007 update, the ICD-9-CM coding set implemented on October 1, 2006, will

continue through September 30, 2007 (FY 2008). The update to the ICD-9-CM coding

system for FY 2008 is discussed above in section II.G.10. of the preamble of this final

rule with comment period. Accordingly, in this final rule with comment period, as

discussed in greater detail below, we are modifying and revising the LTC-DRG

classifications and relative weights, to be effective October 1, 2007 through

September 30, 2008 (FY 2008). In addition, we will notify LTCHs of any revisions to

the GROUPER software used under the IPPS and the LTCH PPS that may be

implemented on April 1, 2008. As discussed in greater detail below, the MS-LTC-DRGs

for FY 2008 in this final rule with comment period are the same as the MS-DRGs

adopted under the IPPS for FY 2008 (GROUPER Version 25.0) discussed in section II.B.

of the preamble to this final rule with comment period.

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 123 of Pub. L. 106-113 as amended by 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. As described

in section II.D. of the preamble of this final rule with comment period, we are adopting

MS-DRGs under the IPPS because we believe that adopting this system will result in a

significant improvement in the DRG system's recognition of severity of illness and

resource usage. We believe these improvements in the DRG system will be equally

applicable to the LTCH PPS. The changes we are currently making for the IPPS are

reflected in the FY 2008 GROUPER, Version 25.0, to be effective for discharges

occurring on or after October 1, 2007 through September 30, 2008. Currently, the

LTC-DRGs used as the patient classification system under the LTCH PPS correspond to

the current CMS DRGs applicable under the IPPS for acute care hospitals

Consistent with our historical practice of having LTC-DRGs correspond to the

DRGs applicable under the IPPS, under the broad authority of section 123(a) of

Pub. L. 106-113, as modified by section 307(b) of Pub. L. 106-554, as proposed, under

the LTCH PPS we are adopting the use of MS-LTC-DRGs, which correspond to the

MS-DRGs we are adopting under the IPPS. In addition, as stated above, we will be using

the FY 2008 GROUPER Version 25.0 to classify cases effective for LTCH discharges

occurring on or after October 1, 2007 through September 30, 2008. The changes to the

current CMS DRG classification system used under the IPPS for FY 2008 (GROUPER

Version 25.0) are discussed in section II.D. of the preamble to this final rule with

comment period.

Comment: Four commenters indicated support for the adoption of the

MS-LTC-DRGs for the LTCH PPS but noted specific concerns and included policy

suggestions that they believed could address these concerns.

Response: We appreciate the commenters' support. We have seriously

considered the areas of concern as well as the policy suggestions. As stated above, we

are adopting the use of MS-LTC-DRGs beginning in FY 2008. Below, we explain our

responses to these stated concerns.

Comment: Several commenters expressed concern about the adoption of the

MS-LTC-DRGs for FY 2008 in advance of RAND's final report. These commenters

envisioned that a report recommending a DRG system other than the MS-DRGs, (upon

which the MS-LTC-DRGs are based) could result in a CMS decision to implement "yet another" patient classification system in FY 2009.

Response: As noted above in our response to similar comments focusing on the use of the MS-DRGs by the IPPS, as RAND has completed its evaluation of the alternative DRG systems, including the MS-DRGs, consistent with RAND's findings, we believe it is appropriate at this time to adopt the MS-DRG system for Medicare in FY 2008 for the IPPS and at the same time, we are also adopting the MS-LTC-DRGs for the LTCH PPS. While there will be an opportunity for the public to comment on RAND's findings, we do not think it is likely that there will be persuasive public comments suggesting that one of the alternative DRG systems being evaluated by RAND is clearly superior. We plan to use RAND's report to continue to examine ways to improve and refine Medicare inpatient payment systems and expect that any future refinements will be based on MS-DRGs. Therefore, as final policy for FY 2008, we are adopting the MS-LTC-DRGs as the new classification system for the LTCH PPS.   However, since we are interested in public input on this issue, we will make RAND's final report available on the CMS Web Site at: http://www.cms.hhs.gov/Reports/downloads/.

Interested members of the public can write to the following address .

Division of Acute Care

Center for Medicare Management

7500 Security Boulevard, C4-08-06

Baltimore, MD 21244

Attn: Mady Hue

Comment: Two commenters requested that CMS delay adoption of the

MS-LTC-DRGs until FY 2009 in order to provide LTCHs additional time to analyze the

impact of the new classification system and to provide meaningful comments. The

commenters suggested that, during this time, CMS examine the interaction of

MS-LTC-DRG relative weights and new policies established for RY 2008 (for example,

revisions to the short-stay outlier policy resulting in the "IPPS comparable threshold")

before implementing MS-LTC-DRGs. The commenters further stated that such a delay

would allow LTCHs the opportunity to adjust to the other recent LTCH PPS changes.

Response: We do not believe that it is either appropriate or necessary to delay the

adoption of the MS-LTC-DRGs until FY 2009 as the commenters suggest. We believe

that we provided a comprehensive analysis of the MS-DRG classification system, upon

which the MS-LTC-DRGs are based, in the proposed rule and, as discussed elsewhere in

these responses, clear and specific direction, which are evidenced by the number of

comments that were received, which allowed hospital stakeholders to simulate the

impacts of the proposed policy change. We do not believe a full year delay in

implementation of the MS-DRGs and the MS-LTC-DRGs is necessary or

appropriate. We believe that implementing the severity-based DRGs will result in more

appropriate Medicare payments, a goal that should not be postponed. However, although

we are not delaying the adoption of the severity-based DRGs for either the IPPS or the

LTCH PPS, we are providing a 2-year transition to the full adoption of both the

MS-DRGs and the MS-LTC-DRGs, described elsewhere in these responses. We believe

the transition will mitigate the payment impact of the new DRG system for both acute

care hospitals and LTCHs as they adapt to the system. Furthermore, as we note in our

discussion of a similar comment regarding the adoption of the MS-DRGs for the IPPS

(see section II.E. of the preamble of this final rule with comment period), many

commenters supported immediate adoption of the MS-DRGs, particularly because they

are so structurally similar to the current DRGs. Therefore, we continue to maintain that a

full year's delay in the adoption of the MS-LTC-DRGs under the LTCH PPS is

unwarranted. While the MS-DRGs do include some consolidations of base DRGs, the

major changes from the current DRGs involve adding severity levels to the base

DRGs.   Therefore, the move to MS-LTC-DRGs will not necessitate additional data

elements. Because we do not believe that extensive preparation for implementation of

the MS-DRGs is necessary, we do not believe that it is appropriate or necessary to delay

adoption of the MS-DRGs until FY 2009. We continue to believe that payment

adjustments that were finalized in the RY 2008 LTCH PPS final rule, among which was

the revision to the short-stay outlier policy noted by the commenters, will result in more

appropriate Medicare payments to LTCHs. The revised SSO policy addresses the issue

of LTCH discharges that are comparable to an acute care IPPS hospital discharge based

on the length of stay for that discharge. That policy is not tied to or affected by the

adoption of the MS-LTC-DRGs. Nor do we believe that the extension of the 25 percent

threshold adjustment that we finalized for RY 2008 at revised §412.534 and new

§412.536, which governs Medicare payments for patients discharged from LTCHs who

were admitted from specific referring hospitals, is tied to or affected by the adoption of

the MS-LTC-DRGs. Furthermore, as noted above, because the MS-LTC-DRGs are so

structurally similar to the LTC-DRGs, we do not believe that postponing the adoption of

the severity-weighted DRGs in order to evaluate the interaction of the policy changes

implemented for the LTCH PPS for RY 2008 would confer any significant advantage to

stakeholders.

Comment: Four commenters urged CMS to establish a 3-year transition to the

full adoption of the MS-LTC-DRGs in order to minimize the "impact of behavioral

changes in coding" resulting from the new system. Referring to the proposed 2.4 percent

downward adjustment, the commenters also maintained that a 3-year transition would

allow CMS to analyze LTCH data which would indicate whether there were coding

changes that could warrant the application of a prospective adjustment to LTCH PPS

payment rates.

Response: We have carefully considered each comment in determining whether

there should be a transition period for the relative weights computed using the

MS-LTC-DRGs, the length of the transition, and how to compute the relative weights

during the transition. Although we received strong general support for adopting the

MS-LTC-DRGs, we agree that some transition is warranted to mitigate the magnitude of

potential changes in payment to LTCHs that could occur in one year. As discussed in

section II.D. of the preamble to this final rule with comment period, although MedPAC

recommended that CMS fully implement MS-DRGs immediately, MedPAC suggested

that, if the agency chose not to fully implement severity-adjusted DRGs in FY 2008,

CMS should implement MS-DRGs over a 2-year transition. Accordingly, as we

discussed earlier regarding implementation of the MS-DRGs under the IPPS, we are also

implementing a 2-year transition to MS-LTC-DRGs. For FY 2008, the first year of the

transition, 50 percent of the relative weight for a MS-LTC-DRG will be based on average

relative weight under Version 24.0 of the LTC-DRG GROUPER. The remaining 50

percent of the FY 2008 relative weight for a MS-LTC-DRG will be based on the

MS-LTC-DRG relative weight. For a more detailed description of the calculation of the

MS-LTC-DRG relative weights for FY 2008 under this transition methodology, we refer

readers to section II.I.4. (step 7 of Steps for Determining the FY 2008 MS-LTC-DRG

Relative Weights) of the preamble of this final rule with comment period.) In FY 2009,

the MS-LTC-DRG relative weights will be based on 100 percent of MS-LTC-DRG

relative weights.

As discussed in detail elsewhere in these responses, we are not finalizing the

proposed 2.4 percent downward adjustment to the MS-LTC-DRG relative weights.

Comment: Some commenters maintained that they are unable to fully evaluate

the impact of the proposed MS-DRG system on their member hospitals due to the lack of

access to the necessary tools. The commenters note that neither an MS-LTC-DRG

GROUPER nor an MS-LTC-DRG Definitions Manual has been made available to help

them completely understand the proposed system. Therefore, the commenters believed

they have been prevented from thoroughly and completely evaluating the proposed

system and providing meaningful comments. The commenter recommended delaying

implementation of the MS-LTC-DRGs until such information has been made available

and providers have had the opportunity to review it and provide meaningful comments.

Response: We disagree that LTCHs have not had adequate access to information

concerning the changes to the MS-DRGs and the MS-LTC-DRGs. Ample and thorough

information was published in the FY 2008 IPPS proposed rule. We refer the commenters

to Section II.D.2., "Development of Proposed Medicare Severity DRGs (MS-DRGs)"

beginning on page 24697 of the May 3, 2007 **Federal Register** (72 FR 24697 through

24707), where CMS' entire process for the creation of the MS-DRGs was explained. We

discussed the creation of base MS-DRGs, upon which the MS-LTC-DRGs are based, and

the consolidation from the existing DRGs is summarized in Table F of the Addendum to

the proposed rule (72 FR 24702). We also discussed the process for applying the severity

criteria to each of the 335 base DRGs, resulting in 745 proposed MS-DRGs.

We discussed the proposed changes to the LTC-DRG classifications

(72 FR 24755 through 24771), and indicated that we proposed to conform the LTC-DRG

system to the IPPS DRG system by using MS-LTC-DRGs which correspond to the

proposed MS-DRGs. Further specific conforming language was spelled out on pages

24756 through 24757 of the FY 2008 IPPS proposed rule.

In addition, we made other information available to the public that would allow

for a detailed analysis of the MS-LTC-DRG proposal. We made available two MedPAR

files (FY 2005 and FY 2006) that included the CMS DRG and MS-DRG assignment for

each case. As discussed in the preamble to the proposed rule, the MS-LTC-DRGs and

MS-DRGs share identical titles. Furthermore, Table 11 of the Addendum to the proposed

rule listed the relative weight for each MS-LTC-DRG. With this information, the public

could determine the MS-LTC-DRG assignment and relative weight for all cases in the

FY 2005 and FY 2006 MedPAR files. Therefore, we believe the public had detailed

information with which to perform a comprehensive analysis of our proposal to adopt

MS-LTC-DRGs.

Because we believe that adequate access to proposed changes to MS-LTC-DRGs

has been provided, as discussed above, we are not delaying their implementation. As

stated above, we are adopting the use of MS-LTC-DRGs under the LTCH PPS, which

correspond to the MS-DRGs adopted under the IPPS. Accordingly, we will be using the

FY 2008 GROUPER Version 25.0 effective for LTCH discharges occurring on or after

October 1, 2007 through September 30, 2008.

In conjunction with the changes to the existing CMS DRGs for the IPPS by

adoption of the MS-DRGs, as discussed above, we are adopting the MS-LTC-DRGs for

the LTCH PPS, as both sets of DRGs are determined from the same DRG structure.

Although the structure of the DRGs used under the IPPS and the LTCH PPS are identical,

we refer to the DRGs under the LTCH PPS as MS-LTC-DRGs. This conforming change,

that is, to replicate the MS-LTC-DRG structure after the MS-DRG structure, is

appropriate in order to maintain consistency and uniformity among a number of

stakeholders, such as acute care hospitals, LTCHs, epidemiologists, rate setting

organizations, and payors, among others. Notwithstanding the value of consistency,

however, we also emphasize, that the adoption of the MS-LTC-DRGs as the patient

classification system for the LTCH PPS will improve identification of severity of illness

and hospital resource use which will result in more appropriate Medicare payments for

LTCHs. As noted above, the patient classification system used under the LTCH PPS is

the same patient classification system used under the IPPS, which historically has been

updated annually as required by section 1886(d)(4)(C) of the Act and is effective for

discharges occurring on or after October 1 through September 30 of each year. As such,

the updates to the MS-DRG classification system used under the IPPS for FY 2008

(GROUPER Version 25.0), discussed in section II.D. of the preamble of this final rule

with comment period, will be applicable to updates under the LTCH PPS (that is, the

MS-LTC-DRGs).

       As discussed above, we proposed to adopt the MS-LTC-DRGs as the patient

classification system under the LTCH PPS, beginning with discharges occurring on or

after October 1, 2007. However, in the proposed rule, we omitted proposed changes to

the regulation text reflecting the proposed change from LTC-DRGs to MS-LTC-DRGs.

As discussed previously in this preamble, in this final rule with comment period, we are

adopting MS-LTC-DRGs for use in the LTCH PPS beginning with discharges on or after

October 1, 2007. In this final rule with comment period, we are revising the regulation

text to conform to our proposed and final policy. Consequently, we are revising the

regulation text at §412.503 where we define terms associated with the LTCH PPS in

order to indicate the adoption of the MS-LTC-DRGs as the patient classification system

under the LTCH PPS beginning with FY 2008 for discharges occurring on or after

October 1, 2007. First, we are adding language to the definition of "LTC-DRG"

indicating that effective, October 1, 2007, the MS-LTC-DRGs are used to classify patient

discharges occurring on or after October 1, 2007, from a long-term care hospital and that

for patient discharges occurring on or after October 1, 2007 and that references to

LTC-DRGs in 42 CFR Part 412, Subpart O for policy descriptions and/or payment

calculations shall be considered to be references to the MS-LTC-DRGs. Secondly, we

are adding a definition of "MS-LTC-DRGs" as "…the severity- adjusted diagnosis-

related group used to classify patient discharges from a long-term care hospital based on

clinical characteristics and average resource use, for prospective payment purposes for

discharges from a long-term care hospital occurring on or after October 1, 2007."

Under the LTCH PPS, as described in greater detail below, we determine relative

weights for each of the MS-LTC-DRGs to account for the difference in resource use by

patients exhibiting the case complexity and multiple medical problems characteristic of

LTCH patients. (Unless otherwise noted in this final rule with comment period, our

MS-LTC-DRG analysis is based on LTCH data from the March 2007 update of the

FY 2006 MedPAR file, which contains hospital bills received through March 31, 2007,

for discharges occurring in FY 2006.)

LTCHs do not typically treat the full range of diagnoses as do acute care

hospitals. Therefore, as we discussed in the August 30, 2002 LTCH PPS final rule

(67 FR 55985), which implemented the LTCH PPS, and the FY 2006 IPPS final rule

(70 FR 47324), we use low-volume quintiles in determining the DRG relative weights for

DRGs with less than 25 LTCH cases (low-volume LTC-DRGs). Specifically, we group

those low-volume DRGs into 5 quintiles based on average charges per discharge. (A

listing of the composition of low-volume quintiles for the FY 2007 LTC-DRGs (based on

FY 2005 MedPAR data) appears in section II.I.2. of the FY 2007 IPPS final rule

(71 FR 47975 through 47978).) 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, as discussed below in section II.I.4. of the preamble of this final

rule with comment period.

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 DRG to which a

beneficiary's stay is assigned. Just as cases have been classified into the MS-DRGs for

acute care hospitals under the IPPS (section II.B. of the preamble of this final rule with

comment period), cases have been classified into MS-LTC-DRGs for payment under the

LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to

six procedures performed during the stay, as well as demographic information about the

patient. The diagnosis and procedure information is reported by the hospital using the

ICD-9-CM coding system. Under the MS-DRGs for the IPPS and the MS-LTC-DRGs

for the LTCH PPS, these factors will not change.

Section II.B. of the preamble of this final rule with comment period discusses the

organization of the existing CMS DRGs, which we are maintaining under the MS-DRG

and MS-LTC-DRG systems. As noted above, the patient classification system for the

LTCH PPS is derived from the IPPS DRGs and is similarly organized into 25 major

diagnostic categories (MDCs).   Most of these MDCs are based on a particular organ

system of the body and the remainder involves multiple organ systems (such as MDC 22,

Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most

MDCs, cases are then divided into surgical DRGs and medical DRGs. Under the present

CMS DRGs, some surgical and medical DRGs are further differentiated based on the

presence or absence of CCs. The existing LTC-DRGs are similarly categorized. (See

section II.B. of the preamble of this final rule with comment period for further discussion

of surgical DRGs and medical DRGs.)

The MS-DRGs and the MS-LTC-DRGs contain base DRGs that have been

subdivided into one, two, or three severity levels. The most severe level has cases with at

least one code that is a major CC, referred to as "with MCC". The next lower severity

level contains cases with at least one CC, referred to as "with CC". Those DRGs without

an MCC or a CC are referred to as "without CC/MCC". When data did not support the

creation of three severity levels, the base DRG was divided into either two levels or the

base was not subdivided. The two-level subdivisions consist of one of the following

subdivisions:

- With CC/MCC

- Without CC/MCC

In this type of subdivision, cases with at least one code that is on the CC or MCC

list are assigned to the "with CC/MCC" DRG. Cases without a CC or an MCC are

assigned to the "without CC/MCC" DRG.

The other type of two-level subdivision is as follows:

- With MCC

- Without MCC

In this type of subdivision, cases with at least one code that is on the MCC list are

assigned to the "with MCC" DRG. Cases that do not have an MCC are assigned to the

"without MCC" DRG. This type of subdivision could include cases with a CC code, but no MCC.

3. Development of the FY 2008 MS-LTC-DRG Relative Weights

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

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case. (As we have noted above, as proposed, we are adopting the MS-LTC-DRGs for the LTCH PPS for FY 2008. However, this change in the patient classification system does not affect the basic principles of the development of relative weights under a DRG-based prospective payment system. For purposes of clarity, in the general discussion below in which we describe the basic methodology of the patient classification system, in use since the start of the LTCH PPS (that is, LTC-DRGs), we use "MS-LTC-DRG" to specify the DRG system that will be used by the LTCH prospective payment system beginning in FY 2008.)

Although the adoption of the MS-LTC-DRGs will result in some modifications of existing procedures for assigning weights in cases of zero volume and/or

nonmonotonicity, discussed in detail in the following sections, as we proposed, the basic

methodology for developing the FY 2008 MS-LTC-DRG relative weights in this final

rule with comment period continue to be determined in accordance with the general

methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989

through 55991). (As noted above, in this preamble, "LTC-DRGs" will be used in

descriptions of the basic methodology established at the beginning of the LTCH PPS that

will remain unchanged with the adoption of the MS-LTC-DRGs. Use of

"MS-LTC-DRGs" will indicate a discussion of specifics aspects of our adoption of the

severity-weighted patient classification system beginning in FY 2008.)

Under the LTCH PPS, relative weights for each MS-LTC-DRG are a primary

element used to account for the variations in cost per discharge and resource utilization

among the payment groups (§412.515). To ensure that Medicare patients classified to

each MS-LTC-DRG have access to an appropriate level of services and to encourage

efficiency, we calculate a relative weight for each MS-LTC-DRG that represents the

resources needed by an average inpatient LTCH case in that MS-LTC-DRG. For

example, cases in an MS-LTC-DRG with a relative weight of 2 will, on average, cost

twice as much to treat as cases in an MS-LTC-DRG with a weight of 1.

b. Data

In the FY 2008 IPPS proposed rule (72 FR 24757), to calculate the proposed

MS-LTC-DRG relative weights for FY 2008, we obtained total Medicare allowable

charges from FY 2006 Medicare LTCH bill data from the December 2006 update of the

MedPAR file, which were the best available data at that time, and we used the proposed

Version 25.0 of the CMS GROUPER proposed for use under the IPPS to classify cases.

We also proposed that if more recent data were available, we would use those data and

the finalized Version 25.0 of the CMS GROUPER. Consistent with that proposal, to

calculate the MS-LTC-DRG relative weights for FY 2008 in this final rule with comment

period, we obtained total Medicare allowable charges from FY 2006 Medicare LTCH bill

data from the March 2007 update of the MedPAR file, which are the best available data

at this time, and we used the Version 25.0 of the CMS GROUPER used under the IPPS

(as discussed in section II.B. of the preamble of this final rule with comment period) to

classify cases.

        As we discussed in the FY 2007 IPPS final rule (71 FR 47974), 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. Data from demonstration projects authorized under section 222(a) of

Pub. L. 92-603 are also excluded. Therefore, in the development of the FY 2008

MS-LTC-DRG relative weights in this final rule with comment period, we have excluded

the data of the 17 all-inclusive rate providers and the 2 LTCHs that are paid in

accordance with demonstration projects that had claims in the FY 2006 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 MS-LTC-DRGs has the potential to inappropriately distort the measure of

average charges. To account for the fact that cases may not be randomly distributed

across LTCHs, as we proposed, in this final rule with comment period, we use a

hospital-specific relative value (HSRV) method to calculate the MS-LTC-DRG relative

weights instead of the methodology used to determine the MS-DRG relative weights

under the IPPS described in section II.H. of the preamble of this final rule with comment

period. 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 MS-LTC-DRG relative weight by converting

each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV 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 continue

to 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.I.4. (step 3) of

the preamble of this final rule with comment period) by the average adjusted charge for

all cases at the LTCH in which the case was treated. Short-stay outliers are cases with a

length of stay that is less than or equal to five-sixths the average length of stay of the

MS-LTC-DRG (see §412.529 and §412.503). (As discussed above, we are revising the

regulations at §412.503 to specify that regulatory references to LTC-DRGs for policy

descriptions and/or payment calculations shall be considered as references to the

MS-LTC-DRGs for LTCH discharges occurring on or after October 1, 2007). The

average adjusted charge reflects the average intensity of the health care services delivered

by a particular LTCH and the average cost level of that LTCH. The resulting ratio is

multiplied by that LTCH's case-mix index to determine the standardized charge for the

case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same

relative charges are given greater weight at a LTCH with higher average costs than they

would at a LTCH with low average costs, which is needed to adjust each LTCH's relative

charge value to reflect its case-mix relative to the average case-mix for all LTCHs.

Because we standardize charges in this manner, we count charges for a Medicare patient

at a LTCH with high average charges as less resource intensive than they would be at a

LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH

with an average adjusted charge of $17,500 reflects a higher level of relative resource use

than a $10,000 charge for a case at a LTCH with the same case-mix, but an average

adjusted charge of $35,000. We believe that the adjusted charge of an individual case

more accurately reflects actual resource use for an individual LTCH because the variation

in charges due to systematic differences in the markup of charges among LTCHs is taken

into account.

d. Treatment of Severity Levels in Developing Relative Weights

With the implementation of the LTCH PPS for FY 2003, we established a

procedure to address setting relative weights for LTC-DRG "pairs" that were

differentiated on the presence or absence of CCs (71 FR 47979). Beginning with

FY 2008, as we proposed, we are adopting a severity-based patient classification system

for the LTCH PPS, the MS-LTC-DRGs described above, which requires us to adapt our

existing procedures for dealing with setting relative weights for the severity levels within

a specific base MS-LTC-DRG. As proposed, we are also modifying our existing

methodology for maintaining monotonicity when setting relative weights for the MS-

LTC-DRGs.

As under the existing procedure, under the MS-LTC-DRGs, for purposes of the

annual setting of the relative weights, there continue to be three different categories of

DRGs based on volume of cases within specific MS-LTC-DRGs. MS-LTC-DRGs with

at least 25 cases are each assigned a unique relative weight; low-volume MS-LTC-DRGs

(that is, MS-LTC-DRGs that contain between one and 24 cases annually) are grouped

into quintiles (described below) and assigned the weight of the quintile. No-volume

MS-LTC-DRGs (that is, no cases in the databases were assigned to those MS-LTC-

DRGs) are crosswalked to other MS-LTC-DRGs based on the clinical similarities and

assigned the weight of the quintile that is closest to the relative weight of the crosswalked

MS-LTC-DRG.   (We provide in-depth discussions of our policy regarding weight setting

for low-volume MS-LTC-DRGs in section II.I.3.e. of the preamble of this final rule with

comment period and for no-volume MS-LTC-DRGs, under Step 5 in section II.I.4. of the

preamble of this final rule with comment period.)

As described above, in response to the need to account for severity and pay

appropriately for cases, we have developed a severity-adjusted patient classification

system which we are adopting for both the IPPS and the LTCH PPS. As described in

greater detail above, the MS-LTC-DRG system can accommodate three severity levels:

"with MCC" (most severe); "with CC," and "without CC/MCC" (the least severe) with

each level assigned an individual MS-LTC-DRG number.   In cases with two

subdivisions, the levels are either "with CC/MCC" and "without CC/MCC" or "with

MCC" and "without MCC". Two parallel numbering systems have been developed to

describe MS-LTC-DRGs, which are identical to the MS-DRGs numbers under the IPPS.

That is, while each severity level in each DRG category gets a unique MS-LTC-DRG

number, in conjunction, each of the severity levels in a single DRG category are also

assigned the same "base-DRG" number. Therefore, under the system, multiple sclerosis

and cerebellar ataxia with MCC is MS-LTC-DRG 58; multiple sclerosis and cerebellar

ataxia with CC is MS-LTC-DRG 59; and multiple sclerosis and cerebellar ataxia without

CC/MCC is MS-LTC-DRG 60.

As noted above, beginning with FY 2008, while the LTCH PPS and the IPPS will

use the same patient classification system, the methodology that is used to set the DRG

weights for use in each payment system differs because the overall volume of cases in the

LTCH PPS is much less than in the IPPS. As a general rule, as proposed, we are

determining the relative weights for the MS-LTC-DRGs using the following steps: (1) if

an MS-LTC-DRG has at least 25 cases, it is assigned its own relative weight; (2) if an

MS-LTC-DRG has between 1 and 24 cases, it is assigned to a quintile to which we will

assign a relative weight; and (3) if an MS-LTC-DRG has no cases, it is crosswalked to

another MS-LTC-DRG based upon clinical similarities to assign an appropriate relative

weight (as described in detail in Step 5 of the Steps for Determining the FY 2008

MS-LTC-DRG Relative Weights, below). Furthermore, in determining the

MS-LTC-DRG relative weights, as proposed, when necessary, adjustments were made to

account for nonmonotonicity, as explained below.

Theoretically, as with the existing LTC-DRG system, cases under the

MS-LTC-DRG system that are more severe require greater expenditure of medical care

resources and will result in higher average charges.   Therefore, in the three severity

levels, weights should increase with severity, from lowest to highest. If the weights do

not increase (that is, if based on the relative weight calculation outlined above, an

MS-LTC-DRG with MCC would have a lower relative weight than one with CC, or the

MS-LTC-DRG without CC/MCC would have a higher relative weight than either of the

others), there is a problem with monotonicity. Since the start of the LTCH PPS for

FY 2003 (67 FR 55990), we have adjusted the setting of the LTC-DRG relative weights

in order to maintain monotonicity by grouping both sets of cases together and

establishing a new relative weight that is assigned to both LTC-DRGs. We continue to

believe that utilizing nonmonotonic relative weights to adjust Medicare payments would

result in inappropriate payments**.** This is because when nonmonotonicity exists, cases

that are more severe and require greater expenditure of medical care resources would be

paid based on a lower relative weight than cases that are less severe and require lower

resource use. Similarly, as proposed, we are establishing a procedure for dealing with

nonmonotonicity under the MS-LTC-DRG classification system, which is discussed in

greater detail below in section II.I.4. (Step 6) of the preamble of this final rule with

comment period.

e. Low-Volume MS-LTC-DRGs

     In order to account for LTC-DRGs with low volume (that is, with fewer than

25 LTCH cases), under current policy, in accordance with the methodology established in

the August 30, 2002 LTCH PPS final rule (67 FR 55984 - 55995), 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. For this FY 2008 IPPS final rule, as we proposed, we are

continuing to employ this treatment of low-volume MS-LTC-DRGs with a modification

to combine MS-LTC-DRGs for the purpose of computing a relative weight in cases

where necessary to maintain monotonicity in determining the FY 2008 MS-LTC-DRG

relative weights using the best available LTCH data. In this final rule with comment

period, using LTCH cases from the March 2007 update of the FY 2006 MedPAR file, we

identified 303 MS-LTC-DRGs that contained between 1 and 24 cases. This list of MS-

LTC-DRGs was then divided into one of the 5 low-volume quintiles, each containing a

maximum of 61 MS-LTC-DRGs ($303/5 = 60$, with a remainder of 3 MS-LTC-DRGs).

Consistent with our current methodology, as proposed, we are making an assignment to a

specific low-volume quintile by sorting the low-volume MS-LTC-DRGs in ascending

order by average charge. For this final rule with comment period, this results in an

assignment to a specific low-volume quintile of the sorted 303 low-volume MS-

LTC-DRGs by ascending order by average charge. Because the number of low-volume

MS-LTC-DRGs for FY 2008 is not evenly divisible by five, to determine the composition

of the low-volume quintiles in accordance with our established methodology, the average

charge of the low-volume MS-LTC-DRG was used to determine which low-volume

quintile received the additional MS-LTC-DRGs. After sorting the 303 low-volume

MS-LTC-DRGs in ascending order, we grouped the first fifth (1st through 60th) of

low-volume MS-LTC-DRGs (with the lowest average charge) into Quintile 1. Because

the average charge of the 61st MS-LTC-DRG in the sorted list is closer to the 60th MS-

LTC-DRGs average charge (assigned to Quintile 1) than to the average charge of the 62nd

MS-LTC-DRG in the sorted list (to be assigned to Quintile 2), we placed the 61st MS-

LTC-DRG into Quintile 1. This process was repeated through the remaining low-volume

MS-LTC-DRGs so that 3 low-volume quintiles contain 61 MS-LTC-DRGs and 2 low-

volume quintiles contain 60 MS-LTC-DRGs. The highest average charge cases were

grouped into Quintile 5.

In order to determine the relative weights for the MS-LTC-DRGs with low-

volume for FY 2008, based on the methodology established in the August 30, 2002

LTCH PPS final rule (67 FR 55984), as proposed, we are using the five low-volume

quintiles described above. In addition, as proposed, in cases where the initial assignment

of the low-volume MS-LTC-DRGs to quintiles results in nonmonotonicity within a base

DRG, in order to ensure appropriate Medicare payments, we make adjustments to the

treatment of low-volume MS-LTC-DRGs to preserve monotonicity, as discussed in detail

in section II.I.4 (Step 6 of the methodology for determining the FY 2008 MS-LTC-DRG

relative weights). The composition of each of the five low-volume quintiles shown in the

chart below was used in determining the MS-LTC-DRG relative weights for FY 2008.

We determine a relative weight and (geometric) average length of stay for each of the

five low-volume quintiles using the methodology that we apply to the regular MS-LTC-

DRGs (25 or more cases), as described below in section II.I.4. of the preamble of this

final rule with comment period. We are assigning the same relative weight and average

length of stay to each of the MS-LTC-DRGs that make up an individual low-volume

quintile. We note that, as this system is dynamic, it is possible that the number and

specific type of MS-LTC-DRGs with a low volume of LTCH cases will vary in the

future. We use the best available claims data in the MedPAR file to identify low-volume

MS-LTC-DRGs and to calculate the relative weights based on our methodology.

Composition of Low-Volume Quintiles for FY 2008

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
QUINTILE 1 (Version 25 relative weight = 0.4739)
30	Spinal procedures w/o CC/MCC
32	Ventricular shunt procedures w CC
33	Ventricular shunt procedures w/o CC/MCC
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC
67	Nonspecific cva & precerebral occlusion w/o infarct w MCC
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC
69	Transient ischemia
72	Nonspecific cerebrovascular disorders w/o CC/MCC
76	Viral meningitis w/o CC/MCC
79	Hypertensive encephalopathy w/o CC/MCC
88	Concussion w MCC***
122	Acute major eye infections w/o CC/MCC
123	Neurological eye disorders
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC***
149	Dysequilibrium
159	Dental & Oral Diseases w/o CC/MCC
182	Respiratory neoplasms w/o CC/MCC
183	Major chest trauma w MCC
184	Major chest trauma w CC**
201	Pneumothorax w/o CC/MCC
261	Cardiac pacemaker revision except device replacement w CC
313	Chest pain
328	Stomach, esophageal & duodenal proc w/o CC/MCC
331	Major small & large bowel procedures w/o CC/MCC
349	Anal & stomal procedures w/o CC/MCC
376	Digestive malignancy w/o CC/MCC
379	G.I. hemorrhage w/o CC/MCC
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC
446	Disorders of the biliary tract w/o CC/MCC
505	Foot procedures w/o CC/MCC
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
547	Connective tissue disorders w/o CC/MCC
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
645	Endocrine disorders w/o CC/MCC
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC
688	Kidney & urinary tract neoplasms w/o CC/MCC
696	Kidney & urinary tract signs & symptoms w/o MCC
714	Transurethral prostatectomy w/o CC/MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC
724	Malignancy, male reproductive system w/o CC/MCC
726	Benign prostatic hypertrophy w/o MCC
756	Malignancy, female reproductive system w/o CC/MCC
759	Infections, female reproductive system w/o CC/MCC
761	Menstrual & other female reproductive system disorders w/o CC/MCC
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC
880	Acute adjustment reaction & psychosocial dysfunction
881	Depressive neuroses
882	Neuroses except depressive
883	Disorders of personality & impulse control
886	Behavioral & developmental disorders
894	Alcohol/drug abuse or dependence, left ama
895	Alcohol/drug abuse or dependence w rehabilitation therapy
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
906	Hand procedures for injuries
916	Allergic reactions w/o MCC
922	Other injury, poisoning & toxic effect diag w MCC
923	Other injury, poisoning & toxic effect diag w/o MCC
965	Other multiple significant trauma w/o CC/MCC
QUINTILE 2 (Version 25 relative weight = 0.6478)	
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC
58	Multiple sclerosis & cerebellar ataxia w MCC
75	Viral meningitis w CC/MCC
77	Hypertensive encephalopathy w MCC
78	Hypertensive encephalopathy w CC**
83	Traumatic stupor & coma, coma >1 hr w CC
84	Traumatic stupor & coma, coma >1 hr w/o CC/MCC
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC
102	Headaches w MCC***
113	Orbital procedures w CC/MCC
121	Acute major eye infections w CC/MCC
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC**
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC**
148	Ear, nose, mouth & throat malignancy w/o CC/MCC
152	Otitis media & URI w MCC
153	Otitis media & URI w/o MCC
156	Nasal trauma & deformity w/o CC/MCC
157	Dental & Oral Diseases w MCC***
184	Major chest trauma w CC***
188	Pleural effusion w/o CC/MCC*
200	Pneumothorax w CC
245	AICD lead & generator procedures
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC
284	Circulatory disorders w AMI, expired w CC*
311	Angina pectoris
336	Peritoneal adhesiolysis w CC
382	Complicated peptic ulcer w/o CC/MCC
384	Uncomplicated peptic ulcer w/o MCC
433	Cirrhosis & alcoholic hepatitis w CC*
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
534	Fractures of femur w/o MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
535	Fractures of hip & pelvis w MCC
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC
598	Malignant breast disorders w CC
599	Malignant breast disorders w/o CC/MCC**
600	Non-malignant breast disorders w CC/MCC
601	Non-malignant breast disorders w/o CC/MCC
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC
642	Inborn errors of metabolism
660	Kidney & ureter procedures for non-neoplasm w CC
687	Kidney & urinary tract neoplasms w CC
693	Urinary stones w/o esw lithotripsy w MCC
694	Urinary stones w/ot esw lithotripsy w/o MCC**
723	Malignancy, male reproductive system w CC
730	Other male reproductive system diagnoses w/o CC/MCC
769	Postpartum & post abortion diagnoses w O.R. procedure
803	Other O.R. proc of the blood & blood forming organs w CC
815	Reticuloendothelial & immunity disorders w CC
816	Reticuloendothelial & immunity disorders w/o CC/MCC**
842	Lymphoma & non-acute leukemia w/o CC/MCC
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC
864	Fever of unknown origin
876	O.R. procedure w principal diagnoses of mental illness
903	Wound debridements for injuries w/o CC/MCC
905	Skin grafts for injuries w/o CC/MCC
917	Poisoning & toxic effects of drugs w MCC
918	Poisoning & toxic effects of drugs w/o MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
956	Limb reattachment, hip & femur proc for multiple significant trauma
964	Other multiple significant trauma w CC
977	HIV w or w/o other related condition
QUINTILE 3 (Version 25 relative weight = 0.7790)	
78	Hypertensive encephalopathy w CC***
102	Headaches w MCC**
103	Headaches w/o MCC**
125	Other disorders of the eye w/o MCC
157	Dental & Oral Diseases w MCC**
158	Dental & Oral Diseases w CC
199	Pneumothorax w MCC
238	Major cardiovascular procedures w/o MCC
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC
254	Other vascular procedures w/o CC/MCC
263	Vein ligation & stripping
285	Circulatory disorders w AMI, expired w/o CC/MCC*
287	Circulatory disorders except AMI, w card cath w/o MCC
294	Deep vein thrombophlebitis w CC/MCC
304	Hypertension w MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
348	Anal & stomal procedures w CC
352	Inguinal & femoral hernia procedures w/o CC/MCC
354	Hernia procedures except inguinal & femoral w CC
358	Other digestive system O.R. procedures w/o CC/MCC
380	Complicated peptic ulcer w MCC
381	Complicated peptic ulcer w CC
383	Uncomplicated peptic ulcer w MCC
387	Inflammatory bowel disease w/o CC/MCC*
390	G.I. obstruction w/o CC/MCC*
421	Hepatobiliary diagnostic procedures w CC
424	Other hepatobiliary or pancreas O.R. procedures w CC
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC
502	Soft tissue procedures w/o CC/MCC
504	Foot procedures w CC
507	Major shoulder or elbow joint procedures w CC/MCC
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC
533	Fractures of femur w MCC
553	Bone diseases & arthropathies w MCC
597	Malignant breast disorders w MCC
599	Malignant breast disorders w/o CC/MCC***
604	Trauma to the skin, subcut tiss & breast w MCC
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC
619	O.R. procedures for obesity w MCC
620	O.R. procedures for obesity w CC**
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
644	Endocrine disorders w CC
657	Kidney & ureter procedures forneoplasm w CC
662	Minor bladder procedures w MCC
665	Prostatectomy w MCC
694	Urinary stones w/ot esw lithotripsy w/o MCC***
695	Kidney & urinary tract signs & symptoms w MCC
722	Malignancy, male reproductive system w MCC
744	D&C, conization, laparascopy & tubal interruption w CC/MCC
746	Vagina, cervix & vulva procedures w CC/MCC
749	Other female reproductive system O.R. procedures w CC/MCC
755	Malignancy, female reproductive system w CC
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC
816	Reticuloendothelial & immunity disorders w/o CC/MCC***
821	Lymphoma & leukemia w major O.R. procedure w CC
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC
835	Acute leukemia w/o major O.R. procedure w CC
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC
843	Other myeloprolif dis or poorly diff neopl diag w MCC***
844	Other myeloprolif dis or poorly diff neopl diag w CC***
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
909	Other O.R. procedures for injuries w/o CC/MCC
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC
QUINTILE 4 (Version 25 relative weight = 1.0810)	
28	Spinal procedures w MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
29	Spinal procedures w CC
38	Extracranial procedures w CC
53	Spinal disorders & injuries w/o CC/MCC*
88	Concussion w MCC**
89	Concussion w CC
103	Headaches w/o MCC***
124	Other disorders of the eye w MCC
168	Other resp system O.R. procedures w/o CC/MCC
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC
242	Permanent cardiac pacemaker implant w MCC***
244	Permanent cardiac pacemaker implant w/o CC/MCC
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC*
286	Circulatory disorders except AMI, w card cath w MCC
347	Anal & stomal procedures w MCC
351	Inguinal & femoral hernia procedures w CC
368	Major esophageal disorders w MCC
369	Major esophageal disorders w CC
370	Major esophageal disorders w/o CC/MCC**
407	Pancreas, liver & shunt procedures w/o CC/MCC
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC***
412	Cholecystectomy w c.d.e. w CC
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC
418	Laparoscopic cholecystectomy w/o c.d.e. w CC
420	Hepatobiliary diagnostic procedures w MCC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC*
478	Biopsies of musculoskeletal system & connective tissue w CC
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC
482	Hip & femur procedures except major joint w/o CC/MCC
486	Knee procedures w pdx of infection w CC
487	Knee procedures w pdx of infection w/o CC/MCC
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices
493	Lower extrem & humer proc except hip,foot,femur w CC
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC
503	Foot procedures w MCC
511	Shoulder,elbow or forearm proc,exc major joint proc w CC
516	Other musculoskelet sys & conn tiss O.R. proc w CC
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
620	O.R. procedures for obesity w CC***
659	Kidney & ureter procedures for non-neoplasm w MCC
667	Prostatectomy w/o CC/MCC
675	Other kidney & urinary tract procedures w/o CC/MCC
709	Penis procedures w CC/MCC
711	Testes procedures w CC/MCC
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC
725	Benign prostatic hypertrophy w MCC
754	Malignancy, female reproductive system w MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
760	Menstrual & other female reproductive system disorders w CC/MCC
776	Postpartum & post abortion diagnoses w/o O.R. procedure
781	Other antepartum diagnoses w medical complications
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC
824	Lymphoma & non-acute leukemia w other O.R. proc w CC
834	Acute leukemia w/o major O.R. procedure w MCC
843	Other myeloprolif dis or poorly diff neopl diag w MCC**
844	Other myeloprolif dis or poorly diff neopl diag w CC**
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC**
928	Full thickness burn w skin graft or inhal inj w CC/MCC
958	Other O.R. procedures for multiple significant trauma w CC
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC
QUINTILE 5 (Version 25 relative weight = 1.5863)	
12	Tracheostomy for face,mouth & neck diagnoses w CC
26	Craniotomy & endovascular intracranial procedures w CC
31	Ventricular shunt procedures w MCC
37	Extracranial procedures w MCC
131	Cranial/facial procedures w CC/MCC
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC***
137	Mouth procedures w CC/MCC
139	Salivary gland procedures
164	Major chest procedures w CC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
237	Major cardiovascular procedures w MCC
242	Permanent cardiac pacemaker implant w MCC**
243	Permanent cardiac pacemaker implant w CC
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC
258	Cardiac pacemaker device replacement w MCC
260	Cardiac pacemaker revision except device replacement w MCC
327	Stomach, esophageal & duodenal proc w CC
329	Major small & large bowel procedures w MCC
330	Major small & large bowel procedures w CC
335	Peritoneal adhesiolysis w MCC
350	Inguinal & femoral hernia procedures w MCC
370	Major esophageal disorders w/o CC/MCC***
405	Pancreas, liver & shunt procedures w MCC
406	Pancreas, liver & shunt procedures w CC
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC**
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC
454	Combined anterior/posterior spinal fusion w CC
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC
459	Spinal fusion except cervical w MCC
460	Spinal fusion except cervical w/o MCC
466	Revision of hip or knee replacement w MCC
467	Revision of hip or knee replacement w CC
469	Major joint replacement or reattachment of lower extremity w MCC

MS-LTC-DRG	MS-LTC-DRG (Version 25) Description
470	Major joint replacement or reattachment of lower extremity w/o MCC
471	Cervical spinal fusion w MCC
472	Cervical spinal fusion w CC
477	Biopsies of musculoskeletal system & connective tissue w MCC
480	Hip & femur procedures except major joint w MCC
481	Hip & femur procedures except major joint w CC
485	Knee procedures w pdx of infection w MCC
488	Knee procedures w/o pdx of infection w CC/MCC
492	Lower extrem & humer proc except hip,foot,femur w MCC
498	Local excision & removal int fix devices of hip & femur w CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC
582	Mastectomy for malignancy w CC/MCC
664	Minor bladder procedures w/o CC/MCC
668	Transurethral procedures w MCC
669	Transurethral procedures w CC
691	Urinary stones w esw lithotripsy w CC/MCC
713	Transurethral prostatectomy w CC/MCC
715	Other male reproductive system O.R. proc for malignancy w CC/MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC***
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft
957	Other O.R. procedures for multiple significant trauma w MCC
963	Other multiple significant trauma w MCC
969	HIV w extensive O.R. procedure w MCC
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC

*One of the original 303 low-volume MS-LTC-DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (see step 6 in section II.I.4.below).
**One of the original 303 low-volume MS-LTC-DRGs initially assigned to a different low-volume quintile but moved to this low-volume quintile in addressing nonmonotonicity (see step 6 in section II.I.4 below).
***One of the original 303 low-volume MS-LTC-DRGs initially assigned to this low-volume quintile but moved to a different low-volume quintile in addressing nonmonotonicity (see step 6 in section II.I.4 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 2008 MS-LTC-DRG Relative Weights

As we noted previously, although the adoption of the MS-LTC-DRGs with three severity levels results in some slight modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, described in detail elsewhere in this section, as proposed, the FY 2008 MS-LTC-DRG relative weights in this final rule with comment period are based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, for FY 2008, LTCH cases are grouped to the appropriate MS-LTC-DRG, while taking into account the low-volume MS-LTC-DRGs as described above, before the FY 2008 MS-LTC-DRG relative weights can be determined. After grouping the cases to the appropriate MS-LTC-DRG, we calculate the relative weights for FY 2008 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 adjust the number of cases in each MS-LTC-DRG for the effect of short-stay outlier cases, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate "relative adjusted weights" in each MS-LTC-DRG using the HSRV method described above.

Below we discuss in detail the steps for calculating the FY 2008 MS-LTC-DRG relative weights. We note that, as we stated above in section II.I.3.b. of the preamble of this final rule with comment period, 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 2006 MedPAR file.

Step 1--Remove statistical outliers.

The first step in the calculation of the FY 2008 MS-LTC-DRG relative weights 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 MS-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

MS-LTC-DRGs.

Step 2--Remove cases with a length of stay of 7 days or less.

The FY 2008 MS-LTC-DRG relative weights reflect the average of resources

used on representative cases of a specific type. Generally, cases with a length of stay of 7

days or less do not belong in a LTCH because these stays do not fully receive or benefit

from treatment that is typical in a LTCH stay, and full resources are often not used in the

earlier stages of admission to a LTCH. As explained above, if we were to include stays

of 7 days or less in the computation of the FY 2008 MS-LTC-DRG relative weights, the

value of many relative weights would decrease and, therefore, payments would decrease

to a level that may no longer be appropriate. We do not believe that it would be

appropriate to compromise the integrity of the payment determination for those LTCH

cases that actually benefit from and receive a full course of treatment at a LTCH, by

including data from these very short-stays. Thus, as explained above, in determining the

FY 2008 MS-LTC-DRG relative weights, as we 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 2008 MS-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) in conjunction with §412.503 for LTCH discharges occurring on

or after October 1, 2007). (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

MS-LTC-DRG, in accordance with §412.529. As discussed above, we are revising the

regulations at §412.503 to specify that regulatory references to LTC-DRGs for policy

descriptions and/or payment calculations shall be considered as references to the

MS-LTC-DRGs for LTCH discharges occurring on or after October 1, 2007.)

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 MS-LTC-DRG for non-short-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 MS-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 MS-LTC-DRG.

As we explained in the FY 2008 IPPS proposed rule (72 FR 24765), counting

short-stay outlier cases as full discharges with no adjustment in determining the

MS-LTC-DRG relative weights would lower the MS-LTC-DRG relative weight for

affected MS-LTC-DRGs because the relatively lower charges of the short-stay outlier

cases would bring down the average charge for all cases within an MS-LTC-DRG. This

would result in an "underpayment" for non-short-stay outlier cases and an "overpayment"

for short-stay outlier cases. Therefore, as we 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 2008 MS-LTC-DRG relative weights on an iterative

basis.

The process of calculating the MS-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 MS-LTC-DRG, as we proposed, the FY 2008 relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the MS-LTC-DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated MS-LTC-DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's MS-LTC-DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above 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 MS-LTC-DRG relative weights across all LTCHs. 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--Determine an FY 2008 relative weight for MS-LTC-DRGs with no LTCH cases.

As we stated above, we determine the relative weight for each MS-LTC-DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the March 2007 update of the FY 2006 MedPAR file for this final rule with comment period). Of the FY 2008 MS-LTC-DRGs, we identified a number of MS-LTC-DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2006 MedPAR file used in this final rule with comment period, no patients who would have been classified to those MS-LTC-DRGs were treated in LTCHs during FY 2006 and, therefore, no charge data were reported for those MS-LTC-DRGs.

Thus, in the process of determining the MS-LTC-DRG relative weights, we are unable to

determine weights for these MS-LTC-DRGs with no LTCH cases using the methodology

described in Steps 1 through 4 above. However, because patients with a number of the

diagnoses under these MS-LTC-DRGs may be treated at LTCHs beginning in FY 2008,

for this final rule with comment period, as we proposed, we are assigning relative weights

to each of the no-volume MS-LTC-DRGs based on clinical similarity and relative

costliness with the exception of "transplant" MS-LTC-DRGs and "error" MS-LTC-DRGs

(as discussed below. In general, as we proposed, we determined relative weights for the

MS-LTC-DRGs with no LTCH cases in the FY 2006 MedPAR file used in this final rule

with comment period by crosswalking these MS-LTC-DRGs to other MS-LTC-DRGs

and then assigning them the relative weight of the appropriate low-volume quintile (as

described in greater detail below).

Specifically, as we stated above, we determine the relative weight for each

MS-LTC-DRG using total Medicare allowable charges reported in the March 2007

update of the FY 2006 MedPAR file. Of the 745 MS-LTC-DRGs for FY 2008, we

identified 185 MS-LTC-DRGs for which there were no LTCH cases in the database. For

this final rule with comment period, as noted above, we are assigning relative weights to

each of the 185 no-volume MS-LTC-DRGs (with the exception of 8 "transplant" MS-

LTC-DRGs and 2 "error" MS-LTC-DRGs, as discussed below) based on clinical

similarity and relative costliness to one of the remaining 560 (745- 185 = 560) MS-LTC-

DRGs for which we are able to determine relative weights, based on FY 2006 LTCH

claims data. Then we assigned them the relative weight of the appropriate low-volume

quintile, as discussed below. (As explained below in Step 7, when necessary, we made

adjustments to account for nonmonotonicity.)

As we proposed, our methodology for determining the relative weights for the

no-volume MS-LTC-DRGs is as follows: We crosswalk the no-volume MS-LTC-DRG

to an MS-LTC-DRG for which there are LTCH cases in the FY 2006 MedPAR file and to

which it is similar clinically and in intensity of use of resources as determined by criteria

such as care provided during the period of time surrounding surgery, surgical approach (if

applicable), length of time of surgical procedure, postoperative care, and length of stay.

If the MS-LTC-DRG to which it is crosswalked is grouped to one of the low-volume

quintiles, we assign the relative weight for the applicable low-volume quintile to the no-

volume MS-LTC-DRG. However, if the MS-LTC-DRG to which the no-volume MS-

LTC-DRG is crosswalked is not one of the MS-LTC-DRGs in a low-volume quintile, we

do the following: (1) compare the relative weight of the MS-LTC-DRG to which the

no-volume MS-LTC-DRG is crosswalked to the relative weights of each of the five

quintiles; (2) assign the no volume MS-LTC-DRG the relative weight of the low-volume

quintile with the relative weight that is closest to the MS-LTC-DRG to which the no

volume MS-LTC-DRG is crosswalked. As stated above, assigning the relative weight of

a quintile to a no-volume MS-LTC-DRG that is cross-walked to a MS-LTC-DRGs that

has 25 or more cases and, therefore, is not in a low-volume quintile is consistent with our

methodology used in determining relative weights for MS-LTC-DRGs that have a low

volume of LTCH cases (that is, 24 or fewer cases), which is discussed above in section

II.I.e. of this preamble. (As we noted above, in the infrequent case where

nonmonotonicity involving a no volume MS-LTC-DRG results, additional measures as

described in Step 6 are required in order to maintain monotonically increasing relative

weights.) For this final rule with comment period, a list of the no-volume FY 2008 MS-

LTC-DRGs and the FY 2008 MS-LTC-DRG to which it is crosswalked is shown in the

chart below.

No-Volume MS-LTC-DRG Crosswalk for FY 2008

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
9	Bone marrow transplant	823
11	Tracheostomy for face,mouth & neck diagnoses w MCC	12
13	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	12
20	Intracranial vascular procedures w PDX hemorrhage w MCC	31
21	Intracranial vascular procedures w PDX hemorrhage w CC	32
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	33
23	Craniotomy w major device implant or acute complex CNS PDX w MCC	31
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	33
25	Craniotomy & endovascular intracranial procedures w MCC	26
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC	26
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedure w CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
90	Concussion w/o CC/MCC	89
114	Orbital procedures w/o CC/MCC	113
115	Extraocular procedures except orbit	125
116	Intraocular procedures w CC/MCC	125
117	Intraocular procedures w/o CC/MCC	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
132	Cranial/facial procedures w/o CC/MCC	131
135	Sinus & mastoid procedures w CC/MCC	133
136	Sinus & mastoid procedures w/o CC/MCC	133
138	Mouth procedures w/o CC/MCC	137
150	Epistaxis w MCC	152
151	Epistaxis w/o MCC	153
165	Major chest procedures w/o CC/MCC	164
185	Major chest trauma w/o CC/MCC	184

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
215	Other heart assist system implant	238
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	238
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	250
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	238
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	250
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	243
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	238
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	238
235	Coronary bypass w/o cardiac cath w MCC	237
236	Coronary bypass w/o cardiac cath w/o MCC	238
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	246
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	248
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
259	Cardiac pacemaker device replacement w/o MCC	258
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	261
295	Deep vein thrombophlebitis w/o CC/MCC	294
296	Cardiac arrest, unexplained w MCC	283
297	Cardiac arrest, unexplained w CC	284
298	Cardiac arrest, unexplained w/o CC/MCC	285
332	Rectal resection w MCC	356
333	Rectal resection w CC	357
334	Rectal resection w/o CC/MCC	358
337	Peritoneal adhesiolysis w/o CC/MCC	336
338	Appendectomy w complicated principal diag w MCC	371
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
344	Minor small & large bowel procedures w MCC	371
345	Minor small & large bowel procedures w CC	372
346	Minor small & large bowel procedures w/o CC/MCC	373
353	Hernia procedures except inguinal & femoral w MCC	354
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	409
411	Cholecystectomy w c.d.e. w MCC	412
413	Cholecystectomy w c.d.e. w/o CC/MCC	412

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	415
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	418
422	Hepatobiliary diagnostic procedures w/o CC/MCC	421
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424
453	Combined anterior/posterior spinal fusion w MCC	454
455	Combined anterior/posterior spinal fusion w/o CC/MCC	454
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	456
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	456
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
468	Revision of hip or knee replacement w/o CC/MCC	467
473	Cervical spinal fusion w/o CC/MCC	472
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
489	Knee procedures w/o pdx of infection w/o CC/MCC	488
491	Back & neck procedures except spinal fusion w/o CC/MCC	490
506	Major thumb or joint procedures	514
508	Major shoulder or elbow joint procedures w/o CC/MCC	507
509	Arthroscopy	505
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	511
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	505
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	505
583	Mastectomy for malignancy w/o CC/MCC	582
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	584
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
621	O.R. procedures for obesity w/o CC/MCC	620
625	Thyroid, parathyroid & thyroglossal procedures w MCC	628
626	Thyroid, parathyroid & thyroglossal procedures w CC	629
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	630
653	Major bladder procedures w MCC	659
654	Major bladder procedures w CC	660
655	Major bladder procedures w/o CC/MCC	661
656	Kidney & ureter procedures for neoplasm w MCC	657
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	657
663	Minor bladder procedures w CC	662
666	Prostatectomy w CC	665
670	Transurethral procedures w/o CC/MCC	665
671	Urethral procedures w CC/MCC	687
672	Urethral procedures w/o CC/MCC	688
692	Urinary stones w esw lithotripsy w/o CC/MCC	691
697	Urethral stricture	688
707	Major male pelvic procedures w CC/MCC	660
708	Major male pelvic procedures w/o CC/MCC	661
710	Penis procedures w/o CC/MCC	709
712	Testes procedures w/o CC/MCC	711
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	715

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	717
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	718
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	754
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	756
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	754
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	755
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	756
742	Uterine & adnexa proc for non-malignancy w CC/MCC	755
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	756
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	744
747	Vagina, cervix & vulva procedures w/o CC/MCC	746
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
765	Cesarean section w CC/MCC	744
766	Cesarean section w/o CC/MCC	769
767	Vaginal delivery w sterilization &/or D&C	769
768	Vaginal delivery w O.R. proc except steril &/or D&C	769
770	Abortion w D&C, aspiration curettage or hysterotomy	769
774	Vaginal delivery w complicating diagnoses	769
775	Vaginal delivery w/o complicating diagnoses	769
777	Ectopic pregnancy	769
778	Threatened abortion	759
779	Abortion w/o D&C	759
780	False labor	759
782	Other antepartum diagnoses w/o medical complications	759
789	Neonates, died or transferred to another acute care facility	761
790	Extreme immaturity or respiratory distress syndrome, neonate	761
791	Prematurity w major problems	760
792	Prematurity w/o major problems	761
793	Full term neonate w major problems	760
794	Neonate w other significant problems	760
795	Normal newborn	761
799	Splenectomy w MCC	423
800	Splenectomy w CC	424
801	Splenectomy w/o CC/MCC	424
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	803
820	Lymphoma & leukemia w major O.R. procedure w MCC	821
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	821
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	826
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	826
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	837
887	Other mental disorder diagnoses	881
915	Allergic reactions w MCC	916
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	933
955	Craniotomy for multiple significant trauma	26

MS-LTC-DRG	MS-LTC-DRG Description	Cross-Walked MS-LTC-DRG
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	958
970	HIV w extensive O.R. procedure w/o MCC	969

To illustrate this methodology for determining the relative weights for the 185

MS-LTC-DRGs with no LTCH cases, we are providing the following example, which

refers to the no volume MS-LTC-DRGs crosswalk information for FY 2008 provided in

the chart above.

Example:

There were no cases in the FY 2006 MedPAR file used for this final rule with

comment period for MS-LTC-DRG 22 (Intracranial vascular procedures w PDX

hemorrhage w/o CC/MCC).   We determined that MS-LTC-DRG 33 (Ventricular shunt

procedures w/o CC/MCC), which is assigned to low-volume Quintile 1 for the purpose of

determining the FY 2008 MS-LTC-DRG relative weights, is similar clinically and based

on resource use to MS-LTC-DRG 22. Therefore, we are assigning the same relative

weight of MS-LTC-DRG 33 of 0.4739 (Quintile 1) for FY 2008 (see the Composition of

Low-Volume Quintiles for FY 2008 chart above in section II.I.3.e. of this preamble) to

MS-LTC-DRG 22.

Furthermore, for FY 2008 as proposed, we are establishing MS-LTC-DRG

relative weights of 0.0000 for the following transplant MS-LTC-DRGs: Heart transplant

or implant of heart assist system w MCC (MS-LTC-DRG 1); Heart transplant or implant

of heart assist system w/o MCC (MS-LTC-DRG 2); Liver transplant w MCC or

intestinal transplant (LTC-DRG 5); Liver transplant w/o MCC (MS-LTC-DRG 6); Lung

transplant (MS-LTC-DRG 7); Simultaneous pancreas/kidney transplant (MS-LTC-DRG

8); Pancreas transplant (MS-LTC-DRG 10) and Kidney transplant (MS-LTC-DRG 652).

(We note that in the FY 2008 IPPS proposed rule (72 FR 24768), we inadvertently

neglected to include proposed MS-LTC-DRG 652 (Kidney transplant) in the list of

transplant MS-LTC-DRGs for which we proposed to assign a relative weight of 0.0000

for FY 2008. However, the proposed relative weight of 0.0000 for MS-LTC-DRG 652

was correctly shown in Table 11 of the FY 2008 IPPS proposed rule and was also

correctly footnoted as being one of the proposed MS-LTC-DRGs that was assigned a

proposed relative weight of 0.0000 (see 72 FR 25109). We also note that this is

consistent with our treatment of the current LTC-DRG for a kidney transplant

(LTC-DRG 302 (see 71 FR 47984). This is because Medicare will only cover these

procedures if they are performed at a hospital that has been certified for the specific

procedures by Medicare and presently no LTCH has been so certified. Based on our

research, we found that most LTCHs only perform minor surgeries, such as minor small

and large bowel procedures, to the extent any surgeries are performed at all. Given the

extensive criteria that must be met to become certified as a transplant center for

Medicare, we believe it is unlikely that any LTCHs will become certified as a transplant

center. In fact, in the 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.

        If in the future a LTCH applies for certification as a Medicare-approved transplant

center, we believe that the application and approval procedure would allow sufficient

time for us to determine appropriate weights for the MS-LTC-DRGs affected. At the

present time, we would only include these eight transplant MS-LTC-DRGs in the

GROUPER program for administrative purposes only. Because we use the same

GROUPER program for LTCHs as is used under the IPPS, removing these

MS-LTC-DRGs would be administratively burdensome.

In this final rule with comment period, as we proposed in Table 11 of the

FY 2008 IPPS proposed rule (72 FR 25114), we are assigning a relative weight of 0.0000

for the 2 "error" MS-LTC-DRGs: MS-LTC-DRG 998 (Principal diagnosis invalid as

discharge diagnosis) and MS-LTC-DRG 999 (Ungroupable), (We note that in the

discussion of proposed MS-LTC-DRGs with no LTCH cases in the FY 2008 IPPS

proposed rule (72 FR 24766 – 247769), we inadvertently neglected to include the 2

proposed "error" MS-LTC-DRGs (i.e., MS-LTC-DRGs 998 and 999) in the list of MS-

LTC-DRGs for which we proposed to assign a relative weight of 0.0000 for FY 2008.

However, as stated above, the proposed relative weight of 0.0000 for MS-LTC-DRGs

998 and 999 were correctly shown in Table 11 of the FY 2008 IPPS proposed rule and

were also correctly footnoted as being one of the proposed MS-LTC-DRGs that was

assigned a proposed relative weight of 0.0000 (see 72 FR 25114). We also note that this

is consistent with our treatment of the current "error LTC-DRGs (that is, LTC-DRG 469

(Principal Diagnosis Invalid as Discharge Diagnosis) and LTC-DRG 470 (Ungroupable))

(see 71 FR 48328)).

Again, we note that, as this system is dynamic, it is entirely possible that the

number of MS-LTC-DRGs with no volume of LTCH cases based on the system will vary

in the future. We used the most recent available claims data in the MedPAR file to

identify no volume MS-LTC-DRGs and to determine the relative weights in this final

rule with comment period.

Step 6--Adjust the FY 2008 MS-LTC-DRG relative weights to account for

nonmonotonically increasing relative weights.

As explained in section II.B. of the preamble of this final rule with comment

period, the IPPS FY 2008 MS-DRGs, on which the FY 2008 MS-LTC-DRGs are based,

provide a significant improvement in the DRG system's recognition of severity of illness

and resource usage. The MS-DRGs contain base DRGs that have been subdivided into

one, two, or three severity levels. Where there are three severity levels, the most severe

level has at least one code that is referred to as an MCC. The next lower severity level

contains cases with at least one code that is a CC. Those cases without a MCC or a CC

are referred to as without CC/MCC. When data did not support the creation of three

severity levels, the base was divided into either two levels or the base was not

subdivided. The two-level subdivisions could consist of the CC/MCC and the without

CC/MCC. Alternatively, the other type of two level subdivision could consist of the

MCC and without MCC. In base MS-LTC-DRGs with two levels, cases classified into a

"without CC/MCC" MS-LTC-DRG are expected to have lower resource use (and lower

costs) than the "with CC/MCC" and "with MCC."

That is, theoretically, cases that are more severe typically require greater

expenditure of medical care resources and will result in higher average charges.

Therefore, in the three severity levels, relative weights should increase by severity, from

lowest to highest. If the weights do not increase (that is, if within a base MS-LTC-DRG,

an MS-LTC-DRG with MCC has a lower relative weight than one with CC, or the

MS-LTC-DRG without CC/MCC has a higher relative weight than either of the others,

they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative

weights to adjust Medicare payments would result in inappropriate payments.

Consequently, as proposed, in general, we combine MS-LTC-DRG severity levels within

a base MS-LTC-DRG for the purpose of computing a relative weight when necessary to

ensure that monotonicity is maintained. Specifically, under each of the example

scenarios provided below, we would combine severity levels within a base

MS-LTC-DRG as follows:

The first example of nonmonotonically increasing relative weights for

MS-LTC-DRG pertains to base MS-LTC-DRGs with a three-level split and each of the

three levels has 25 or more LTCH cases and, therefore, did not fall into one of the five

low-volume quintiles. If nonmonotonicity is detected in the relative weights of

MS-LTC-DRGs in adjacent severity levels (for example, the relative weight of the "with

MCC" (the highest severity level) is less than the "with CC" (the middle level), or the

"with CC" is less than the "without CC/MCC"), we combine the adjacent

MS-LTC-DRGs and determine one relative weight based on the case-weighted average

of the combined LTCH cases of the nonmonotonic MS-LTC-DRG. The case-weighted

average charge is determined by dividing the total charges for all LTCH cases in both

severity levels by the total number of LTCH cases for the combined MS-LTC-DRGs.

We apply this relative weight to both affected levels of the base MS-LTC-DRG. If

nonmonotonicity remains an issue because the above process results in a relative weight

that is still nonmonotonic to the remaining MS-LTC-DRG within the base MS-LTC-

DRG, we combine all three of the severity levels to determine one relative weight based

on the case-weighted average charge of the combined severity levels which is assigned to

each of the MS-LTC-DRGs in that base MS-LTC-DRG.

A second example of nonmonotonically increasing relative weights for an

MS-LTC-DRG pertains to the situation where there are three severity levels and one or

more of the severity levels within a base MS-LTC-DRG has less than 25 LTCH cases

(that is, low volume). If nonmonotonicity occurs in the case where either the highest or

lowest severity level (with MCC" or "without CC/MCC") has 25 LTCH cases or more

and the other two severity levels are low volume (and therefore the other two severity

levels would otherwise be assigned the relative weight of the applicable quintile(s)), we

combine the data for the cases in the two adjacent low-volume MS-LTC-DRGs for the

purpose of determining a relative weight. If the combination results in at least 25 cases,

we calculate one relative weight based on the case-weighted average charge of the

combined severity levels and assign it to both of the severity levels. If the combination

results in less than 25 cases, based on the case-weighted average charge of the combined

low-volume MS-LTC-DRGs, both MS-LTC-DRGs are assigned the relative weight of

the quintile that has the closest relative weight to the case-weighted average charge of the

combined low volume MS-LTC-DRGs. If nonmonotonicity persists, we combine all

three severity levels and one relative weight would be assigned to all three levels based

on the case-weighted average charge of the combined severity levels. Similarly, in

nonmonotonic cases where the middle level has 25 cases or more but either or both the

lowest or highest severity level has less than 25 cases (that is, low volume), we combine

the nonmonotonic low-volume MS-LTC-DRG with the middle level MS-LTC-DRG of

the base DRG. We calculate one relative weight based on the case-weighted average

charge of the combined severity levels and apply it to both of the affected MS-LTC-

DRGs.   If the nonmonotonicity persists, we combine all three levels for the purpose of

determining a relative weight based on the case-weighted average charge of the combined

severity levels, and apply that relative weight to all three levels.

        A third example of nonmonotonicity involves a base MS-LTC-DRG with three

severity levels where at least one of the severity levels has no cases. As discussed in

greater detail in Step 5, based on clinical similarity, we initially cross-walk the no-

volume MS-LTC-DRG to an MS-LTC-DRG to which it is similar clinically and in

intensity of resource use and then assign the no-volume MS-LTC-DRG the relative

weight of the quintile with the relative weight closest to that of the MS-LTC-DRG to

which the no-volume MS-LTC-DRG had been cross-walked. If this results in

nonmonotonicity, in the case where the no-volume MS-LTC-DRG is either the lowest or

highest severity level, we assign to the no-volume MS-LTC-DRG the same relative

weight that is assigned to the middle level of the MS-LTC-DRG in that base DRG. If

nonmonotonicity persists, all three severity levels are combined for the purpose of

calculating one relative weight based on the case-weighted average charge of the

combined severity levels which is applied to each of the three levels. In the proposed

rule, we noted that this is a departure from our current treatment of no-volume

LTC-DRGs which results in an ultimate assignment to a quintile. However, this was not

accurate. In fact, this policy is consistent with our existing policy. We believe this

treatment achieves monotonically increasing relative weights while providing appropriate

payment for the no-volume MS-LTC-DRG because the relative weight assigned to the

no-volume MS-LTC-DRG is based on the average charges of services rendered within

the same base MS-LTC-DRG.

We apply the same process where the base MS-LTC-DRG contains a two-level

split. For example, if nonmonotonicity occurs in a base MS-LTC-DRG with two severity

levels (that is, the higher severity level relative weight is less than the lower severity

level), where both of the MS-LTC-DRGs have at least 25 cases or where one or both of

the MS-LTC-DRGs is low volume, we combine the two MS-LTC-DRGs of that base

MS-LTC-DRG for the purpose of determining a case-weighted relative weight. If the

combination results in at least 25 cases, we calculate one relative weight and assign it to

both of the MS-LTC-DRGs. If the combination results in less than 25 cases, we calculate

the case-weighted average charge for the combined MS-LTC-DRG. After we calculate

the case-weighted average charge for the combined MS-LTC-DRGs, we compare that

weight to the weights of the quintiles and apply the quintile weight closest to that

case-weighted average weight to both of these MS-LTC-DRGs.

Step 7 – Calculate MS-LTC-DRG transition blended relative weights for FY 2008

As discussed above in section II.I.2.a. of this preamble, we are implementing the

MS-LTC-DRGs with a 2-year transition beginning in FY 2008. For FY 2008, the first

year of the transition, 50 percent of the relative weight for a MS-LTC-DRG will be based

on the average LTC-DRG relative weight under Version 24.0 of the LTC-DRG

GROUPER. The remaining 50 percent of the relative weight will be based on the

MS-LTC-DRG relative weight under Version 25.0 of the MS-LTC-DRG GROUPER. In

FY 2009, the MS-LTC-DRG relative weights will be based on 100 percent of the

MS-LTC-DRG relative weights.

We used the following methodology to calculate the transition blended

MS-LTC-DRG relative weights for FY 2008. To determine the payment for a particular

case under the MS-LTC-DRGs in FY 2008, we will group cases to MS-LTC-DRGs

(using the Version 25.0 GROUPER), but the relative weight for each case will be

determined based on a 50/50 blend of the MS-LTC-DRG relative weight applying steps

1-6 above and the LTC-DRG relative weight applying steps 1-6 above. Thus, we

determined a blended weight for each MS-LTC-DRG in the Version 25.0 GROUPER.

Using LTCH claims in the FY 2006 MedPAR file, we grouped each case to an LTC-

DRG (using the Version 24.0 GROUPER) and an MS-LTC-DRG (using the Version 25.0

GROUPER) and applied steps 1-6 above to each set of grouped claims to determine a set

of LTC-DRG relative weights and a set of MS-LTC-DRG relative weights. Commonly,

a set of cases that grouped to a single MS-LTC-DRG grouped to two or more

LTC-DRGs. Therefore, we determined an average LTC-DRG relative weight using the

Version 24.0 GROUPER for all cases that grouped to each MS-LTC-DRG. Specifically,

we summed the LTC-DRG relative weights of all the cases that grouped to each MS-

LTC-DRG and then divided that number by the number of LTCH cases. To establish the

final transition blended weight for each MS-LTC-DRG in the Version 25.0 GROUPER,

we added 50 percent of the MS-LTC-DRG relative weight to 50 percent of the average

LTC-DRG relative weight for that MS-LTC-DRG.

We also note that after calculating the transition blended relative weights, we

adjusted the FY 2008 MS-LTC-DRG relative weights to account for nonmonotonically

increasing relative weights using the method described above in Step 6. As noted above,

we continue to believe that utilizing nonmonotonic relative weights to adjust Medicare

payments would result in inappropriate payments. Therefore, in general, we combine

MS-LTC-DRG severity levels within a base MS-LTC-DRG for the purpose of

determining the transition blended relative weight when necessary to ensure that

monotonicity is maintained. (For specific details on how severity levels within a base

MS-LTC-DRG are combined when nonmonotonicity occurs, refer to Step 6 above.)

Step 8-- Calculate the FY 2008 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the

broad authority conferred upon the Secretary under section 123 of Pub. L. 106-113 as

amended by section 307(b) of Pub. L. 106-554 to develop the LTCH PPS, beginning with

the MS-LTC-DRG update for FY 2008, the annual update to the MS-LTC-DRG

classifications and relative weights will be done in a budget neutral manner such that

estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither

greater than nor less than the estimated aggregate LTCH PPS payments that would have

been made without the MS-LTC-DRG classification and relative weight changes.

Historically, we have not updated the LTC-DRGs in a budget neutral manner because we

believed that past fluctuations in the LTC-DRG relative weights were primarily due to

changes in LTCH coding practices. We believe that changes in the LTCH PPS payment

rates, including the LTC-DRG relative weights, should accurately reflect changes in

LTCHs' true cost of treating patients (real CMI increase), and should not be influenced

by changes in coding practices (apparent CMI increase). As we explained in the

RY 2008 LTCH PPS final rule (72 FR 26882), because LTCH 2006 claims data does not

appear to significantly reflect changes in LTCH coding practices in response to the

implementation of the LTCH PPS, we believe that, beginning with FY 2008, it is

appropriate to update the MS-LTC-DRGs so that estimated aggregate LTCH PPS

payments will neither increase nor decrease. Thus, in that same final rule, we established

under §412.517(b) that the annual update to the MS-LTC-DRG classifications and

relative weights be done in a budget neutral manner. (As discussed above, we are

revising the regulations at §412.503 to specify that "MS-LTC-DRG" is used in place of

"LTC-DRG" for discharges occurring on or after October 1, 2007. For a detailed

discussion on the establishment of the requirement to update the MS-LTC-DRG

classifications and relative weights in a budget neutral manner, refer to the RY 2008

LTCH PPS final rule (72 FR 26880 through 26884). Updating the MS-LTC-DRGs in a

budget neutral manner will result in an annual update to the individual MS-LTC-DRG

classifications and relative weights based on the most recent available data to reflect

changes in relative LTCH resource use, and the MS-LTC-DRG relative weights will be

uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS

would not be affected (that is, decreased or increased). Consistent with that provision,

we are updating the MS-LTC-DRG classifications and relative weights for FY 2008

based on the most recent available data and include a budget neutrality adjustment.

To ensure budget neutrality in updating the MS-LTC-DRG classifications and

relative weights under new §412.517(b), as we proposed, we are using a method that is

similar to the methodology used under the IPPS. (A discussion of the IPPS DRG budget

neutrality adjustment can be found in the FY 2007 IPPS final rule (71 FR 47970).) We

note that, in this final rule with comment period, we have modified our proposed

methodology for ensuring budget neutrality in updating the MS-LTC-DRG classifications

and relative weights for FY 2008 to accommodate the use of blended transition relative

weights (discussed in Step 7 above).   Specifically, after recalibrating the MS-LTC-DRG

relative weights, as we do under the methodology as described in detail in Steps 1

through 7 above, we calculate and apply a normalization factor to the MS-LTC-DRG

relative weights to ensure that estimated payments are not influenced by changes in the

composition of case types or changes made to the classification system. That is, the

normalization adjustment is intended to ensure that the recalibration of the MS-LTC-

DRG relative weights (that is, the process itself) neither increases nor decreases total

estimated payments. To calculate the normalization factor for FY 2008 , as proposed

(with modifications to accommodate the use of blended transition relative weights) we

use the following steps: (1) we use the most recent available claims data (FY 2006) and

the MS-LTC-DRG transition blended relative weights (determined above in Step 7 of the

Steps for Determining the FY 2008 MS-LTC-DRG Relative Weights) to calculate the

average CMI; (2) we group the same claims data (FY 2006) using the FY 2007

GROUPER (Version 24.0) and FY 2007 relative weights (established in the FY 2007

IPPS final rule (71 FR 47971 – 47984 and 48321 – 48331) and calculate the average

CMI: (3), we compute the ratio of these average CMIs by dividing the average CMI

determined in step (2) by the average CMI determined in step (1). In determining the

MS-LTC-DRG relative weights for FY 2008, based on the latest available data, the

normalization factor is estimated as 1.020905, which is applied to each MS-LTC-DRG

transition blended relative weight. That is, each MS-LTC-DRG transition blended

relative weight is multiplied by 1.020905 in the first step of the budget neutrality process.

Accordingly, the relative weights in Table 11 in the Addendum of this final rule with

comment period reflect this normalization factor. We also ensure that estimated

aggregate LTCH PPS payments (based on the most recent available LTCH claims data)

after reclassification and recalibration (the new (i.e., FY 2008) relative weights) are equal

to estimated aggregate LTCH PPS payments (for the same most recent available LTCH

claims data) before reclassification and recalibration (the existing (i.e., FY 2007) relative

weights). Therefore, in general, we calculate the budget neutrality adjustment factor by

simulating estimated total payments under both sets of GROUPERs and relative weights

using current LTCH PPS payment policies (RY 2008) and the most recent available

claims data (from the FY 2006 MedPAR file). (We note, in the FY 2008 IPPS proposed

rule (72 FR 24770), we proposed to simulate estimated total payments for purposes of

determining the proposed FY 2008 budget neutrality adjustment using current LTCH PPS

payment policies, which at that time, were RY 2007 LTCH PPS rates and policies. Since

the publication of the proposed rule, we have established RY 2008 LTCH PPS rates and

policies in the RY 2008 LTCH PPS final rule (72 FR 26870 – 27029). Accordingly, we

are using RY 2008 LTCH PPS rates and policies in determining the determining the

FY 2008 budget neutrality adjustment in this final rule with comment period.) In this

final rule with comment period, the budget neutrality adjustment was determined using

the following steps: (1) we simulate estimated total payments using the normalized

transition blended relative weights under GROUPER Version 25.0 (as described above in

Step 7); (2) we simulate estimated total payments using the FY 2007 GROUPER

(Version 24.0) and FY 2007 LTC-DRG relative weights (as established in the FY 2007

IPPS final rule (71 FR 47971 – 47984 and 48321 – 48331); (3) we calculate the ratio of

these estimated total payments by dividing the estimated total payments determined in

step (2) by the estimated total payments determined in step (1). Then, for FY 2008, each

of the normalized transition blended relative weights is multiplied by the budget

neutrality factor to determine the budget neutral relative weight for each MS-LTC-DRG.

Accordingly, in determining the MS-LTC-DRG relative weights for FY 2008, based on

the most recent available data, we are establishing a budget neutrality factor of 0.996467,

which is applied to the transition blended relative weights after normalizing. The

FY 2008 MS-LTC-DRG relative weights in Table 11 in the Addendum of this final rule

with comment period reflect this budget neutrality factor.

Table 11 in the Addendum to this final rule with comment period lists the

MS-LTC-DRGs and their respective transition blended budget neutral relative weights,

geometric mean length of stay, and five-sixths of the geometric mean length of stay (used

in the determination of short-stay outlier payments under §412.529) for FY 2008. The

"IPPS Comparable Threshold" (that is, the IPPS geometric average length of stay plus

one standard deviation) for each MS-LTC-DRG (used in the determination of short-stay

outlier payments under §412.529(c)(3) as established in the RY 2008 LTCH PPS final

rule (72 FR 26904 - 26918)) for FY 2008 is also included in Table 11 in the Addendum

to this final rule with comment period.

In determining the proposed MS-LTC-DRG relative weights for FY 2008, in the

FY 2008 IPPS proposed rule (72 FR 24771), we proposed to apply a case-mix budget

neutrality factor to the MS-LTC-DRG relative weight to eliminate the effect of changes

in coding or classification of discharges that do not reflect real change in case-mix. The

budget neutrality factor was proposed because we believed that adoption of the

MS-LTC-DRGs would create a risk of increased aggregate levels of payment as a result

of increased documentation and coding. We believed this adjustment would be necessary

for FY 2008 and FY 2009 to ensure that estimated aggregate LTCH PPS payments would

be neither greater than nor less than the estimated aggregate LTCH PPS payments that

would have been made without the adoption of the MS-LTC-DRG patient classification

system. Accordingly, in the proposed rule each proposed MS-LTC--RG relative weights

presented in Table 11 was multiplied by a factor of 0.976 to account for improvements in

coding and documentation resulting from the adoption of the new patient classification

system.

In this final rule with comment period, as discussed in the responses below, we

are not implementing the proposed case-mix budget neutrality factor to the

MS-LTC-DRG relative weights. Accordingly, the MS-LTC-DRG relative weights in

Table 11 of the Addendum to this final rule with comment period do not reflect any

adjustment to account for changes in coding and documentation that do not reflect real

change in case-mix.

 Comment: While several commenters supported the adoption of a patient

classification system that recognizes differences in patient acuity in LTCHs, a number of

commenters opposed CMS' proposal to apply a budget neutrality adjustment factor to the

MS-LTC-DRG relative weights in anticipation of changes in coding or classification of

discharges resulting from the adoption of the MS-LTC-DRGs. Commenters expressed

doubt that the adoption of the proposed MS-LTC-DRGs would lead to the coding

changes CMS expects. Specifically, these commenters believed that in certain situations,

such as where there are corresponding and equivalent subclassifications under both the

proposed and existing systems, there may not be any real opportunity for coding

improvements for those groups. For instance, one commenter cited MS-LTC-DRG 207

and 208 (LTC-DRGs 565 and 566) as an example of a DRG group that would not

experience upcoding. Consequently, several commenters opposed the application of the

adjustment for improved coding practices across all MS-LTC-DRGs and requested that

CMS refrain from applying an adjustment to any MS-LTC-DRG for which they believed

coding changes is inapplicable. A commenter asserted specifically that for the DRGs in

which upcoding is impossible, CMS would be "imposing a payment penalty for these

cases." One commenter, a LTCH trade association group, commissioned a report to

evaluate the proposed "coding adjustment" to the MS-LTC-DRG relative weights to

account for changes in coding or classification of discharges resulting from the adoption

of the new patient classification system. CMS had stated in the proposed rule that the

"coding adjustment" is necessary in order to maintain budget neutrality. Based on the

commissioned report, the commenter concluded that the magnitude of the proposed

"coding adjustment" is inappropriate for LTCHs because it would not result in budget

neutrality, rather, it would result in an overall reduction in aggregate LTCH payments.

The commenter noted that since approximately 34 percent of LTCH cases are paid under

the short-stay outlier policy where cases are paid at or below costs, there is no

opportunity for upcoding in those cases. Furthermore, according to the commissioned

report, approximately 61 percent of current LTCH discharges already are coded at what

would be the highest severity level under the new MS-LTC-DRG system.   That is, the

commenter asserted that there is no opportunity to up-code these cases because they are

either in a base MS-DRG with only one severity level or these cases are already coded in

the highest severity level of a base MS-DRG with multiple severity levels. The report

noted that according to their own analysis, this number of LTCH cases is almost triple the

number of IPPS discharges that appear in the highest severity level MS-DRGs. The

commissioned report further attempted to analyze LTCH discharges and for the potential

for upcoding within a base MS-DRG ("MS-DRG family") by calculating what the report

terms as "upcode ratios." The report defines an "upcode ratio" as the ratio of the relative

weight of the MS-DRG with the highest severity level within the MS-DRG family to the

relative weight of the base MS-DRG with the lowest severity level. Presumably, the

higher the "upcode ratio," the greater the incentive for upcoding into the highest severity

level since the upcoding would result in a higher payment. Based on the "upcode ratios,"

the report contrasted the potential for upcoding by LTCHs and IPPS hospitals. The

report concluded that since 97 percent of LTCH discharges are distributed in the lowest

"upcode ratio" quartile versus 25 percent of IPPS discharges, LTCHs therefore have less

incentive to upcode within the same base MS-DRG than IPPS hospitals. The report also

estimated that if every LTCH upcoded every discharge to the highest possible severity

level, LTCHs' maximum potential for upcoding would result in a 3.61 percent increase in

the case-mix index. The report translated this finding to mean that 66 percent of all

LTCH cases would have to be upcoded to the highest severity level in order to make the

proposed adjustment to the LTCH relative weights budget neutral. The commenter

believed it was unreasonable for CMS to assume that LTCHs could improve coding to

that extent. Finally, the report also predicted that a significant number of LTCH

discharges would be subjected to the 25 percent rule and thus paid at rates that are similar

to IPPS rates and not based on MS-LTC-DRGs. The report noted that IPPS hospitals are

not subject to the 25 percent rule, implying that the magnitude of the "coding adjustment"

which was based on primarily IPPS data, is inappropriate for LTCHs. The commenter

concludes that "the vast majority of LTCH discharges present no opportunity to upcode

and most of the remaining LTCH discharges provide little potential to do so." Another

commenter stated that the significant year-to-year changes in LTCH payments due to

both policy changes and routine rate and weighting adjustments which results in large

payment fluctuations for some DRGS, creates a challenge to LTCHs to effectively

operate, plan for the future, and maintain quality care for Medicare patients. In

particular, one commenter using MedPAR 2005 claims data compared estimated

payments under the proposed MS-DRG system (with the "coding adjustment" included)

to estimated payment under the current system and asserted that according to their

analysis, large payment changes would result in the ten most common LTC-DRGs. The

commenter cited specifically that the change in payment for the top ten DRGs ranges

from over a 25 percent reduction in some cases to over a 30 percent increase in others. In

light of the volatility apparent in adopting the new MS-LTC-DRG system, the commenter

recommended that CMS delay making an adjustment for improved coding practices until

after a transition to the MS-LTC-DRG system has occurred. The commenter suggested

that once the transition has fully occurred, CMS could apply an appropriate adjustment

based on actual, rather than anticipated, coding change.

Response: In the proposed rule, we indicated that we believe that adoption of the

proposed MS-LTC-DRGs would create a risk of increased aggregate levels of payment as

a result of increased documentation and coding. MedPAC noted that "refinements in

DRG definitions have sometimes led to substantial unwarranted increase in payments to

hospitals, reflecting more complete reporting of patients' diagnoses and procedures."

MedPAC further noted that "refinements to the DRG definitions and weights would

substantially strengthen providers' incentives to accurately report patients' 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" [Report to Congress

on Physician-Owned Specialty Hospitals, March 2005, p. 42]. While we modeled the

changes to the DRG system and relative weights to ensure budget neutrality, we are

concerned that the large increase in the number of DRGs and refinements of severity

levels 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 LTC-DRGs may result in a case being assigned to a higher

paid DRG under the proposed MS-LTC-DRGs. We note that while the commenters have

attempted to analyze the potential for improvements in documentation and coding to

affect the MS-LTC-DRG assignment within a base MS-LTC-DRG, improved

documentation may also result in a case being assigned from a lower paid MS-LTC-DRG

into a higher paid MS-LTC-DRG of a completely different base MS-LTC-DRG. In

particular, the commissioned report submitted by the LTCH trade association

demonstrated to us that commenters are pre-occupied with focusing on the potential for

improving documentation and coding where the MS-LTC-DRG assignment would

change from a lower severity level to a higher severity level within the same base

MS-LTC-DRG. We are emphasizing here that in addition to the potential for

improvements in documentation and coding to change the severity level within a base

DRG ("intra-DRG change"), the potential for improvements in documentation and

coding to result in the assignment of a case into a higher paid MS-LTC-DRG outside of

the base MS-LTC-DRG ("inter-DRG documentation and coding changes) is also a likely

consequence of more accurate and complete documentation and possible for LTCH

discharges because patients are admitted with multiple CCs. In general, the commenters

expressed the belief that "the vast majority of LTCH discharges present <u>no</u> opportunity to

upcode" (emphasis added). We disagree with this belief since generally, the commenters

have provided arguments based on examples which focus entirely on "intra-DRG

change" without accounting for the "inter-DRG change" potential which may be possible

for LTCH discharges because patients are admitted with multiple complications and

comorbidities. One commenter cited two MS-LTC-DRGs for patients on ventilators,

MS-LTC-DRG 207 and 208 (previously LTC-DRG 565 and 566), as MS-LTC-DRGs

that would not experience "intra-DRG change" because the classification groups under

the old and new classification systems for these ventilator patients remains unchanged.

We acknowledge that for MS-LTC-DRG 207, which is a high paying MS-LTC-DRG,

there appears to be no incentive for improvements in documentation and coding that

result in "intra-DRG change" from the lower paid MS-LTC-DRG 208 to the higher paid

MS-LTC-DRG 207 or for documentation and coding improvements that affect

"inter-DRG change" because this DRG is already such a high paying DRG. However,

for patients that were classified in MS-LTC-DRG 208, there may be some opportunity for

documentation and coding improvements that affect "inter-DRG change," depending on

the existence of specific CCs. While we take issue with some of the commenters'

generalizations, we agree that there are significant differences in the distribution of

patients among the severity DRGs between those in IPPS hospitals and those in LTCHs.

Accordingly, we agree with the comments that it would be appropriate to further adjust

the proposed budget neutrality adjustment that we are utilizing for IPPS hospitals to

reflect the experiences of the LTCHs. However, due to the complexity of the

interactions, at this time we are unable to determine the extent to which MS-LTC-DRGs

are susceptible to increased case-mix improvements in documentation and coding in

order to estimate an appropriate adjustment for such improvements that would be

applicable to LTCHs. Accordingly, we are not finalizing the proposed case-mix budget

neutrality factor to the MS-LTC-DRG relative weights at this time.

While some commenters have noted that not all M-LTC-DRGs are equally

susceptible to improvements in documentation and coding and suggested that we apply

the adjustment for such improvements to only those MS-LTC-DRGs for which

improvements in documentation and coding are possible, we note that in general, we

apply adjustments to the LTCH PPS on a system-wide basis since the LTCH PPS is a

system devised upon averages. We also note that some commenters attempted to analyze

the impact of the short-stay outlier policy and the 25 percent rule on improvements in

documentation and coding. As we stated previously in this final rule, we continue to

believe that payment adjustments that were finalized in the RY 2008 LTCH PPS final

rule, among which was the revision to the short-stay outlier policy (§412.529(c)) noted

by the commenters, will result in more appropriate Medicare payments to LTCHs. The

revised short-stay outlier policy addresses the issue of LTCH discharges that are

comparable to an acute care IPPS hospital discharge based on the length of stay for that

discharge. That policy is not tied to or affected by the adoption of the MS-LTC-DRGs.

Nor do we believe that the extension of the 25 percent threshold adjustment that we

finalized for RY 2008 at revised 412.534 and new 412.536, which governs Medicare

payments for patients discharged from LTCHs who were admitted from specific referring

hospitals, is tied to or affected by the adoption of the MS-LTC-DRGs. Furthermore, as

noted above, since the MS-LTC-DRGs are so structurally similar to the LTC-DRGs, we

do not believe that postponing the adoption of the severity-weighted DRGs in order to

evaluate the interaction of the policy changes implemented for the LTCH PPS for

RY 2008 would confer any significant advantage to stakeholders. However, we agree

with the commenters that the fact that a large number of LTCH discharges are paid as

short-stay outliers based on cost could have an effect on the budget neutrality adjustment

applicable to LTCHs as compared to the adjustment we are finalizing for the IPPS and

the LTCH budget neutrality would need to be adjusted accordingly.

In response to the commenter's concern that our policy changes and routine rate

and weighting adjustments result in large payment fluctuations for some DRGs, we note

that fluctuations are seen year to year resulting from refinements to the LTC PPS that are

necessary in order to pay appropriately for LTCH cases. Each year, we recalibrate the

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 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 the fluctuations in payments for certain

MS-LTC-DRGs based on the proposed FY 2008 reweighting of the MS-LTC–DRGs.

However, we remind the commenters that the existing budget neutrality requirement for

changes in DRGs and recalibrating the relative weights mitigates any effect of the change

to MS-LTC-DRGs on estimated aggregate LTCH PPS payments. Additionally, as we

have discussed earlier, transitioning the relative weights for FY 2008 should further

mitigate the effects from adoption of the MS-LTC-DRG system. For the reasons

discussed in the comments and responses section of this final rule with comment period,

we will not be implementing the proposed case-mix budget neutrality factor to the

MS-LTC-DRG relative weights at this time.

While we agree that the IPPS adjustment would need to be adjusted to be

applicable to LTCHs, we continue to believe more accurate and complete documentation

and coding will occur because it will result in higher aggregate payments under the MS-

LTC-DRG system. We have every reason to expect that hospitals will respond to the

adoption of MS-LTC-DRGs in much the same way as they have responded to similar

events in the past. They will improve their documentation and coding of diagnoses and

procedures, and this change will lead to increases in reported case mix. The reason to

make offsetting adjustments is also the same. Although hospitals' efforts to improve the

specificity and accuracy of documentation and coding are perfectly legitimate, the

increases in payments that result are not warranted because the increase in measured

case-mix does not reflect any real change in illness severity or the cost of care for the

patients being treated. Therefore, offsetting adjustments to the PPS payment rates are

needed to protect the Medicare program from unwarranted increases in spending. We

believe the question is not whether documentation and coding will improve, resulting in

higher case mix and payments, rather, the question is only how much will coding change

when the incentives to code particular secondary diagnoses change with the adoption of

MS-LTC-DRGs, and how long will these changes continue.

Section 123 of the BBRA, as amended by section 307(b) of the BIPA, provides

that the Secretary may specify appropriate adjustments to the long-term care hospital

payment system, including updates. This broad discretionary authority includes our

ability to make adjustments and updates for case-mix changes due to improved coding

and documentation changes that do not reflect real change in case mix regardless of

whether such adjustment is for anticipated case-mix changes or case-mix changes that

occurred in a previous time period. We remain convinced that an adjustment is needed to

eliminate the effect of changes in coding or classification of LTCH discharges that do not

reflect real change in case-mix resulting from the adoption of the proposed

MS-LTC-DRGs. However, as discussed above, after revisiting this issue, we believe that

the adjustment for anticipated improvements in coding and documentation adopted in this

final rule with comment period for IPPS hospitals needs to be adjusted to apply to

LTCHs. At this time, CMS has not been able to determine an appropriate adjustment to

the factor used for IPPS hospitals in order to make it applicable to LTCHs; however, we

will continue to monitor LTCHs' response to the MS-LTC-DRG transition. Beginning

with RY 2009, if CMS is able to estimate an appropriate adjustment factor applicable to

LTCHs, CMS would propose an adjustment factor to LTCHs to account prospectively for

coding and documentation changes. We note that in previous years, we have adjusted the

annual update to the LTCH PPS standardized rate for case-mix changes due to coding

and documentation changes to recoup payments made in a prior period by making a

prospective adjustment during the rate setting cycle. Specifically, the adjustments for

coding and documentation changes implemented in the RY 2007 and RY 2008

regulations were based on actual LTCH case mix data from FY 2004 and FY 2005,

respectively (71 FR 27820-2 and 72 FR 26887-90).   Since we have an established

mechanism to adjust LTCH payments to account for the effect of changes in coding and

documentation which is based on actual LTCH data and since we cannot determine an

appropriate adjustment factor applicable to LTCHs at this time, we believe it is

appropriate to continue using this established process rather than making an adjustment at

this time based on an estimate of projected LTCH specific case-mix change due to

improved coding and documentation.   Therefore, at this time, we are not finalizing the

proposed case-mix budget neutrality factor to the MS-LTC-DRG relative weights in

FY 2008. Instead, consistent with past LTCH payment policy, we could propose to make

future adjustments to account for improvements in coding and documentation that do not

reflect real changes in case mix during these years that we are implementing

MS-LTC-DRGs.

Comment: Finally, one commenter believed that CMS' proposal for FY 2008

would effectively penalize LTCHs twice for the same case-mix changes. That is, the

commenter noted that in RY 2008, CMS finalized a retrospective adjustment to account

for past coding improvements by reducing the expected update (i.e., full market basket)

to the standard payment rate by 2.49 percent in order to recoup payments made in a prior

period (FY 2005). The commenter further noted that the reduction in the market basket

update reduces the base rate and therefore has a permanent prospective effect. The

commenter stated that "the effect of the case-mix reduction to the market basket of 2.49

percent is applicable to payments in RY 2008 and each rate year thereafter. It is never

made up." The commenter concluded that the "additional downward coding adjustment

factor of 2.4 percent in each of two years, or any other adjustment that is not borne out by

careful retrospective analyses after the full transition to MS-LTC-DRGs, to payments to

LTCHs in future years, is redundant and unsupported."

Response: As discussed above, we are not implementing the proposed case-mix

budget neutrality factor to the MS-LTC-DRG relative weights in FY 2008. Where CMS

ultimately determines that an adjustment is necessary, CMS will propose adjustments to

the LTCH PPS in order to account for changes to coding or documentation that do not

reflect real changes in case-mix.

J. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and

ensuring adequate payment for new medical services and technologies (sometimes

collectively referred to in this section as "new technologies") under the IPPS. Section

1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be

considered new if it meets criteria established by the Secretary after notice and

opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the

process must apply to a new medical service or technology if, "based on the estimated

costs incurred with respect to discharges involving such service or technology, the DRG

prospective payment rate otherwise applicable to such discharges under this subsection is

inadequate."

The regulations implementing this provision establish three criteria for new

medical services and technologies to receive an additional payment. First, §412.87(b)(2)

states that a specific medical service or technology will be considered new for purposes

of new medical service or technology add-on payments until such time as 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 (generally on the date that the technology receives FDA

approval) 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

2006 are used to calculate the FY 2008 DRG weights in this final rule with comment

period. 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 has 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 technologies ceases (§412.87(b)(2)).

For example, an approved new technology that received FDA approval in October 2006 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2010 (discharges occurring before October 1, 2009), when data reflecting the costs of the technology could be used to recalibrate the DRG weights. Because the FY 2009 DRG weights would be calculated using FY 2007 MedPAR data, the costs of such a new technology would be reflected in the FY 2009 DRG weights.

Section 412.87(b)(3) further provides that new medical services or technologies must be inadequately paid otherwise under the DRG system to receive the add-on payment. 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), 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).

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 refer readers to section IV.D. of the preamble to the

FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations

to incorporate the change made by section 503(b)(1) of Pub. L. 108-173.) Table 10 of the

Addendum to the FY 2007 IPPS final rule (71 FR 48319) contained the final thresholds

that are being used to evaluate applications for new technology add-on payments for

FY 2008. An applicant must demonstrate that the cost threshold is met using information

from inpatient hospital claims.

We were recently asked to revisit the issue of whether the HIPAA Privacy Rule at

45 CFR Parts 160 and 164 applies to claims information that providers submit with

applications for new technology add-on payments. We previously addressed this issue in

the September 7, 2001 final rule (66 FR 46917) that established the new technology

add-on payment regulations. In the preamble to that final rule, we explained that health

plans, including Medicare, and providers that conduct certain transactions electronically,

including the hospitals that would be receiving payment under the FY 2001 IPPS final

rule, are required to comply with the HIPAA Privacy Rule. We further explained how

such entities could meet the applicable HIPAA requirements by discussing how the

HIPAA Privacy Rule permitted providers to share with health plans information needed

to ensure correct payment, if they had obtained consent from the patient to use that

patient's data for treatment, payment, or health care operations. We also explained that

because the information to be provided within applications for new technology add-on

payment would be needed to ensure correct payment, no additional consent would be

required. The HHS Office of Civil Rights has since amended the HIPAA Privacy Rule,

but the results remain. The HIPAA Privacy Rule no longer requires covered entities to

obtain consent from patients to use or disclose protected health information for treatment,

payment, or health care operations, and expressly permits such entities to use or to

disclose protected health information for any of these purposes. (We refer readers to

45 CFR 164.502(a)(1)(ii), and 506(c)(1) and (c)(3) and the Standards for Privacy of

Individually Identifiable Health Information published in the **Federal Register** on

August 14, 2002, for a full discussion of changes in consent requirements).

Section 412.87(b)(1) of our existing regulations provides that a new technology is

an appropriate candidate for an additional payment when it represents "an advance that

substantially improves, relative to technologies previously available, the diagnosis or

treatment of Medicare beneficiaries." For example, a new technology represents a

substantial clinical improvement when it reduces mortality, decreases the number of

hospitalizations or physician visits, or reduces recovery time compared to the

technologies previously available. (We refer readers to the September 7, 2001 final rule

(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.

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. Further, the Congressional report language accompanying section 533 of Pub. L. 106-554 indicated Congress' intent to require the Secretary to implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106-1033, 106th Cong., 2nd Sess. at 897 (2000)). 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 2009 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical

evaluations demonstrating that the new medical service or technology represents a

substantial clinical improvement, along with a significant sample of data to demonstrate

the medical service or technology meets the high-cost threshold. Complete application

information, along with final deadlines for submitting a full application, will be available

on our Web site after the publication of this FY 2008 IPPS final rule at:

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 2009, 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
medical service or technology represents a substantial clinical improvement to the
clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for
new medical services and technologies for FY 2008 before publication of the FY 2008
IPPS proposed rule, we published a notice in the **Federal Register** on
December 22, 2006 (71 FR 77031), and held a town hall meeting at the CMS
Headquarters Office in Baltimore, MD, on February 22, 2007. In the announcement
notice for the meeting, we stated that the opinions and alternatives provided during the
meeting would assist us in our evaluations of applications by allowing public discussion
of the substantial clinical improvement criterion for each of the FY 2008 new medical
service and technology add-on payment applications before the publication of the
FY 2008 IPPS proposed rule.

Approximately 70 individuals attended the town hall meeting in person, while
additional participants listened over an open telephone line. Boston Scientific presented
data on how its product (Wingspan® Stent System with Gateway™ PTA Balloon
Catheter) meets the substantial clinical improvement criterion, as well as the need for
additional payments to ensure its access to Medicare beneficiaries. No other attendees at

the town hall meeting made a presentation with regard to the Wingspan® new technology

add-on payment application.

In the FY 2008 IPPS proposed rule, we considered Boston Scientific's

presentation made at the town hall meeting, as well as written comments submitted with

their application, in our evaluation of the Wingspan® new technology application for

FY 2008 in the FY 2008 IPPS proposed rule. We have summarized these comments

under section I.4. of the preamble of this final rule with comment period. At the Town

Hall meeting, we did not receive any other comments regarding substantial clinical

improvement of Wingspan®.

There were a number of public comments made at the Town Hall meeting

suggesting that CMS provide more specific detail about how it would apply the

substantial clinical improvement criterion. For example, the public commenters at the

Town Hall meeting suggested that CMS provide clear guidance with respect to the type

of data that applicants should submit to support an application for add-on payments for

new medical services and technologies. We were asked to work with stakeholders,

including researchers, clinicians, representatives of patients, and manufacturers, to

develop specific criteria and data quality standards that would make determinations of

"substantial clinical improvement" more predictable and transparent.

In the FY 2008 IPPS proposed rule, we welcomed public comment on this issue.

In particular, we indicated that we were interested in any "specific criteria or data quality

standards" that the commenters believed we should adopt to improve the new technology

add-on application process, or any concerns or challenges that commenters believed we

may encounter in undertaking this effort. Again, as we stated at the new technology

Town Hall meeting, we indicated that we continue to be interested in working with our

stakeholders to improve the inpatient new technology add-on payment process. We

stated that we were interested in ensuring that the latest medical technology that improves

care for the Medicare patient population continues to be available to our beneficiaries.

Comment: One commenter supported how CMS currently evaluates whether a

technology represents a substantial clinical improvement over existing technologies.

Specifically, the commenter stated, "we believe the new technology add-on payment

mechanism is structured fairly and provides technologies that truly improve care with a

challenging yet reasonable opportunity to qualify for enhanced payment status… the

criteria articulated by CMS to prove substantial clinical improvement offer significant

discretion and flexibility on the parts of both applicants and CMS to, respectively,

demonstrate and decide whether a new technology truly represents an advancement in

care."

Response: We appreciate the commenter's support of our application of the

criteria we currently use to determine whether a new technology merits an add-on

payment. The commenter noted that the current standards allow us an opportunity to be

both fair and flexible and for each individual application to be evaluated on a case-by-

case basis rather than by a stringent set of inflexible criteria. We believe the commenter

raises a reasonable concern that establishing specific data standards may make it more

difficult for an applicant to qualify for a new technology add-on payment because such

standards cannot account for the various types of new technologies that may become

available in the future and the types of requirements that those novel technologies may or

may not be able to meet.

Comment: Several commenters suggested that CMS revise or alter the standards

we use to determine whether a technology meets the substantial clinical improvement

criterion. One commenter requested that CMS "quickly announce its proposed data

standards for a showing of substantial clinical improvement" and stated that, in the past,

CMS did not provide clear guidance on the type of data that applicants would need to

submit. The commenter applauded CMS' recent endeavor to provide clear guidance on

the issue. Another commenter supported the provision of more detailed criteria for the

types of data and documentation that would help to demonstrate whether a new

technology was a substantial clinical improvement, but did not recommend any specific

standards that CMS could use. The commenter did, however, recommend that applicants

utilize credentialed coding professionals to ensure correct codes and DRGs are identified

prior to submitting a detailed cost analysis.

Response: The purpose of us asking for public input on how to improve the

substantial clinical improvement criterion was to garner information and ideas from the

public and stakeholders about how that specific criterion could be improved. We note

that we did not propose any specific standards for substantial clinical improvement, but

instead, we were anticipating that members of the public, including those who

recommended we revise our standards, would suggest some ideas that we could consider

adopting in a subsequent notice of proposed rule-making. Our goal was to present the

ideas submitted by the public commenters to learn whether past or potential future

applicants would find them useful.

In response to the comment suggesting that an applicant seek coding advice

before submitting a new technology application, our regulations neither require nor

prohibit an applicant from using the any specific type of expertise available in the health

care community in preparing its application. We certainly encourage applicants to make

the best possible case for why the technology that interests them should receive an add-on

payment. If that effort involves use of a medical coder, we encourage the applicant to

seek that expertise.

Comment: One commenter recommended that CMS deem the "drugs and

biologicals for which the FDA has granted fast track approval or approval based on

surrogate endpoints to represent substantial clinical improvements." The commenter also

suggested that CMS deem a device to be a substantial clinical improvement "…if it has

been granted a humanitarian device exemption or priority review based on the fact that it

represents breakthrough technologies, that offer significant advantages over existing

approved alternatives, for which no alternatives exist, or the availability of which is in the

best interests of the patients."

Response: The FDA provides a number of different types of approvals to devices,

drugs and other medical products. At this time, we do not believe that any particular type

of FDA approval alone would automatically demonstrate a substantial clinical

improvement for the Medicare population. However, as noted in previous final rules, we

do take FDA approval into consideration in our evaluation of new technology

applications. We note that an Humanitarian Device Exemption (HDE) approval only

requires an approval threshold of safety and *probable* benefit as opposed to the safety and

effectiveness standard that exists for pre-market approval (PMA). Among other

requirements, the labeling of a humanitarian use device must state that the effectiveness

of the device for the specific indication has not been demonstrated. While an HDE

approval certainly does not preclude us from considering a technology for an add-on

payment (as we do in this final rule with comment period for Wingspan®), neither does it

suggest that the product automatically meets the requirement to be judged a substantial

clinical improvement. We will continue to evaluate products receiving an HDE approval

by measuring it against the specific criteria we listed for determining substantial clinical

improvement at 66 FR 46914.

Comment: One commenter stated that our current administration of the

substantial clinical improvement criterion is "inconsistent and unnecessarily opaque."

The commenter recommended that CMS "convene a panel of stakeholders, including

researchers, clinicians, industry representatives and patient groups to develop specific,

generally applicable criteria for determining whether a new product represents a

substantial clinical improvement, including the creation of objective standards for the use

of external data." The commenter specifically recommended that we convene a panel to

consider, as a starting point for developing more specific standards on substantial clinical

improvement, the following criteria:

● **Clinical Effectiveness**: The expected magnitude of improvement in patient

health outcomes, including mortality, morbidity, quality of life, and functional status.

●   **Clinical and Organizational Efficiency**: The expected impact of the

technology on resource utilization, assessed at the level of individual patients. CMS

would consider improvements in the timely and efficient delivery of care, as well as short

and long-term savings across various settings of care. In addition, CMS would weigh the

expected impact of the technology on resource utilization, assessed at the level of health

care institutions and the health care system. This would include the impact on worker

productivity, the extent to which the technology increases the capacity of existing

facilities, etc.

●   **Strength and Consistency of Evidence**: The level of confidence that the

judgments about clinical effectiveness and clinical efficiency are reliable and based on

scientific studies, pathophysiologic reasoning, economic modeling, clinical judgment and

other sources of information. The assessment of evidence should be undertaken with

recognition of the practical and economic challenges to proving definitively the benefits

of novel technologies.

●   **Safety**: The degree to which the technology may reduce the risk of adverse

events for patients and health care providers.

Response: In response to the comment that suggested that our application of the

substantial clinical improvement criterion is "inconsistent and unnecessarily opaque," we

again note that the intent of soliciting comments on this topic in the proposed rule was to

obtain ideas for how to make improvements in our policy from those who are dissatisfied

with it. Nevertheless, we reiterate that CMS has been committed to providing ample

opportunity for applicants and other interested parties to make their views known to us

through 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.

In response to the comment about convening a panel of stakeholders, we believe

the commenter is suggesting that we establish an advisory panel under the Federal

Advisory Committee Act (FACA). Although we believe it may be unnecessary to

establish a FACA committee solely for this purpose, we do not have objections to having

a one-time public meeting specifically to consider ideas that are raised on this topic. We

convened a new technology and coding workshop this past year prior to the New

Technology Town Hall meeting. We received favorable feedback from the many

attendees at that meeting and we would consider having a similar meeting intended to

garner ideas for addressing the topic of specific data standards.

In response to the ideas offered in the public comments that could be used as a

basis of developing more specific and transparent criteria for evaluating whether a

technology represents a substantial clinical improvement, it is exactly these kinds of ideas

for which we would like further public reaction—potentially through a forum like the

public meeting noted above. We are interested in public comments from past or potential

future new technology applicants and other stakeholders whether these ideas would

improve the new technology application process and if they should be developed further.

Comment: A number of commenters addressed topics relating to the marginal cost factor for new technology, implementation of ICD-10-CM, external data, and changing our standards under the newness criterion.

Response: We did not request comment nor propose to make any changes to any of the issues addressed by the commenters. As the comments are unrelated to any of the provisions in the proposed rule, we are not responding to them in this final rule with comment period.

3. FY 2008 Status of Technologies Approved for FY 2007 Add-On Payments

a. 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. FDA approved GORE TAG on March 23, 2005. Because the technology remained within the 2- to 3-year period during which it could be considered new for FY 2007, we continued add-on payments for the endovascular graft repair of the thoracic aorta in the FY 2007 IPPS final rule (71 FR 47999). GORE TAG will have been on the market for more than 3 years as of March 23, 2008, or less than 6 months of FY 2008. Our practice has been to begin and end new technology add-on payments on the basis of a fiscal year. In general, we extend add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year (70 FR 47362). Because the 3-year anniversary date of GORE TAG's entry onto the market was in the first half of the fiscal year, in the FY 2008 IPPS proposed rule, we proposed to discontinue its new technology add-on payment for FY 2008. In response to the proposed rule, we received the following public comments:

Comment: One commenter recommended that we continue to make add-on payments for GORE TAG since the approval date of the device is only 8 days away from being in the second half of FY 2008. The commenter requested that CMS should consider the possible delay in making this technology available on the market since devices can routinely take several months to enter the general provider population.

Another commenter, the manufacturer of GORE TAG, also requested that we continue to make the new technology add-on payments for an additional year and noted that the technology remains inadequately paid under the MS-DRGs.

Response: As we stated in the proposed rule, GORE TAG received FDA

approval on March 23, 2005 which falls in the first half of FY 2005. The 3-year

anniversary of the product's FDA approval will be during the first half of FY 2008. Our

policy is that we only provide an additional year of new technology add-on payment if

the 3-year anniversary of FDA approval is during the second half of the year fiscal year

unless we receive evidence of a documented delay in making the product available on the

market. The manufacturer did not provide a documented delay in marketing of the

device. Therefore, our policy is not to allow the product to receive an additional year of

new technology add-on payments.

Although we are not extending an additional year of new technology add-on

payments to GORE TAG, we note that cases where a thoracic aortic stent is placed

through an endovascular procedure will be reassigned from MS-DRG 238 (Major

Cardiovascular Procedures without MCC) to MS-DRG 237 (Major Cardiovascular

Procedures without MCC). For more information, we refer readers to section II.D. of the

preamble of this final rule with comment period.

Because the technology no longer meets the newness criterion, we are finalizing

our proposal to discontinue new technology add-on payments for GORE TAG for

FY 2008.

b. 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 and FY 2007. 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).

The FDA approved the Restore® Rechargeable Implantable Neurostimulator in

2005. However, as noted 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. Because the Restore®

Rechargeable Implantable Neurostimulator will be beyond the 2- to 3-year period during

which it can be considered new for FY 2008, in the FY 2008 IPPS proposed rule, we

proposed to discontinue add-on payments for the technology in FY 2008. In response to

the proposed rule, we received the following public comments:

Comment: The manufacturer of Restore® recommended that we continue to make add-on payments for rechargeable implantable neurostimulators for an additional year. The commenter indicated that an additional year of the add-on payment, "maintains the hospital payment level for rechargeable neurostimulator devices until data reflects the market volume and costs associated with rechargeable technology." The commenter stated that "rechargeable neurostimulators were launched in 2005 in a limited fashion and the majority were sold during the second half of FY 2005." The commenter also noted that Restore® was launched on the market on April 8, 2005 and that a unique ICD-9-CM procedure code to identify rechargeable neurostimulators was not created until FY 2006. According to the commenter, prior to the date for which a unique ICD-9-CM code was effective, "there was no way to identify rechargeable neurostimulators separately from non-rechargeable ones." The manufacturer stated that there were 12,801 rechargeable neurostimulators sold in FY 2006, but its analysis of FY 2006 MedPAR data showed that only 0.3 percent of all rechargeable neurostimulators sold in the United States were implanted in Medicare patients in the inpatient hospital setting. Therefore, the manufacturer suggested, the low utilization of rechargeable stimulators in FY 2005 may be justification for extending the add-on payment period because they "still fall within the 2-3 year period of newness to qualify for add-on."

Response: Implantable rechargeable neurostimulators do not qualify for an additional year of new technology add-on payments. As we indicated in the FY 2006 final rule, the Advanced Bionics Precision® Rechargeable Neurostimulator was approved by the FDA on April 2004 (70 FR 47358). Thus, the FDA approved a substantially

similar rechargeable neurostimulator product more than 3 years ago. No commenters

provided documentation or even asserted that there was a delay in the marketing of the

Advanced Bionics Precision® Rechargeable Neurostimulator. Therefore, we are

finalizing our proposal to discontinue new technology add-on payments for rechargeable

implantable neurostimulators for FY 2008. Although we are not extending an additional

year of new technology add-on payments for rechargeable implantable neurostimulators,

we are making the following DRG reassignments:

● MDC 1 - Spinal neurostimulators from MS-DRG 30 (Spinal Procedures

without CC) to MS-DRG-29 (Spinal Procedures with CC);

● MDC 1 - Peripheral neurostimulators from MS-DRG 42 (Peripheral and

Cranial Nerve and Other Nervous System Procedures without CC) to MS-DRG 41

(Peripheral and Cranial Nerve and Other Nervous System Procedures with CC);

● MDC 8 - Full system spinal cord neurostimulators from MS-DRG 491 (Back

and Neck Procedures Except Spinal Fusion without CC/MCC) to MS-DRG 490 (Back

and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Devices).

For more information on DRG reassignments for rechargeable implantable

neurostimulators, we refer readers to section II.G.2. of the preamble of this final rule with

comment period.

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 (X STOP)

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, 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's extension that compresses the nerve's 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 was initially 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. As noted in section II.G.4.c. of this

preamble of this final rule with comment period, X STOP will be identified by ICD-9-

CM code 84.80 (Insertion or replacement of interspinous process device(s)), effective

October 1, 2007.

In the FY 2007 final rule, with respect to substantial clinical improvement, we noted our concern that, during the FDA approval process, the Center for Devices and Radiological Health Advisory Panel voted against pre-market approval of X STOP because of concerns about proper patient selection, as well as the lack of objective endpoints. The applicant addressed our concerns by demonstrating that 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 indicated that we believed 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 approved the X STOP Interspinous Process Decompression System for new technology add-on payment for FY 2007. For FY 2007, cases involving X STOP were identified by ICD-9-CM code 84.58 (Implantation of interspinous process decompression device). These cases were generally included in CMS-DRG 499 (Back and Neck Procedures Except Spinal Fusion with CC) and CMS-DRG 500 (Back and Neck Procedures Except Spinal Fusion without CC) for FY 2007. As noted in section II.G.4.c. of the preamble of this final rule with comment period, beginning FY 2008, cases involving X STOP will be identified with ICD-9-CM code 84.80 and will generally be included in MS-DRG 490

(Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Devices or

Neurostimulator).

The X STOP Interspinous Process Decompression System is still within the 2- to

3-year period during which it can be considered new for FY 2008. However, in the

proposed rule, we noted that we were concerned that it may no longer meet the cost-

threshold criterion. In section II.G.4.c. of the preamble of the FY 2008 IPPS proposed

rule (72 FR 24734), we proposed to adopt MS-DRGs for FY 2008 and assign cases with

procedure codes 84.58 (replaced by procedure code "84.80" in this final rule with

comment period) into proposed MS-DRG 490. Proposed MS-DRG 490 would include

back and neck procedures except spinal fusion with a CC or MCC. As indicated earlier,

we did a comprehensive review of the spinal fusion and nonspinal fusion DRGs. Based

on this review, we proposed to further modify MS-DRG 490 to also include the higher

cost of cases where the patient receives a spinal disc device such as an artificial spinal

disc prosthesis, or an interspinous process decompression system. Our earlier analysis of

the spinal and nonspinal fusion DRGs showed that the average charge per case for cases

involving X STOP is $29,162. The average charge per case for MS-DRG 490 is $29,656.

Therefore, cases that use X STOP have a lower average charge per case than all cases in

MS-DRG 490. The data show that the technology is not inadequately paid under the

revised MS-DRGs, and it no longer meets the cost threshold for new technology add-on

payment. For this reason, we proposed to discontinue new technology add-on payments

for X STOP in FY 2008 and correlate the payments under MS-DRG 490. In the FY 2008

IPPS proposed rule, we noted that the high costs for cases using X STOP that

necessitated an add-on payment under the CMS DRGs would no longer be necessary if we were to adopt MS-DRGs because of the higher payment that would be made under MS-DRG 490 (72 FR 24734).

We received the following public comments on this proposal:

Comment: One commenter supported our recommendation to discontinue add-on payment for X STOP since it would no longer meet the cost threshold under the MS-DRG system. However, the commenter noted that it would expect the add-on payment to continue if the MS-DRG system was not finalized as proposed.

Response: In this final rule with comment period, we are finalizing our proposals to discontinue new technology add-on payments for X STOP in FY 2008 and to correlate the payments under MS-DRG 490.

4. FY 2008 Application for New Technology Add-On Payments

Boston Scientific submitted an application for the Wingspan® Stent System with Gateway™ PTA Balloon Catheter (Wingspan®) for new technology add-on payments for FY 2008. The device is designed for the treatment of patients with significant intracranial arterial stenosis who are refractory to medical management. The device consists of the following: a self-expanding nitinol stent; a multilumen over wire delivery catheter; and a Gateway™ PTA Balloon Catheter. The device is used to treat stenoses that occur in the intracranial vessels. Prior to stent placement, the Gateway™ PTA Balloon is inflated to dilate the target lesion, and then the stent is deployed across the lesion to restore and maintain luminal patency. Effective October 1, 2004, two new ICD-9-CM procedure codes were created to code intracranial angioplasty and intracranial

stenting procedures: procedure codes 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessels) and 00.65 (Percutaneous insertion of intracranial vascular stents).

On August 3, 2005, the Wingspan® was approved by the FDA as an HDE. We note that the applicant submitted an application for new technology add-on payment in FY 2006 but was not approved for add-on payment because it had not yet received FDA approval. In November 2006, we issued a national coverage determination (NCD) on intracranial stents. The NCD stated that the treatment of cerebral artery stenosis in patients with intracranial atherosclerotic disease with intracranial percutaneous transluminal angioplasty (PTA) and stenting is reasonable and necessary when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. Currently, there are no clinical trials in place for the Wingspan®. However, because the technology is covered by Medicare, if it is used in the setting of a clinical trial, in the FY 2008 IPPS proposed rule, we evaluated whether the Wingspan® met the criteria for an inpatient new technology add-on payment. Wingspan® has been available on the market since August 3, 2005. Therefore, we believe that the technology meets the newness criterion.

The applicant noted in its application that cases of intracranial angioplasty and stenting cases are currently grouped to CMS DRGs 533 (Extracranial Procedure with CC) and 534 (Extracranial Procedure Without CC). However, the applicant believes these cases should be assigned to CMS DRGs 1 (Craniotomy Age > 17 with CC), 2 (Craniotomy Age > 17 without CC), and 543 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis) based on resource use and

for clinical consistency with other endovascular intracranial procedures assigned to these

DRGs. As discussed in section II.D. of the preamble of the proposed rule and this final

rule with comment period, we proposed to move procedure code 00.62 to MS-DRGs 25,

26, and 27 (Craniotomy & Endovascular Intracranial Procedures with MCC, with CC,

and without CC/MCC, respectively) and MS-DRGs 23 and 24 (Craniotomy with Major

Device Implant or Acute Complex Central Nervous System Principal Diagnosis with

MCC or without MCC, respectively) under the MS-DRG system, which are comparable

to DRGs 1, 2, and 543 under the current CMS-DRG system.

          To demonstrate that the Wingspan® meets the cost threshold, the manufacturer

submitted data from MedPAR and non-MedPAR databases. Using the FY 2005

MedPAR data, the applicant identified cases of intracranial angioplasty that had a

procedure code of 39.50 (Angioplasty or atherectomy of other noncoronary vessels) in

combination with one of the following principal diagnosis codes: any principal diagnosis

code that begins with the prefix of 433 (Occlusion and stenosis of precerebral arteries),

excluding 433.10 (Cartoid artery without mention of cerebral infarction) and 433.11

(Cartoid artery with cerebral infarction); any principal diagnosis code that begins with the

prefix of 434 (Occlusion of cerebral arteries), 437.0 (Cerebral atherosclerosis), 437.1

(Other generalized ischemic cerebrovascular disease), or 437.9 (Unspecified). The

applicant noted that procedure code 39.50 is the predecessor code for identifying cases of

intracranial angioplasty. The applicant explained that, given the newness of procedure

codes 00.62 and 00.65 that were implemented beginning October 1, 2005, it believes

there are still cases being coded with the predecessor procedure codes. Using this

methodology, the applicant found 577 cases in DRG 533 and 179 cases in DRG 534. The

applicant noted that charges in the MedPAR file do not include the total costs of devices,

drugs, and medical supplies associated with the Wingspan®, so the applicant conducted

an estimate of the charges associated with the Wingspan®. The applicant determined

that costs associated with the Wingspan® are approximately $10,073. Because we use

charges to determine if a technology meets the threshold, it is necessary to inflate the

costs to charges. Using the national average CCR of 0.47, the applicant inflated the costs

associated with the Wingspan® to $21,432 in charges. After adding the charges

associated with the Wingspan®, the average standardized charge per case was $76,416

and $51,277 for DRGs 533 and 534, respectively.

In the proposed rule, we stated our concern that the cases identified by the

applicant may not be a useful proxy to identify cases of intracranial angioplasty.

Procedure code 39.50 describes cases of angioplasty in any artery of the body except the

heart. Intracranial angioplasty with stenting was not covered by Medicare in any

circumstance prior to October 2006. Therefore, the Medicare cases submitted by the

applicant under procedure code 39.50 should not involve intracranial angioplasty because

they are neither described by the code nor covered by Medicare. Furthermore, procedure

code 00.62 is assigned to the Non-Covered Procedure edit of the MCE. The applicant

supplied Medicare data from FY 2005 for claims coded with procedure code 00.62. It is

unclear to us how these claims were processed despite the Non-Covered Procedure edit.

Because these data appear to be based on claims that may not have been coded or

processed correctly, we question the reliability and validity of these data. In the FY 2008

IPPS proposed rule, we noted our concern that it may not be appropriate to rely on these data for purposes of determining whether the technology meets the cost threshold (72 FR 24775).

As stated above, the applicant also submitted non-Medicare data. The applicant used the 2005 patient discharge data from California's Office of Statewide Health Planning and Development database for hospitals in California and the 2005 patient data from Florida's Agency for Health Care Administration for hospitals in Florida. Similar to the analysis above, the applicant identified cases of intracranial angioplasty using procedure code 39.50 in combination with the diagnosis codes listed above. The applicant identified 43 cases in DRG 533, and 21 cases in DRG 534. These cases already included charges associated with Wingspan® so it was not necessary to further increase them to include the cost of the technology like the applicant did with the Medicare data. The average standardized charge per case was $89,697 and $40,475 for DRGs 533 and 534, respectively. As discussed above, we are concerned about whether these cases actually represent cases of intracranial angioplasty and are concerned about our inability to validate non-Medicare data. In addition, similar to the analysis described above, the applicant also identified cases of intracranial angioplasty using procedure code 00.62. The applicant found 30 cases in DRG 533, and 23 cases in DRG 534. The average standardized charge per case was $93,215 and $31,479 for DRGs 533 and 534, respectively. Based on these data, the applicant maintains that the technology meets the cost threshold.

As noted above, the applicant has requested that cases of the Wingspan® be reassigned to CMS DRGs 1, 2 and 543. In section II.G.2. of the preamble of the proposed rule, we proposed to assign procedure code 00.62 to proposed MS-DRGs 23, 24, 25, 26 and 27, which we proposed to replace DRGs 1, 2, and 543 of the CMS DRGs. The thresholds in Table 10 of the Addendum of the FY 2007 IPPS final rule (as corrected at 71 FR 60040) for DRGs 1, 2 and 543 are $53,969, $37,116 and $64,397, respectively. Analyzing the same Medicare and non-Medicare data that the applicant used to demonstrate that the Wingspan® exceeds the cost threshold for DRGs 533 and 534, the applicant compared the average standardized charge per case to the thresholds for DRGs 1, 2, and 543. The applicant maintains that the Wingspan® would still exceed the cost threshold even if it were reassigned to DRGs 1, 2, and 543.

However, for the reasons described above, it was not clear to us at the time of the proposed rule whether Wingspan® met the cost threshold for new technology add-on payment. In the proposed rule, we welcomed public comments on this issue. In response, we received the following public comments:

Comment: One commenter was concerned that the technology will not meet the cost criterion unless CMS accepts the external data submitted by the applicant. The commenter raised further concerns that CMS' narrow application of the cost criterion combined with the proposed MS-DRGs will prevent technologies from being approved and discourage manufacturers from seeking add-on payments in the future. The commenter urged CMS to implement new technology add-on payments in a manner that encourages continued innovation and access to advanced technologies.

The applicant supported our decision to reassign the technology from the

MS-DRGs for extracranial procedures to the MS-DRGs for craniotomy. However, it

stated that CMS should accept the MedPAR and non-MedPAR analyses to evaluate

whether the technology meets the cost criterion. The commenter explained that the

analysis is based on claims with unique codes which describe intracranial angioplasty and

stenting and the economic results are consistent with analogous neuroendovascular

procedures. The commenter also noted that two years of MedPAR data showed

consistency in resources, mean length of stay and mean standardized charges.

Additionally, the costs for cases of intracranial angioplasty with stenting (including

resources such as hours spent in radiology, clinical monitoring, and advance imaging

evaluations, among others) are consistent with unruptured brain aneurysm treatments

with craniotomy assigned to CMS DRGs 1 and 2. The commenter stated that the

MedPAR data currently reflect a low volume of cases of intracranial angioplasty because

procedures using the technology have not been covered by Medicare. However, the

applicant anticipates the volume of cases to increase now that Medicare coverage has

been expanded to include the Wingspan® HDE population. In addition, due to the

newness of procedure code 00.62, the applicant supplemented the MedPAR data with

external data that includes intracranial angioplasty and stenting which it asserts

demonstrates the technology meets the cost criterion.

In addition, the applicant submitted FY 2005 and FY 2006 MedPAR data that

included any paid or unpaid cases where procedure code 00.62 was coded. In the

FY 2005 MedPAR, the applicant found 21 cases in DRG 533 and fewer than 11 cases in

DRG 534. The average standardized charge per case including an additional $21,432 for charges related to the device was $90,312 and $47,144 for DRGs 533 and 534 respectively. In the FY 2006 MedPAR, the applicant found 15 cases in DRG 533 and fewer than 11 cases in DRG 534. The average standardized charge per case including an additional $21,432 for charges related to the device was $75,032 and $55,759 for DRGs 533 and 534 respectively. Based on the data it submitted, the applicant maintains that the Wingspan® meets the cost criteria for MS-DRGs 23, 24, 25, 26 and 27—the MS-DRGs to which the technology is assigned beginning in FY 2008.

Response: Without further detail from the commenter, we cannot respond to the comment suggesting that we have applied the cost criterion too narrowly. However, we note that CMS policy is to accept external data to determine whether a technology meets the cost criterion provided that it can be validated. Although our preference is to evaluate the cost criterion using data that reflect the cost of cases using the technology in Medicare patients, we do have a policy that permits us to use external data.

We continue to have concerns about validity and reliability of the claims for Medicare cases submitted by the applicant because of Medicare's policy of not covering intracranial angioplasty with stenting at all or only through an FDA approved clinical trial. We note that there is currently no clinical trial in place for Wingspan® in the United States. Therefore, Medicare should not have paid for any case of intracranial angioplasty with stenting during the time period for which the applicant submitted claims. With respect to the external data submitted by the applicant, we believe it is a useful proxy to determine whether the average standardized charge per case exceeds the

thresholds in Table 10. As the applicant notes, the external data show that the average

cost of these cases including the technology exceeds the cost thresholds shown in the

IPPS rule for MS-DRGs 23 through 27.

The applicant also maintains that the technology meets the substantial clinical

improvement criterion. In the past there has been no surgical or medical treatment

available for recurrent strokes that occur despite optimal medical management. The

applicant asserts that the Wingspan® provides a new treatment option for these patients.

The applicant submitted three studies to support this position.

First, the applicant cites data derived from a series of cases of 45 patients who

received the Wingspan® that demonstrate 4.4 percent composite ipsilateral stroke or

death at 30 days, 7.0 percent composite ipsilateral stroke or death at 6 months, and

9.3 percent ipsilateral stroke or death at 13 months. The applicant then used patients in

the well known Warfarin-Aspirin Symptomatic Intracranial Disease (WASID) trial as a

historical control against which to compare patients who received Wingspan®. The

WASID trial compared the warfarin vs. aspirin therapy in treating symptomatic

intracranial arterial stenosis, and it demonstrated a 23 percent stroke/death rate at one

year in patients with severe (70 percent or greater) stenosis, and a 21 percent stroke/death

rate at 2 years in patients with 50 percent or greater stenosis. The applicant also

submitted data from an ongoing Wingspan® registry of patients that demonstrate a 4.8

percent stroke/death rate at 30 days, and a 9.7 percent stroke/death rate at 3 to 6 month

follow up in 72 patients. In addition, the applicant submitted data from a multicenter

NIH registry of 131 patients with 70 percent or greater stenosis that demonstrate an

8.4 percent rate of stroke, intracerebral hemorrhage or death at 30 days and a 9.9 percent

rate of stroke and death at the mean 3.2 months followup.

As we noted in the FY 2008 IPPS proposed rule, while we recognize that

Wingspan® may represent a promising technology in patients with significant

intracranial arterial stenosis who are refractory to medical management, we are concerned

that, to date, there has been no controlled, randomized trial to demonstrate its clinical

efficacy (72 FR 24775). We are also concerned that the Wingspan® data did not

compare patients over the same followup periods as WASID. In addition, we are

concerned over the use of WASID patients as a control group against which to compare

Wingspan® patients. The current FDA Humanitarian Device Exemption, in combination

with the current CMS NCD, while providing access to this technology for very ill

patients with generally poor prognoses who have few other options, also effectively

designates the technology as investigational, and in need of further studies to prove its

effectiveness. We would prefer that the product's effectiveness be demonstrated before

we judge whether the product represents a substantial clinical improvement. For these

reasons, we are concerned that there may not be sufficient evidence that Wingspan®

represents an advance that substantially improves the diagnosis or treatment of Medicare

beneficiaries. However, in the proposed rule, we welcomed public comments that may

pertain to this matter.

Comment: Some commenters recommended that CMS approve Wingspan®.

None of the comments, except for a comment from the manufacturer, contained any data

or analysis in response to our concerns regarding the substantial clinical improvement

criterion. However, the manufacturer did submit a detailed comment, including two studies which were not published at the time of the initial application. One study was the original Wingspan® study used to achieve HDE status with the FDA; this study was discussed in the FY 2008 IPPS proposed rule (72 FR 24774-24775) and does not contain any new information regarding the efficacy of intracranial stenting. The second study involved a registry of 78 patients with > 50 percent stenosis treated at four U.S. institutions, and it was designed to evaluate the acute results of intracranial stenting with the Wingspan® device. Findings include a 6.1 percent major peri-procedural morbidity and mortality (5 of 78), of which 4 of 78 resulted in death within 30 days. The technical success rate was found to be 98.8 % (81/82). The authors of the study concluded that Wingspan® has a high degree of technical success, that it has an acceptable risk of peri-procedural morbidity and mortality, and that it is a viable endovascular treatment option.

The manufacturer asserted again that the Wingspan® device "addresses a treatment need for a patient population, who are unresponsive or inappropriate for other available options and otherwise face a high risk of stroke and death, if left untreated," and also that "Wingspan's self-expanding stent design represents a substantial clinical improvement over off-label balloon expandable stents because of improved access, superior conformability in curved intracranial vessels, and atraumatic deployment to reduce the risk of vessel rupture." Finally, the manufacturer asserts significantly improved outcomes in patients receiving Wingspan® compared to patients treated medically in the WASID study.

Response: We acknowledge that the Wingspan® technology has the potential to provide a new treatment option for patients who have severe intracranial arterial disease and who are failing currently available medical therapy. The FDA recognized the technology's potential by granting HDE status, and CMS did so by extending limited Medicare coverage in the context of an FDA approved clinical trial. However, neither FDA's HDE approval nor CMS's coverage with evidence development decision prove the technology's effectiveness. As we stated in the FY 2008 IPPS proposed rule, we would prefer that the product's effectiveness be demonstrated before we judge whether Wingspan® is a substantial clinical improvement in patients that otherwise would have no treatment options. We note that the studies provided by the applicant articulate the need for controlled, randomized prospective studies to determine the effectiveness of the device. Therefore, even information submitted by the applicant raises the concern that it may be premature to find the technology to be a substantial clinical improvement because its effectiveness is yet to be determined.

We remain concerned that in the absence of compelling data such as a prospective, randomized controlled study comparing similar groups of patients, there is not sufficient data to demonstrate that Wingspan® patients have better outcomes than those who receive medical treatment. Similarly, the data presented also did not demonstrate Wingspan® patients will not have *worse* outcomes than those who receive medical treatment. In addition, we do not believe that the currently available data adequately demonstrate effectiveness to qualify as a substantial clinical improvement over existing treatment, particularly in light of the very serious potential adverse events

associated with the device. For these reasons, we are not approving the Wingspan® for new technology add-on payments for FY 2008.

5. Technical Correction

Section 1886(d)(5)(K)(i) of the Act requires that the Secretary establish a mechanism to recognize the costs of new medical services and technologies under subsection (d) of section 1886 of the Act. As made clear under section 1886(d)(1)(A) of the Act, subsection (d) provides the methodology for payment with respect to the operating costs of inpatient hospital services. Section 1886(g) of the Act provides for payment of capital costs of inpatient hospital services. Although it has always been our policy that new technology add-on payment is available only with respect to operating costs, §412.88(a)(2) of our regulations does not specifically refer to operating costs or the operating CCR. Therefore, we proposed to revise §412.88(a)(2) to clarify that the new technology add-on payment is available only for operating costs, and that we estimate the costs of a case by applying the hospital's operating CCR to the billed charges.

We did not receive any public comment on this proposal. Therefore, we are finalizing the proposed revision of §412.88(a)(2) to clarify that the new technology add-on payment is available only for operating costs. This correction will not have an impact on new technology add-on payments because, to the best of our knowledge, MACs already correctly apply only the operating CCR to calculate new technology add-on payments.

III. Changes to the Hospital Wage Index

<u>A. Background</u>

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 2008 hospital wage index based on the statistical

areas, including OMB's revised definitions of Metropolitan Areas, appears under

section III.B. of the preamble of this final rule with comment period.

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 2008

is discussed in section II.B. of the Addendum to this final rule with comment period.

As discussed below in section III.I. of the preamble of this final rule with

comment period, we also take into account the geographic reclassification of hospitals in

accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating

IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is

required to adjust the standardized amounts so as to ensure that aggregate payments

under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C)

and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would

have been made absent these provisions. The budget neutrality adjustment for FY 2008

is discussed in section II.A.4.b. of the Addendum to this final rule with comment period.

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, 2007 (the FY 2008 wage index) appears under

section III.C. of the preamble of this final rule with comment period.

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). For a discussion of OMB's revised

definitions of CBSAs and our implementation of the CBSA definitions, we refer readers

to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032). The

revised area designations established by OMB 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 became classified as rural. 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. As part of that transition, we allowed

urban hospitals that became rural under the new definitions to maintain their assignment

to the Metropolitan Statistical Area (MSA) where they were previously located for the

3-year period of FY 2005, FY 2006, and FY 2007. For a discussion of the transition, we

refer readers to the FY 2005 IPPS final rule (69 FR 49032 through 49034).

    FY 2007 was the last year of the transition period for urban hospitals that became

classified as rural. Therefore, for discharges on or after October 1, 2007 (FY 2008), these

hospitals will receive their statewide rural wage index or their FY 2008 MGCRB

reclassified wage index. (These hospitals were and are eligible to apply for

reclassification by the MGCRB both during the transition period and in subsequent years.

These hospitals are considered rural for reclassification purposes.)

    Consistent with the FY 2005, FY 2006, and FY 2007 IPPS final rules, for

FY 2008 we are providing that hospitals receive 100 percent of their wage index based

upon the CBSA configurations. Specifically, for each hospital, we will determine a wage

index for FY 2008 employing wage index data from FY 2004 hospital cost reports and

using the CBSA labor market definitions. We consider CBSAs that are MSAs to be

urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of

CBSAs to be rural. In addition, where an MSA has been divided into Metropolitan

Divisions, we consider the Metropolitan Division to comprise the labor market areas for

purposes of calculating the wage index (69 FR 49029).

On December 18, 2006, OMB announced the inclusion of two new CBSAs and

the revision of designations for six areas (OMB Bulletin No. 07-01). The new CBSAs

are as follows:

● Lake Havasu-Kingman, Arizona (CBSA 29420). This CBSA comes from

Mohave County, Arizona.

● Palm Coast, Florida (CBSA 37380). This CBSA comes from Flager County,

Florida.

The revised CBSA designations are as follows:

● Mauldin, South Carolina and Easley, South Carolina qualify as new principal

cities of the Greenville-Mauldin-Easley, South Carolina CBSA.

● Conway, Arkansas qualifies as a new principal city of the Little Rock-North

Little Rock-Conway, Arkansas CBSA.

● Goleta, California qualifies as a new principal city of the Santa Barbara-Santa

Maria-Goleta, California CBSA.

● Franklin, Tennessee qualifies as a new principal city of the Nashville-

Davidson-Murfreesboro-Franklin, Tennessee CBSA.

● Fort Pierce, Florida no longer qualifies as a principal city of the Port St. Lucie-

Fort Pierce, Florida CBSA; the new designation is Port St. Lucie, Florida CBSA.

(We note also that OMB renamed the Essex County, Massachusetts Metropolitan Division as the Peabody, Massachusetts Metropolitan Division. OMB also changed the CBSA code from 21604 to 37764.)

The OMB bulletin is available on the OMB Web site at http://www.whitehouse.gov/OMB -- go to "Bulletins" or "Statistical Programs and Standards." CMS will apply these changes to the IPPS beginning October 1, 2007.

Comment: One commenter stated that the term "Core-Based Statistical Area" actually includes both Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (Micropolitan). The commenter also noted that Micropolitan Areas are considered by CMS to be part of statewide rural areas. The commenter agreed that, for the FY 2005 proposed and final rules, it was a good idea for CMS to differentiate between the old and new Census definitions by utilizing the term CBSA rather than MSA. However, the commenter suggested that, to be technically correct, CMS should now return to using the term MSAs when referring to urban areas.

Response: We disagree with the commenter that we should now use the term "MSA" rather than "CBSA" when referring to urban areas. As the commenter noted, CBSA is the broader classification for MSAs and Micropolitan Areas. Therefore, it is technically correct to refer to either MSA or Micropolitan Areas as CBSAs. Further, when it is necessary for CMS to distinguish between urban and rural areas, we specify "urban" or "rural". In addition, we believe that our labor market area terminology and definitions are explained clearly enough in the preamble of our proposed and final rules to minimize confusion.

C. Occupational Mix Adjustment to the FY 2008 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the FY 2008 Occupational Mix Adjustment

On October 14, 2005, we published a notice in the **Federal Register** (70 FR 60092) proposing to use a new survey, the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to apply an occupational mix adjustment to the FY 2008 wage index. In the proposed 2006 survey, we included several modifications based on the comments and recommendations we received on the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

We made the changes to the occupational categories in response to MedPAC comments to the FY 2005 IPPS final rule (69 FR 49036). Specifically, MedPAC

recommended that CMS assess whether including subcategories of registered nurses

would result in a more accurate occupational mix adjustment. MedPAC believed that

including all registered nurses in a single category may obscure significant wage

differences among the subcategories of registered nurses, for example, the wages of

surgical registered nurses and floor registered nurses may differ. Also, to offset

additional reporting burden for hospitals, MedPAC recommended that CMS should

combine the general service categories that account for only a small percentage of a

hospital's total hours with the "all other occupations" category because most of the

occupational mix adjustment is correlated with the nursing general service category.

In addition, in response to the public comments on the October 14, 2005 notice,

we modified the 2006 survey. On February 10, 2006, we published a **Federal Register**

notice (71 FR 7047) that solicited comments and announced our intent to seek OMB

approval on the revised occupational mix survey (Form CMS-10079 (2006)). OMB

approved the survey on April 25, 2006.

The 2006 survey 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 included only two general occupational categories: nursing and

"all other occupations." The nursing category has four subcategories: registered nurses,

licensed practical nurses, aides, orderlies, attendants, and medical assistants. The

registered nurse subcategory includes two functional subcategories: management

personnel and staff nurses or clinicians. As indicated above, the 2006 survey provided

for a 6-month data collection period, from January 1, 2006 through June 30, 2006.

However, we allowed flexibility for the reporting period begin and end dates to

accommodate some hospitals' bi-weekly payroll and reporting systems. That is, the

6-month reporting period had to begin on or after December 25, 2005, and end before

July 9, 2006.

        We are using the 6-month 2006 survey data to calculate the occupational mix

adjustment for the FY 2008 wage index. We used the 1st quarter of 2006 survey data in

the FY 2007 wage index to comply with a court decision in Bellevue Hosp. Center v.

Leavitt, 443 F.3d 163 (2nd Cir. 2006). For a discussion of our use of the 2006 survey

data in the FY 2007 wage index, in compliance with the Bellevue decision, we refer

readers to the FY 2007 IPPS final rule (71 FR 48007) as well as the FY 2007 IPPS final

notice (71 FR 59886). However, as stated above, we are using the entire 6-month 2006

survey data (that is, from the period January 1, 2006 through June 30, 2006) to calculate

the occupational mix adjustment for the FY 2008 wage index.

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

In a Joint-Signature Memorandum that we issued on April 21, 2006 (JSM-06412), and in the FY 2007 IPPS final rule (71 FR 48008), we discussed the schedule for the 1st quarter 2006 occupational mix survey data that would be used in the FY 2007 wage index. The schedule included deadlines for--

● Hospitals to submit 1st quarter occupational mix data. The deadline was June 1, 2006.

● Fiscal intermediary/MAC review of the submitted 1st quarter data. The deadline was June 22, 2006.

● Availability of the submitted first quarter data on the CMS Web site. The deadline was June 29, 2006.

● Hospitals to submit requests to their fiscal intermediary/MAC for corrections to their 1st quarter occupational mix data. The deadline was July 13, 2006.

● Fiscal intermediaries/MAC to submit corrected 1st quarter occupational mix survey data to CMS. The deadline was July 27, 2006.

In the Joint-Signature Memorandum, we also indicated that hospitals were to submit their 2nd quarter 2006 occupational mix survey data to their fiscal intermediary/MAC by August 31, 2006.   On October 6, we published on our Web site both the audited 1st quarter and unaudited 2nd quarter 2006 occupational survey data and Worksheet S-3 wage data to be used in calculating the FY 2008 wage index. In addition, we sent a letter to hospitals through their fiscal intermediary/MAC (dated October 6, 2006) that discussed the timeframe for reviewing and correcting Worksheet

S-3 wage data and the 2nd quarter 2006 survey data, and an opportunity for hospitals to request additional adjustments to their 1st quarter 2006 survey data for the FY 2008 wage index. The revision and correction process for all of the data used for computing the FY 2008 wage index is discussed in detail in section III.K. of the preamble of this final rule with comment period.

3. Calculation of the Occupational Mix Adjustment for FY 2008

For FY 2008 (as we did for FY 2007), we are calculating the occupational mix adjustment factor using the following steps:

Step 1--For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours (registered nurse management personnel and registered nurse staff nurses or clinicians are treated as separate nursing subcategories). Repeat this computation for each of the five nursing subcategories: registered nurse management personnel; registered nurse staff nurses or clinicians; licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2 – Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3--For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from

Step 1) by the national average hourly rate for that nursing subcategory (from Step 2).

Repeat this calculation for each of the five nursing subcategories.

Step 4--For each hospital, determine the adjusted average hourly rate for the total

nursing category by summing the adjusted average hourly rate (from Step 3) for each of

the nursing subcategories.

Step 5 – Determine the national average hourly rate for the total nursing category

by dividing total nursing category salaries for all hospitals in the occupational mix survey

database by total nursing category hours for all hospitals in the occupational mix survey

database.

Step 6--For each hospital, compute the occupational mix adjustment factor for the

total nursing category by dividing the national average hourly rate for the total nursing

category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing

category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average

hourly rate (indicating the hospital employs a less costly mix of nursing employees), the

occupational mix adjustment factor is greater than 1.0000. If the hospital's adjusted

average hourly rate is greater than the national average hourly rate, the occupational mix

adjustment factor is less than 1.0000.

Step 7--For each hospital, calculate the occupational mix adjusted salaries and

wage-related costs for the total nursing category by multiplying the hospital's total

salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in

section III.F. of the preamble of this final rule with comment period) 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 the preamble of this final rule with comment period).

Step 9--To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10--To compute the national occupational mix adjusted average hourly

wage, sum the total occupational mix adjusted salaries and wage-related costs for all

hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next,

divide the national occupational mix adjusted salaries and wage-related costs by the

national hours. The FY 2008 final occupational mix adjusted national average hourly

wage is $30.9133.

Step 11--To compute the occupational mix adjusted wage index, divide each

area's occupational mix adjusted average hourly wage (Step 9) by the national

occupational mix adjusted average hourly wage (Step 10).

Step 12--To compute the Puerto Rico specific occupational mix adjusted wage

index, follow Steps 1 through 11 above. The FY 2008 final occupational mix adjusted

Puerto Rico specific average hourly wage is $13.5536.

The table below is an illustrative example of the occupational mix adjustment.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupa-tional Mix Adjust-ment Factor**	**Provider % by Total**
RN Management	202,387.00	$780,640.00	**9.84%**	$50.00	**$4.92**			
RN Staff	1,439,742.00	$17,345,123.00	**70.00%**	$30.00	**$21.00**			
LPNs	67,860.00	$404,822.00	**3.30%**	$20.00	**$0.66**			
Nurse Aides	259,177.00	$1,762,579.00	**12.60%**	$13.00	**$1.64**			
Medical Assistants	87,622.00	$577,045.00	**4.26%**	$12.00	**$0.51**			
Total Nurse Hours and Salaries	2,056,788.00	$20,870,209.00			**$28.73**	**$27.00**	**0.9398**	**52.40%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**47.60%**
TOTAL	**7,056,788.00**	**$39,827,219.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	**$21.72**							
Nurse Occupational Mix Wages	**$41,030,019**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$39,655,400**	Step 7						

			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
Total Occupational Mix Wages	**$80,685,419**	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	**$21.03**	Step 8						
Hospital B								
							Nurse Occupa-tional Mix Adjustment Factor	
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**		**Provider % by Total**
RN Management	70,333.00	$680,650.00	**3.01%**	$50.00	**$1.51**			
RN Staff	1,430,114.00	$17,245,113.00	**61.27%**	$30.00	**$18.38**			
LPNs	159,795.00	$304,832.00	**6.85%**	$20.00	**$1.37**			
Nurse Aides	391,201.00	$2,762,589.00	**16.76%**	$13.00	**$2.18**			
Medical Assistants	282,728.00	$677,035.00	**12.11%**	$12.00	**$1.45**			
Total Nurse Hours and Salaries	2,334,171.00	$21,670,219.00			**$24.89**	**$27.00**	**1.0848**	**53.34%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**46.66%**
TOTAL	**7,334,171.00**	**$40,627,229.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$15,032,916**	Step 7						

All Other Unadjusted Occupational Mix Wages	$12,122,355	Step 7						
Total Occupational Mix Wages	$27,155,271	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	$24.74	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

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 2008 wage index.

For the FY 2007 wage index, if a hospital did not respond to the occupational mix

survey, or if we determined that a hospital's submitted data were too erroneous to include

in the wage index, we assigned the hospital the average occupational mix adjustment for

the labor market area (71 FR 48013). We believed this method had the least impact on

the wage index for other hospitals in the area. For areas where no hospital submitted data

for purposes of calculating the occupational mix adjustment, we applied the national

occupational mix factor of 1.0000 in calculating the area's FY 2007 occupational mix

adjusted wage index. We indicated in the FY 2007 IPPS final rule that we reserve the

right to apply a different approach in future years, including potentially penalizing

nonresponsive hospitals.

For the FY 2008 wage index, we are handling the data for hospitals that did not

respond to the occupational mix survey (neither the 1st quarter nor 2nd quarter data) in the

same manner as discussed above for the FY 2007 wage index. In addition, if a hospital

submitted survey data for either the 1st quarter or 2nd quarter, but not for both quarters, we

used the data the hospital submitted for one quarter to calculate the hospital's FY 2008

occupational mix adjustment factor. Lastly, if a hospital submitted a survey(s), but that

survey data could not be used because we determined it to be aberrant, we also assigned

the hospital the average occupational mix adjustment for its labor market area. For

example, if a hospital's individual nurse category average hourly wages were out of range

(that is, unusually high or low), and the hospital did not provide sufficient documentation

to explain the aberrancy, or the hospital did not submit any registered nurse staff salaries

or hours data, we assigned the hospital the average occupational mix adjustment for the

labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market

area, we replicated Steps 1 through 6 of the calculation for the occupational mix

adjustment. However, instead of performing these steps at the hospital level, we

aggregated the data at the labor market area level. In following these steps, for example,

for CBSAs that contain providers that did not submit occupational mix survey data, the

occupational mix adjustment factor ranged from a low of 0.8971 (CBSA 39820, Redding,

CA), to a high of 1.0731 (CBSA 19, Rural Louisiana). Also, in computing a hospital's

occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7

of the calculation), in the absence of occupational mix survey data, we multiplied the

hospital's total salaries and wage-related costs by the percentage of the area's total

workers attributable to the area's total nursing category. For FY 2008, there is one CBSA

in which none of the providers submitted the occupational mix survey (CBSA 49740,

Yuma, AZ). In the absence of any data in this labor market area, we applied an

occupational mix adjustment factor of 1.0 to all provider(s).

In the FY 2007 IPPS final rule, we also indicated that we would give serious

consideration to applying a hospital-specific penalty if a hospital does not comply with

regulations requiring submission of occupational mix survey data in future years. We

stated that we believe that section 1886(d)(5)(I)(i) of the Act provides us with the

authority to penalize hospitals that do not submit occupational mix survey data. That

section authorizes us to provide for exceptions and adjustments to the payment amounts

under IPPS as the Secretary deems appropriate. We also indicated that we would address

this issue in the FY 2008 IPPS proposed rule.

In the FY 2008 IPPS proposed rule, we solicited comments and suggestions for a

hospital-specific penalty for hospitals that do not submit occupational mix survey. In

response to the FY 2007 IPPS proposed rule, some commenters suggested a 1-percent to

2-percent reduction in the hospital's wage index value or a set percentage of the

standardized amount. We note that any penalty that we would determine for

nonresponsive hospitals would apply to a future wage index, not the FY 2008 wage

index.

Below is a summary of the public comments we received on the FY 2008 IPPS

proposed rule and our responses:

Comment: Commenters supported CMS's proposal for the FY 2008 wage index

to handle the occupational mix data for nonresponsive hospitals in the same manner as

the data were handled for the FY 2007 wage index. The commenters also opined that full

participation in the occupational mix survey is critical, and hospitals that do not

participate should not benefit from the participation of others. Several commenters

encouraged CMS to develop a methodology that encourages hospitals to report but does

not unfairly penalize neighboring hospitals.

In addition, two commenters recommended that, for future surveys, CMS should not simply provide substitute data for nonresponsive hospitals, because that data will also have an impact on other hospitals. One commenter suggested that CMS should consider a penalty for hospitals that do not respond to the occupational mix survey that would either reduce the hospital's wage index value by no more than 0.5 percentage points, or reduce the hospital's standardized amount by no more than 0.4 percentage points (the original penalty applied to hospitals that did not submit quality data). The commenter noted that, since CMS began imposing the penalty for not reporting quality data, the rate of reporting that data has increased. Another commenter suggested a penalty of a 2-percent reduction in a hospital's wage index value for nonsubmission or submission of aberrant occupational mix data. Several commenters also suggested that, if CMS decides to adopt a penalty for non-responsive hospitals, CMS should also establish an appeal process for hospitals with extenuating circumstances (for example, hospitals affected by Hurricane Katrina).

Response: As proposed, in the FY 2008 final wage index in this rule, we have assigned nonresponsive hospitals the average occupational mix adjustment for the labor market area. For areas where no hospital submitted survey data, we applied the national occupational mix adjustment factor of 1.0000 in calculating the area's FY 2008 occupational mix adjusted wage index. We appreciate the suggestions we received regarding future penalties for hospitals that do not submit occupational mix survey data. We may consider proposing a policy to penalize hospitals that do not submit occupational mix survey data for FY 2010, the first year of the application of the new 2007-2008

occupational mix survey. One option we may consider is paying hospitals that do not

submit occupational mix survey data at the same reduced IPPS rate that currently applies

to hospitals that do not submit quality data (or an update to the standardized amount that

equals the market basket less 2.0 percentage points). We agree that hospitals may have

extenuating circumstances that preclude them from submitting occupational mix survey

data and they should not be subject to a nonresponse penalty. For instance, hospitals that

do not begin operations until after the survey period would clearly be unable to provide

occupational mix survey data. There may be other extenuating circumstances as well that

warrant special consideration. The survey period for the FY 2010 occupational mix

adjustment is July 1, 2007 to June 30, 2008. Hospitals will be required to submit

occupational mix survey data from that time period to their fiscal intermediaries (or

MAC) by September 1, 2008, or one month prior to the first day of FY 2009. Therefore,

we would have more than a year to address any potential extenuating circumstances that

could apply to hospitals that do not submit survey data. If we decide to adopt a policy

that will penalize hospitals for not responding to the occupational mix survey, we will

announce it in the FY 2009 IPPS proposed rule so hospitals will be aware of the policy

prior to the deadline for submitting the data. The FY 2009 IPPS final rule will be made

available to the public by August 1, 2008.

4. 2007-2008 Occupational Mix Survey for the FY 2010 Wage Index

       As stated earlier, section 304(c) of Pub. L. 106-554 amended section

1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational

mix of employees for each short-term, acute care hospital participating in the Medicare

program. We used occupational mix survey data collected in 2006 in the FY 2007 IPPS.

Since we implemented the 2006 survey, we received several public comments suggesting

further improvements to the occupational mix survey instructions and definitions.

Specifically, some commenters recommended that we include certain employees, such as

surgical technicians and paramedics in the occupational mix adjustment. The

commenters indicated that these occupations perform similar functions, and in some

cases, are used as substitutes for nursing staff. Therefore, they recommended that CMS

include these occupations with the nursing categories on the survey. (On the 2003 and

2006 surveys, these categories were included in the "All Other Occupations" category.)

The commenters also recommended that CMS expand the list of cost centers for the

survey to include additional cost centers that contain a significant number of nursing

personnel.

        Some commenters suggested that CMS not collect occupational mix data for the

"Registered Nurse" subcategories (that is, Management Personnel and Staff

Nurse/Clinician). The commenters expressed concern that requiring the subcategories

led to errors and inconsistencies in reporting, and added to the hospitals' collection

burden. The commenters did not believe that this level of specificity significantly affects

the adjustment. Therefore they recommended that CMS eliminate the registered nurse

subcategories.

        In addition, commenters recommended that CMS provide for a 1-year data

collection period rather than a 6-month data collection period for the next survey

collection. The commenters suggested that a 1-year data collection period would provide

a better representation of a hospital's employment mix, which can vary during different times of the year. The commenters also indicated that a 1-year data collection period would allow hospitals to verify their wages and hours to year-end payroll reports and contractor invoices.

In response to these suggestions we have modified the occupational mix survey. The revised 2007-2008 occupational mix survey will provide for the collection of hospital-specific wages and hours data for a 1-year prospective reporting period from July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The revised 2007-2008 Medicare occupational mix survey will be applied beginning with the FY 2010 wage index.

On February 2, 2007, we published a notice soliciting comments on the proposed revisions to the occupational mix survey (Form CMS-10079 (2006)) (72 FR 5055). The comment period for the proposed survey ended on April 3, 2007. We are in the process of developing a final notice for publication in the **Federal Register**.

D. Worksheet S-3 Wage Data for the FY 2008 Wage Index

The FY 2008 wage index values (to be effective for hospital discharges occurring on or after October 1, 2007, and before October 1, 2008) in section II.B. of the Addendum to this final rule with comment period are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2004 (the FY 2007 wage index was based on FY 2003 wage data).

1. Included Categories of Costs

The FY 2008 wage index includes the following categories of data associated

with costs paid under the IPPS (as well as outpatient costs):

• Salaries and hours from short-term, acute care hospitals (including paid lunch

hours and hours associated with military leave and jury duty).

• Home office costs and hours.

• Certain contract labor costs and hours (which includes direct patient care,

certain top management, pharmacy, laboratory, and nonteaching physician Part A

services, and certain indirect patient care as discussed in section III.D.2. of the preamble

of this final rule with comment period).

• Wage-related costs, including pensions and other deferred compensation costs.

2. Contract Labor for Indirect Patient Care Services

In the FY 2003 IPPS final rule (67 FR 50022), we discussed the inclusion of

contract labor cost in calculating the wage index. Our policy has evolved over the years

with the increasing role of contract labor in meeting special personnel needs of hospitals.

In response to suggestions that we further expand our definition of contract labor for the

wage index, we indicated our intent to begin collecting data in future Medicare cost

reports on the following overhead services: administrative and general (A&G);

housekeeping; and dietary. We selected these three overhead services for consideration

because they are provided at all hospitals, either directly or through contracts, and

together they comprise about 60 percent of a hospital's overhead hours. Consistent with

our consideration of contract A&G services, we also stated that we would begin

collecting costs and hours data associated with other contract management services that would not be included on the cost report as overhead A&G and are not top management contracts (that is, the chief executive officer, chief financial officer, chief operating officer, and nurse administrator) that are included on Line 9 of Worksheet S-3, Part II.

We revised the cost report, beginning October 1, 2003 (the FY 2004 cost report), to provide for the collection of cost and hours data for the four identified contract indirect patient care services. We added four new line items to Worksheet S-3, Part II: Line 9.03 (Contract management and administrative services); Line 22.01 (Contract A & G services); Line 26.01 (Contract housekeeping services); and Line 27.01 (Contract dietary services). We stated in the FY 2003 final rule that our decision on whether to include these costs in calculating the wage index would depend on our analyses of the data and public comments. The FY 2008 wage index, which is based on FY 2004 cost report data, is the first year that we can assess the impact of including these costs in the wage index.

As part of the FY 2008 wage index desk review program, we required the fiscal intermediaries (or, if applicable, the MAC) to verify the accuracy of the data reported on the new Lines 9.03, 22.01, 26.01, and 27.01. As we discussed in the FY 2008 IPPS proposed rule, after completion of these reviews, some hospitals continued to fail our edits for reasonableness. Many of these edit failures were for wage data that were not to be included in the wage index and would be excluded through the wage index calculation. Some hospitals that continued to critically fail edits related to contract labor were also designated for removal from the FY 2008 wage index due to failure of other critical wage edits. In addition, some of the aberrant data were resolved through the

correction process described in section III.K. of the preamble of this final rule with

comment period. Ultimately, we believe that the amount of aberrant data on these new

line items is minimal and will have little impact on area wage index values. In addition,

we have simulated the effect of including these wage data for contract indirect patient

care services on the wage index.   We note that the results of these simulations differ

from those specified in the FY 2008 IPPS proposed rule (72 FR 24782) not only because

we used more updated and accurate wage data for the final rule analysis, but also because

of changes we incorporated into Step 2 and Step 4 of the wage index calculation for this

final rule with comment period to more accurately account for the wages and hours of

contract labor. (We refer readers to section III.G., Computation of the FY 2008

Unadjusted Wage Index, of this preamble for a more detailed explanation of the changes

to the wage index calculation).

        Under this simulation, we found that the resulting average hourly wage will not be

affected for 3,032 hospitals (85.0 percent), will decrease for 327 hospitals (9.2 percent),

and will increase for 209 hospitals (5.9 percent). The average hourly wage for 12

hospitals will decline by 5 percent or greater (the largest being 7.8 percent). The average

hourly wage for 67 hospitals will decline between 1 and 5 percent. Twenty-one hospitals

are experiencing an increase of 1 percent or greater in average hourly wage from this

policy, with the increase for 2 of these hospitals being larger than 5 percent (the largest

increase is 7.8 percent.) At the labor market area level, we found that the resulting

average hourly wage will not affect 232 areas (53.3 percent), will decrease for 132 areas

(30.3 percent), and will increase for 71 areas (16.3 percent). The wage index of 13 areas

will decrease between 1 percent and 5 percent, with the largest decrease for an urban area

being 4.07 percent and the largest decrease for a rural area being 0.63 percent. The

largest increase in an area's wage index is 0.69 percent for an urban area and 0.30 percent

for a rural area.

As a result of the correction, and using the final data, the combined effect on the

FY 2008 wage index of including the new contract labor lines 9.03, 22.01, 26.01, and

27.01 is the following for hospitals:

Percent Change to Wage Index	Number of Hospitals
Greater than -5 percent	0
-1 percent to -5 percent	47
Between -1 percent and +1 percent	3,522
+1 percent to +5 percent	0
Greater than +5 percent	0

The wage index values for 98.7 percent of all hospitals will change by less than

1 percent, and 119 hospitals (3.3 percent) will experience no change as a result of

including the new contract labor lines. We believe that the combined effect of including

these costs in the wage index is negligible because the higher labor costs associated with

contract management and A&G services are offset by the lower labor costs associated

with contract housekeeping and dietary services.

Public commenters have expressed interest in including in the wage index the

costs and hours for contract management, A&G, housekeeping, and dietary services. We

also believe that including a more comprehensive measure of area differences in the cost

of labor will improve the accuracy of the wage index. For these reasons, we are

including these contract services in the wage index, beginning with FY 2008.

In the FY 2008 IPPS proposed rule, we invited public comment on whether we

should revise a future cost report to collect contract labor data for the remaining indirect

patient care cost centers on Worksheet S-3, Part II for possible inclusion in the wage

index. We indicated that we would consider these comments in the context of potential

reforms of the IPPS wage index for FY 2009 and subsequent years. As indicated in

section III.M. of the preamble of this final rule with comment period, section 106(b) of

the MIEA-TRHCA (Pub. L. 109-432) requires the Secretary to consider a MedPAC study

and nine specific aspects of the wage index in making one or more proposals for

revisions in FY 2009.

Comment: Several commenters stated that they supported including salaries and

hours for contract indirect patient care services in the wage index, as it discourages

hospitals from outsourcing in order to raise their average hourly wage for the wage index.

However, they noted that CMS had made an error in computing the wage index in the

proposed rule with regards to lines 22.01, 26.01, and 27.01. The new lines were included

in Step 4 of the calculation (the step that allocates a portion of overhead wages and

wage-related costs to excluded areas, and then subtracts the associated amount from total

wages and wage-related costs). However, lines 22.01, 26.01, and 27.01 were not

included in total wages in Step 2. Therefore, an amount for overhead wages and

wage-related costs for excluded areas was subtracted from total wages that did not

include those costs. The commenters requested that CMS correct the calculation and

reassess the impact on hospitals of including the new contract indirect patient care

services in the wage index.

Some commenters recommended that CMS provide a transition if the impact of

including overhead contract labor costs in the wage index on any hospital is great. One

commenter suggested that CMS should provide a 2-3 year transition for labor market

areas that have more than a 2 percent reduction in the wage index. In addition, the

commenter urged CMS to revise future cost reports to collect the remaining contract

labor indirect patient care costs on Worksheet S-3, Part II for possible inclusion in the

wage index.

Response: We appreciate the commenters bringing to our attention the error in

the proposed wage index calculation. As indicated above, we have corrected the

calculation.

As discussed above, we believe the impact of this policy is generally very minor,

and we do not believe the additional complexity of a transition wage index is warranted

for an impact this small. Further, we continue to believe it is prudent policy to include in

the wage index the costs for these contract indirect patient care services. Therefore, we

are adopting this policy, beginning with the FY 2008 wage index. We will consider the

inclusion of contract labor costs associated with the remaining indirect cost centers on

Worksheet S-3, Part II, in our study of wage index reforms for FY 2009 and future years.

3. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2007, the wage index for

FY 2008 also excludes the direct and overhead salaries and hours for services not subject

to IPPS payment, such as SNF services, home health services, costs related to GME

(teaching physicians and residents) and certified registered nurse anesthetists (CRNAs),

and other subprovider components that are not paid under the IPPS. The FY 2008 wage

index also excludes the salaries, hours, and wage-related costs of hospital-based rural

health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare

pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and

wage-related costs of CAHs are excluded from the wage index, for the reasons explained

in the FY 2004 IPPS final rule (68 FR 45397).

4. Use of Wage Index Data by Providers Other Than Acute Care Hospitals under the

IPPS

        Data collected for the IPPS wage index are also currently used to calculate wage

indices applicable to other providers, such as SNFs, home health agencies, and hospices.

In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for

hospital outpatient services. We note that, in the IPPS rules, we do not address comments

pertaining to the wage indices for non-IPPS providers. Such comments should be made

in response to separate proposed rules for those providers.

E. Verification of Worksheet S-3 Wage Data

        The wage data for the FY 2008 wage index were obtained from Worksheet S-3,

Parts II and III of the FY 2004 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 includes

FY 2004 data submitted to us as of February 26, 2007. As in past years, we performed an

intensive review of the wage data, mostly through the use of edits designed to identify

aberrant data.

We asked our fiscal intermediaries/MAC to revise or verify data elements that

resulted in specific edit failures. For the proposed FY 2008 wage index, we identified

and excluded 23 hospitals with data that was too aberrant to include in the proposed wage

index, although we stated that if these data elements were corrected, we intended to

include some of these providers in the FY 2008 final wage index. However, because

some unresolved data elements were included in the calculation of the proposed FY 2008

wage index, we instructed fiscal intermediaries/MAC to complete their data verification

of questionable data elements and to transmit any changes to the wage data no later than

April 13, 2007. While the data for some hospitals were resolved, the data for some other

hospitals were identified as too aberrant to include in the final wage index. Therefore, we

determined that the data for 30 hospitals should not be included in the FY 2008 final

wage index.

In constructing the FY 2008 wage index, we include the wage data for facilities

that were IPPS hospitals in FY 2004, 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. For this final rule with comment period, we removed 19

hospitals that converted to CAH status between February 17, 2006, the cut-off date for

CAH exclusion from the FY 2007 wage index, and February 16, 2007, the cut-off date

for CAH exclusion from the FY 2008 wage index. After removing hospitals with

aberrant data and hospitals that converted to CAH status, the FY 2008 wage index is

calculated based on 3,569 hospitals.

F. Wage Index for Multicampus Hospitals

        As discussed earlier under section III.B. of the preamble of this final rule with

comment period, effective October 1, 2004, for the IPPS, CMS implemented new labor

market areas based on the CBSA definitions of MSAs. As a result of these labor market

areas, there are multicampus hospitals previously located in a single MSA that are now

located in more than one CBSA. A multicampus hospital is a single integrated

institution. For this reason, the multicampus hospital has one provider number and

submits a single cost report that combines the total wages and hours of each of its

campuses. When campuses of a multicampus hospital are located in the same CBSA, the

wages and hours for the entire institution are included in the calculation of the wage

index for that labor market area and there is no need to separate the data by campus.

However, when a multicampus hospital has campuses located in different labor market

areas, wages and hours are reported in a single CBSA even though the hospital's staff is

working at campuses in more than one labor market area. The wage data are reported in

the labor market area of the hospital campus associated with the provider number.

Wages and hours are not reported separately for each campus and no data from the

multicampus hospital are used in determining the wage index for the labor market area(s)

where the other campus(es) are located. Under §412.64(b)(5) of our regulations, the

wage-adjusted standardized amount is based on geographic location of the hospital facility at which the discharge occurred. Therefore, the wage index for each hospital campus used to make the IPPS payment is based on its geographic location, while the wage data from all of the campuses, including those that may be located in a different geographic area, are applied to one area only. We have received inquiries from several hospitals suggesting that we should adopt a policy that results in an allocation of a multicampus hospital's wages and hours across the different labor market areas where its campuses are located.

The wage index was developed to adjust the IPPS standardized amount to reflect area differences in hospital wage levels in the hospital's geographic area compared to the national hospital wage level as required under section 1886(d)(3)(E) of the Act. Although we acknowledge that reporting the wage data into a single labor market area when individual campuses of a multicampus hospital are located in different labor market areas may not allocate wage data with exact precision, the Medicare cost report, in its current form, does not enable a multicampus hospital to separately report its costs by location. The fact that a multicampus hospital submits a single cost report reflects that it is an integrated institution with one accounting structure. Nevertheless, we agree with the comments brought to our attention that we should consider a policy that allocates a multicampus hospital's wages and hours among the different labor market areas where it is located. That is, rather than giving 100 percent of the hospital's wage data to the labor market area associated with its provider number, we believe that an allocation of its wage data should be made to each campus.

We considered three alternative methods of apportionment: beds, discharges, or FTE staff. A hospital's number of discharges can fluctuate from year to year and may be an unstable data source to use in allocating a hospital's wages and hours among the different campuses. Alternatively, while a hospital's number of beds is a more static number, it likely does not correlate well with how a hospital incurs its wage costs. Furthermore, neither of these numbers is available on a campus-specific basis in Medicare's data systems. (While an individual campus of a multicampus hospital located in a different labor market area than the remainder of the institution is required to indicate a suffix on its provider number when submitting a claim in order to receive payment using the wage index for its geographic location, the suffix is only used by the fiscal intermediary (or, if applicable, the MAC) and is not retained in Medicare's historical data files that we use to determine IPPS rates).

Given the unavailability of beds and discharges and their respective drawbacks for allocating wages and hours across multiple campuses, in the FY 2008 IPPS proposed rule, we proposed to apportion wages and hours for each campus of a multicampus hospital based on FTE staff. For example, a multicampus hospital may have three campuses located in two different labor market areas. Campuses A and B are located in labor market area 1 and have 50 and 25 FTEs, respectively. Campus C is located in labor market area 2 and has an additional 25 FTEs. Therefore, 75 percent of the hospital's FTEs work in labor market 1 and 25 percent in labor market area 2. Under the proposed policy, we would apportion 75 percent of the hospital's occupational mix adjusted total salaries, wage-related costs and hours to labor market 1 and 25 percent to labor market 2.

We believe that the number of FTEs will provide the best method of apportioning wages and hours among the different campuses, thereby allowing the apportioned wage data to be included in each geographic area where the hospital has employees working.

We indicated that the proposed policy would require the identification of all multicampus hospitals located in more than one CBSA, the county, State, and zip code of each campus, and the campus-specific number of FTEs. Based on our comprehensive interactions with our fiscal intermediaries since adopting the revised labor market areas beginning in FY 2005, we are only aware of three multicampus hospitals that are located in more than one labor market area. We are beginning the process to make updates and refinements to the cost report for the future. We are currently planning to add additional lines to Worksheet S-2 of the cost report that will allow a multicampus hospital to report the locations of its different campuses (county, State, and zip code) and number of FTE staff by location so this information would become part of the cost report submission process. The effective date of the revised cost report is not expected until FY 2009. Therefore, we would not have data from multicampus hospitals under our normal wage data collection process to be able to allocate wages to each labor market area by FTEs until at least the FY 2013 wage index. In the interim, we proposed to collect this information from multicampus hospitals on a small survey form through our fiscal intermediaries/MAC as part of the wage index desk review process beginning with the FY 2009 wage index. In the proposed rule, we indicated that we will not be able to apply this policy to the FY 2008 wage index unless we have this information from multicampus hospitals prior to the close of the comment period for the proposed rule. Therefore, for

the FY 2008 wage index, we indicated that multicampus hospitals with campuses located

in more than one geographic area should submit the information during the comment

period on the proposed rule for the county, State, and zip code of its campuses, and the

FTE number, including contract labor, per campus along with supporting documentation.

We stated that the hospitals should submit data from their FY 2004 cost reporting

period to match the same data that will be used for the FY 2008 wage index. However, if

unavailable, the hospital may submit the data for a subsequent cost reporting period that

is closest to the FY 2004 reporting period that provides the information in order to

apportion the hospital's wage data among its campuses. These data will enable CMS to

apportion the wages and hours of the multicampus hospital among its different campuses

for use in the FY 2008 wage index calculations should the proposal become final.

As stated earlier, we are only aware of three hospitals that would be affected by

this information collection request. As stipulated under 5 CFR 1320.3(c)(4), the

proposed information collection request is exempt from the Paperwork Reduction Act

(PRA) as it does not affect 10 or more persons within a 12-month period. In the proposed

rule, we stated that if, during the IPPS rule comment period, we determine the number of

affected persons surpasses the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we

would not adopt the policy until FY 2009 in order for us to seek the requisite approval

from OMB under the PRA. As we discuss below, only two hospitals are affected by the

data submission. Therefore, the information collection is exempt from the PRA.

Comment: Several commenters were supportive of our proposed policy to

include the wages and hours of each campus of a multicampus hospital in the wage index

calculation of its respective CBSA, as opposed to the current situation where all wages

and hours for the entire hospital are included in the CBSA where the campus associated

with the provider number is located. However, the commenters urged that we exercise

flexibility with respect to the basis for allocating the wage data among the campuses.

Some commenters stressed the difficulty for hospitals with fully integrated operations to

collect data and determine an FTE count for each campus, particularly in light of the

short timeframe to submit this information. One commenter suggested three alternative

approaches to allocating wage data that may be much less administratively burdensome

than collecting FTE information: Medicare discharges; Medicare inpatient and outpatient

reimbursement; and number of beds.

        Another commenter, a multicampus hospital, believed that providing FTEs for

each campus is extremely burdensome, given the fully integrated structure of its

organization. The commenter stated that over half of the organization's employees have

responsibilities at two and three of its campuses. The commenter indicated that some

types of employees, such as those involved with information services and human

resources, spend time at all three campuses and nurses move from facility to facility

depending on need. While this commenter offered support for CMS' proposal, the

commenter also suggested that there are better, simpler, and easier methods to consider.

The commenter suggested that CMS allow discharges as the basis for allocating salaries

and hours among campuses. Another multicampus hospital recommended that, in order

to determine the FTEs per campus, CMS should allow multicampus hospitals to use a

methodology that allocates the wages and hours of staff not directly assigned to a single

campus using the same proportions as the staff that are directly assigned to a single

campus.

There was consensus among the commenters that the benefit of having more

accuracy in the wage index calculations should outweigh concerns over which alternative

methods to use in of allocating salaries and hours, particularly as it relates to FY 2008

and the time constraints involved. Moreover, one commenter believed that discharge

data from its campuses would be a more accurate means of allocating at this point

because there was not enough time to accurately assign FTEs to each campus. Another

commenter pointed out that to not allocate salaries and hours to each campus runs

contrary to Congress' intent when it established the area wage adjustment and the method

is not as important as is the result.

Response: For the FY 2008 wage index, we received the requested data from one

multicampus hospital. Although the hospital stated some of the concerns summarized in

the comments above about the difficulty of providing these data, it was able to provide

FTEs per campus by the close of the comment period on June 12, 2007. We appreciate

the efforts this multicampus hospital made to provide the requested data, given the short

timeframe and the difficulty it reported in collecting the data.

Another commenter submitted a multicampus hospital's number of beds and

suggested that CMS use this information to allocate the multicampus hospital's wages

and hours by campus in the absence of the number of FTEs if the multicampus hospital

did not provide the requested information.

We continue to believe that using FTE data is the most appropriate methodology

for apportioning salaries and hours among the campuses. However, in light of the

comments and after further consideration, we have concluded that, given the time

constraints, it is reasonable to use Medicare discharge data in the absence of FTE data

until we have a routine process for collecting this information via Worksheet S-3 of the

Medicare cost report. Although we stated in the proposed rule that discharge data are not

available on a campus-specific basis in Medicare's data systems, we have since

determined that the data can be obtained through the local systems of the fiscal

intermediaries/MAC. We believe that Medicare discharge data, although not ideal for

allocating salaries and hours, provide a reasonable indication of staffing requirements for

each campus. We continue to believe that the number of beds does not correlate well

with how a hospital incurs its wage costs. A hospital's bed size alone, without its

occupancy rate, does not necessarily reflect a hospital's staffing needs, whereas the

number of discharges does provide a more accurate measure of a hospital's staffing

requirements. Therefore, we have chosen not to use the number of beds as an alternative

method for allocating wage data to the campuses of multicampus hospitals in the absence

of FTE data. Therefore, as our final policy, and as reflected in the FY 2008 wage index

in this final rule with comment period, we are using FTEs or Medicare discharge data to

allocate salaries and hours to the campuses of multicampus hospitals that are located in

different labor markets. We will continue the policy of using annually reported FTEs or

Medicare discharges to allocate wage data by campus until revisions are made to

Worksheet S-3 of the Medicare cost report to require reporting of FTE data by campus,

and until such data in the cost report can be used to calculate the wage index, at which

time the wage data of a multicampus hospital will be allocated among its campuses based

only on reported FTE counts by campus. Once Worksheet S-3 of the Medicare cost

report is revised to require reporting of FTE data by campus, all multicampus hospitals

that cross labor market area boundaries will have to provide the FTE data by campus on

the cost report.

We agree with the commenter that suggested that hospitals should be allowed to

report the number of directly assigned staff to each campus, and all other employees can

be allocated to each campus using the same proportions as the directly assigned staff.

Once revisions to the cost report have been made, we will provide further detailed

instructions for how to report FTE data by campus.

Also, until the cost report data can be used to allocate wages and hours,

multicampus hospitals having campuses that are located in more than one labor market

are to report their FTEs or Medicare discharge data to CMS during the comment period

for the respective IPPS update. Therefore, for the FY 2009 wage index, such hospitals

are to report their FTEs or Medicare discharge data during the FY 2009 comment period.

If a multicampus hospital that crosses labor market areas fails to submit FTE or Medicare

discharge data, and CMS is aware that the hospital meets this criteria, CMS will

automatically allocate the hospital's wages and hours to its campuses based on Medicare

discharge data obtained from the intermediary/MAC. Given the consensus among

commenters that the benefit of having more accuracy in the wage index calculations

outweighs concerns over which alternative methods to use in allocating wage data, we

believe that it is a reasonable policy to automatically allocate a hospital's wage and hours based on discharge data in the absence of FTE data.

For the FY 2008 wage index, we allocated salaries and hours to the campuses of two multicampus hospitals. One Illinois hospital submitted FTEs per campus. Two of their three campuses are located in Cook County, the Chicago-Naperville-Joliet, IL CBSA, with 60.61 percent of their FTEs at one of the campuses and 17.18 percent of the FTEs at the other campus. The third campus is located in Lake County, Lake County-Kenosha County, IL-WI CBSA, and has 22.21 percent of the hospital's FTEs.

As recommended by the second multicampus hospital, which is located in Massachusetts, we used Medicare discharge data to allocate salaries and hours to its campuses. The hospital also has three campuses with two of them located in Bristol County, the Providence-New Bedford-Fall River, RI-MA CBSA, and the third campus located in Plymouth County, the Boston-Quincy CBSA. The two campuses in Bristol County have 90 percent of the Medicare discharges, while the campus in the Boston-Quincy area has 10 percent of Medicare discharges.

Based on the above proportions, we allocated the hospitals' salaries and hours to the respective CBSAs of each campus. For wage index calculation purposes, we created two new records for each of these providers, one record for each CBSA allocation. Although we are not including a separate entry for each campus in Table 2, as discussed in section III.I.7. of the preamble of this final rule with comment period, each campus's wage data will be included in a public use file, "Three Year MGCRB Reclassification Data for FY 2009 Application," that will be posted on the CMS Web site at:

http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage, concurrent with

the publication of this final rule with comment period. As discussed in section III.I.7. of

the preamble of this final rule with comment period, these campus-specific data will be

considered appropriate wage data for reclassification under §§412.230. 412.232 and

412.234 because they will be part of the CMS hospital wage survey used to construct the

wage index. We consider these data to constitute "published hospital wage survey data"

under section 1886(d)(10)(D)(vi) of the Act. The wage indices for the four affected

CBSAs were recalculated with the following results:

FY 2008 Final Pre-Reclassification Occupational Mix Adjusted Wage Index

CBSA	Wage and Hour Allocation	Wage Index (without allocation)	Wage Index (with allocation)
Massachusetts			
Boston-Quincy, MA (14484)	10.0%	1.1736	1.1883
Providence-New Bedford-Falls River, RI-MA (39300)	90.0%	1.0645	1.0567
Total	100%	--	--
Illinois			
Chicago-Naperville-Naperville, IL (16974)	77.8%	1.0643	1.0623
Lake County-Kenosha County, IL-WI (29404)	22.2%	1.0341	1.0618
Total	100%	--	--

*The final FY 2008 post-reclassified wage indices are included in Table 4A of the
Addendum to this final rule with comment period.

G. Computation of the FY 2008 Unadjusted Wage Index

1. Method for Computing the FY 2008 Unadjusted Wage Index

        The method used to compute the FY 2008 wage index without an occupational

mix adjustment follows:

Step 1--As noted above, we based the FY 2008 wage index on wage data reported

on the FY 2004 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, 2003, and before October 1, 2004. In addition, we include data from

some hospitals that had cost reporting periods beginning before October 2003 and

reported a cost reporting period covering all of FY 2004. These data are included

because no other data from these hospitals would be available for the cost reporting

period described above, and because particular labor market areas might be affected due

to the omission of these hospitals. However, we generally describe these wage data as

FY 2004 data. We note that, if a hospital had more than one cost reporting period

beginning during FY 2004 (for example, a hospital had two short cost reporting periods

beginning on or after October 1, 2003, and before October 1, 2004), 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. (We note that, as we stated in

section III.D.2. of this final rule with comment period, we are including lines 22.01,

26.01, and 27.01 of Worksheet S-3, Part II for overhead services in the wage index

beginning in FY 2008. However, because these lines were only used for purposes of data

collection up to this point, and had not been incorporated into the wage index or onto line

101 of Worksheet A, the electronic cost reporting software had not been modified to incorporate these 3 line items, for wages and hours respectively, into line 1 of Worksheet S-3, Part II. Therefore, the first step in the wage index calculation for FY 2008 is to compute a "revised" Line 1, by adding to the Line 1 on Worksheet S-3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3--Hours--With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4--For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S-3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S-3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S-3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) we determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours, since hospitals typically do not provide fringe benefits (wage-related costs) to contract personnel. Therefore, it is not necessary for the wage index calculation to exclude overhead wage-related costs for contract personnel. Further, if a hospital does contribute to wage-related costs for contracted personnel, the instructions for lines 22.01, 26.01, and 27.01 require that associated wage-related costs be

combined with wages on the respective contract labor lines.); (2) we compute overhead

wage-related costs by multiplying the overhead hours ratio by wage-related costs

reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead

wage-related costs by the above excluded area hours ratio. Finally, we subtract the

computed overhead salaries, wage-related costs, and hours associated with excluded areas

from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5--For each hospital, we adjust the total salaries plus wage-related costs to a

common period to determine total adjusted salaries plus wage-related costs. To make the

wage adjustment, we estimate the percentage change in the employment cost index (ECI)

for compensation for each 30-day increment from October 14, 2003, through

April 15, 2005, for private industry hospital workers from the BLS' Compensation and

Working Conditions. We use the ECI because it reflects the price increase associated

with total compensation (salaries plus fringes) rather than just the increase in salaries. In

addition, the ECI includes managers as well as other hospital workers. This methodology

to compute the monthly update factors uses actual quarterly ECI data and assures that the

update factors match the actual quarterly and annual percent changes. We also note that,

since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different

classification system, the North American Industrial Classification System (NAICS),

instead of the Standard Industrial Codes (SICs), which no longer exist. We have

consistently used the ECI as the data source for our wages and salaries and other price

proxies in the IPPS market basket and are not making any changes to the usage at this

time. However, in the proposed rule, we solicited comments on our continued use of the

BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI. 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
10/14/2003	11/15/2003	1.05743
11/14/2003	12/15/2003	1.05355
12/14/2003	01/15/2004	1.04964
01/14/2004	02/15/2004	1.04578
02/14/2004	03/15/2004	1.04198
03/14/2004	04/15/2004	1.03830
04/14/2004	05/15/2004	1.03482
05/14/2004	06/15/2004	1.03153
06/14/2004	07/15/2004	1.02821
07/14/2004	08/15/2004	1.02466
08/14/2004	09/15/2004	1.02086
09/14/2004	10/15/2004	1.01705
10/14/2004	11/15/2004	1.01344
11/14/2004	12/15/2004	1.01003
12/14/2004	01/15/2005	1.00671
01/14/2005	02/15/2005	1.00336
02/14/2005	03/15/2005	1.00000
03/14/2005	04/15/2005	0.99663

For example, the midpoint of a cost reporting period beginning January 1, 2004,

and ending December 31, 2004, is June 30, 2004. An adjustment factor of 1.02821

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 2004 and covered a

period of less than 360 days or more than 370 days, we annualize the data to reflect a

1-year cost report. Dividing the data by the number of days in the cost report and then

multiplying the results by 365 accomplishes annualization.

Step 6--Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7--We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8--We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage (unadjusted for occupational mix) is $30.9346.

Step 9--For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10--Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly

wage as described above.) We add the total adjusted salaries plus wage-related costs (as

calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours

for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage

(unadjusted for occupational mix) of $13.5584 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 FY 2008, this change affects 340 hospitals in 68 urban areas.

The areas affected by this provision are identified by a footnote in Table 4A in the

Addendum of this final rule with comment period.

2. Expiration of the Imputed Floor

Section 4410 of Pub. L. 105-33 provides that 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 of that State ("the rural floor"). There

are two States that have no rural areas (New Jersey and Rhode Island) and one State that

has rural areas but no IPPS hospitals located in the rural areas of the State

(Massachusetts). In the FY 2005 IPPS final rule (69 FR 49109), we temporarily adopted

an "imputed" floor measure to address a concern by some individuals that hospitals in all-

urban States were disadvantaged by the absence of rural areas, because there is no floor

within the State. We limited application of the policy to FYs 2005, 2006, and 2007 and

indicated our intent to make additional changes to the policy or eliminate it for fiscal

years after FY 2007.

In FY 2008, the rural floor will apply to 340 hospitals in 24 States. If the imputed

rural floor were to continue into FY 2008, it would apply to an additional 30 hospitals in

New Jersey. In FY 2007, 40 hospitals in 10 urban areas received higher wage indices due

to the imputed floor policy: Massachusetts (10 hospitals in 2 areas); New Jersey (30

hospitals in 8 areas); Rhode Island (no areas and no hospitals). In Massachusetts, the

imputed rural floor will no longer apply because one hospital acquired rural status under

§412.103. We note that if a State has a hospital reclassified as rural under §412.103, the

State will be considered to have IPPS hospitals located in rural areas because, in this

case, the reclassified hospital is treated as being located in a rural area in accordance with

section 1886(d)(8)(E) of the Act. This policy also accords with how we defined an "all-

urban State" under §412.64(h)(5) of the regulations, which specifies that "A State with

rural areas and with hospitals reclassified as rural under §412.103 is not an all-urban

State." Therefore, in the case where a State has no hospitals that are geographically

located in its rural areas, and one or more hospitals in the State are reclassified as rural

under §412.103, the data for the reclassified rural hospitals will be used to set the rural

floor for the State until a new geographically located rural hospital opens and data are

available from that hospital (as noted above, 4 years later) to compute the rural floor.

In the FY 2008 IPPS proposed rule, we proposed to discontinue the imputed floor

policy after the FY 2007 wage index. We stated that after further considering the issue,

we do not believe that it is necessary to have an "imputed" rural floor in States that have

no rural areas or no rural hospitals. As discussed above, the imputed floor would not

apply to two of the three States: it is not necessary for Rhode Island and it is no longer

necessary for Massachusetts. In addition, we stated that the imputed rural floor

methodology creates a disadvantage in the application of the wage index to hospitals in

States with rural hospitals but no urban hospitals receiving the rural floor. Because the

application of a rural floor requires a transfer of payments from hospitals in States with

rural hospitals but where the rural floor is not applied to hospitals in States where either a

rural or imputed floor is applied, we stated that we believed the policy should apply only

when required by statute. Thus, only States with both rural areas and hospitals located in

such areas (including any hospital reclassified under §412.103) would benefit from the

rural floor, as required by Congress.

However, in light of the public comments, we believe it appropriate to transition

the expiration of the imputed rural floor over a 2-year period. We will continue the

imputed rural floor for FY 2008, but allow it to expire in FY 2009. Thus, beginning in

FY 2009, only States with both rural areas and hospitals located in such areas (including

any hospital reclassified under §412.103) would benefit from the rural floor, as required

by Congress.

As in past years, we applied a budget neutrality adjustment to the standardized

amount to ensure that payments remained constant to payments that would have occurred

in the absence of the imputed rural floor policy.

Comment: Several commenters in States affected (and potentially affected) by the imputed floor policy questioned whether CMS has given enough reason to allow the imputed floor provision to expire. They mentioned that the imputed floor was created to protect all-urban States by offering them a wage index protection similar to that offered to other States with a rural floor. The commenters noted that the rationale behind creating the imputed floor still exists and that hospitals benefiting from the policy were counting on it to continue. The commenters added that because CMS has used its broad authority to enact other policies absent statutory authority, many of them disagreed with CMS' contention that an imputed floor system should be applied only if required by statute. The commenters requested that CMS consider the severe negative financial impact of its proposed policy on several New Jersey hospitals, and requested a rationale to justify the estimated 0.2 percent decrease in urban hospital reimbursement rates resulting from the expiration of the imputed floor. Other commenters explained that about 8 Massachusetts hospitals would experience a decrease in Medicare payments of $8 million, or 3.9 percent of their Medicare inpatient and outpatient revenue, if CMS no longer imputes a rural floor for that State. Some commenters stated that as the number of States utilizing the imputed floor decreases, the original rationale of protecting States with "unique circumstances" holds more true today than when originally proposed.

One commenter supported CMS's proposal to discontinue the imputed floor because it agreed that this type of floor should only apply when required by statute.

Response: With respect to the impact on payment for Massachusetts hospitals from discontinuing the imputed rural floor, we note that an urban hospital applied to be

redesignated as rural under 42 CFR §412.103. Therefore, as this hospital was approved

for an urban-to-rural designation, it is now considered to be rural for purposes of its IPPS

payments. Therefore, its wage index will set the rural floor for Massachusetts, and the

imputed rural floor would no longer apply in Massachusetts. Thus, the payment impact

of concern to the commenter about hospitals in Massachusetts would occur irrespective

of whether we continued the imputed rural floor. (We refer readers to the next

comment/response for more information about this issue.)

The imputed floor was originally authorized for only 3 years. In the FY 2005

IPPS final rule (69 FR 49110), we indicated that during the 3 years that the policy is in

effect, we would determine whether to make additional changes to the policy or eliminate

it. Given that we had indicated in the FY 2005 IPPS final rule that the provision was set

to expire after 3 years, we believe that hospitals in all urban States should not have been

relying on the policy to continue. Hospitals in these States were given a reasonable

expectation that the policy would expire after 3 years.

The intent of the imputed floor was to create a protection for all-urban States

similar to the protection offered to urban-rural mixed States by the rural floor. However,

about 50 percent of urban-rural mixed States do not benefit from the rural floor provision

because, in those States, the urban wage indices are all above the rural floor. Thus, like

hospitals in all urban States prior to the creation of the imputed rural floor, hospitals in

these States do not receive any benefit from a rural floor.

We further note that the imputed rural floor provides a guaranteed benefit for

certain all-urban States that is not guaranteed to hospitals in urban-rural mixed States.

Specifically, the imputed rural floor methodology creates a mathematical certainty that

New Jersey hospitals will benefit from the imputed rural floor and Rhode Island hospitals

will not. The imputed rural floor is based on a comparison of the average of the ratios of

the lowest-to-highest wage indices of all of the all-urban States to the ratio of the lowest-

to-highest wage index of each of those States individually. For each State, we then take

the higher of the State-specific ratio and the average of the ratios of the all-urban States

and multiply it by the highest area wage index applicable in the State. The product

becomes the imputed floor below which no wage index in the State could fall. The ratio

of the lowest-to-highest wage index within each State multiplied by the highest wage

index will never provide any benefit to hospitals within an individual State. This

calculation will only set the floor equal to the wage index that is already the lowest within

the State. The methodology can only have a benefit to hospitals within a State if its

State-specific ratio of the lowest-to-highest wage index is lower than the average of these

ratios across all of the all urban States. New Jersey will always have a lowest-to-highest

wage index ratio of less than 1.0 because it has more than one labor market area. Rhode

Island has only one labor market area so the ratio of its lowest-to-highest wage index will

always be 1.0. As long as Rhode Island has only one labor market area, New Jersey will

always have the lower ratio of the lowest-to-highest wage index among these two States,

and thus New Jersey's ratio of the lowest-to-highest wage index will always be lower

than the average of these ratios for New Jersey and Rhode Island. By contrast, Rhode

Island's ratio of the lowest-to-highest wage index will always be higher than the average

of these two States (and all three all urban States if the imputed rural floor were still

applicable in Massachusetts) and it can never obtain any benefit. Thus, the provision, as

currently formulated, provides a guaranteed benefit to New Jersey hospitals that is not

afforded to mixed urban-rural States, and no protection at all for Rhode Island hospitals.

The imputed floor was never intended to provide an exclusive and unending benefit to a

single state. Because, in the current system, New Jersey would always have hospitals

benefiting from the imputed floor, and only slightly more than half of all urban-rural

mixed States have hospitals benefiting from the rural floor, we no longer view the

imputed floor as being a protective measure.

However, in light of the public comments, we believe it appropriate to transition

the expiration of the imputed rural floor over a 2-year period. We will continue the

imputed rural floor for FY 2008, but beginning with the FY 2009 wage index, we will no

longer apply an imputed floor policy for all-urban States. .

Comment: One commenter questioned whether Massachusetts should indeed lose

its imputed floor due to a hospital acquiring an urban-to-rural reclassification under

42 CFR 412.103. The commenter noted that the "hold harmless" provisions (in section

1886(d)(8)(C) of the Act) protect a State's rural floor from being unduly reduced due to

the effects of reclassification/redesignation. The commenter believed the imputed floor

should be treated in a similar manner.

Response: As discussed in section III.I.2. of the preamble of this final rule with

comment period, we have a policy that precludes an urban-to-rural redesignation under

§412.103 from reducing the rural wage index. However, when no hospitals are

geographically located in a rural area, or when no rural hospitals' wage data can be used

to calculate the rural wage index, there is no rural wage index. Therefore, the urban-to-rural redesignation is not reducing the rural wage index. Rather, the data of the redesignated hospital establish the rural wage index. The imputed floor was intended to be applied in states where a rural floor could not be calculated and is rendered moot when an urban-to-rural redesignation within a State establishes a situation where a rural floor can be calculated. Therefore, we disagree with this commenter and are calculating a rural wage index for Massachusetts based on the average hourly wage for the one hospital that has been redesignated as rural. This rural wage index will become the rural floor for Massachusetts hospitals for FY 2008.

For all of the reasons stated above, we are not continuing the imputed rural floor in fiscal years after FY 2008. Nevertheless, we recognize that we still need a policy for determining the rural wage index when a new IPPS hospital opens in a State that has rural areas, but no IPPS hospitals. There is a lag between the time a hospital opens or becomes an IPPS provider and when the hospital's cost report wage data are available to include in calculating the area wage index. For example, if a hospital files its first Medicare cost report as an IPPS provider with a beginning date of January 1, 2007, and an ending date of December 31, 2007, the hospital's FY 2007 wage data would not be included in the wage index until the FY 2011 IPPS update. Therefore, when a rural IPPS hospital opens in a State that has rural areas, but no wage data are available to calculate a rural wage index, in the FY 2008 proposed rule, we proposed to apply a wage index to that hospital using the same methodology that we currently use for home health and other postacute care providers in rural Massachusetts (71 FR 65906). That is, we will use the unweighted

average of the wage indices from all CBSAs that are contiguous to the rural counties of

the State. (We define contiguous as sharing a border.).

Comment: One organization commented that CMS should allow data from a new

hospital that opens in a rural area to be included in the rural wage index as soon as a full

year's cost report is available for the hospital. The commenter stated that it is "unfair,

inconsistent, and unnecessary to have to wait 4 years" for a new hospital's data to be

included in the rural wage index. However, this commenter and others stated that they

supported the use of data from contiguous counties to establish the rural wage index

when a new rural hospital opens and there are no data available to calculate the rural

wage index.

Response: We note that we did not receive any comments opposing our proposal

to use data from contiguous counties to establish the rural wage index when a new rural

hospital opens and there are no data available to calculate the rural wage index.

The IPPS final rule for FY 2007 provides a detailed response to a similar

comment explaining why the wage data submission and review process occurs over a

4-year time period (71 FR 48016). As we stated, the 4-year time period is necessary to

allow time for hospitals to complete and submit their wage data for the fiscal year, 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 wage indices to be calculated

and published in advance of the fiscal year. The commenter suggested that we use wage

data for a new rural hospital that are from a later time period than all other hospitals that

does not go through this rigorous collection, review and correction process. We have two

concerns about the commenter's suggestion. First, we would be concerned about the

consistency of using wage data from a new rural hospital that does not undergo the same

rigorous collection, review and correction process as wage data for other hospitals.

Second, as the wage index is a relative measure of area differences in wage levels, it is

imperative that the data included in the calculation are from the same time period,

particularly because wage costs are subject to inflationary effects and hospital

employment trends fluctuate over time (for example, outsourcing is more common now

than it was several years ago). Therefore, our methodology would be flawed if we used

data from very different time periods.

We appreciate the commenters' support of our proposal to use the unweighted

average of the wage indices from all CBSAs that are contiguous to the rural counties of

the State to compute the rural wage index when a new hospital opens and there are no

other data available to calculate the rural wage index. Because we received no comments

that oppose this proposal, we are adopting this policy as final in this final rule with

comment period. The policy affects no rural areas for the FY 2008 wage index.

We will apply the wage index calculated above until the new IPPS hospital files a

cost report for the base year that is used in calculating the wage index. (In the above

example, the rural hospital's wage index will be calculated for FYs 2008, 2009, and 2010

using urban area data.) Further, under section 4410 of Pub. L. 105-33, the wage index

for this rural hospital would become the State's rural floor. As stated above, however, if

a State has rural areas, and a hospital is reclassified as rural under §412.103, then there

would be no need to apply the above policy. The reclassified hospital would set the rural floor, and the wage data of the newly opened rural hospitals would be included in the calculation of the wage index of the rural area only once their wage data correlated with the survey year used to establish the wage index (4 years after wage data are reported).

3. CAHs Reverting Back to IPPS Hospitals and Raising the Rural Floor

Medicare payments to CAHs are based on 101 percent of reasonable costs and are generally greater than the payments Medicare would make if the same hospitals were paid under the IPPS, which pays hospitals a fixed rate per discharge. Also, as a CAH, a hospital is guaranteed to recover its costs, while under the IPPS, it is not. We are aware of a situation where two rural hospitals in a State are considering converting from CAH status back to IPPS even though they continue to be CAH eligible. The CAHs would convert back to IPPS even though it would not directly benefit them. As IPPS providers, the hospitals' wage data would eventually set the rural floor for the State (that is, in 4 years when the hospitals' first IPPS cost reports would be included in a base year used in calculating the State's rural wage index). In this case, we are concerned that these hospitals are converting solely in order to take advantage of the rural floor provisions for the other hospitals in the State, but not for any reasons that are intrinsic to the two specific hospitals. Because the hospitals' wage levels are higher than most, if not all, of the urban IPPS hospitals in the State, including one hospital in the State that acquired rural status under §412.103, the wage indices for most, if not all, of the State's urban hospitals would increase as a result of the rural floor provision if the CAHs convert to IPPS status. Such an arrangement would increase payments to the hospitals in the State

at the expense of every other IPPS hospital in the nation. The two rural hospitals that are

currently CAHs were last paid under the IPPS in FY 2003. We simulated the effect of

allowing these two hospitals to set the State's rural floor with the same data used to

calculate the FY 2003 wage index as would occur in FY 2011 if these hospitals were to

convert to IPPS status in FY 2007 and no other hospitals were to open in the rural area of

the State. Based on this simulation, all hospitals except two would be paid using the rural

floor, increasing payments in excess of $220 million for a single year. If the average

hourly wage for these two hospitals increased faster than the national average, the

increase in payments would be even higher. It seems likely that over 5 years, Medicare

payments to hospitals in this State would increase by more than $1 billion. Again, these

increased payments would be budget neutralized at the expense of all other IPPS

hospitals nationwide. Given that the hospitals continue to be eligible for the higher

paying CAH status, we are concerned that hospitals are converting to IPPS status solely

in order to raise the State's rural floor. We are concerned about the propriety of such an

arrangement if the intent is to manipulate the State's area wage index values to receive

higher Medicare reimbursement.

Section 1886(d)(5)(I)(i) of the Act allows the Secretary the authority to "provide

by regulation for such other exceptions and adjustments…as the Secretary deems

appropriate." In the FY 2008 IPPS proposed rule, we solicited public comments

regarding whether it would be appropriate for CMS to establish a policy under this

authority to preclude the arrangement described above and, if so, how such a policy

would be applied. We believe that any policy should only apply to a CAH that continues

to meet the CAH certification requirements and should not apply if a CAH no longer met those requirements and converted to an IPPS provider.

Comment: Several commenters shared the concerns of CMS about the possibility of intentional gaming of the CAH conversion system in order to achieve greater payments through the establishment of a state rural floor. The commenters in general were supportive of CMS developing a policy to prevent or mitigate the impacts of a situation where a State will gain benefits at the expense of all other IPPS hospitals nationwide. Some commenters suggested that CMS should consider this issue in the broader context of wage index reform planned for the FY 2009 IPPS proposed rule. Some commenters provided suggestions to assist in determining what CAH conversions should or should not be precluded based on historical data.

Other commenters were concerned that CMS may be overreaching its authority by granting itself the ability to restrict a hospital's ability to choose the type of Medicare provider it wishes to be. The commenters were also concerned with CMS attempting to determine the intent of hospitals seeking conversion. One commenter added that as long as a hospital is essentially the same provider as when it was previously an IPPS hospital, CMS should reinstate the provider as an IPPS hospital. Another commenter suggested that "Section 1886(d)(5)(I)(i) does not provide CMS the authority to adopt a policy that precludes qualified CAHs from converting to IPPS", and even if CMS has the authority, the policy would be "discriminatory and constitutes bad public policy." Some commenters also suggested that CMS was inappropriately "singling out" hospitals in one State to apply this policy.

Response: We appreciate the commenters' ideas and contributions to this matter

for consideration. While we have proposed no policy pertaining to this issue at this time,

we will consider all of these comments as we develop the FY 2009 IPPS proposed rule.

One approach that we will explore in the context of wage index reform is to apply the

rural floor budget neutrality adjustment at the State level. Such an application would

protect hospitals in other States from being harmed by potential gaming associated with

the rural floor. Thus, in the scenario of concern to us, the CAHs would convert to IPPS

status and set a rural floor that would raise the wage index for most or all urban hospitals

within the State. However, budget neutrality would be achieved by adjusting the wage

index for all hospitals within the State rather than all hospitals nationwide. Under such a

policy, we would no longer be concerned about the scenario of CAHs converting to IPPS

status to raise the rural floor. While the former CAHs that pay high wages in this

circumstance would continue to set the rural floor, the policy would be redistributive

within the State rather than across States. Under such a policy, we would not have to

address the concern raised in the comments of having to determine the motives of the

CAH converting to IPPS status because the within State budget neutrality adjustment

would provide no advantage to the State's hospitals in the aggregate and would merely

redistribute existing Medicare payments differently within the State. The new policy that

we intend to explore in next year's IPPS rule would also resolve the concern that CMS is

"singling out" one State because we would propose to apply the new policy (that is,

applying budget neutrality within a State rather than across all hospitals nationwide) in

any State that benefits from the rural floor.

Again, we look forward to addressing this issue in next year's IPPS proposed rule
as we develop a proposal (or proposals) to reform the IPPS wage index as required under
section 106(b) of the MIEA-TRHCA.

4. Application of Rural Floor Budget Neutrality

Section 4410 of the Balanced Budget Act of 1997 (BBA) established the rural
floor by requiring that the wage index for a hospital in any urban area cannot be less than
the area wage index determined for the State's rural area. Since FY 1998, we have
implemented the budget neutrality requirement of this provision by adjusting the
standardized amounts. A discussion and illustration of the calculation of the standardized
amounts is shown in the Addendum of every year's IPPS rule.[27]

In the FY 2008 IPPS proposed rule, we proposed a prospective change to how
budget neutrality is applied to implement the rural floor for FY 2008 and subsequent
years. Section 4410(a) of the BBA indicates that "the area wage index applicable…to
any hospital which is not located in a rural area…may not be less than the area wage
index applicable…to hospitals located in rural areas in the State in which the hospital is
located." Section 4410(b) of the BBA imposes the budget neutrality requirement and
states that the Secretary shall "adjust the area wage index referred to in subsection (a) for
hospitals not described in such subsection."

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[27] The BBA was enacted on August 5, 1997, and required application of the rural floor beginning with the
FY 1998 IPPS. See the following for a description and calculation of the IPPS standardized amounts since
that time: 62 FR 46038-46043, August 29, 1997; 63 FR 41006-41010, July 31, 1998;
64 FR 41544-41549, July 30, 1999; 65 FR 47111-47116, August 1, 2000; 66 FR 39939-39946,
August 1, 2001; 67 FR 50120-50126, August 1, 2002; 68 FR 45474-45480, August 1, 2003;
69 FR 49273-49282, August 11, 2004; 70 FR 47491-47498, August 12, 2005; 71 FR 59889-58980,
October 11, 2006.

One possible interpretation of section 4410(b) of the BBA is that the budget

neutrality adjustment would be applied only to those hospitals that do not receive the

rural floor. In other words, the wage index of an urban hospital subject to the rural floor

would be increased to the level of the rural wage index in the same State, but would not

be adjusted for budget neutrality. Thus, urban hospitals receiving the rural floor would

receive a higher wage index than the rural hospitals within the same State (because rural

floor hospitals would not be subject to budget neutrality, whereas rural hospitals would

be). We believe such a reading would not be in accordance with Congressional intent,

which was to set a floor for urban hospitals, not to pay urban hospitals a wage index

higher than the wage index applicable to rural hospitals.

In order to avoid the apparent contradiction between raising an urban hospital's

wage index to the rural floor and not applying budget neutrality to its wage index, we

also believe the statute could be read to allow an iterative calculation of budget neutrality

and wage indices. Under such iterative calculations (consistent with section 4410(a) of

the BBA), we would raise the wage index for urban hospitals to the level of the

pre-budget neutrality rural wage index. Consistent with section 4410(b) of the BBA, we

would adjust the wage index for all nonrural floor hospitals to achieve budget neutrality.

However, such an adjustment would result in an urban hospital that would receive the

rural floor having a higher wage index than a rural hospital in the same State. Therefore,

we would then decrease wage indices for the rural floor hospitals so they are equal to the

adjusted rural wage index in the same State. At this point, payments would be less in the

aggregate than they were prior to applying the rural floor.   Accordingly, a new budget

neutrality adjustment would have to be calculated to raise the wage indices and total

payments for rural hospitals and nonrural floor urban hospitals. The rural wage index

would now be higher than the wage index for the rural floor hospitals in the same State.

Therefore, the wage index for rural floor hospitals would then be increased again to the

level of the State's rural wage index, leading to budget neutrality being recalculated

again, the wage index reduced for rural floor hospitals, and so forth until the wage index

and the budget neutrality adjustment stabilize.

         We have determined that the iterative method is substantively equivalent to

simply adjusting all area wage indices by a uniform percentage. We have performed the

iterative calculation using provider-level data based on FY 2007 MedPAR data and the

first half of FY 2007 wage index data. Using such data, we determined that the iterative

method results in the same final wage indices through four decimal places that would

result if a uniform budget neutrality factor were applied to all hospitals' wage indices.

Furthermore, an iterative method, which requires adjusting only the wage index values of

nonrural floor providers, reassigning the lowered rural floor value to rural floor providers,

and reiterating the budget neutrality factor applied to the nonrural floor providers would

require an excessive number of iterations and computer processing, which is not

necessary if we simply apply a uniform budget neutrality adjustment to all wage index

values. The latter method is accomplished more quickly, is less complex, and arrives at

the same final wage index values. Because the IPPS schedule is relatively condensed,

with a proposed rule issued in April, a 60-day comment period until June, and then only

2 months to analyze comments, respond to them, determine final policies and calculate

final rates prior to the August 1 publication, we believe it would not be practical to

require such multiple layers of calculations, when a uniform adjustment would produce

substantively identical results. Therefore, we proposed to implement the rural floor

budget neutrality requirement by applying a uniform budget neutrality adjustment to all

hospital wage indices rather than the more complicated iterative process illustrated

below.

The following hypothetical example, which includes a series of nine iterations,

illustrates how the iterative process works. The example assumes three IPPS hospitals in

one State. Hospital A is rural and Hospitals B and C are urban.

Pre-Floor Wage Index

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.8600	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$129,000	$458,000

Note: Hospital C is urban and has a lower wage index than Hospital A which is rural.

Post-Floor Wage Index; Pre-Budget Neutrality

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.9500	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$142,500	$471,500

Note: Hospital C's wage index is raised to the same level as Hospital A.

Post Floor – Budget Neutrality Process

Iteration 1:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9110	1.1220	0.9500	BN Factor
Relative Weights	100	200	150	0.95897
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$91,102	$224,398	$142,500	$458,000

Step 2: Reduce Hospital C's wage index to Hospital A's level.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9110	1.1220	0.9110	BN Factor
Relative Weights	100	200	150	0.95897
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$91,102	$224,398	$136,653	$452,153

Iteration 2:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9279	1.1428	0.9110	BN Factor
Relative Weights	100	200	150	1.01853
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,790	$228,557	$136,653	$458,000

Step 2: Increase Hospital C's wage index to Hospital A's level.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9279	1.1428	0.9279	BN Factor
Relative Weights	100	200	150	1.01854
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,790	$228,557	$139,185	$460,532

Iteration 3:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9206	1.1338	0.9279	BN Factor
Relative Weights	100	200	150	0.99212
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,059	$226,756	$139,185	$458,000

Step 2: Reduce Hospital C's wage index to Hospital A's level.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9206	1.1338	0.9206	BN Factor
Relative Weights	100	200	150	0.99212
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,059	$226,756	$138,088	$456,903

Iteration 4:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9238	1.1377	0.9206	BN Factor
Relative Weights	100	200	150	1.00344
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,376	$227,536	$138,088	$458,000

Step 2: Increase Hospital C's wage index to Hospital A's level.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9238	1.1377	0.9238	BN Factor
Relative Weights	100	200	150	1.00344
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,376	$227,536	$138,563	$458,475

Iteration 5:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9224	1.1360	0.9238	BN Factor
Relative Weights	100	200	150	0.99852
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,238	$227,198	$138,563	$458,000

Step 2: Reduce Hospital C's wage index to Hospital A's level.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9224	1.1360	0.9224	BN Factor
Relative Weights	100	200	150	0.99852
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,238	$227,198	$138,358	$457,794

Iteration 6:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9230	1.1367	0.9224	BN Factor
Relative Weights	100	200	150	1.00064
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,298	$227,344	$138,358	$458,000

Step 2: Increase Hospital C's wage index to Hospital A's level.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9230	1.1367	0.9230	BN Factor
Relative Weights	100	200	150	1.00064
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,298	$227,344	$138,447	$458,089

Iteration 7:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9227	1.1364	0.9230	BN Factor
Relative Weights	100	200	150	0.99972
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,272	$227,281	$138,447	$458,000

Step 2: Reduce Hospital C's wage index to Hospital A's level.

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9227	1.1364	0.9227	BN Factor
Relative Weights	100	200	150	0.99972
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,272	$227,281	$138,408	$457,961

Iteration 8:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9227	BN Factor
Relative Weights	100	200	150	1.00012
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,283	$227,308	$138,408	$458,000

Step 2: Increase Hospital C's wage index to Hospital A's level.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9228	BN Factor
Relative Weights	100	200	150	1.00012
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,283	$227,308	$138,425	$458,016

Iteration 9:

Step 1: Apply budget neutrality to Hospital A and Hospital B.

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9228	1.1365	0.9228	BN Factor
Relative Weights	100	200	150	0.99995
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,279	$227,297	$138,425	$458,000

In the example above, the wage indices are shown only to the 4th decimal place even though they are not rounded. However, the actual wage indices that we calculate for the IPPS are rounded to 4 decimal places. In the 9th and final iteration of the budget

neutrality adjustment shown above, there was no change to the wage indices through the 4th decimal place relative to the 8th iteration. Therefore, because the wage indices stopped changing, we could not obtain further precision in the budget neutrality and wage index calculations in the example shown above with further iterations. We note that the example above produces the same result as simply applying a uniform adjustment to hospital wage indices. Using the same data as the above hypothetical example, we show this result below:

Pre-Floor Wage Index

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.8600	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$129,000	$458,000

Note: Hospital C is urban and has a lower wage index than Hospital A which is rural.

Post-Floor Wage Index; Pre-Budget Neutrality

	Hospital A	Hospital B	Hospital C	Total
Wage Index	0.9500	1.1700	0.9500	
Relative Weights	100	200	150	
Location	Rural	Urban	Urban	
Standardized Amounts	$1,000	$1,000	$1,000	
Payments	$95,000	$234,000	$142,500	$471,500

Note: Hospital C's wage index is raised to the same level as Hospital A.

Post Floor – Budget Neutrality

	Hospital A	**Hospital B**	**Hospital C**	**Total**
Wage Index	0.9228	1.1365	0.9228	BN Factor
Relative Weights	100	200	150	0.971368
Location	Rural	Urban	Urban	Target
Standardized Amounts	$1,000	$1,000	$1,000	$458,000
Payments	$92,280	$227,300	$138,420	$458,000

We note that, as proposed, our change applies the budget neutrality adjustment to the wage index, and not to the standardized amount. In previous years, we applied a budget neutrality adjustment to the standardized amount to ensure that payments remained constant to payments that would have occurred in the absence of the rural floor requirement in section 4410 of the BBA. We believe such an adjustment is in keeping with the statute, which requires that the rural floor not result in aggregate payments that are greater or less than those that would have been made in the absence of a rural floor. We believe that an adjustment to the wage index would result in a substantially similar payment as an adjustment to the standardized amount, as both involve multipliers to the standardized amount, and both would be based upon the same modeling parameters. We do note that because hospitals have different labor-related shares (62 percent for hospitals with wage indices less than or equal to 1; 69.7 percent for hospitals with wage indices greater than 1), an adjustment to the wage index would have slightly different effects from an adjustment to the standardized amount, as each wage index would be adjusted by a uniform percentage.

For FY 2008, we are using FY 2006 discharge data and FY 2008 wage indices to simulate IPPS payments without the rural floor. We compare these simulated payments to simulated payments using the same data with a rural floor.

We believe that the statute supports either an adjustment to the standardized amount or the wage indices because under either methodology, the rural floor would not result in aggregate payments that were greater or less than those that would have been made in the absence of a rural floor.

Comment: Many commenters requested additional information as to the purpose and method CMS is proposing for applying the rural floor budget neutrality adjustment to the wage index. Most commenters were supportive of CMS' proposal. Other commenters expressed concern that CMS acknowledged that because the labor-related share is higher for hospitals with a wage index greater than 1.0000, an adjustment to the wage index, as opposed to the standardized amount, will treat hospitals in an inequitable manner. One commenter did not view it to be appropriate to intentionally move from an equitable adjustment system to one known to be potentially problematic. Another commenter stated that, for past years, the methodology for applying the adjustment was flawed because the adjustment was a cumulative adjustment (that is, previous year adjustments were not removed before making current year adjustments), causing an "inappropriate duplicating effect" to be "permanently built into the standardized amount." Commenters requested clarification as to whether the proposed one-time 1.002214 adjustment is meant to address a single year transition to a new system of budget neutrality adjustment, or is meant to reverse effects of prior year cumulative

adjustments. One commenter requested CMS to more clearly explain and fully disclose

any known errors in the calculation from past years' methodologies, as well as report

standardized amount adjustment figures from 1999 through 2007. Several commenters

suggested that besides removing any compounding effect on the standardized amount

(which some deemed to be "budget-negative") for the current year, a positive adjustment

should also be implemented in FY 2008 to retroactively reimburse hospitals. Some

commenters claimed that the proposed adjustment is not adequate to fix the effects of

past data errors, nor adequate to reimburse hospitals for past underpayments.

        Response: We appreciate that most commenters supported our proposal to apply

the rural floor budget neutrality adjustment to the wage index rather than the standardized

amount. For FY 2008, we will apply budget neutrality for application of the rural floor to

the wage index rather than the standardized amounts.

        With respect to the concern that the budget neutrality adjustment will have a

greater impact on hospitals with a labor-related share of 69.7, we believe that this policy

is consistent with the intent of section 403 of Pub. L. 108-173. Under section 403 of

Pub. L. 108-103, CMS must use a labor-related share of 62 percent for hospitals with a

wage index less than or equal to 1, unless application of a labor-related share of 62

percent would result in lower payments to a hospital than would otherwise be made. We

believe that Congress intended that the wage index adjustment should have less of an

impact on hospitals with lower wage indexes. Thus, although we could evenly distribute

the effect of the budget neutrality adjustment across all hospitals by applying one budget

neutrality factor to the wage indexes of hospitals with a labor-related share of 69.7 and a

different factor to the wage indexes of hospitals with a labor-related share of 62 percent,

we do not believe such an adjustment would be as consistent with the intent of Congress.

Regarding the cumulative nature of the budget neutrality adjustment, the rural

floor budget neutrality adjustment previously was a cumulative adjustment, similar to the

adjustments we currently make for updates to the wage index and DRG reclassification

and recalibration. Beginning in FY 2008, the rural floor budget neutrality adjustment

will be noncumulative. However, we do not believe that our prior policy of cumulatively

adjusting for rural floor budget neutrality was improper. The commenters are correct that

the one-time 1.002214 adjustment is meant to address a single year transition to a

noncumulative system of budget neutrality adjustment.

With regard to alleged errors in FYs 1999 through 2007, our calculation of budget

neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors

were made in prior fiscal years, we would not make an adjustment to make up for those

errors when setting rates for FY 2008. It is our longstanding policy that finality is critical

to a prospective payment system. Although errors in ratesetting are inevitable, we

believe the need to establish final prospective rates outweighs the greater accuracy we

might gain if we retroactively recomputed rates whenever an error is discovered.

H. Analysis and Implementation of the Occupational Mix Adjustment and the FY 2008

Occupational Mix Adjusted Wage Index

As discussed in section III.C. of the preamble of this final rule with comment

period, for FY 2008, we apply the occupational mix adjustment to 100 percent of the FY

2008 wage index. We calculated the occupational mix adjustment using data from the

2006 occupational mix survey data, using the methodology described in section III.C.3.

of the preamble of this final rule with comment period.

Using the first and second quarter occupational mix survey data and applying the

occupational mix adjustment to 100 percent of the final FY 2008 wage index results in a

national average hourly wage of $30.9133 and a Puerto-Rico specific average hourly

wage of $13.5536. After excluding data of hospitals that either submitted aberrant data

that failed critical edits, or that do not have FY 2004 Worksheet S-3 cost report data for

use in calculating the FY 2008 wage index, we calculated the FY 2008 wage index using

the occupational mix survey data from 3,367 hospitals. Using the Worksheet S-3 cost

report data of 3,569 hospitals and occupational mix first and/or second quarter survey

data from 3,367 hospitals represents a 94.3 percent survey response rate. The FY 2008

national average hourly wages for each occupational mix nursing subcategory as

calculated in Step 2 of the occupational mix calculation are as follows:

4. Occupational Mix Nursing Subcategory	5. Average Hourly Wage
National RN Management	$38.6202
National RN Staff	$33.4705
National LPN	$19.2209
National Nurse Aides, Orderlies, and Attendants	$13.6938
National Medical Assistants	$15.7737
National Nurse Category	$28.7329

The national average hourly wage for the entire nurse category as computed in

Step 5 of the occupational mix calculation is $28.7329. Hospitals with a nurse category

average hourly wage (as calculated in Step 4) of greater than the national nurse category

average hourly wage receive an occupational mix adjustment factor (as calculated in Step

6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in

Step 4) of less than the national nurse category average hourly wage receive an

occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the January through June 2006 occupational mix survey data, we

determined (in Step 7 of the occupational mix calculation) that the national percentage of

hospital employees in the Nurse category is 42.96 percent, and the national percentage of

hospital employees in the All Other Occupations category is 57.04 percent. At the CBSA

level, the percentage of hospital employees in the Nurse category ranged from a low of

27.26 percent in one CBSA, to a high of 85.30 percent in another CBSA.

We compared the final FY 2007 occupational mix adjusted wage indices for each

CBSA to the final FY 2008 wage indices adjusted for occupational mix. In implementing

an occupational mix adjusted wage index based on the above calculation using 6 months

of survey data for FY 2008 as opposed to 3 months of survey data used for FY 2007, the

final wage index values for 20 rural areas (42.5 percent) and 188 urban areas (48.4

percent) will decrease as a result of the adjustment. Eleven rural areas (23.4 percent) and

120 urban areas (30.9 percent) will experience a decrease of 1 percent or greater in their

wage index values. The largest negative impacts will be 5.91 percent and 14.85 percent

for a rural and urban area, respectively. In addition, 26 rural areas (55.3 percent) and 198

urban areas (51.0 percent) will experience an increase in their wage index values. Eleven

rural areas (23.4 percent) and 134 urban areas (34.5 percent) will experience an increase

of 1 percent or greater in their wage index values. The largest increase for a rural area

will be 13.28 percent and the largest increase for an urban area will be 11.56 percent.

One rural area will be unaffected. These results indicate that a larger percentage of rural

areas (55.3 percent) benefit from an occupational mix adjustment than do urban areas

(51.0 percent), although the difference in these percentages is smaller than it has been in

past years. Furthermore, while approximately one-third of rural CBSAs have

experienced a decrease in their wage indices as a result of the occupational mix

adjustment from the time the occupational mix adjustment was first implemented in FY

2005 until FY 2007, this percentage has grown to 42.5 percent for FY 2008.

The wage index values for FY 2008 (except those for hospitals receiving wage

index adjustments under section 1886(d)(13) of the Act) are shown in Tables 4A, 4B, 4C,

and 4F in the Addendum to this final rule with comment period.

Tables 3A and 3B in the Addendum to this final rule with comment period list the

3-year average hourly wage for each labor market area before the redesignation of

hospitals based on FYs 2006, 2007, and 2008 cost reporting periods. Table 3A lists these

data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in

the Addendum to this final rule with comment period includes the adjusted average

hourly wage for each hospital from the FY 2002 and FY 2003 cost reporting periods, as

well as the FY 2004 period used to calculate the FY 2008 wage index. The 3-year

averages are calculated by dividing the sum of the dollars (adjusted to a common

reporting period using the method described previously) across all 3 years, by the sum of

the hours. If a hospital is missing data for any of the previous years, its average hourly

wage for the 3-year period is calculated based on the data available during that period.

The wage index values in Tables 2, 4A, 4B, 4C, and 4F and the average hourly

wages in Tables 2, 3A, and 3B in the Addendum to this final rule with comment period

include the occupational mix adjustment as well as the budget neutrality adjustment for

the rural floor.

I. 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.I.8. of the preamble of this final rule

with comment period.

2. Effects of Reclassification/Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index

to redesignated hospitals is dependent on the hypothetical impact that the wage data from

these hospitals would have on the wage index value for the area to which they have been

redesignated. These requirements for determining the wage index values for redesignated

hospitals are applicable both to the hospitals 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. Therefore, as provided in

section 1886(d)(8)(C) of the Act, the wage index values were determined by considering

the following:

• If including the wage data for the redesignated hospitals would reduce the wage

index value for the area to which the hospitals are redesignated by 1 percentage point or

less, the area wage index value determined exclusive of the wage data for the

redesignated hospitals applies to the redesignated hospitals.

• If including the wage data for the redesignated hospitals reduces the wage index

value for the area to which the hospitals are redesignated by more than 1 percentage

point, the area wage index determined inclusive of the wage data for the redesignated

hospitals (the combined wage index value) applies to the redesignated hospitals.

• If including the wage data for the redesignated hospitals increases the wage

index value for the urban area to which the hospitals are redesignated, both the area and

the redesignated hospitals receive the combined wage index value. Otherwise, the

hospitals located in the urban area receive a wage index excluding the wage data of

hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage

data for hospitals that have been redesignated to another area continue to have their wage

index values calculated as if no redesignation had occurred (otherwise, redesignated rural

hospitals are excluded from the calculation of the rural wage index).   The wage index

value for a redesignated rural hospital cannot be reduced below the wage index value for

the rural areas of the State in which the hospital is located.

CMS has also adopted the following policies:

• The wage data for a reclassified urban hospital is included in both the wage

index calculation of the area to which the hospital is reclassified (subject to the rules

described above) and the wage index calculation of the urban area where the hospital is

physically located.

• In cases where urban hospitals have reclassified to rural areas under

42 CFR 412.103, the urban hospital wage data are: (a) included in the rural wage index

calculation, unless doing so would reduce the rural wage index; and (b) included in the

urban area where the hospital is physically located.

3. FY 2008 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.

At the time this final rule with comment period was constructed, the MGCRB had

completed its review of FY 2008 reclassification requests. There were 365 hospitals

approved for wage index reclassifications by the MGCRB for FY 2008. Because

MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified

during FY 2006 or FY 2007 are eligible to continue to be reclassified based on prior

reclassifications to current MSAs during FY 2008. There were 299 hospitals approved

for wage index reclassifications in FY 2006 and 214 hospitals approved for wage index

reclassifications in FY 2007. Some of the hospitals that reclassified for FY 2006 and FY

2007 have elected not to continue their reclassifications in FY 2008 because, under the

revised labor market area definitions, they are now physically located in the areas to

which they previously reclassified. Of all of the hospitals approved for reclassification

for FY 2006, FY 2007, and FY 2008, 866 hospitals are in a reclassification status for FY

2008.

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 was discussed under section IV.F.4. of the preamble of the

FY 2007 IPPS final rule (71 FR 48066).)

Under §412.273, hospitals that have been reclassified by the MGCRB were

permitted to withdraw their applications within 45 days of the publication of the proposed

rule. The request for withdrawal of an application for reclassification or termination of

an existing 3-year reclassification that would be effective in FY 2008 had to be received

by the MGCRB within 45 days of the publication of the proposed rule, that is, by

June 18, 2007. If a hospital elected to withdraw its wage index application after the

MGCRB had issued its decision, but prior to the above date, it could later cancel its

withdrawal in a subsequent year and request the MGCRB to reinstate its wage index

reclassification for the remaining fiscal year(s) of the 3-year period (§412.273(b)(2)(i)).

The request to cancel a prior withdrawal or termination had to be in writing to the

MGCRB no later than the deadline for submitting reclassification applications for the

following fiscal year (§412.273(d)). For further information about withdrawing,

terminating, or canceling a previous withdrawal or termination of a 3-year reclassification

for wage index purposes, we refer the reader to §412.273, as well as the August 1, 2002,

IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

Changes to the wage index that result from withdrawals of requests for

reclassification, wage index corrections, appeals, and the Administrator's review process

are incorporated into the wage index values published in this final rule with comment

period. These changes affect not only the wage index value for specific geographic areas,

but also the wage index value redesignated hospitals receive; that is, whether they receive

the wage index that includes the data for both the hospitals already in the area and the

redesignated hospitals. Further, the wage index value for the area from which the

hospitals are redesignated may have been affected.

Applications for FY 2009 reclassifications are due to the MGCRB by

September 4, 2007 (the first working day of September 2007). We note that this is also

the deadline for canceling a previous wage index reclassification withdrawal or

termination under §412.273(d). Applications and other information about MGCRB

reclassifications were available, beginning in mid-July 2007, via the CMS Internet Web

site at: **http://cms.hhs.gov/providers/prrb/mgcinfo.asp**, or by calling the MGCRB at

(410)786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive,

Suite L, Baltimore, MD 21244-2670.

Comment: Several commenters stated that, although the reclassification rules

provide some flexibility, there is a problem when a hospital qualifies for reclassification

to two different areas. The commenters stated that, with fluctuations in area wage

indices, the primary area might not be the higher wage index for each year of the 3-year

reclassification. Thus, the commenter suggested that CMS allow hospitals to reclassify to

the best eligible location based on the proposed post-reclassified wage index published in

Tables 4A, 4B, and 4C in the applicable IPPS proposed rule.

Response: The Medicare regulations at §412.230(a)(5)(ii) state that "a hospital

may not be redesignated to more than one area." Although wage index values may

fluctuate from year to year, a hospital cannot be reclassified to a primary and secondary

area at the same time in order to choose the higher area wage index value for the current

year. Instead, we allow hospitals to decide, on a yearly basis, whether to withdraw,

terminate, reinstate, or fallback to their existing reclassification based on the higher of the

published area wage indices. We believe that the current policy allows hospitals enough

flexibility to select the wage index that would benefit them the most during each fiscal

year. Therefore, we are making no changes to our policies with regards to this matter.

4. Hospitals That Applied for Reclassification Effective in FY 2008 and Reinstating

Reclassifications in FY 2008

Applications for FY 2008 reclassifications were due to the MGCRB by

September 1, 2006. We note that this deadline also applied for canceling a previous

wage index reclassification withdrawal or termination under §412.273(d). The MGCRB,

in evaluating a hospital's request for reclassification for FY 2008 for the wage index,

utilized the official data used to develop the FY 2007 wage index. The wage data used to

support the hospital's wage comparisons were 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, the wage tables identifying the 3-year average hourly wage of

hospitals were not available in time to include them in the FY 2007 IPPS final rule.

Therefore, we made the data available subsequent to the publication of the FY 2007 IPPS

final rule.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change

in geographic classification for a fiscal year 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 fiscal year. Thus, the statute requires that FY 2008 reclassification

applications were to be submitted to the MGCRB by no later than September 1, 2006.

For this reason, we required hospitals to 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 were not yet available. However, as outlined in

§412.256(c)(2), we also allowed hospitals with incomplete applications submitted by the

deadline to request an extension beyond September 1, 2006, to complete their

applications. We also allowed hospitals 30 days from the date the final wage data were

posted on the CMS Web site to request to cancel a withdrawal or termination in order to

reinstate a reclassification for FY 2008 or FY 2009, or both fiscal years. For a more

detailed discussion of the procedures used for the FY 2008 MGCRB applications, we

refer readers to the FY 2007 IPPS final rule (71 FR 48022-48023).

Comment: One commenter requested that CMS provide a special 30-day period

from the publication date of the FY 2008 IPPS final rule to allow hospitals to reinstate or

withdraw their reclassification requests, as CMS provided in the FYs 2005 and 2007

IPPS final rules. The commenter requested this special accommodation due to the

unexpected change in the wage index calculation (see section III.G. of this preamble for

the correction to Step 2 of the calculation) and the published corrections to the proposed

out-migration adjustments (72 FR 31510).

Response: We understand the commenter's concern, but we believe that no

additional time period is needed for hospitals to determine whether they should reinstate

or withdraw their reclassifications for FY 2008 wage index. The FYs 2005 and 2007

IPPS final rules included provisions necessary to allow hospitals additional time to

analyze the wage data and reassess their reclassification decisions with respect to

significant changes in policies and the wage index that occurred in those years. We

included a provision in the FY 2005 IPPS final rule that established an extra 30-day

period after the final rule was published to allow hospitals more time to assess their

situations with regards to the change in the labor market area definitions and the new

policies for implementing that change. In the FY 2007 IPPS final rule, due to changes in

the wage index as a result of a court decision (*Bellevue Hosp. Center v. Leavitt, 443 F.3d*

163, 179 (2nd Cir. 2006), CMS made reclassification decisions on behalf of hospitals and

allowed hospitals a 30-day period, after the final wage data were posted on CMS's Web

site, to reverse a withdrawal or to terminate a reclassification.

In the current situation, regarding the post-publication corrections to the proposed

FY 2008 out-migration adjustments, CMS published these corrections on June 7, 2007.

With the 45-day period for reclassification withdrawals and terminations ending on

June 18, 2007, we believe that hospitals had sufficient time to reevaluate their

reclassifications based on the revised published data. Regarding the correction to Step 2

of the wage index calculation, this change generally had a minor effect on area average

hourly wages and wage index values. Although the average hourly wages for some

hospitals were more significantly impacted, hospitals could have determined their correct

average hourly wages using the wage data that were posted on our web site and by adding

the correction to Step 2 in the calculator that was also posted on our Web site. We note

that the national and state hospital associations and many hospitals commented that they

were aware of an error in the calculation. Therefore, we do not believe it is necessary and

will not provide a 30-day period from publication of the FY 2008 IPPS final rule to allow

hospitals to reinstate or withdraw their reclassification requests.

Comment: One commenter requested clarification on whether the 45-day period

to withdraw reclassification requests runs from the posting of the display version of the

IPPS proposed rule on the CMS Web site or from the date of its publication in the

Federal Register.

Response: We appreciate the commenter's concern. We are clarifying in this

final rule with comment period that the 45-day period to withdraw or terminate

reclassification requests begins the day the proposed rule is published in the **Federal**

Register.

5. Clarification of Policy on Reinstating Reclassifications

Under §412.273(a) of our regulations, a hospital or group of hospitals may

withdraw its application for reclassification at any time before the MGCRB issues its

decision or, if after the MGCRB issues its decision, within 45 days after publication of

CMS's annual notice of proposed rulemaking for the upcoming fiscal year. In addition, a

hospital may terminate a reclassification that is already in effect within 45 days after

publication of the notice of proposed rulemaking for the upcoming fiscal year. Once a

withdrawal or termination has been made, the hospital or group of hospitals will not be

reclassified for purposes of the wage index to the same area for that year. The hospital

also will not be reclassified to the withdrawn or terminated reclassification area in

subsequent fiscal years unless the hospital subsequently cancels its withdrawal or

termination. The procedures for making a withdrawal or termination, as well as for

canceling a withdrawal or termination are specified at §412.273. In the FY 2003 IPPS

final rule (67 FR 50065-50066), we clarified our existing policy stating that a previous

3-year reclassification may not be reinstated after a subsequent 3-year reclassification to

another area takes effect. Therefore, a hospital can only have one active 3-year

reclassification at a time.

We have been asked whether a hospital (or group of hospitals) can reinstate the

two remaining years of a previously approved 3-year reclassification to one area, while at

the same time the individual hospital (or group) request a new 3-year reclassification

from the MGCRB to a different area and be approved for both at the same time. In this

case, the hospital or group of hospitals is permitted to apply to a different area than the

previously approved reclassification but, as stated in §412.273(b)(2), once they accept a

newly approved reclassification, a previously terminated and reinstated 3-year

reclassification would be permanently terminated.

Following the policy set forth at §412.273(d), a hospital may cancel a previous

withdrawal or termination by submitting written notice of its intent to the MGCRB no

later than September 1 for reclassifications effective at the start of the second following

fiscal year 13 months later. At the same time (because the deadline for geographic

reclassification applications for the second following fiscal year 13 months later is also

September 1), a hospital or group of hospitals could apply for reclassification to a

different area. If the application is denied, the hospital or group of hospitals can select

between the reinstated geographic reclassification and the home area wage index for the

following fiscal year. The hospital or group of hospitals must file a written request to the

MGCRB within 45 days after publication of the notice of proposed rulemaking to

terminate the reinstated reclassification and receive the home area wage index. If the

hospital or group of hospitals takes no action, the pending geographic reclassification will

go into effect. If the new geographic reclassification application is approved, the hospital

or group of hospitals will have 45 days from publication of the notice of proposed

rulemaking to accept either of the two pending geographic reclassifications or revert to

the home area wage index. If the hospital or group of hospitals takes no action, the most

recent approved geographic reclassification will go into effect and the prior

reclassification will be permanently terminated. Alternatively, the hospital or group of

hospitals can withdraw the most recent approved reclassification and accept the

previously approved and reinstated reclassification within 45 days of publication of the

notice of proposed rulemaking. Such an action will permanently terminate the most

recently approved geographic reclassification. Finally, the hospital or group hospitals

can write to the MGCRB within 45 days of publication of the notice of proposed

rulemaking to withdraw both geographic reclassifications in order to receive the home

area wage index. In this case, the hospital or group of hospitals can only reinstate one of

the two geographic reclassifications. The other geographic reclassification is

permanently terminated. Once a hospital or group of hospitals makes a decision for the

following fiscal year within 45 days of publication of the notice of proposed rulemaking,

the hospital or group of hospitals cannot change the decision for that fiscal year. It is also

important to note that the reinstatement of a reclassification only applies to those

withdrawals which were made after the MGCRB issued an approved 3-year decision, not

a withdrawal made prior to the MGCRB issuing an approval decision.

For example, a hospital has been reclassified to area "A" for FYs 2007 through

2009. The hospital accepts this geographic reclassification for FY 2007. The hospital

also applies for reclassification to a different area "B" for FYs 2008 through 2010 by

September 1, 2006. If reclassification to area "B" is denied, the hospital can either

withdraw or terminate its reclassification to area "A" within 45 days of publication of the

proposed rule for FY 2008 and receive the home area wage index for FY 2008 or receive

the reclassification to area "A" for FY 2008. If the hospital does nothing, it will receive

the area "A" reclassification. If the hospital's reclassification application to area "B" is

approved by the MGCRB, the hospital can (1) do nothing (and, therefore, receives the

reclassification to area "B" for FY 2008, permanently terminating the reclassification to

area "A"); (2) within 45 days of publication of the notice of proposed rulemaking,

withdraw the reclassification to area "B" and receive the reclassification to area "A" for

FY 2008 (permanently terminating the reclassification to area "B"); or (3) withdraw or

terminate both the reclassifications to both areas "A" and "B" and receive the home area

wage index for FY 2008. If the latter option is selected, the hospital can only reinstate

one of the withdrawn/terminated reclassifications by September 1, 2007 (to take effect

for FY 2009). Upon the sunset of the 45-day window, the reclassification selection is

final and the hospital will receive that wage index for the fiscal year, in this case for

FY 2008.

6. "Fallback" Reclassifications

As indicated in section III.I.3. of the preamble of this final rule with comment

period, the regulations at §412.273 provide the process that a hospital wishing to

withdraw or terminate a reclassification must follow.   If a hospital has an existing

reclassification and then applies to the MGCRB to a second area and is approved, it has a

choice between two reclassifications and its home area wage index for the following

fiscal year. We have been asked a procedural question about how the hospital accepts its

previously approved reclassification (its "fall back" reclassification) or how it can "fall

back" to its home area wage index. As the example provided in the section III.I.5. of the

preamble of this final rule with comment period illustrates, a hospital will automatically

be given its most recently approved reclassification (thereby permanently terminating any

previously approved reclassifications) unless it provides written notice to the MGCRB

within 45 days of publication of the notice of proposed rulemaking that it wishes to

withdraw its most recently approved reclassification and "fall back" to either its prior

reclassification or its home area wage index for the following fiscal year. If the hospital

wishes to accept its home area wage index in preference to its previous "fall back"

reclassification, the hospital must also state in its request to the MGCRB that it is not

only withdrawing its most recently approved reclassification but also terminating its

previously approved reclassification.

7. Geographic Reclassification Issues for Multicampus Hospitals

In FY 2005, 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 the geographic area in which another campus is located

using the average hourly wage data submitted on the cost report for the entire hospital.

This special rule applies for applications for reclassifications effective in FY 2006

through FY 2008. In the FY 2007 IPPS final rule, we decided not to extend this special

rule for multicampus hospitals. However, we believe that the change to how we allocate

a multicampus hospital's wage data has implications for multicampus hospitals'

reclassification requests.

As stated above, we proposed to allocate the multicampus hospital's wage data

across the different labor market areas where the campuses are located based upon FTEs.

After consideration of the public comments received on the proposed rule, as discussed in

section III.F. of the preamble of this final rule with comment period, we are finalizing the

policy that we will use FTEs or Medicare discharge data to allocate salaries and hours to

the campuses of multicampus hospitals that are located in different labor market areas

(although we note that, as discussed in section III.F. of the preamble of this final rule

with comment period, once the cost report is revised to require reporting of FTE data by

campus and such data are available for use in calculating the wage index, the wage data

of a multicampus hospital will be allocated among its campuses based only on reported

FTEs). For this reason, an individual campus located in a geographic area distinct from

the geographic area associated with the provider number of the multicampus hospital will

now have published, hospital-specific wage data that it may use to support a request for

an individual reclassification. The campus' wage data will be included in a public use

file, titled, "Three Year MGCRB Reclassification Data for FY 2009 Applications", that

will be posted on the Internet at

http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage, concurrent with

the publication of this final rule with comment period. The campus-specific data will

also be provided to the MGCRB. These data will be considered appropriate wage data

under §412.230, because they will be part of the CMS hospital wage survey used to

construct the wage index. Furthermore, we consider these data to constitute "published

hospital wage survey data" under section 1886(d)(10)(D)(vi) of the Act. We received no

public comments regarding our proposal in the proposed rule. Therefore, we are

finalizing the policy that a hospital may use this campus-specific data (derived from

allocating hospital wage data among campuses based on Medicare discharges or FTEs) to

support a request for reclassification. Thus, our policy allowing the allocation of wage

data using FTE or Medicare discharge data is somewhat different from our prior policy

on multicampus hospitals because under the policy being finalized in this final rule with

comment period, an individual campus of a multicampus hospital will be considered to

have campus-specific data to support an individual reclassification request. In addition,

we note that when a multicampus hospital's wage data are divided by FTEs or Medicare

discharges, the ratio of wages to hours remains constant. Thus, the effect of our policy,

in some sense, is that the individual campus of a multicampus hospital effectively uses

the average hourly wage of the entire multicampus institution to support its individual

reclassification request (see campus-specific average hourly wages in Table 2 of the

Addendum to this final rule with comment period). However, as stated above, an

individual campus of a multicampus hospital will now be considered to have hospital-

specific data to support an individual reclassification request. We are revising our

regulations at §412.230(d)(2) to reflect this final policy.

In the FY 2008 IPPS proposed rule, we noted that where a multicampus hospital

spanning two or more geographic areas does not provide us with appropriate FTE data,

its campus-specific data would not be included in the public use file we use to construct

the wage index. We stated that, for this reason, unless a multicampus hospital has

provided us with FTE data, we would not have appropriate campus-specific wage data

that could be used to support an individual reclassification under §412.230, and the

reclassification request for the individual campus would be denied. However, because

we have decided to automatically allocate a multicampus hospital's wages and hours

among its campuses based on discharge data if a hospital fails to submit FTE or discharge

data to us (as discussed in section III.F. of the preamble of this final rule with comment

period), a hospital campus located in a geographic area distinct from the geographic area

associated with the provider number of the multicampus hospital will now automatically

have appropriate campus-specific wage data that could be used to support an individual

reclassification.

Under current policy, an individual campus of a multicampus hospital located in a

different area than the one associated with the provider number does not have to provide

any official wage index data to join a group reclassification. However, given that we are

allocating a portion of the average hourly wage of the hospital's data to the labor market

area that includes this campus, we also proposed that this same data be used as part of a

group reclassification application. We are adopting this policy as final in this final rule

with comment period. Again, these data will be published in a public use file and will be

considered appropriate wage data under §§412.232 and 412.234. We are amending our

regulations at §412.232 and §412.234 to reflect this final policy. As we stated above,

because we have decided to automatically allocate a multicampus hospital's wages and

hours among its campuses based on discharge data if a hospital fails to submit FTE or

discharge data to us (as discussed in section III.F. of the preamble of this final rule with

comment period), a hospital campus located in a geographic area distinct from the

geographic area associated with the provider number of the multicampus hospital will

now automatically have official wage data to include in a group reclassification

application.

8. Redesignations of Hospitals 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.

Hospitals located in these counties have been known as "Lugar" hospitals and the

counties themselves are often referred to as "Lugar" counties. We provide the chart

below with the listing of the rural counties designated as urban under

section 1886(d)(8)(B) of the Act that we are using for FY 2008. For discharges occurring

on or after October 1, 2007, hospitals located in the rural county in the first column of

this chart will be redesignated for purposes of using the wage index of the urban area

listed in the second column.

**Rural Counties Redesignated as Urban
under Section 1886(d)(8)(B) of the Act
(Based on CBSAs and Census 2000 Data)**

Rural County	CBSA
Cherokee, AL	Rome, GA
Macon, AL	Auburn-Opelika, AL
Talladega, AL	Anniston-Oxford, AL
Hot Springs, AR	Hot Springs, AR
Windham, CT	Hartford-West Hartford-East Hartford, CT
Bradford, FL	Gainesville, FL
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL
Levy, FL	Gainesville, FL
Walton, FL	Fort Walton Beach-Crestview-Destin, FL
Banks, GA	Gainesville, GA
Chattooga, GA	Chattanooga, TN-GA
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA

Rural County	CBSA
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA
Peach, GA	Macon, GA
Polk, GA	Atlanta-Sandy Springs-Marietta, GA
Talbot, GA	Columbus, GA-AL
Bingham, ID	Idaho Falls, ID
Christian, IL	Springfield, IL
DeWitt, IL	Bloomington-Normal, IL
Iroquois, IL	Kankakee-Bradley, IL
Logan, IL	Springfield, IL
Mason, IL	Peoria, IL
Ogle, IL	Rockford, IL
Clinton, IN	Lafayette, IN
Henry, IN	Indianapolis-Carmel, IN
Spencer, IN	Evansville, IN-KY
Starke, IN	Gary, IN
Warren, IN	Lafayette, IN
Boone, IA	Ames, IA
Buchanan, IA	Waterloo-Cedar Falls, IA
Cedar, IA	Iowa City, IA
Allen, KY	Bowling Green, KY
Assumption Parish, LA	Baton Rouge, LA
St. James Parish, LA	Baton Rouge, LA
Allegan, MI	Holland-Grand Haven, MI
Montcalm, MI	Grand Rapids-Wyoming, MI
Oceana, MI	Muskegon-Norton Shores, MI
Shiawassee, MI	Lansing-East Lansing, MI
Tuscola, MI	Saginaw-Saginaw Township North, MI
Fillmore, MN	Rochester, MN
Dade, MO	Springfield, MO
Pearl River, MS	Gulfport-Biloxi, MS
Caswell, NC	Burlington, NC
Davidson, NC	Greensboro-High Point, NC
Granville, NC	Durham, NC
Harnett, NC	Raleigh-Cary, NC
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC
Polk, NC	Spartanburg, 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

Rural County	CBSA
Greene, NY	Albany-Schenectady-Troy, NY
Schuyler, NY	Ithaca, NY
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY
Wyoming, NY	Buffalo-Niagara Falls, NY
Ashtabula, OH	Cleveland-Elyria-Mentor, OH
Champaign, OH	Springfield, OH
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA
Cotton, OK	Lawton, OK
Linn, OR	Corvallis, OR
Adams, PA	York-Hanover, PA
Clinton, PA	Williamsport, PA
Greene, PA	Pittsburgh, PA
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ
Schuylkill, PA	Reading, PA
Susquehanna, PA	Binghamton, NY
Clarendon, SC	Sumter, SC
Lee, SC	Sumter, SC
Oconee, SC	Greenville, SC
Union, SC	Spartanburg, SC
Meigs, TN	Cleveland, TN
Bosque, TX	Waco, TX
Falls, TX	Waco, TX
Fannin, TX	Dallas-Plano-Irving, TX
Grimes, TX	College Station-Bryan, TX
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA
Page, VA	Harrisonburg, VA
Shenandoah, VA	Winchester, VA-WV
Island, WA	Seattle-Bellevue-Everett, WA
Mason, WA	Olympia, WA
Wahkiakum, WA	Longview, WA
Jackson, WV	Charleston, WV
Roane, WV	Charleston, WV
Green, WI	Madison, WI
Green Lake, WI	Fond du Lac, WI

Rural County	CBSA
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI
Walworth, WI	Milwaukee-Waukesha-West Allis, WI

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to this final rule with comment period into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals could withdraw from an MCGRB reclassification within 45 days of the publication of the proposed rule.

Comment: One hospital commented that its county should have been listed as a Lugar county in the proposed rule and inquired about their absence on the Lugar county list. The commenter stated it had used 2002 and 2003 Census data to calculate the commuting exchange between counties.

Response: Section 1886(d)(8)(B) of the Act requires the Secretary of Health and Human Services to determine Lugar counties using the standards published in the **Federal Register** by the Director of the Office of Management and Budget based on the most recent decennial census. The most recent decennial census was completed in 2000. The law does not permit us to use 2003 Census data to determine the Lugar status for FY 2008. Davidson County must qualify for Lugar status based on 2000 Census data. We reviewed the 2000 Census data and determined that Davidson County, NC does meet the criteria to be a Lugar county. Therefore, in this final rule with comment period, we added Davidson County, NC to the above list of rural counties that are redesignated as

urban for FY 2008 under section 1886(d)(8)(B) of the Act. Thus, for FY 2008, the

hospitals in Davidson County, NC will receive the wage index for hospitals that are

reclassified to Greensboro-High Point, NC in Table 4C of the Addendum to this final rule

with comment period.

9. Reclassifications under Section 1886(d)(8)(B) of the Act

We have been asked whether Lugar hospitals and counties (discussed above in

section III.H.8. of the preamble of this final rule with comment period) are considered

urban or rural for MGCRB reclassification purposes. As stated in the regulations at 42

CFR 412.64(b)(3), as well as in section 1886(d)(8)(B) of the Act, Lugar hospitals are

deemed to be located in an urban area. Therefore, because they are physically located in

a rural area and are deemed urban, they receive the reclassified wage index (Table 4C in

the Addendum to this final rule with comment period) for the urban area to which they

have been redesignated. Because Lugar hospitals are treated like reclassified hospitals,

when they are seeking reclassification by the MCGRB, they are subject to the rural

reclassification rules set forth at §412.230. The procedural rules set forth at §412.230 list

the criteria which a hospital must meet in order to reclassify as a rural hospital. Lugar

hospitals will be subject to the proximity criteria and payment thresholds that apply to

rural hospitals. Specifically, the hospital will have to be no more than 35 miles from the

area to which it seeks reclassification (§412.230(b)(1)); the hospital will have to show

that its average hourly wage is at least 106 percent of the average hourly wage of all other

hospitals in the area in which the hospital is located (§412.230(d)(1)(iii)(C)); and the

hospital will have to demonstrate that its average hourly wage is equal to at least 82

percent of the average hourly wage of hospitals in the area to which it seeks redesignation
(§412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area
where the Lugar hospitals have been redesignated are not permitted to measure to the
Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and
no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or
SCHs) in order to be reclassified to such urban area. These hospitals must measure to the
urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural
area requirement.

10. New England Deemed Counties

Our regulations at 42 CFR 412.64(b)(1)(ii)(B) list New England counties that are
deemed to be parts of urban areas under section 601(g) of the Social Security
Amendments of 1983 (Pub. L. 98-21, 42 U.S.C. 1395ww(note)). These counties include
Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine;
Merrimack County, New Hampshire; and Newport County, Rhode Island. OMB
standards designate and define two categories of CBSAs: Metropolitan Statistical Areas
(MSAs) and Micropolitan Statistical Areas (65 FR 82235). For our labor market area
definitions, we treat micropolitan areas as rural.

Of these five counties, three (York County, Sagadahoc County, and Newport
County) are also included in metropolitan areas by OMB, whereas the remaining two,
Litchfield County and Merrimack County, are located in micropolitan statistical areas and
would be treated as rural under our labor market area definitions were they not deemed

urban under §412.64(b)(1)(ii)(B) of the regulations. Litchfield County and Merrimack

County have been listed as being part of urban CBSA 25540 Hartford-West

Hartford-East Hartford, CT, and urban CBSA 31700 Manchester-Nashua, NH,

respectively. Even though hospitals located in Litchfield County and Merrimack County

are in micropolitan statistical areas, they have been treated as urban for reclassification

purposes. Under our regulations, we have deemed both of these two New England

counties and the hospitals within them as urban. Because the counties themselves were

deemed urban, the hospitals within them have also been treated as urban for

reclassification purposes, even though Litchfield and Merrimack counties are in

micropolitan statistical areas. However, upon further consideration of this issue, we

believe the hospitals located within these New England counties should be treated the

same as Lugar hospitals. That is, the area would be considered rural but the hospitals

within them would be deemed to be urban.

Comment: Many commenters opposed the proposed change to treat the two New

England deemed counties (Litchfield, CT and Merrimack, NH) as rural. The commenters

stated that the statute requires continuing the 1979 urban classifications of these New

England hospitals in determining if a hospital is in an urban or rural area for purposes of

section 1886(d) of the Act. Most of the commenters believed the change is not

warranted and is contrary to the meaning of the statute. However, some commenters

stated that they would be willing to accept the policy change if their published proposed

statewide rural wage index does not change in the final rule as a result of this policy

change.

Response: We appreciate the commenters' concerns regarding our proposed

policy. We believe that our proposed policy change is consistent with section 601(g) of

Pub. L. 98-21, which requires certain hospitals located in New England to be classified as

being located in an urban area. The statute does not require that the counties in which

these hospitals are located be deemed urban. Furthermore, the proposed change to how

New England deemed counties are to be treated in the wage index calculation was not

designed to reduce the statewide rural floor. Rather, it was to promote consistency within

the regulations with regard to how we treat rural hospitals that are redesignated to urban

areas for purposes of the wage index. That is, we found that there is no practical

difference between the purpose of the "Lugar" and deemed urban counties provisions of

the statute with regard to the IPPS. Both provisions treat hospitals that are

geographically rural as urban for the purposes of section 1886(d) of the Act. For this

reason, we believe that Medicare should have a consistent policy between these two types

of rural counties with respect to how the hospitals located in such counties are treated for

geographic reclassification purposes and for purposes of calculating pre and post-

reclassified wage indices.

We note that section 1886(d)(8)(C) of the Act protects rural area IPPS wage

indices from reductions that will occur due to the effects of reclassifications. That is, a

rural area IPPS wage index can not decrease as a result of hospitals reclassifying in or out

of the area. Therefore, the rural IPPS wage index will not change as a result of this

policy change. However, we cannot ensure that the IPPS wage index that is published in

the proposed rule will not change in the final rule. The wage index correction process is

not finalized each year until after the proposed rule is published. During the correction

process, a hospital's wage index data can change and cause the area wage index to

fluctuate up or down. Therefore, any change to the area or national average hourly wage

as a result of the wage data correction process may cause a change between the proposed

and final rule in an area wage index. If any change occurred between the proposed and

final rule in the wage index for rural Connecticut or New Hampshire, it happened as a

result of corrections to the wage data and not this policy.

After consideration of the public comments received, we are adopting as final,

without modification, the proposed policy to treat New England deemed counties that are

still considered rural by OMB as rural under IPPS, and the hospitals within them as being

reclassified to their deemed urban area and subject to the rural reclassification rules. As

we proposed, we are changing our policy and considering Litchfield County and

Merrimack County as rural but will continue to consider the hospitals within them as

being redesignated to urban CBSA 25540 Hartford-West Hartford-East Hartford, CT, and

urban CBSA 31700 Manchester-Nashua, NH, respectively. Under our policy, hospitals

located in these counties--like the Lugar hospitals described in section III.I.8. of the

preamble of this final rule with comment period--must meet the rural requirements set

forth at §412.230 for individual reclassifications and §412.232 for group

reclassifications. We are revising §412.64(b)(1)(ii)(B) accordingly. Hospitals not

located inside one of these deemed New England counties are not permitted to measure to

these counties to demonstrate close proximity in order to be reclassified to the CBSA(s)

to which the hospitals in Litchfield and Merrimack counties are redesignated. Due to

policies in place that protect the rural wage index from decreasing as a result of hospital

reclassifications, the proposed policy would have no effect on the rural wage index for

IPPS hospitals. However, non-IPPS payment systems (SNF, IRF, and HHA, among

others) that use the pre-reclassified wage index may be affected by this policy change.

However, we are limiting this policy change for deemed New England Counties only to

IPPS hospitals because it was only discussed in the FY 2008 IPPS proposed rule. Any

change to non-IPPS provider wage indices would be addressed in the respective payment

rules for those payment systems.

 11. 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 were

applicable to discharges occurring during the 3-year period beginning April 1, 2004, and

ending March 31, 2007. Section 106(a) of the MIEA-TRHCA (Pub. L. 109-432),

extended any geographic reclassifications of hospitals that were made under section 508

and that would expire on March 31, 2007, by 6 months until September 30, 2007. On

March 23, 2007, we published a notice in the **Federal Register** (72 FR 13799) that

indicated how we are implementing section 106(a) of the MIEA-TRHCA through

September 30, 2007. Because the section 508 provision will expire on

September 30, 2007, and will not be applicable in FY 2008, in this final rule with comment period, we are not making any changes related to the provision.

Comment: A number of commenters expressed support for the reclassification opportunities provided by provisions in section 508 of Pub. L. 108-173 (MMA). The commenters highlighted the necessity to preserve these provisions to allow certain hospitals to continue to compete for labor in markets they would not be able to reclassify to under prior reclassification standards.

Response: Provisions in section 508 of Pub. L. 108-173 allocated a capped amount of funding to allow some hospitals that otherwise would not qualify to do so to seek a form of geographic reclassification. The section 508 provisions were mandated by Congressional action and were originally set to expire on March 31, 2007. However, section 106(a) of the MIEA-TRHCA extended any geographic reclassifications that were set to expire on March 31, 2007, by 6 months, through September 30, 2007. Further extension of section 508 would require a change in the Medicare statute.

Comment: One commenter addressed the use of our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) in the FY 2007 IPPS final rule to grant a hospital a reclassified wage index for FY 2008 (we refer readers to 71 FR 48070 for more information). The commenter stated that a special exception was granted to this hospital because it was not reclassified under section 508 of Pub. L. 108-173, although multiple hospitals in neighboring areas were so reclassified. (In FY 2007, the Secretary invoked the special exceptions and adjustments authority to allow this hospital to receive the same reclassified wage index as the neighboring hospitals on the grounds that the

reclassifications of neighboring hospitals under section 508 of Pub. L. 108-173, in combination with other factors, created unique circumstances making such an exception appropriate in this situation.) The commenter believed that, while this special exception allowed the hospital to increase employee salaries, another one-year extension is necessary to allow the hospital to further overcome competitive disadvantages. The commenter added that, prior to the Secretary's action, neighboring hospitals had a period of 2 and 1/2 years of enhanced wage indices due to section 508 provisions. Because the hospital has limited ability under current rules to seek a higher wage index reclassification, the commenter stated that further action is needed to allow the hospital to compete with its peers.

Response: In the FY 2007 final rule, CMS cited the unique circumstances surrounding the section 508 reclassifications in granting the adjustment to this hospital. We stated that it was appropriate to give the hospital in the single hospital urban area the same wage index as the nearby section 508 hospitals until the expiration of the provision on March 31, 2007. As the MIEA-TRHCA extended any geographic reclassifications that were set to expire on March 31, 2007, by 6 months, through September 30, 2007, we also extended the special exception and gave this hospital the same wage index as the neighboring section 508 hospitals through the end of FY 2007. By law, the section 508 reclassifications will expire on September 30, 2007. Therefore, the basis for providing this hospital with a special wage index will end with the expiration of section 508 on September 30, 2007.

12. Other Issues

We have been advised of a reclassification scenario of concern to a particular

hospital. In this scenario, two hospitals were approved by the Medicare Geographic

Classification Review Board (MGCRB) for a 3-year group reclassification. Prior to the

second year of the 3-year reclassification, one of the hospitals reclassified individually to

another area. Consistent with our policy, the second hospital retained its group

geographic reclassification for the two remaining years (66 FR 39888, August 1, 2001).

However, once the group reclassification expires, the second hospital does not qualify to

reclassify individually to another area. We have been asked to consider potential

regulatory options that would allow this hospital to either reclassify or receive a declining

blend of its home area and reclassified wage index as a transition to its post-reclassified

wage index.

In the proposed rule, we indicated that there are no options under our current

regulations that would allow this hospital to reclassify individually or as a group. The

hospital does not meet the well established wage data comparison criteria to reclassify as

an individual hospital. In order for a group reclassification to be approved, all hospitals

in the county must apply as a group. We have been informed that one hospital will not

join the group reclassification because it qualifies individually to reclassify to a different

area with a higher wage index than where the group applied.

We considered whether to change our regulations for this type of situation.

However, we decided not to propose a change to our regulations, given the need to gather

additional information and better understand the policy issues in such a case. In this

regard, we solicited public comments on whether such a situation is consistent with the

purpose of reclassification. In particular, we requested comments on how a hospital that is applying to reclassify would demonstrate similarity to hospitals in the neighboring area when the hospital would qualify to be part of a group reclassification if all other hospitals in the county in which the hospital is located agreed to apply.

In addition, we requested comments on how we could make a determination that a hospital's own area wage index is inappropriate when the hospital does not meet the current criteria for reclassification on its own, but would meet the criteria for a group reclassification in the event all hospitals in the county in which the hospital is located would agree to submit a group application. Finally, given that reclassifications are in effect for three years, we requested comments on whether or how we could address this situation while simultaneously maintaining the distinction between group and individual reclassifications—particularly the rule that all members of a group must apply for a group reclassification.

For all the above reasons, we decided, as noted, not to propose changes to the regulations to address the situation brought to our attention. Rather, we believe it is appropriate to gather additional information and seek comment on this or similar situations. We indicated that if commenters wished to raise issues with the points described in this section or comment on other issues we did not consider in the questions raised above, we welcomed such public comments.

Comment: One commenter requested that CMS exercise caution when expanding reclassification options or adding exceptions to the current wage index process. The

commenter suggested that CMS collect additional information on similar situations and

should consider the matter when considering global wage index reform for FY 2009.

Response: We appreciate the commenter's suggestions. At this time, CMS has

made no policy proposal to address this particular issue. As indicated above, section

106(b)(2) of Pub. L. 109-432 instructs the Secretary of Health and Human Services,

taking into account MedPAC's recommendations on the Medicare wage index

classification system, to include in the FY 2009 IPPS proposed rule one or more

proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the

Act for purposes of the IPPS. The proposal (or proposals) must consider a variety of

issues including "the modification or elimination of geographic reclassifications and

other adjustments." We will consider this issue and many others as part of our

comprehensive review of the wage index and geographic reclassification for FY 2009.

Under section 1886(d)(10)(C)(iii) of the Act, the MGCRB's decision may be

appealed to the Secretary and the "decision of the Secretary shall be final and shall not be

subject to judicial review." Under §412.276(b) of our regulations, the decision of the

MGCRB is final and binding on the parties unless it is reviewed by the Administrator and

the decision is changed by the Administrator based on the hospital's appeal or the

Administrator's discretionary review of the decision. Under the statute and regulations,

the Administrator's review must take place within certain timeframes. After those

timeframes have expired, the decision is final.

We are concerned about the role that an error in the average hourly wage might

have had on a reclassification decision by the MGCRB. We seek comment on the

appropriateness of prospectively addressing situations where there is an error made in a

hospital's average hourly wage that is later used for a geographic reclassification

application. For example, if we became aware or were made aware through subsequent

public input that an error existed in the average hourly wage of a hospital that can be used

in a geographic reclassification application prior to it being awarded, we might republish

the wage data from the IPPS final rule. If significant, we might also consider prospective

adjustments to the 3-year average hourly wage for future reclassifications if some or all

of those 3 years span the time period that the hospital was reclassified based on erroneous

data. We welcome ideas from the public on this and other suggestions for addressing this

issue.

J. FY 2008 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. To date, we have used pre-reclassified wage indices when determining the out-migration adjustment. In the FY 2005 IPPS final rule (69 FR 49061 through 49063), we stated that it was reasonable to interpret the term "wage index" in section 1886(d)(13)(D) of the Act to mean the pre-reclassified, pre-adjusted wage index. At the time, we stated that it was unclear whether to use the pre- or post-reclassified wage index as the basis for comparison to determine the out-migration adjustment. We also cited complicating factors such as the use of blended wage indices as a result of the labor market area transition as another reason to base the out-migration adjustment on the pre-reclassified wage index. However, we indicated that we will continue to examine the possibility of employing post-reclassification wage indices as we refine our policy for future adjustments.

We have reconsidered our policy in this final rule with comment period and as proposed, we are calculating the out-migration adjustment using the post-reclassified wage index. First, the labor-market area transition has ended and the use of blended wage indices is no longer a complicating factor in determining whether to use pre- or post-reclassified wage indices to determine the out-migration adjustment. Second, we are applying budget neutrality for application of the rural floor to area wage indices rather than to the standardized amount beginning in FY 2008. The budget neutrality adjustment for the rural floor is being applied to the post-reclassification wage indices and is a component of the wage index that is being used to adjust for area differences in wages. Therefore, we believe the out-migration adjustment should be determined using the post-reclassified wage index that reflects the budget neutrality adjustment for application of the rural floor.

We are using the same formula described in the FY 2005 final rule (69 FR 49064), with the addition of now using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index

area. For each of the higher wage areas, multiply this result by the result obtaining in

Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has

workers commuting to more than one higher wage area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees

who are residing in the qualifying county and who are employed in any higher wage

index area.

These adjustments will be effective for each county for a period of 3 fiscal years.

Hospitals that received the adjustment in FY 2007 will be eligible to retain that same

adjustment for FY 2008. 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, 2007.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of

the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act

unless they waive the out-migration adjustment. Consistent with our FY 2005, 2006, and

2007 final rules, we are specifying that hospitals redesignated under section 1886(d)(8) of

the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have

chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that

wish to receive the out-migration adjustment, rather than their reclassification, had to

follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section

III.I.3. of the preamble of this final rule with comment period. Otherwise, they were

deemed to have waived the out-migration adjustment. Hospitals redesignated under

section 1886(d)(8) of the Act were deemed to have waived the out-migration adjustment,

unless they explicitly notified CMS that they elected to receive the out-migration

adjustment instead within 45 days from the publication of the proposed rule.

Comment: Several commenters expressed concern about using post-reclassified

wage data instead of the current policy of using pre-reclassified wage data for the

out-migration adjustment. The commenters stated that the out-migration adjustment is

not subject to budget neutrality requirements set forth at section1886(d)(3)(E) of the Act

and using pre-reclassified wage data is more technically correct. Another commenter

suggested that use of the post-reclassified wage indices would result in a "mismatch of

the wage indices compared to the commuting patterns of employees. According to the

commenters, the use of the attaching area wage index that includes the wage data of

reclassified hospitals would mean that the adjustment includes "counties that are not

included in the underlying census data."

Response: The out-migration adjustments are not included in any budget

neutrality calculations and there is no adjustment to either the standardized amount or the

wage index to make the additional payments under section 1886(d)(13) of the Act budget

neutral. Under section 1886(d)(13) of the Act, the home area wage index for hospitals

eligible for an out-migration adjustment is increased based on the weighted average of

the difference between the wage index for the higher wage index MSA(s) to which its

hospital employees commute and the wage index of the labor market area in which the

qualifying county is located, multiplied by the overall percentage of hospital workers

residing in the qualifying county who are employed in any MSA with a higher wage

index. This adjustment to the wage index for all eligible hospitals increases aggregate

Medicare payments and does not result in any redistribution of payments as would occur

if there were a budget neutrality adjustment to either the standardized amount or the wage

index like there is for revisions to area wage indices, geographic reclassification, and

application of the rural floor. Application of the out-migration adjustment remains a

nonbudget neutral policy as it has always been in the past.

        Use of a post-reclassified area wage index does have the potential to result in the

out-migration adjustment being determined using wage data for hospitals geographically

located in the labor market area as well as other hospitals reclassified into the

area. Under section 1886(d)(8)(C) of the Act, an area wage index may increase as a

result of including the wage data of hospitals that are reclassified to the area (the same

section precludes an area wage index from decreasing as a result of hospitals

reclassifying into the area). However, for most labor market areas, the post-reclassified

area wage index and the pre-reclassified area wage index are the same and reflect only

the wage data of hospitals that are geographically located in the area. This result occurs

because hospitals generally reclassify to areas that have similar wage levels as their own,

so the data for reclassifying hospitals rarely affect the area wage index. Therefore, we

believe that the post-reclassified wage index accurately reflects an area's wage levels,

even though it may sometimes include the data for hospitals that are reclassified to the

area. We also believe that using the post-reclassified wage index instead of the

pre-reclassified wage index is technically more appropriate for computing the

out-migration adjustment. Because the out-migration adjustment is an add-on to the

post-reclassified wage index adjusted for rural floor budget neutrality, consistently, the

out-migration adjustment itself should be computed using post-reclassified wage indices

adjusted for rural floor budget neutrality. Under the new policy that we are adopting in

this final rule with comment period, the out-migration adjustment is calculated based on

the post-reclassified area wage index values in Tables 4A and 4B of the Addendum to

this final rule with comment period. The attaching area wage index values in Table 4C of

the Addendum to this final rule with comment period are not used in computing the

adjustment.

Further, we note that in the FY 2005 final rule (69 FR 49063), we originally

stated that we were concerned about using the post-reclassification wage index as a basis

for determining the out-migration adjustment because, in some counties, not all hospitals

are receiving the same wage index due to individual hospital reclassifications (for

example, in the FY 2005 final rule, we stated that, in one county, there may be two

hospitals that receive different wage indexes because one hospital has been reclassified).

We stated that, given the differing wage indexes in this situation, it was unclear which

wage index would be most appropriate to use as the basis for comparison for this county.

After further considering this issue, we no longer believe that use of the

post-reclassification wage index presents a concern in this situation. If a hospital

reclassifies to another labor market area, the reclassified hospital may raise the wage

index of that labor market area (creating a new, higher post-reclassification wage index),

but there is still only one wage index for each county in that specific geographic area.

Under section 1886(d)(8)(C) of the Act, a reclassified hospital may receive a separate

wage index that is different from the wage index of the area to which the hospital

reclassified. However, under section 1886(d)(13)(G) of the Act, a reclassified hospital is

not eligible to receive the out-migration adjustment. Therefore, it is not possible for two

hospitals in the same county to qualify for the out-migration adjustment and yet have

different wage indices. In addition, we acknowledge that, due to the application of the

rural floor, a CBSA could have more than one wage index value. Specifically, if a CBSA

crosses State lines, and the rural floor is applied in some counties and not others in the

CBSA, hospitals in the CBSA could receive different wage indices, depending on the

State in which they are geographically located. However, even in this situation, there is

only one wage index for a particular county. For labor market areas that have more than

one wage index, both the computation and the application of the out-migration

adjustment would be based on the wage index of the qualifying county in which the

hospital workers reside and the county to which the workers are commuting.

Comment: Commenters expressed concern about a New England hospital not

qualifying to receive an out-migration adjustment. The commenters stated that the reason

for a change in the county's eligibility for the out-migration adjustment is due to CMS'

proposed policy to use the post-reclassified wage data instead of pre-reclassified wage

data.

Response: Some hospitals that previously qualified for an out-migration

adjustment may not qualify in FY 2008 because we recalculate the out-migration

adjustment every 3 years for all hospitals. In recalculating the out-migration adjustment,

there is a possibility that a hospital that previously received an out-migration adjustment

may no longer qualify for the adjustment because its count no longer meets the

10-percent commuting threshold to a higher wage index area (that is, less than 10 percent

of the county's hospital employees commute to a labor market area with a higher wage

index (or wage indices)). Another criterion for qualifying for the out-migration

adjustment is that the 3-year average hourly wage of the hospital(s) in the county where

the hospital is located must equal or exceed the 3-year average hourly wage of all

hospitals in the labor market area in which the county is located. The New England

hospital in question is in a single county CBSA. Therefore, the 3-year average hourly

wage of the hospitals in the county equals the 3-year average hourly wage of all hospitals

in the CBSA in which the county is located. However, the county does not meet the

10-percent threshold, which requires that at least 10 percent of the county's hospital

employees commute to higher wage index areas. The county no longer qualifies for the

out-commuting adjustment because of changes in the wage indices for the areas to where

its hospital workers commute. The use of post-reclassified wage index had no effect on

this hospital no longer qualifying for an out-migration adjustment.

Comment: One commenter expressed confusion regarding a county that was once

eligible for the out-migration adjustment but, for FY 2008, the county is no longer

eligible.

Response: We understand the concern for counties that previously were eligible

for the out-migration adjustment but were not included on Table 4J of the Addendum to

the proposed rule to receive an adjustment. Eligibility for the out-migration adjustment is

affected by the percentage of a county's hospital employees who commute to areas with

higher wage indices, and the difference between the 3-year average hourly wage of the

hospitals in the county and the 3-year average hourly wage of all hospitals in the labor

market area in which the county is located. The amount of the out-migration adjustment

is affected by the percentage of hospital employees who commute to areas with higher

wage indices, and the difference between the wage index of each higher wage index area

to which the county's hospital employees commute and the wage index of the labor

market area in which the county is located. Thus, eligibility for the out-migration

adjustment and the out-migration percentage for each county is a function of both the

commuting data and changes in the wage index values. Because the wage indices

associated with each resident county and the labor market areas to which county residents

commute change each year, a county's out-migration percentage can vary each 3-year

period that a county is qualified for the out-migration adjustment because a higher wage

index area in one year might not be a higher wage index area in the next year. These

normal changes in wage index values could also result in a county not deemed a

qualifying county in one year becoming a qualifying county at a later point, or vice versa.

A county could, therefore, not be listed in the proposed rule and be listed in the final rule

due to the county wage data fluctuating. Therefore, if a county is not listed as eligible for

receiving the out-migration adjustment on Table 4J of the Addendum to this final rule

with comment period, the county's wage data or commuting patterns did not warrant an

adjustment.

Table 4J in the Addendum to this final rule with comment period lists the out-

migration wage index adjustments for FY 2008. Hospitals that are not otherwise

reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act

will automatically receive the listed adjustment.   In accordance with the procedures

discussed above, redesignated/reclassified hospitals were deemed to have waived the out-

migration adjustment unless CMS was otherwise notified. Hospitals that were eligible to

receive the out-migration wage index adjustment and that withdrew their application for

reclassification will automatically receive the wage index adjustment listed in Table 4J in

the Addendum to this final rule with comment period.

K. Process for Requests for Wage Index Data Corrections

        The preliminary Worksheet S-3 wage data and occupational mix survey data files

(1st and 2nd quarter 2006) for the FY 2008 wage index were made available on

October 6, 2006, through the Internet on the CMS Web site at:

http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage. In a

memorandum dated October 6, 2006, we instructed all fiscal intermediaries/MAC to

inform the IPPS hospitals they service of the availability of the wage index data files and

the process and timeframe for requesting revisions (including the specific deadlines listed

below). We also instructed the fiscal intermediaries/MAC to advise hospitals that these

data were also made available directly through their representative hospital organizations.

        If a hospital wished to request a change to its data as shown in the

October 6, 2006 wage and occupational mix data files, the hospital was to submit

corrections along with complete, detailed supporting documentation to its fiscal

intermediary by December 4, 2006. 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 6, 2006 memorandum referenced above.

In the October 6, 2006 memorandum, we also specified that a hospital could

request revisions to 1st and/or 2nd quarter occupational mix survey data if they missed the

previous deadlines (June 1, 2006, for the 1st quarter data collection and August 31, 2006,

for the 2nd quarter collection) for submitting occupational mix survey data to their fiscal

intermediaries. A hospital requesting revisions to its 1st and/or 2nd quarter occupational

mix survey data was to copy its record(s) from the CY 2006 occupational mix

preliminary files posted to our Web site in October, highlight the revised cells on its

spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal

intermediary no later than December 4, 2006.

The fiscal intermediaries (or, if applicable, the MAC) notified the hospitals by

mid-February 2007 of any changes to the wage index data as a result of the desk reviews

and the resolution of the hospitals' early-December revision requests. The fiscal

intermediaries/MAC also submitted the revised data to CMS by mid-February 2007.

CMS published the proposed wage index public use files that included hospitals' revised

wage data on February 23, 2007. In a memorandum also dated February 23, 2007, we

instructed fiscal intermediaries/MAC to notify all hospitals regarding the availability of

the proposed wage index public use files and the criteria and process for requesting

corrections and revisions to the wage index data. Hospitals had until March 12, 2007 to

submit requests to the fiscal intermediaries/MAC for reconsideration of adjustments

made by the fiscal intermediaries/MAC as a result of the desk review, and to correct

errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's)

mishandling of the wage index data. Hospitals were also required to submit sufficient

documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/

MAC were required to transmit any additional revisions resulting from the hospitals'

reconsideration requests by April 13, 2007. The deadline for a hospital to request CMS

intervention in cases where the hospital disagreed with the fiscal intermediary's (or, if

applicable, the MAC's) policy interpretations was April 20, 2007.

Hospitals were given the opportunity to also examine Table 2 in the Addendum to

the proposed rule. Table 2 of the proposed rule contained each hospital's adjusted

average hourly wage used to construct the wage index values for the past 3 years,

including the FY 2004 data used to construct the proposed FY 2008 wage index. We

noted that the hospital average hourly wages shown in Table 2 only reflected changes

made to a hospital's data and transmitted to CMS by February 21, 2007.

We released the final wage index data public use files in early May 2007 on the

Internet at **http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage**.

The May 2007 public use files were made available solely for the limited purpose of

identifying any potential errors made by CMS or the fiscal intermediary/MAC in the

entry of the final wage index data that result from the correction process described above

(revisions submitted to CMS by the fiscal intermediaries/MAC by April 13, 2007). If,

after reviewing the May 2007 final files, a hospital believed that its wage or occupational

mix data were incorrect due to a fiscal intermediary or MAC or CMS error in the entry or

tabulation of the final data, the hospital had to send a letter to both its fiscal intermediary

or MAC and CMS that outlined why the hospital believed an error existed and to provide

all supporting information, including relevant dates (for example, when it first became

aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MAC) had

to receive these requests no later than June 08, 2007.

Each request also had to be sent to the fiscal intermediary or the MAC. The fiscal

intermediary or the MAC reviewed requests upon receipt and contacted CMS

immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2007 wage index

data files, changes to the wage and occupational mix data were only made in those very

limited situations involving an error by the fiscal intermediary or the MAC or CMS that

the hospital could not have known about before its review of the final wage index data

files. Specifically, neither the fiscal intermediary or the MAC nor CMS approved the

following types of requests:

● Requests for wage index data corrections that were submitted too late to be

included in the data transmitted to CMS by fiscal intermediaries or the MAC on or before

April 13, 2007.

● Requests for correction of errors that were not, but could have been, identified

during the hospital's review of the February 23, 2007 wage index public use files.

● Requests to revisit factual determinations or policy interpretations made by the

fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal

intermediaries or the MAC (that is, by June 08, 2007) were incorporated into the final

wage index in this final rule with comment period, which will be effective

October 1, 2007.

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 2008 payment rates. Accordingly, hospitals that did not meet the procedural

deadlines set forth above will not be afforded a later opportunity to submit wage index

data corrections or to dispute the fiscal intermediary's (or, if applicable the MAC's)

decision with respect to requested changes. Specifically, our policy is that hospitals that

do not meet the procedural deadlines set forth above will not be permitted to challenge

later, before the Provider Reimbursement Review Board, the failure of CMS to make a

requested data revision. (See W. A. Foote Memorial Hospital v. Shalala, No. 99-CV-

75202-DT (E.D. Mich. 2001) and Palisades General Hospital v. Thompson, No. 99-1230

(D.D.C. 2003).) We refer the reader also to the FY 2000 final rule (64 FR 41513) for a

discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above

provides hospitals with sufficient opportunity to bring errors in their wage and

occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention.

Moreover, because hospitals had access to the final wage index data by early May 2007,

they had the opportunity to detect any data entry or tabulation errors made by the fiscal

intermediary or the MAC or CMS before the development and publication of the final

FY 2008 wage index by August 1, 2007, and the implementation of the FY 2008 wage

index on October 1, 2007. If hospitals availed themselves of the opportunities afforded to

provide and make corrections to the wage and occupational mix data, the wage index

implemented on October 1 should be accurate. Nevertheless, in the event that errors are

identified by hospitals and brought to our attention after June 08, 2007, 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 the MAC or CMS made an error in tabulating its data; and

(2) the requesting hospital could not have known about the error or did not have an

opportunity to correct the error, before the beginning of the fiscal year. For purposes of

this provision, "before the beginning of the fiscal year" means by the June deadline for

making corrections to the wage data for the following fiscal year's wage index. This

provision is not available to a hospital seeking to revise another hospital's data that may

be affecting the requesting hospital's wage index for the labor market area. As indicated

earlier, since CMS makes the wage index data available to hospitals on the CMS Web

site prior to publishing both the proposed and final IPPS rules, and the fiscal

intermediaries or the MAC notify hospitals directly of any wage index data changes after

completing their desk reviews, we do not expect that midyear corrections will be

necessary. However, under our current policy, if the correction of a data error changes

the wage index value for an area, the revised wage index value will be effective

prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised §412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) the fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or if applicable the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 08, 2007 deadline for the FY 2008 wage index); and (3) CMS agreed that the fiscal intermediary (or if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; it can only be used for the current Federal fiscal year. In other situations where our policies would allow

midyear corrections, we continue to believe that it is appropriate to make

prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive

correction will be made irrespective of whether the change increases or decreases a

hospital's payment rate. In addition, we note that the policy of retroactive adjustment

will still apply in those instances where a judicial decision reverses a CMS denial of a

hospital's wage index data revision request.

Comment: One commenter suggested that, for future wage indices, CMS should

provide an additional public use file that reflects the data that are actually used in

computing the wage index that is published in the proposed rule. The commenter noted

that after CMS posts the February public use file, CMS makes revisions and corrections

to the file and includes the updates in the proposed wage index. The commenter

expressed support for CMS' decision to use the latest available data to compute the

proposed wage index and for the timing and purpose of the February and May public use

files. However, the commenter opined that a data file that matches the proposed wage

index would be particularly helpful to the public for review and comments on the

proposed rule, and CMS could release the file strictly for this purpose. The commenter

also noted that releasing this new wage data file would be consistent with CMS releasing

an up-to-date version of the MedPAR file along with each proposed rule.

Response: We believe that the commenter's suggestion is reasonable. In the

interest of meeting the data needs of the public, beginning with the FY 2009 wage index,

we will post an additional public use file on our Web site that reflects the actual data that

are used in computing the proposed wage index. The release of this new file will not

alter the current wage index process or schedule. We will notify the hospital community

of the availability of these data as we do with the current public use wage data files

through our Hospital Open Door forum. We encourage hospitals to sign up for automatic

notifications of information about hospital issues and the scheduling of the Hospital Open

Door forums at: http://www.cms.hhs.gov/OpenDoorForums/.

L. Labor-Related Share for the Wage Index for FY 2008

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 with

comment period, 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, 2007. Tables 1A and 1B in the Addendum to this final rule with comment

period 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, 2007. 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 is reflected in the Table 1C of the Addendum to this final rule

with comment period.

M. Wage Index Study Required under Pub. L. 109-432

Section 106(b)(1) of the MIEA-TRHCA (Pub. L. 109-432) requires MedPAC to

submit to Congress, not later than June 30, 2007, a report on the Medicare wage index

classification system applied under the Medicare Inpatient Prospective Payment System.

Section 106(b) of MIEA-TRHCA requires the report to include any alternatives that

MedPAC recommends to the method to compute the wage index under section

1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of the MIEA-TRHCA instructs the Secretary of

Health and Human Services, taking into account MedPAC's recommendations on the

Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule

one or more proposals to revise the wage index adjustment applied under section

1886(d)(3)(E) of the Act for purposes of the IPPS. The proposal (or proposals) must

consider each of the following:

● Problems associated with the definition of labor markets for the wage index

adjustment;

● The modification or elimination of geographic reclassifications and other

adjustments;

● The use of Bureau of Labor of Statistics data or other data or methodologies to

calculate relative wages for each geographic area;

● Minimizing variations in wage index adjustments between and within MSAs

and statewide rural areas;

● The feasibility of applying all components of CMS' proposal to other settings;

● Methods to minimize the volatility of wage index adjustments while

maintaining the principle of budget neutrality;

● The effect that the implementation of the proposal would have on health care

providers on each region of the country;

● Methods for implementing the proposal(s) including methods to phase in such

implementations; and

● Issues relating to occupational mix such as staffing practices and any evidence

on quality of care and patient safety including any recommendation for alternative

calculations to the occupational mix.

In the proposed rule, we indicated that we look forward to reviewing the MedPAC

report on the wage index later this year. As required by the law, we will consider

MedPAC's recommendations and each of the factors specified above in making a

proposal (or proposals) in the FY 2009 IPPS proposed rule.

Comment: Many commenters provided comments and suggestions on the

MIEA-TRHCA requirements to study the wage index.

Response: We appreciate the commenters' ideas and suggestions on the wage

index in response to the statutory requirements under Pub. L. 109-432. We plan to

consider all of the comments we received when developing our FY 2009 proposed rule.

We note that MedPAC released its June 2007 report to Congress on

June 15, 2007. As the statute requires, the report includes MedPAC's analysis and

recommendations on alternatives to the method to compute the wage index. The full

report can be downloaded from MedPAC's Web site at

http://www.medpac.gov/documents/Jun07_EntireReport.pdf.

N. 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 proposed 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

began using a different classification system, the North American Industrial

Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which no

longer exists. 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. Thus, we used the BLS-NAICS-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), set

out new requirements for the Reporting Hospital Quality Data for Annual Payment

Update (RHQDAPU) program. We established the RHQDAPU program in order to

implement section 501(b) of Pub. L. 108-173. 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 their quality of care.

Section 5001(a) of the DRA revised the mechanism used to update the

standardized amount for payment for hospital inpatient operating costs. Specifically,

sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for

FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any

"subsection (d) hospital" (that is, a hospital paid under the IPPS) that does not submit

certain quality data in a form and manner, and at a time, specified by the Secretary.

Sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act required that we expand the

"starter set" of 10 quality measures established by the Secretary as of November 1, 2003,

provided that certain requirements were met. In expanding this set of 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 the MMA[28],

effective for payments beginning with FY 2007.

The IOM measures include: Hospital Quality Alliance (HQA) quality measures

(the HQA is a public-private collaboration to improve the quality of care provided by the

nation's hospitals by measuring and publicly reporting on that care), the HCAHPS patient

perspective survey, and three structural measures. The structural measures are:

(1) implementation of computerized provider order entry for prescriptions, (2) staffing of

intensive care units with intensivists, and (3) evidence-based hospital referrals. These

structural measures constitute the Leapfrog Group's original "three leaps," and are part of

the National Quality Forum's 30 Safe Practices for Better Healthcare.

Sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for

payments beginning with FY 2008, 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

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[28] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005,
available at http://www.iom.edu/CMS/3809/19805/31310.aspx

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.

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.

Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a

hospital's payment update will apply only with respect to the fiscal year involved, and

will not be taken into account for computing the applicable percentage increase for a

subsequent fiscal year.

The "starter set" of 10 quality measures we established as of November 1, 2003

are as follows:

Heart Attack (Acute Myocardial Infarction or AMI)

- Was aspirin given to the patient upon arrival to the hospital?

- Was aspirin prescribed when the patient was discharged?

- Was a beta-blocker given to the patient upon arrival to the hospital?

- Was a beta-blocker prescribed when the patient was discharged?

- Was an 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 joined in 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

(the Joint Commission), the National Quality Forum (NQF), the American Medical

Association, the Consumer-Purchaser Disclosure Project, the AARP, the American

Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare

Research and Quality (AHRQ), as well as CMS and others. This collaboration, originally

known as the National Voluntary Hospital Reporting Initiative, is now known as the

HQA.

This starter set of 10 quality measures was endorsed by the NQF. The NQF is a

voluntary consensus standard-setting organization established to standardize health care

quality measurement and reporting through its consensus development process. In

addition, this starter set is a subset of measures currently collected for the Joint

Commission as part of its certification program.

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.

Hospitals submit quality data through the QualityNet Exchange secure Web site

(www.qnetexchange.org). We believe that this Web site meets or exceeds all current

Health Insurance Portability and Accountability Act requirements for security of personal

health information. Data from this initiative are used to populate the Hospital Compare

Web site, 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 care they provide.

In the FY 2007 IPPS final rule (71 FR 48137), we amended 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 the DRA. We also

added 11 additional quality measures to the 10 measure starter set to establish an

expanded set of 21 quality measures (71 FR 48029 through 48037). These 21 measures

are as follows:

Topic	Quality Measure
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 *
	● Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	● Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival
	● Adult smoking cessation advice/counseling
Heart Failure (HF)	
	● Left ventricular function assessment *
	● 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

* Measure included in 10 measure starter set.

In addition, in the FY 2007 IPPS final rule (71 FR 48031 through 48044), we set

out RHQDAPU program procedures for data submission, program withdrawal, data

validation, attestation, public display of hospitals' quality data, and reconsiderations. In

response to public comments, we required that reporting of the expanded quality

measures begin with discharges occurring on or after the third calendar quarter of 2006

(July through September discharges). We also responded to public comments regarding

whether we should establish more structured reconsideration procedures for FY 2008 and

what such procedures might include.

Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with

FY 2008, we are required to add other measures that reflect consensus among affected

parties, and, to the extent feasible and practicable, we must include measures set forth by

one or more national consensus building entities.

2. FY 2008 Quality Measures

Commenters on the FY 2007 IPPS proposed rule requested that we notify the

public as far in advance as possible of any proposed expansions of the measurement set

and program procedures in order to encourage broad collaboration and to give hospitals

time to prepare for any anticipated change. Taking these concerns into account, in the

CY 2007 OPPS final rule (71 FR 68201), we adopted additional quality measures for the

FY 2008 update. The six additional measures we adopted are as follows:

- ● HCAHPS survey

- ● SCIP Quality Measures

-- SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for

surgery patient

-- SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery

-- SCIP Infection 2: Prophylactic antibiotic selection for surgical patients

- ● Mortality (Medicare Patients)

-- Acute Myocardial Infarction 30-day mortality Medicare patients

-- Heart Failure 30-day mortality Medicare patients

For the FY 2008 payment determination, we are requiring hospitals to report the

following 27 measures:

Topic	Quality Measure
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 *
	● Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival**
	● Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival**
	● Adult smoking cessation advice/counseling**
Heart Failure (HF)	
	● Left ventricular function assessment *
	● 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**
	● SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients***
	● SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery***
	● SCIP Infection 2: Prophylactic antibiotic selection for surgical patients***

Topic	Quality Measure
Mortality Measures (Medicare patients)	
	● Acute Myocardial Infarction 30-day mortality Medicare patients***
	● Heart Failure 30-day mortality Medicare patients***
Patients' Experience of Care	
	● HCAHPS patient survey***

*Measure included in 10 measure starter set.
**Measure included in 21 measure expanded set.
***Measure added in CY 2007 OPPS final rule.

Comment: One commenter stated that CMS' proposal to expand the surgical

infection set, add a 30-day mortality measure, and add patient experience (HCAHPS) are

consistent with priorities it suggested for the hospital measure set.

Response: CMS adopted the SCIP Infection 2 measure, the HCAHPS survey

measure, AMI and Heart Failure 30-Day Mortality for Medicare Patients in the CY 2007

OPPS final rule (71 FR 68201) for the FY 2008 update.

Comment: One commenter applauded CMS' decision to add two additional SCIP

measures, SCIP-VTE 1 and SCIP-VTE 2, to the RHQDAPU program. The commenter

believed that the addition of these measures will help improve quality of care for

Medicare beneficiaries and reduce the risk of postoperative complications associated with

VTE (venous thromboembolism) occurring after approximately 25 percent of all major

surgical procedures performed without prophylaxis. The commenter noted that VTE is

preventable through the use of well-researched measures of established efficacy and

believed such prophylactic measures should be applied in settings beyond surgical ones.

For example, the commenter encouraged CMS to include safety measures relating to

VTE as medical prophylaxis to the RHQDAPU program.

Response: We appreciate the commenter's support of CMS' decision to add

SCIP VTE-1 and SCIP VTE-2 to the RHQDAPU program. CMS recognizes the

commenter's suggestion that CMS should include safety measures relating to VTE as

medical prophylaxis to the RHQDAPU program. The NQF is currently conducting an

evaluation of VTE measures that was sponsored by the Joint Commission. A variety of

VTE measures are currently being evaluated and tested and we are supportive of this

evaluation to test additional VTE measures. CMS hopes that these evaluations will result

in VTE measures that may be considered for RHQDAPU in the future.

Comment: One commenter asked that CMS clarify the AMI topic. The

commenter stated that under the Joint Commission's requirements, starting with 3rd

quarter 2006, hospitals are required to submit data on PCI received within 90 minutes of

hospital arrival versus the 120 minute criteria for the AMI topic. However, the current

document lists RHQDAPU program measures for 2007 (72 FR 24804) and 2008 and

2009 (72 FR 24804) and includes the criteria of 120 minutes instead of 90 minutes.

Response: We acknowledge NQF has changed its endorsement of the PCI

measure from 120 minutes to 90 minutes of hospital arrival. We also acknowledge that

the Joint Commission has changed its reporting requirement for the PCI measure to

correspond with the NQF endorsement. Although we generally look to the NQF as an

appropriate consensus building entity that endorses many quality measures we believe

would be appropriate for inclusion in the RHQDAPU program, NQF endorsement of a

particular measure, or an NQF change regarding endorsement of a particular measure,

does not automatically lead to an immediate adoption of a measure or a change in our

definition of a measure for purposes of the RHQDAPU program. At this time, we are not

adopting this change in this final rule with comment period. However, if we believe that

the NQF change is an appropriate change for the RHQDAPU program, we would expect

to adopt this change through a future rulemaking.

Comment: One commenter commended CMS for publishing the FY 2008

reporting measures as part of the CY 2007 OPPS final rule. The commenter finds the

ability to comment and plan a year in advance very helpful. The FY 2008 IPPS proposed

rule included five new measures for FY 2009—four process and one outcome measure.

The commenter commended CMS for putting these measures forth in the proposed rule

because it will give hospitals time to plan and establish proper data collection

mechanisms.

Response: We appreciate the commenter's support and we will continue to

provide the public with as much notice as possible when adopting new measures in the

future.

Comment: One commenter believed that the current Heart Attack (Acute

Myocardial Infarction) measures do not reflect the current standard of care. The

commenter believes that these measures require some modification in order to reflect

available clinical evidence. The commenter also encouraged CMS to consider adopting a

system whereby hospitals that participate in heart registries are deemed to have submitted

and met necessary baselines for the AMI measures.

Response: The current performance measures for assessing quality of care for

acute myocardial infarction were endorsed by the National Quality Forum, and based on

the joint performance measurement recommendations of the American College of

Cardiology and the American Heart Association, two well-respected consensus-building

entities. As clinical science changes, CMS will align and modify our performance

measures.

We agree that registries hold much potential to reduce data collection burden.

However, before we could "deem" a hospital that participates in a registry to have met

the RHQDAPU requirements for the AMI measures, as the commenter suggests, we

would have to ensure that the specifications, including data definitions of the registry

were sufficiently comparable to those used in the RHQDAPU program.

Comment: One commenter stated that although the RHQDAPU AMI measures

are important in improving AMI outcomes, studies have shown that they are not very

effective at capturing the variation in short-term 30-day mortality rates.

Response: We acknowledge that many of the current process of care measures,

including the AMI measures, are based on studies showing the relationship between the

process of care and long-term patient outcomes (not necessarily 30-day mortality rates).

We believe that, at the patient level, the measures are very important because they are

positively related to outcomes. One reason why the current RHQDAPU program process

measures are weakly correlated with the 30-day mortality measures is because there is a

low variation of the process measures to explain the variation of the mortality measures.

More importantly, the current set of process measures is only a small part of a broad

spectrum of measures or factors that are relevant to outcomes. They are not expected to

capture completely the variation in 30-day mortality rates.

Comment: One commenter stated that in addition to the current process measures, CMS should consider adopting measures that reflect a greater variety of processes and also outcomes. To that end, the commenter suggested that CMS should take a leadership role with stakeholders to develop consensus recommendations regarding the addition of new AMI quality measures under the RHQDAPU program. As the leading Federal agency in the development of quality measures for hospitals, the commenter believed CMS has a responsibility to keep abreast of changes in the standard of care, bring together the relevant stakeholders to build consensus, and act quickly and appropriately to update the quality measures for the RHQDAPU program.

Response: In selecting the measures for the RHQDAPU program, CMS makes every effort to remain abreast of changes in clinical guidelines and standards of care. We work closely with the Joint Commission, the HQA, and the NQF, among others, in this effort. Specifically, we collaborate with technical expert panels that include clinician experts, specialty societies, practice guideline committees, and others. We work with relevant stakeholders in developing performance measures that reflect current standards of care. For example, the performance measures selected by CMS for inclusion in the RHQDAPU program to assess quality of care for acute myocardial infarction not only were endorsed by the National Quality Forum, but CMS also considered the recommendations of a joint performance measurement committee of the American College of Cardiology and the American Heart Association. Similar technical panels exist for all of the current RHQDAPU process measure sets.

We are not adopting any other new RHQDAPU measures for FY 2008.

3. New Quality Measures and Program Requirements for FY 2009 and Subsequent Years

a. New Quality Measures for FY 2009 and Subsequent Years

In the FY 2008 IPPS proposed rule (72 FR 24805), we proposed to add 1 outcome

measure and 4 process measures to the existing 27 measure set to establish a new set of

32 quality measures to be used for the FY 2009 annual payment determination. We

proposed to adopt these measures a year in advance in order to provide additional time

for hospitals to prepare for changes related to the RHQDAPU program. We proposed to

add the following quality measures for the FY 2009 RHQDAPU program:

- Pneumonia 30-day Mortality (Medicare patients)

- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative

Serum Glucose

- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

- SCIP Infection 7: Colorectal Patients with Immediate Postoperative

Normothermia

- SCIP Cardiovascular-2: Surgery Patients on a Beta-Blocker Prior to Arrival

Who Received a Beta-Blocker During the Perioperative Period

We stated that the above measures reflect our continuing commitment to quality

improvement in both clinical care and patient safety. These additional measures also

demonstrate our commitment to include in the RHQDAPU program only those quality

measures that reflect consensus among the affected parties and that have been reviewed

by a consensus building process. The proposed measures have been put forth by the

HQA for inclusion in its public reporting set, contingent on endorsement by the NQF. (In

the case of SCIP Infection 7, the HQA recently withdrew its previous support unless the

measure receives NQF endorsement.) We stated that we anticipated that the NQF would

endorse these measures prior to the publication of this final rule with comment period.

Notwithstanding, we indicated that any measure that was not endorsed by that time would

not be finalized in this final rule with comment period.

We requested public comment on these five measures and indicated that we

would finalize the FY 2009 RHQDAPU measure set in this final rule with comment

period. However, as we explained, at this time we are only finalizing one of the

additional measures we proposed to add as part of the complete FY 2009 measure set.

We will further address adding additional measures to the final FY 2009 measure set for

the RHQDAPU program in the CY 2008 Outpatient Prospective Payment System (OPPS)

final rule scheduled for publication in November 2007 and, if necessary, in the FY 2009

IPPS proposed and final rules.

Comment: Numerous commenters stated that they support CMS' continued focus

on quality measures and value-based purchasing. In addition, the commenters stated that

they were aware that the Deficit Reduction Act of 2005 expanded quality reporting

requirements for hospitals and provided the Secretary with the discretion to add

additional quality measures that reflect consensus among affected parties. In the

proposed rule, CMS proposed to add five new measures and described the process for

adding additional measures, and the commenters supported CMS' proposed addition of

these five measures because they align with CMS' focus on measures that can be

implemented successfully and which represent aspects of care that are important to patients, efficiency, effectiveness, and patient-centered care.

Response: We appreciate the commenters' support of our continued focus on quality measures and value-based purchasing. Indeed, in adopting additional measures, We aim to choose measures that promote efficiency, effectiveness, and patient-centered care.

Comment: One commenter stated that including four more SCIP measures will be time-consuming and will require more training for the data collectors and medical records coders. As for the fifth measure, Pneumonia 30-day mortality, the commenter noted that this will require no additional effort on its part since the data will come from Medicare claims data. The new risk adjustment methodology utilized for the AMI and HF 30-day mortality measures is an improvement on earlier methodology used for CMS mortality measures published in the 1980's. The commenter assumed the new risk adjustment methodology will be utilized for Pneumonia mortality.

Response: We appreciate the time and effort required to abstract medical record information for quality measures while recognizing the vital utility of the information derived from abstraction to improve our nation's healthcare services. Throughout, we have encouraged hospitals to leverage the primary intent of the SCIP measures, namely, systems level change through the institution. For this reason, we believe that the optimal effect of SCIP will be to change the processes of care for surgical patients making the act of data acquisition a consequence of the delivery of care rather than an after thought. To be specific, the additional measures require the answer to 10 questions: the answers to six

questions are known prior to incision, the answers to two more are known in the post-anesthesia care unit (PACU), and the answers to the final two, required only for cardiac surgery patients, are known by postoperative day number two. In brief, the documentation of these questions should be coordinated with the entire surgical team to make collection easier and to serve as checks on the quality of surgical services.

The commenter's assumption that AMI, HF, and pneumonia measures share common new risk adjustment methodology and confidence intervals for estimating three possible categories for calculation is correct. The three categories into which a hospital can fall based on this methodology are displayed on Hospital Compare as "Better than U.S. National Rate," "No Different than U.S. National Rate," and "Worse than U.S. National Rate."

Comment: Several commenters appreciated and supported the focus on quality but opined strongly that CMS does not understand the resources and internal systems requirements not only to report but to actually do the work of improving care. The commenters stated that the number of measures is growing too quickly, from 10 to 21 to 27 to 32, in 4 years time, without any recognition for the work it takes to report and improve care. While the commenters appreciated the full year notice for new measures, the commenters were very concerned about the number of new measures added each year and suggested that CMS consider what it means for hospitals to garner the resources necessary to assess and improve care processes and to influence clinical practice changes to align with the evidence and to be able to report the measures.

Response: We are aware of the burden on hospitals to abstract data to report the current measures of quality. There are ongoing efforts to define measures that can be based on claims (for example, AMI mortality), to reduce the burden of data collection on current process of care measures, and to learn how currently reported measures might be collected from a functional electronic medical record system. However, it is important for hospitals to continue to incorporate the process of data collection for the current measures into their routine of care. The incorporation of data collection into the hospitals' daily routine will ultimately reduce their overall burden. When making decisions about future measure requirements, CMS intends to continue to carefully consider the resources and internal systems a hospital will need to report measures and implement them into their standard of care.

Comment: One commenter stated that adding monitoring of these measures does not help improve patient care, instead, it just makes sure that hospitals have good documentation. The commenter believed that organizations with small sample size can be at a disadvantage with the implementation of these measures.

Response: We believe that careful and complete documentation is a very important facet of delivering quality and safe health care. Many quality improvement experts believe that even a few performance measure "failures" provide enough information to develop quality improvement interventions. A single case that fails a performance measure may identify a flaw in the system of care that prevented the patient from receiving evidence-based care. In addition, we continue to look for ways to address concerns related to small sample sizes.

Comment: One commenter did not believe that quality improvement has been addressed with the first set of 27 measures and that the data collection burdens of the current 27 and the five additional proposed for FY 2009 had not been addressed. The commenter noted that not every provider has all of this documentation electronically and that to gather this data requires more time and cost. The commenter requested that CMS evaluate whether the quality of care has been improved with the current measures before adding additional measures that may or may not improve quality.

Response: We believe that there is substantial evidence that quality of care and patient outcomes have improved over the years that CMS has focused on hospital quality. Multiple published studies as well as the annual National Healthcare Quality Report that the Agency for Healthcare Research and Quality produces for Congress have highlighted the improvements in processes of care. These processes are very important at the patient-level in reducing mortality, improving quality of life, and reducing readmission. The NQF endorsement process also considers the impact of process measures on outcomes. NQF endorses process measures that possess a considerable evidence base between the process measure and patient outcomes. There has been a steady decline in hospital and 30-day rates of mortality for conditions such as AMI and pneumonia which may be due in part to improvements in care for the current RHQDAPU process measures.

We are aware that there is a burden of data collection for all of the RHQDAPU process measures. Few institutions have the ability to capture this data electronically and even those with fully integrated electronic medical records often have to resort to manual data collection to capture the information for the performance measures. There are

ongoing efforts to work with vendors of electronic record systems to incorporate the data

elements for the RHQDAPU process measures into their tools.

Comment: Two commenters stated that CMS should continue to allow private

sector organizations to have full access to provider performance information (numerator

and denominator) from the Hospital Compare Web site. Many plans rely heavily on the

all-payer data to populate their provider selection tools; withholding or limiting access to

granular performance data would impose additional reporting requirements on providers.

Response: A downloadable Microsoft Access database is available on Hospital

Compare Web site and it is updated on a quarterly basis. It contains counts of each

hospital's patients actually receiving each measure's process of care (that is, numerators)

and counts of each hospital's patients eligible to receive each measure's process of care

(that is, denominators) for hospitals represented on Hospital Compare. There are no

plans to discontinue this service.

Comment: One commenter supported the CMS RHQDAPU program that

provides hospitals the opportunity to submit quality data. The commenter continued to

support the reportable measures under the pneumonia topic, in particular the provision of

adult smoking cessation counseling services, a clinical intervention in which respiratory

therapists are acknowledged experts.

Response: CMS continues to believe that the provision of preventive services

such as smoking cessation counseling are important to improving patient outcomes and

we encourage hospitals to develop systems approaches that would include team members

such as respiratory therapists to provide this patient education.

Comment: One commenter proposed that CMS study application of an exclusionary criterion to the 30-day pneumonia mortality measure in the presence of this ICD-9 Diagnosis Code for the index admission for pneumonia. Otherwise, the commenter believed that a hospital's pneumonia 30-day mortality rate will be unfairly represented in public reporting and annual payment determination because they may be caring for many pneumonia patients who are actually receiving CMO (comfort measures only).

Response: We addressed this concern by taking each patient's health status on admission into consideration. Using inpatient and outpatient claims data for the year prior to admission, the pneumonia 30-day mortality measure model adjusts for a number of factors associated with the likelihood that patients are at the end of their lives, including protein-calorie malnutrition, metastatic cancer, dementia, and age. Hospitals with very sick patients, therefore, will be expected to have more deaths, and the model will adjust their risk-standardized mortality rate (RSMR) accordingly.

In addition, we were careful in our approach to include information about each patient's status at admission and to not adjust for possible complications of the admission. Although some codes, by definition, represent conditions that are present before admission (for example cancer), other codes and conditions cannot be differentiated from complications that occur during the hospitalization (for example infection, shock, and transition to comfort care-only or hospice status). Excluding patients from the analysis who transition to comfort care or hospice may inadvertently reward hospitals that poorly manage their patients.

Comment: One commenter supported CMS' decision to add a SCIP measure related to glycemic control, SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose and noted that there is clinical evidence to support the importance and contribution of postoperative glycemic control for cardiac surgery patients. The commenter also suggested that CMS work with the quality organizations and other stakeholders to develop measures to assess glycemic control in all hospital inpatients.

Response: We appreciate the supportive comment and we look forward to continuing to review the evidence base for glycemic control to potentially expand the suite of measures to accommodate other patient populations. With respect to SCIP infection 4, we are deferring finalizing this measure until it receives NQF endorsement and will further address its inclusion in the FY 2009 RHQDAPU measurement set (effective with discharges CY 2008 discharges) in the CY 2008 OPPS final rule which is scheduled for publication in November 2007.

Comment: Two commenters strongly supported the expansion of the quality items to include additional anti-infection process measures. For FY 2008, the commenter supported the inclusion of SCIP Infection 4, SCIP Infection 6, and SCIP Infection 7.

Response: We appreciate the comment and support for the proposed inclusion of SCIP Infection 4, SCIP Infection 6, and SCIP Infection 7 in the FY 2009 RHQDAPU measurement set (effective with CY 2008 discharges). However, we are not adding these measures in this final rule with comment period, because they have yet received the endorsement of a consensus building entity such as the NQF, which we rely upon to

ensure that our selection of each RHQDAPU measure is an appropriate one for the

program. We intend to add SCIP Infection 4 and SCIP Infection 6 to the FY 2009

measurement set (effective with CY 2008 discharges) in the CY 2008 OPPS final rule

which is scheduled for publication in November 2007, if these measures have received

NQF endorsement. With regard to SCIP Infection 7, we believe it is feasible and

appropriate to wait to adopt this measure until the NQF endorses it.

Comment: Three commenters recommend that SCIP Infection 7 be withheld

from the RHQDAPU program until it is NQF approved.

Response: We appreciate the importance of relying on the endorsement of a

consensus building entity such as the NQF to assure broad consensus and reliability for

our measures. SCIP Infection 7 is still pending NQF endorsement, and as a result, we are

not finalizing the adoption of this measure for the RHQDAPU program at this time. We

believe it is feasible and appropriate to wait to adopt this measure until a consensus

building entity such as the NQF endorses it. When CMS determines adoption of this

measure is timely, we will do so through the rulemaking process. We will address the

status of this measure in the CY 2008 OPPS final rule.

Comment: One commenter requested that SCIP-Cardiovascular-2 not be

required. The commenter indicated that this measure has good intentions but, as written,

is very difficult to abstract. The commenter added that if the definition of perioperative

end time is edited to be more consistent, the commenter would welcome this measure.

Until then, the commenter feared it would only cause more problems then it would solve.

The commenter gives beta-blockers after surgery—but not likely within the nebulous end

time of the perioperative period. Because the commenter believed that this definition was

a convoluted definition, it stated that there was no easy way to create policies or

procedures to address this measure in a reasonable and logical manner.

Response: We are not adopting this measure at this time because it has not yet

received the endorsement of a consensus building entity such as the NQF. However, we

continue to believe that this measure is appropriate because the peri-operative period for

the SCIP cardiac measures is defined as 24 hours prior to surgical incision through

discharge from the post anesthesia care/recovery area. Beta blockers have been shown to

reduce complications in patients at risk for cardiovascular complications. Patients with a

history of myocardial infarction who have beta blocker therapy initiated and maintained

show a 20-30 percent reduction in subsequent cardiac events. Studies show that mortality

from cardiac events is reduced substantially when beta blocker therapy is given in the

peri-operative period. If SCIP Cardiovascular-2 receives NQF endorsement, we intend to

add it for purposes of the FY 2009 RHQDAPU program in the CY 2008 OPPS final rule.

After careful consideration of the public comments received, we are taking the

following actions with respect to the five proposed measures: We are adopting as final

the Pneumonia 30-day Mortality measure we proposed. We intend to add SCIP Infection

4, SCIP Infection 6 and SCIP Cardiovascular-2 to the FY 2009 RHQDAPU measurement

set (effective with CY 2008 discharges) in the CY 2008 OPPS final rule which is

scheduled for publication in November 2007 if these measures have received NQF

endorsement. We are not adopting the proposed SCIP Infection 7 measure in this final

rule with comment period. We believe it is feasible and appropriate to wait to adopt this

measure until the NQF endorses it. When CMS determines adoption of this measure is

timely, we will finalize its adoption for the RHQDAPU program through the rulemaking

process.

The following table contains a list of 18 measures and 8 measure sets from which

we proposed that additional quality measures could be selected for inclusion in the

RHQDAPU program. It includes measures and measure sets that highlight CMS' interest

in improving patient safety and outcomes of care, with a particular focus on the quality of

surgical care and patient outcomes. In order to engender a broad review of potential

performance measures, the list includes measures that have not yet been considered for

approval by the HQA or received endorsement by the NQF consensus review process for

public reporting. It also includes measures developed by organizations other than CMS

as well as measures that are to be derived from administrative data (such as claims) that

may need to be modified for specific use by the Medicare program if implemented under

the RHQDAPU program.

We solicited public comment from a broad set of stakeholders on the measures

and measure sets that were listed, as well as any critical gaps or "missing" measures or

measure sets. We specifically requested input concerning the following:

● Which of the measures or measure sets should be included in the FY 2009

RHQDAPU program or in subsequent years?

● What challenges for data collection and reporting are posed by the identified

measures and measure sets? What improvements could be made to data collection or

reporting that might offset or otherwise address those challenges?

Possible Measures and Measure Sets for the RHQDAPU Program for FY 2009 and Subsequent Years	
Measure	Clinical Condition
Intensive Care Unit (ICU) Critical Care Measures	
1	Stress Ulcer Disease Prophylaxis	ICU/critical care
2	Urinary Catheter-Associated Urinary Tract Infection For Intensive Care Unit (ICU) Patients	ICU/critical care
	Readmission Measures	
3	Readmission Heart Failure (HF) Within 30 Days Rate -- Medicare Only (CMS Methodology)	Efficiency/HF
4	Readmission (same hospital) Acute Myocardial Infarction (AMI) Within 30 Days Rate	Efficiency/AMI
5	Readmission (same hospital) PNE Within 30 Days Rate	Efficiency/PNE
6	Readmission Within 30 Days Of Surgery - Medicare Only (SCIP Global-2)	Surgical Care
NQF -- Nursing Sensitive Condition Set (Outcomes Measures Only)	
7	Failure To Rescue – Nursing Sensitive Measure	Patient centered
8	Pressure Ulcer Prevalence - Nursing Sensitive Measure	Patient centered
9	Patient Falls Prevalence - Nursing Sensitive Measure	Patient centered
10	Patient Falls With Injury - Nursing Sensitive Measure	Patient centered
Cancer (Inpatient) Measures	
11	Patients With Early Stage Breast Cancer Who Have Evaluation Of The Axilla	Cancer – Breast
12	College Of American Pathologists Breast Cancer Protocol	Cancer – Breast
13	Surgical Resection Includes At Least 12 Nodes (ACOS-02)	Cancer – Colon
14	College Of American Pathologists Colon And Rectum Protocol	Cancer – Colon
15	Completeness Of Pathologic Reporting (CCO-04)	Cancer – Colon
Leapfrog Leaps, identified by IOM and Deficit Reduction Act	
16	Use Of Computerized Physician Order Entry (CPOE) Systems	Patient safety
17	Use of Intensivists in ICUs/ ICU Physician Staffing (IPS)	Patient safety
18	Evidence-Based Hospital Referrals	Patient Safety
Measure Sets of Potential Interest	
Sets Under Active Review by National Quality Forum (NQF)	
1	Healthcare-Associated Infection measures – under consideration by the NQF National Voluntary Consensus Standards for Reporting of Healthcare-associated Infections Data Project	Patient Safety
2	Readmission Rates by Condition – under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Efficiency
3	Average Length of Stay (ALOS) by Condition – under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Efficiency
4	AHRQ Quality Indicators, including Patient Safety Indicators -- under consideration by NQF National Voluntary Consensus Standards for Hospital Care: Additional Priorities, 2007 Project	Patient Safety, various conditions
Measure Sets/Practices Previously Endorsed by NQF	

Possible Measures and Measure Sets for the RHQDAPU Program for FY 2009 and Subsequent Years		
Measure		Clinical Condition
5	Safe Practices for Better Healthcare	Patient Safety
6	Serious Reportable Events in Healthcare ("Never Events")	Patient Safety
	Other Hospital Measure Sets	
7	Hospital Emergency Department Measures	Various
8	Vascular Surgery Complications (for Carotid Endarterectomy, Lower Extremity Bypass, Open Surgery Abdominal Aortic Aneurysm Repair, Endovascular Abdominal Aortic Aneurysm Repair)	Surgical Care

Comment: Numerous commenters stated that CMS should only choose measures that have been selected by these two groups (NQF-endorsed, HQA-adopted).

Response: We are committed to adopting NQF-endorsed and HQA-adopted measures whenever possible. Currently, the only measures that are publicly reported or tied to the annual payment update are those measures that are NQF-endorsed and HQA-adopted.

Comment: Numerous commenters stated that CMS should look to the NQF goals as a framework for the types of measures that should be included in the RHQDAPU program.

Response: NQF goals, priorities and measurement frameworks have been, and will continue to be, considered when we select measures to adopt for the RHQDAPU program.

Comment: One commenter stated that CMS should also reiterate that it will follow the goals of the NQF in considering new measures in connection with future reporting under other voluntary initiatives. Included for future consideration should be measures that span multiple populations, for instance, pediatric asthma measures. By

including these measures on the list of reportable measures, hospitals can submit the data

to the Quality Improvement Organization (QIO) Clinical Warehouse, and report them on

Hospital Compare even though the measures will not be included in the RHQDAPU

program.

Response: It is our intent to consider NQF goals and priorities when identifying

measures for future reporting. In terms of reporting measures that are not RHQDAPU-

required, we have in the past, and will most likely in the future, make public on Hospital

Compare data pertaining to measures that we have asked hospitals to report under another

voluntary reporting initiative but that are not, at the time, RHQDAPU-required. Since

CMS plays an important role in the provision of health care services to multiple

populations though the Medicare and Medicaid programs, the development of

standardized performance measures that promote care for all populations is important,

whether or not those measures are included in the RHQDAPU program.

Comment: One commenter fully supported the mortality rate reporting and would

like to see mortality measures for additional diagnoses included in the RHQDAPU

program. The commenter stated that its hospitals would appreciate receiving reports on a

quarterly basis to further inform care improvement efforts.

Response: The methodology used to calculate the current risk-standardized

mortality rates requires one year of inpatient Medicare claims data plus one year of data

on the patient's prior hospitalizations and outpatient care (Part A and Part B data).

Quarterly reporting using the current methodology is not feasible and would likely not

provide useful information on trends in mortality. Additional work is also needed to

include additional diagnoses beyond AMI, HF, and pneumonia to validate the risk

adjustment models using claims-based data.

Comment: One commenter was concerned that CMS has not yet implemented

hospital reporting for three Leapfrog Leap measures identified by the Institute of

Medicine and included in the DRA—use of computerized physician order entry (CPOE)

systems, use of intensivists in ICUs/ICU physician staffing, and evidence-based hospital

referrals. The commenter urged that CMS implement these important measures of

patient safety in FY 2008.

Response: The Leapfrog measures are under consideration for inclusion in the

RHQDAPU program in FY 2010 and subsequent years. However, while we believe that

these measures are important in large institutions or academic centers, it is unclear that

they are broadly applicable to the more than 3000 PPS hospitals that participate in the

RHQDAPU program. In addition, these measures of structure have broad financial

implications for hospitals such as the costs of implementing CPOE systems, the

availability of trained intensivists in many communities, and the need for access to

healthcare services in many regions of the country. For the majority of surgical services

and almost all medical diagnoses, there is limited evidence to support improved patient

outcomes based on hospital referral to high-volume hospitals. For a small number of

operations or diagnoses, it may be reasonable to develop metrics for "evidence-based

referrals." We will continue to study these issues and will propose to adopt the Leapfrog

measures if we believe they are appropriate for the RHQDAPU program.

Comment: Two commenters opposed the inclusion of the three structural

measures supported by The Leapfrog Group. They indicated that these structural

standards are best viewed as "aspirational best practices" (as The Leapfrog Group itself

intended), as opposed to a national standard of care. Because the proposed standards

represent "leaps" beyond normal practices, the commenters stated that rural hospitals

have not been asked by the Leapfrog Group to comply with the standards. In addition,

they indicated that these measures are not NQF-endorsed and HQA-recommended for

inclusion in the program.

Response: We appreciate this comment. The purpose of the list of possible

measures for FY 2009 and beyond is to elicit comment from a wide array of stakeholders.

As we have stated, we are committed to using measures that are endorsed by a consensus

building entity such as the NQF and supported by the HQA. We will consider this

comment in future decisions about measures expansion.

Comment: One commenter stated that it is not clear from the information

provided in the proposed rule, how the patient safety measures 16, 17, and 18 would be

reported and whether they would be reported on an annual basis. The commenter also

stated that all measures currently reported for RHQDAPU are at the patient level, and

these Leapfrog Leap Measures address structural components and, therefore, would

require a different infrastructure to collect.

Response: We appreciate these comments, and they highlight important

operational questions that CMS must answer before it considers adding these measures in

the future. We will consider data collection frequency and data infrastructure needs of

these structural measures in our future measures expansion decisions.

Comment: One commenter stated that it is critical to include the Joint

Commission Mortality measure for ICUs in the RHQDAPU measure set. The Leapfrog

Group Intensivist Physician Staffing Leap could be augmented by use of the Joint

Commission ICU mortality measure now in the field.

Response: We do not believe that the Joint Commission ICU mortality measure

has been endorsed by a consensus building entity such as the NQF. CMS strives to use

consensus based measures for inclusion in the RHQDAPU measure set, and NQF

endorsement is only one of many possible methods to demonstrate this consensus basis.

Comment: One commenter stated that a glaring weakness of the Leapfrog data is

that they are self-reported and becoming ever more complicated, which will certainly

lead to disparities in data interpretation. While it is a useful exercise for an individual

provider to work through the Leapfrog questions, the commenter believed that it was

ridiculous to assume that providers' responses can be compared to each other

meaningfully.

Response The Leapfrog survey data is not one of the measures recommended by

the IOM report, and we are not otherwise considering adopting it for the RHQDAPU

program.

Comment: Two commenters asked that as CMS moves forward with the initial

expansion of these quality measures, as well as future measures, CMS be cognizant of the

need for appropriate recognition of imaging technology within these measures. For

example, the commenters supported CMS' efforts in adopting the current quality

measures, such as the measure requiring that patients receiving a percutaneous coronary

intervention receive the intervention within the first 120 minutes of admission for

myocardial infarction. The commenters state that Medicare beneficiaries can benefit

greatly from this life-saving procedure and imaging equipment is intrinsic to performing

this procedure. As CMS looks to the future and implements its value-based purchasing

program for Medicare, the commenters asked that appropriate imaging used during

specific diagnostic and therapeutic procedures be properly addressed within the

measures.

Response: We are aware of the role that imaging technology can play in the

delivery of quality healthcare and will, as appropriate, consider these technologies as

measure sets and priority areas expand in the future. However, we are not aware of

specific quality metrics that have focused on the type of imaging equipment that is used

related to the current performance measures for hospital quality.

Comment: One commenter believed that wherever possible, quality measures

developed as part of the RHQDAPU program should be applied in other care settings

through inclusion in the Physician Quality Reporting Initiative (PQRI) and the outpatient

quality reporting program measure sets. The commenter believed it made sense for

CMS' quality measures to be consistent across provider settings.

Response: We agree and are involved in efforts to do just that. In particular, we

are participating in an NQF group dealing with harmonization of measures across

settings. In the future, we intend, as often as possible, to adopt measures that have been

developed for one setting (for example, physician practices) in other appropriate and

feasible settings (for example, hospital outpatient department). It makes sense to align

the incentives for high quality care.

Comment: One commenter urged CMS to take the leadership role with

stakeholders to develop consensus recommendations for care coordination quality

measures for adoption into the RHQDAPU program. In the absence of care coordination,

patient safety issues, medication errors, and miscommunication can lead to suboptimal

outcomes and increased costs, as documented by numerous studies. Care coordination is

particularly important for vulnerable populations that have chronic health care needs,

although everyone that suffers acute illness will need at least temporary care coordination

on some level. The commenter believed that CMS should take the lead in encouraging

the development of measures in this area because it likely would improve the outcomes

among patients who receive care across different types of facilities and also should help

reduce unnecessary expenditures for duplicative care as patients move between care

settings.

Response: This is an important comment and we could not agree more. There are

ongoing efforts to develop a standard framework for quality improvement and quality

assessment that addresses care transitions that is in part based on recently NQF-endorsed

measures of care transition.

Hospital performance on the 30-day mortality measures reflects both the quality

of care during patients' hospitalizations and the coordination of their care at discharge or

transfer. By addressing 30-day (rather than in-hospital) mortality and assigning the

outcome for transfer patients to the first admitting hospital, the measures hold hospitals accountable for transitions in care to other settings and discharge planning. Actions taken at the admitting hospital, during a transfer, at a receiving hospital, and in outpatient settings after discharge all can affect 30-day mortality. CMS hopes this approach will encourage coordination between hospitals and their provider networks. CMS is also developing a readmission measure that will complement the mortality measure by promoting efforts to reduce unnecessary readmissions. Readmission rates are influenced by the quality of inpatient and outpatient care, availability and use of effective disease management programs and the capacity of the health care system. Short-term readmission is almost always an adverse event for patients and expensive for the health care system. Measurement and dissemination of readmission rates, which are the joint responsibility of hospitals and clinicians, will create incentives to invest in interventions to facilitate transitions in care and improve patient outcomes.

Comment: One commenter recommended that in order to ensure that patient needs are met across multiple providers, CMS should encourage consensus organizations to develop appropriate measures at the practice, group, hospital, or organizational level and that CMS should encourage the development of measures that address each of the following areas, identified by the NQF as "essential components and subcomponents for which performance measures should be developed if care coordination is to be comprehensively measured and improved:"

- Medical home for each patient;

- Proactive plan of care and follow-up for each patient;

- Use of standardized, integrated information systems;

- Standardized data elements for patient's personal medication records;

- Standardized data elements for medication reconciliation; and

- Standardized care guidelines for transitions between care settings that include

medication reconciliation and care plan and communication plan between medical team

members, patients, and caregivers.

Response: We appreciate this thoughtful comment. Although the

recommendations are challenging to implement, we are committed to moving forward to

develop measures that incorporate these types of goals and frameworks. Again, there are

ongoing efforts to develop a standard quality framework based on measures of care

transition between the hospital and the post-acute setting that are endorsed by one or

more consensus building entities such as the NQF.

Comment: One commenter stated that from an administrative point of view, it

was worth pointing out that not all the potential new measures are included in the medical

records consistently, for example, Stress Ulcer Disease Prophylaxis, Community

Acquired Pneumonia, and American College of Surgeons protocols. Readmission rates

would have to be captured from Medicare claims data.

Response: For stress ulcer prophylaxis, since these medications do require a

physician's signed order, we believe that they can always be found in the chart.

Antibiotics for pneumonia or for prevention of surgical site infections also require a

physician's order and we also believe they can be found in the chart. We agree that

readmission rates would most likely be captured from Medicare claims data.

Comment: One commenter stated that among the AHRQ data measures, Failure

to Rescue is a poor measure of quality. The data come from administrative files, are

subject to coding disparities, and do not adequately consider co-morbid or chronic

conditions.

Response: We proposed this measure and other AHRQ data measures for

potential inclusion in future years to solicit public comment. We thank the commenter

and will consider this comment in measure selection for future years.

Comment: One commenter stated that for some of the possible measures

identified for inclusion in the RHQDAPU program for FY 2009 and subsequent years,

the documentation exists in the medical record now but is not currently being abstracted.

Thus, it would take considerable extra effort to find and report it. Another commenter

had concerns regarding two ICU critical care measures—stress ulcer disease prophylaxis

and urinary catheter-associated urinary tract infection. The commenter agreed that both

are worthy subjects. However, in this commenter's institution, this information is on the

medical chart and would require chart extraction, which is time-consuming and costly.

The commenter stated that as CMS continues to expand the measures for hospital quality,

it is import that it be recognized that there are costs to this process.

Response: We recognize the burden and resources required for collection of data

to report the measures of hospital quality included in the RHQDAPU program and will

consider the burden when we select additional measures to adopt in the future. We also

note that there are ongoing efforts to develop measures that do not require chart

abstraction (for example, claims-based measures of mortality), efforts to streamline data

collection tools, and efforts to incorporate the data requirements for many of these

performance measures into electronic medical record tools.

Comment: One commenter urged CMS to proceed to adopt additional infection

prevention measures, regardless of whether they have been formally agreed to through

the sometimes over-lengthy consensus process. Specifically, the commenter supported

the inclusion of urinary catheter-associated urinary tract infection (UTI) for ICU patients

as an outcome measure.

Response: Whenever possible, we use measures that are based on high-quality

scientific evidence, widely accepted clinical guidelines, and consensus recommendations

endorsed by the National Quality Forum. We realize that at times this can create delays

in implementing measures, but it ensures that all the relevant stakeholders, including

relevant medical experts, have adequately reviewed the measures.

Comment: One commenter urged CMS to turn its focus on outcome measures

relating to issues other than hospital-acquired infections. The commenter supported the

30 day morality measures for AMI and Heart Failure for inclusion in the FY 2008 rule.

The commenter also supported the other outcome measures listed for possible inclusion

in FY 2009 and future. Specifically, the commenter supported the 30-day Pneumonia

mortality measure, the four 30-day readmission measures, and the AHRQ quality and

patient safety indicators.

Response: This year, CMS will be publicly reporting data on measures of 30-day

mortality for AMI and HF, and beginning next year will report the hospital 30-day

pneumonia mortality we are adopting as final in this rule. There are ongoing efforts to

develop measures of outcome such as hospital readmission and measures of inpatient care that focus on patient safety.

Comment: One commenter was concerned about the readmission measures for acute myocardial infarction and pneumonia within 30 days at the same hospital and believed that by restricting these measures to the same hospital, an inappropriate incentive is created for these cases to be referred to a different hospital. The commenter believed that these measures should apply to both readmission to the same hospital or to another hospital where the readmission has occurred and believed that only by reviewing both statistics will one have a balanced view of what is happening with patients returning to any hospital within 30 days for the same condition.

Response: We are considering readmission to any hospital in connection with the readmission measures that were identified in the proposed rule as possible measures for the RHQDAPU program for FY 2009 and subsequent years.

Comment: One commenter stated that, as with previous measures now being reported under the RHQDAPU program, it is important to have an initial data collection period prior to a public reporting period to assess the reliability and validity of the measures and data collection processes. During the initial data collection period, many problems are uncovered and details can be worked through. The commenter believed that a number of the measures listed for consideration, however, remain far from being ready for field-testing.

Response: We agree that the measures and measure set in the list of possible

measures for FY 2009 and beyond are at different stages of development, and that not all

can be used as early as FY 2009 without additional development.

Comment: Two commenters requested that CMS address the deficit of measures

relating to medical prophylaxis of VTE. Given the effectiveness of available

prophylactic measures, the commenter also asks that CMS promote the development of a

measure relating to VTE readmission. The commenters also asked CMS to promote the

development of measures related to glycemic control for all inpatients. In recognition of

the importance of coordinating care for a single patient across an array of providers, the

commenters encouraged CMS to consider taking an active role in encouraging the

development of measures relating to care coordination.

Response: We appreciate this comment. The NQF is currently conducting an

evaluation of VTE measures that was sponsored by the Joint Commission. A variety of

VTE measures are being evaluated and tested and CMS is supportive of this effort.

Comment: Several commenters strongly encouraged CMS to adopt measure 13,

one of the possible cancer (inpatient) measures, for implementation under the

RHQDAPU program in FY 2009, if not sooner. The commenters believed that

incorporation of measure 13 would send the message that adequate lymph node

evaluation of at least 12 nodes is critical to patient care and would result in better

outcome with increased survival for stage II and III colon cancer patients and noted that

the evaluation of at least 12 lymph nodes is critical in determining colon cancer patient

prognosis, planning for treatment options, and is associated with increased survival. One

commenter supported the consideration of the number of lymph nodes evaluated as a measure of the quality of colon cancer care.

Response: We appreciate these comments, and agree that this measure shows much potential for future adoption in the program to improve quality of care for colon cancer patients. As we have stated, we are committed to using measures that are endorsed by a consensus building entity such as the NQF and supported by the HQA. Our current process for measure adoption includes consideration of measures that can be implemented nationally and have been endorsed by the NQF. We are constantly reviewing and updating our portfolio of quality measures to incorporate such new and innovative measures that speak directly to our goal of improving the quality of care for our beneficiaries.

Comment: Two commenters stated that CMS should consider computer-assisted navigation of surgical procedure measures. The commenters also state that CMS encourage hospitals to report the computer assisted surgery codes (00.31; 00.32; 00.33; and 00.34) when the technology is used with total joint procedures. The commenters also encouraged CMS to remind hospitals to code for computer-assisted navigation surgery when it is used to encourage more accurate billing and charges for computer-assisted surgery for total joint procedures and more complete data for analysis and DRG assignment. This is important because of the need for more accurate data to analyze the impact of navigation on improved patient outcomes.

Response: We will consider this measure in future measures expansion decisions. Computer assisted surgery is in its infancy and we are sure there will be opportunity to

design quality measures for this adjunctive technique as the evidence base grows. We

encourage complete and accurate coding for all procedures and CMS has a very proactive

program to promote that at many levels. Accurate coding is also critical to producing

valid measure estimates of surgical process measures, since these surgical procedure

codes are used as one data element to define the population of patients eligible to receive

surgical processes of care measured. We agree that the claims database represents a

tremendous opportunity to understand clinical patterns in computer-assisted surgery.

Comment: One commenter stated that in keeping with the continued expansion of

quality measures and the appropriate criteria that CMS has specified, CMS should add

computer assisted surgery to the list of inpatient quality measures. The commenter

indicated that computer assisted surgery improves outcomes and often reduces length of

stay. However, the commenter added, the capital equipment needed for these procedures

requires an initial investment from the hospital. The commenter believed that the new

quality measures are therefore ideally suited for this situation; creating a quality measure

for computer assisted surgery will award hospitals for prioritizing patient care, clinical

outcomes, and long-term efficiency over short term financial interests.

Response: Computer assisted surgery is in its infancy and we are sure there will

be opportunity to design quality measures for this adjunctive technique as the evidence-

base grows. For the most part, CMS SCIP measures are designed to improve the quality

of systems of perioperative care delivery. As we have stated, we are committed to

adopting consensus-based and evidence-based measures for the RHQDAPU program.

Comment: Three commenters recommended that CMS evaluate whether the measures currently utilized are capturing improvements in quality and ensure that additional measures will result in meaningful quality improvements rather than merely increased administrative burden by hospitals without measurable improvement in patient care or results.

Response: The current RHQDAPU process measures are based on strong evidence linking the process measure (for example, giving an aspirin at arrival) to improved patient outcomes. The individual process of care measures are based on studies that have shown, at the patient level, that providing the process improves patient outcomes. The 30-day mortality measures have been validated against medical record based estimates of 30-day patient mortality. The HCAHPS measures have been extensively tested in pilot studies. All of the process and mortality measures that are currently utilized have been reviewed through technical expert panels made up of representatives of topic-specific specialty societies and clinical experts in the field. The NQF has endorsed all the current RHQDAPU measures that are publicly reported. We agree that there is a need to focus on additional measures that evaluate overall quality of the entire system providing care to the patient (for example, readmission, care transitions).

Comment: Two commenters strongly agreed with CMS' consideration of the ICU measures for FY 2009 and subsequent years, however, they strongly disagreed with the following measures:

● Readmission Measures—this represents a burdensome data collection for

hospitals. Data must be derived from medical records as there is not an effective

mechanism from identifying readmissions using administrative data.

● Nursing Sensitive Condition Set—these measures require chart abstraction to

verify and are far from ready for implementation.

● Inpatient Cancer Measures—inpatient cancer treatment is low volume and

would result in small numbers of reported cases. This leads to low statistical value.

● Leapfrog Measures—hospitals have been reporting these measures for

sometime, yet they have limited value in assessing quality.

Response: The readmission measures will most likely be produced using

Medicare administrative data. We are considering the other issues raised by the

commenters as we evaluate these measures for subsequent years.

Comment: One commenter believed that health care quality improvement

programs should adopt standard quality measures that are developed with the

involvement of pharmacists, are evidence-based, and promote the demonstrated role of

pharmacists in improving patient outcomes.

Response: We agree that pharmacists play an important role in the provision of

high quality care to patients. Representatives of the American Society of Healthsystem

Pharmacists have played an important role in the development of the Surgical Infection

Prevention Project and the subsequent Surgical Care Improvement Project. Pharmacists

play an important role on many of the guideline committees upon which many of the

evidence-based performance measures for national implementation are developed.

Comment: Three commenters urged CMS to carefully evaluate the value of the measures considered for future reporting and recommended that measures be evidence-based, contribute to the comprehensiveness of performance measurement, be under a hospital's control, and account for potential unintended consequences.

Response: Whenever possible, we use only measures which have a strong evidence base and have been endorsed by a consensus building entity such as the NQF. We maintain the evidence base by conducting frequent literature reviews. If new literature shows the measure is no longer valid or is leading to unintended consequences, we will take appropriate action to modify or suppress the measure or to retire the measure through future rulemaking. We maintain a process for continued enhancements and updates as clinical evidence changes.

Comment: One commenter commended CMS for considering whether to include breast cancer as one of the clinical conditions under the proposed new quality measures for FY 2009 and subsequent years and requested that CMS allow manufacturers of advanced therapies involved in the treatment of breast cancer to be involved in the development of the quality measures.

Response: Any performance measures that are developed will be based on published evidence and guidelines for care, with the input of clinical experts

Comment: One commenter encouraged the development and application of measures of resource use, such as the 30-day readmission rates that are included in the proposed table of possible measures and measure sets for FY 2009 and subsequent years. The commenter believed that reducing potentially avoidable readmissions should be a

part of the efforts to increase the value of health care because it reduces unnecessary

spending for the Medicare program and enhances the quality of care for beneficiaries.

Response: We agree that measures such as readmission rate provide additional

information, in combination with the other quality measures, on the quality of care

provided in hospitals.

Comment: One commenter was concerned about the choice of length of stay as a

resource use measure because it does not necessarily align with improving transitions

from the inpatient setting to other care settings or to home. The commenter believed that,

ideally, Medicare's payment systems should provide an incentive to use the most

efficient mix of services possible during and after a hospital stay. The commenter added

that rewarding below-average hospital lengths of stay through a quality incentive

payment program would strengthen the incentive to transfer patients to a post-acute

setting as quickly as possible, without regard for whether this is the most efficient course

of treatment for the overall episode of care. The commenter believed that such a

measurement may conflict with hospitals' efforts to avoid readmissions, if doing so

would lengthen patients' initial stays.

Response: We appreciate this comment, and will consider in future measures

expansion decisions. We understand that a comprehensive estimate of hospital quality

and efficiency would assess both length of stay and balancing measures that addressed

hospital readmission and utilization of ambulatory care resources.

Comment: One commenter recommended that HQA determine the measures or

measure sets to be included in the FY 2009, and develop an implementation schedule for

subsequent years. One commenter believed that in order for it to provide comments and recommendations on measure sets of potential interest within the table, more information would be needed than was available in the proposed rule (for example, Nursing Sensitive Condition Set).

Response: CMS ultimately decides on the measures for inclusion in the RHQDAPU program. However, CMS solicits input from the HQA before setting selected priorities for hospital performance measure implementation in the RHQDAPU program. The HQA has proposed to CMS potential measures on a timeline for implementation in the future.

Comment: One commenter urged CMS to rapidly incorporate additional measures for FY 2009 to offer a more robust dashboard of publicly reported measures and strongly supported the infusion of efficiency, outcome, outpatient, care coordination, patient safety, and structural measures into the RHQDAPU program. The commenter also strongly supported the development of measures to assess equity in order to reduce health care disparities and encouraged the provision of quality care for at-risk populations.

Response: We agree with the commenter. There are ongoing efforts to develop new measures to address efficiency of care, outpatient department performance, care coordination, and patient safety. Because there are few measures that have been developed and thoroughly tested for validity and reliability on a national scale, it will take some time to adequately test new measures and obtain the endorsement of these measures from a consensus building entity. We also have considerable interest in

reducing disparities in care through performance measurements and incentives. There are

ongoing evaluations to determine if some of the disparities on performance for the

hospital quality measures represent disparities by group within a specific hospital, or

disparities across all groups between hospitals.

Comment: One commenter stated that composite measures increase the

meaningfulness of health care performance information and are critical to help consumers

integrate complex information into their decision making and that CMS should move

rapidly to report composite measures on the Hospital Compare Web site while retaining

the "drill down" function to permit a more granular assessment of performance.

Response: We interpret the term composite measures to mean single combined

measures calculated from multiple individual measures submitted by hospitals.

Composite measures might include both measures listed in RHQDAPU requirements and

non-RHQDAPU measures voluntary reported by hospitals. While it seems that composite

measures may provide information that is more meaningful to consumers, there has not

been extensive testing of this premise. CMS is soliciting input from the HQA on the issue

of reporting composite measures of care on the Hospital Compare Web site. For the

RHQDAPU program, CMS expects to continue to require hospitals to submit individual

measures that would comprise any composite measure calculated from these individual

measures. CMS and its partners expect to benefit from the work on composite measures

that has been done in the Premier Hospital Quality Incentive Demonstration and

elsewhere.

Comment: Two commenters stated that the NQF Nursing Sensitive Measurement Set and measures that access the care provided to "transfer patients" may be applicable to small and rural hospitals, and hoped that CMS will act favorably on such measures to broaden the ability of all hospitals to participate in public reporting and to increase the consumer appeal of the Web site. The commenter also believed that reporting measures for the outpatient setting-Emergency Room and ambulatory surgery on the Hospital Compare Web site would be responsive to consumer and purchaser needs.

Response: We are engaged in efforts to broaden the hospital quality measure set to include measures appropriate to the outpatient hospital setting, including care provided to "transfer patients" currently excluded from RHQDAPU heart care measures. We believe that these measures are useful for all hospitals that treat and subsequently transfer, regardless of hospital size and urban/rural setting. CMS plans to begin reporting outpatient/ambulatory care measure results on the Hospital Compare Web site in the near future.

Comment: One commenter believed that CMS needed to evaluate the resource impact on providers by requiring the collection and reporting of additional abstracted measures such as the Intensive Care and Cancer measures and that these specifications are old and were not implemented due to complexity of data extraction. The commenter believed that CMS should not require hospitals to collect additional measures on top the current requirements. The commenter stated that hospital spend all available resources to collect data on Heart Attack, Heart Failure, Pneumonia, and SCIP measures. The

commenter wanted CMS to consider the retirement and/or rotation of measures to lessen

future data collection burden on hospitals.

Response: We are aware of the burden of data collection for all of the

RHQDAPU measures. The burden of data collection is considered with the

implementation of any new measure set. Few institutions have the ability to capture most

quality data electronically and even those with fully integrated electronic medical records

often have to resort to manual data collection to capture the information for the

performance measures. There are ongoing efforts to work with vendors of electronic

record systems to incorporate the data elements for the RHQDAPU measures into their

tools. There are ongoing discussions about how to retire measures from reporting when

high rates of improvement have been achieved.

Comment: One commenter stated that CMS should consider prioritizing the

implementation of administrative measures over measures requiring abstracted data from

the medical record and that CMS needs to continue to test these administrative measures

prior to the public reporting. The commenter believed that the process for introducing

public reporting with a dry run hospital preview period for Heart Attack (AMI) and Heart

Failure 30-day mortality measures should continue as standard practice.

Response: We recognize that adopting measures for the RHQDAPU program that

use administrative data, instead of abstracted data, has its advantages, including

decreased data collection cost. However, there are also many challenges associated with

using administrative data for quality measurement and reporting, including risk

adjustment, differentiating performance between hospitals, and minimizing time lag

between delivery of care and public reporting. We plan to develop additional administrative data-based measures.

Comment: One commenter asks that CMS consider adding the stroke measure set developed by the Stroke Performance Measures Consensus Group to the RHQDAPU program for FY 2009 and to the new hospital value-based purchasing program when it is approved and implemented by CMS.

Response: We agree that the stroke measure set is a potentially useful addition to the RHQDAPU program. The quality measurement collaboration between the American Heart Association/American Stroke Association, along with CDC and the Joint Commission has agreed to a common set of 10 performance measures that were designed for certification of stroke centers. We are currently evaluating the list of 10 measures to determine if any are suitable for inclusion in the RHQDAPU program and the Hospital Compare Web site. We note, however, that the RHQDAPU program applies to all IPPS hospitals, not just certified stroke centers.

Comment: One commenter urged CMS to develop a policy to harmonize measures which relate to payment, such as the NQF's move from a four hour timeframe for initial antibiotic administration for pneumonia patients to a six hour timeframe. The commenter believed that CMS is still requiring four hours. NQF made this change due to clinical concerns that patients whose pneumonia diagnoses were not yet confirmed were receiving unnecessary antibiotics, which is a national healthcare problem.

Response: We appreciate this comment, and are aware of the current NQF endorsement status of the six hour pneumonia measure. This endorsement occurred after

publication of the FY 2008 IPPS proposed rule. CMS will evaluate this change, and if

we believe it is an appropriate one for the RHQDAPU program, will align this measure

with the NQF's current endorsed measure.

Comment: Several commenters expressed concerns with the abstraction

instruction in the CMS/The Joint Commission National Hospital Quality Measure

Specifications Manual that the medical charts be abstracted at "face-value." The medical

chart is written for medical persons and should be taken in the context of medical care.

The most troublesome aspect of the "face value" rule is that the commenter was alerted to

it in April and told that it would apply back to October discharges. The rule change

caused substantial rework for the chart abstractors. A commenter suggested that

providers receive the specifications for abstraction before the time period for which they

apply.

Response: The "face value" instruction cited by the commenter was included in

the specifications manual published in June 2006, approximately 120 days prior to the

initial October 1, 2006 discharges. The later communication by CMS was intended to

alert hospitals about the existing abstraction instructions already published on the

QualityNet Web site. The RHQDAPU chart audit validation requirement uses

independent reabstraction of medical charts by CMS contractor abstractors to assess

abstraction accuracy. The CMS abstraction contractor is not associated with the hospital

and is not intimately involved in providing the care to the patient referenced in the

medical chart, and must abstract the data elements using only the documentation included

in the medical record. CMS and The Joint Commission coauthor the specifications

manual to provide the same set of explicit instructions to all parties, hospitals and CMS abstraction contractors. The "face value" provides explicit instruction that matches the instructions that CMS provides to its abstractors.

Comment: One commenter suggested that CMS add the NQF-endorsed measure "Anti-platelet medications at discharge for Cardiac Surgery" to the hospital data reporting requirements for FY 2008. This measure is very different from the measures SCIP Cardiovascular-2: Surgery Patients on a Beta-Blocker Prior to Arrival, and the two AMI measures Aspirin at Arrival, and Aspirin Prescribed at Discharge. Aspirin and anti-platelet therapy are clinically very different. NQF has endorsed "Anti-platelet medications at discharge for Cardiac Surgery."

Response: We will consider this comment in our future decisions to expand the RHQDAPU program's list of measures. We understand that current SCIP initiatives related to cardiac surgery do not focus on discharge medications at this time, and must consider factors including the following: the number of surgeries affected by the measure; the relative strength of evidence related to improving outcomes, and relative data collection burden.

Comment: One commenter recommended that CMS continue to expand to new disease states (cancer measures) as well as focus on efficiency measures (Average Length of Stay by Condition), surgical care, and patient safety measurement.

Response: CMS is continuously working on developing new measures and is considering the pros and cons of expanding RHQDAPU measures to include measures related to disease processes such as ESRD, diabetes, asthma, and cancer.

After careful consideration of the comments received regarding the 18 measures and eight measure sets we set out in the FY 2008 IPPS proposed rule that could be included in the RHQDAPU program for FY 2009 or subsequent years, we have decided not to adopt any of these measures or measure sets for FY 2009. As discussed above, we will continue to consider some of these measures and measure sets for future years.

b. Data Submission

In order to be eligible for the full FY 2009 market basket update, we proposed that hospitals be required to submit data on 32 measures (the 27 existing measures plus the 5 proposed new measures). The technical specifications for this requirement are published in the CMS/Joint Commission Specifications Manual for National Hospital Quality Measures. This manual can be found on the QualityNet.org Web site.

For the additional SCIP measures that we proposed to add in the FY 2008 IPPS proposed rule, (SCIP Infection 4, 6, and 7 and SCIP-Cardiovascular-2), hospitals would be required to submit data to the QIO Clinical Warehouse starting with discharges that occur in CY 2008. We proposed that the deadline for hospitals to submit this data for first calendar quarter of 2008 would be August 15, 2008. Data must be submitted for each subsequent quarter by 4.5 months after the end of the quarter.

We proposed this time period to allow hospitals sufficient time to prepare for the data collection. The three SCIP Infection measures that we proposed to include for FY 2009 were added to the Manual in version 2.0, effective with third calendar quarter of 2006 (3Q06) and the proposed SCIP Cardiovascular measure was added in version 2.1d of the Manual, effective with fourth calendar quarter of 2006 (4Q06). Hospitals may

report data on these measures for discharges prior to CY 2008 discharges, if they so

choose.

For the proposed Pneumonia 30-day mortality measure, we proposed to use

claims data that are already being collected for index hospitalizations to calculate the

mortality rates. As is the case with the other 30-day mortality (outcome) measures

already associated with the RHQDAPU program (AMI, HF), hospitals would not need to

submit additional data. Claims data submitted to CMS for index hospitalizations

occurring from July 2006 through June 2007 (3Q06 through 2Q07) would be used to

calculate the Pneumonia 30-day mortality rate that will be used for FY 2009 annual

payment determination.

As noted above, we are not adopting the SCIP infection or cardiovascular

measures for the FY 2009 RHQDAPU program at this time, but intend to adopt SCIP

Infection 4, SCIP Infection 6 and SCIP Cardiovascular 2 measures in the CY 2008 OPPS

final rule, if these measures have been NQF-endorsed. If the measures are endorsed, we

intend to finalize our proposal to require their reporting under the RHQDAPU program

effective with CY 2008 discharges and we anticipate that the submission deadlines for

the first quarter of CY 2008 discharges will be August 15, 2008. We are not adopting the

proposed SCIP Infection 7 in this final rule with comment period. We intend to adopt

this measure after the NQF endorses it. When we determine to adopt this measure, we

will do so through the rulemaking process and we will include data submission

timeframes. We are finalizing our proposal to use the claims data submitted to CMS for

index hospitalizations occurring from July 2006 through June 2007 (3Q06 through 2Q07)

to calculate the Pneumonia 30-day mortality rate that will be used for FY 2009 annual

payment determination.

Comment: One commenter did not believe it was reasonable to assume billing,

including the reprocessing and resubmission of any corrected bills, will be complete for

100 percent of cases to allow for data submission to begin within 60 days post-discharge.

Response: We appreciate this comment. We interpret your comment to refer to

the 60 day submission deadline as proposed in the Value Based Purchasing listening

session held in April 2007. The current CMS RHQDAPU quarterly submission deadline

is currently about 135 days after the last discharge date of the quarter. This submission

deadline schedule is published on the QualityNet Web site.

All measures that we have previously finalized, and that we finalize in the future

through the rulemaking process, will be required for the RHQDAPU program annual

payment determination each year until further notice. CMS, working in conjunction with

the Joint Commission, maintains the specifications for the set of measures used both for

the RHQDAPU program and for reporting under the HQA initiative. The specifications

are updated semiannually and changes are made prospectively, except in exceptional

circumstances. Revised specifications can be found at www.qualitynet.org.

4. Retiring or Replacing RHQDAPU Program Quality Measures

Over time, CMS expects that the set of measures used for the RHQDAPU

program will evolve and change. New measures will be added to reflect clinical and

other program goals. Measures that are no longer supported by clinical evidence will be

modified or dropped. Through its public reporting and RHQDAPU program activities,

CMS seeks to balance the competing goals of assuring the development of a comprehensive yet parsimonious set of quality measures while reducing the reporting burden on hospitals. Section 1886(b)(3)(B)(viii)(VI) of the Act gives the Secretary authority to replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance, or the measures or indicators have been subsequently shown not to represent the best clinical practice. CMS recognizes the need to develop a process related to the retirement and/or replacement of measures that comprise the RHQDAPU program measure set. In the FY 2008 IPPS proposed rule (72 FR 24807), we solicited public comment and suggestions concerning the criteria and mechanism for a process that would identify and, where appropriate, retire or replace measures that comprise the RHQDAPU program measure set.

Comment: Two commenters recognized the need to retire or replace measures. However, in doing so, they stated that CMS should guard against a decrease in hospital measure rates once a theoretical or real maximum has been achieved, since the removal of public reporting might lessen hospital attention on these processes of care.

Response: We also understand that there is a risk in retiring measures that have 'topped out' and will attempt to mitigate that risk if any measures are retired, including possible monitoring of these measure rates to ensure continued high performance.

Comment: One commenter stated that CMS should decide to drop a measure if it finds that hospitals have exhibited and maintained a high quality of care per that particular quality measure.

Response: We appreciate this comment and will consider the comment when it

makes future proposals regarding the RHQDAPU measure set. In the future, CMS and

its contractors plan to periodically review measures and make recommendations

regarding, among other possibilities, retirement of measures for future proposed

RHQDAPU measure sets.

Comment: Numerous commenters stated that CMS should develop a policy for

suspending measure when there is a change in science or an implementation issue arises

during a reporting period and needs to be addressed immediately.

Response: We have a history of suspending measures for public reporting

purposes only due to changes in science or implementation issues. Examples include

suspending public reporting of the influenza vaccination measure at times of national

shortage or national delays in vaccine delivery, and suspension of SCIP Infection 2

(prophylactic antibiotic selection for surgery) when there were shortages of

recommended antimicrobials for colorectal surgery prophylaxis. Specifically, we review

measures on a continuous basis and can react if there is a change in science or if an error

in the technical specifications is identified. If immediate revision of the measure is not

feasible, we would suspend the measure for public reporting purposes until it can be

reintroduced into the measure set. CMS utilizes the Measure Management System to

maintain and retire measures. There are currently no plans to retire any measures utilized

for RHQDAPU.

Comment: One commenter stated that some measures that may no longer

differentiate top performers from low performance over time, continue to have value for

public reporting. Sustainability for key quality measures is important from a patient and

a hospital perspective. For this reason, the commenter recommended that measures that

are closely linked to patient outcomes, such as measures related to drug treatment of

acute myocardial infarction and congestive heart failure, be retained and not retired,

despite improved performance on these measures.

Response: We are aware of these issues, in particular, the idea that a measure

may be suited for one purpose but not another. CMS will take into consideration the

clinical importance of a measure when continued, across the board high performance

occurs. CMS currently does not have any plans to retire any of the process measures.

Comment: One commenter stated that the primary goal is to ensure that the

measures are keeping pace with the science and that a process is developed that can

respond to these changes in a timely manner. At the same time, there is also a need to

balance the yearly requirements for the payment programs based on these exact

measures. The commenter recommended that a multi-stakeholder group be convened to

identify an appropriate and equitable process. This group should be tasked with

developing a process for when a measure needs to be temporarily removed from public

reporting as well as eliminated from any payment determination due to changes in

clinical science.

Response: CMS, with input from the Joint Commission and in cooperation with

the HQA of which the NQF is a member, devotes a large amount of resources to measure

maintenance.

Currently, updating performance measure is a continuous process that is based on concurrent reviews of medical literature, input from topic-specific technical expert panels, and input from specialty societies and practice guideline committees. We evaluate all proposed changes, in part by vetting them through a joint committee made up of representatives of CMS, CMS contractors and the Joint Commission, with input from the HQA. There are a number of examples where we have temporarily removed from public reporting hospital quality measures because of circumstances outside of the control of hospitals (for example, delays in influenza vaccine delivery, shortages of antibiotics for surgical prophylaxis).

Comment: One commenter suggested that CMS remove from the RHQDAPU program measures that have been topped out, that is, measures where the data shows that a large majority of the participating hospitals have achieved very high levels of performance. However, the commenter recommended that hospitals continue to report results on Hospital Compare. By taking the measures out of the RHQDAPU program, it allows hospitals and CMS to focus their respective resources on those areas where patient care can benefit most.

Response: We appreciate this comment. While it is true that some measures appear to have "topped out" for some hospitals, we still see considerable variation in performance between top performers and low performers for most measures. It is also not clear how having a hospital continue to report results on Hospital Compare for topped out measures would reduce resource requirements for an individual hospital. For example, the three RHQDAPU SCIP infection measures on timing, appropriate

administration, and discontinuation of antibiotic prophylaxis use many of the same data elements, such as a list of antibiotics and their administration times. More relative data collection burden is saved when measures with no duplicative data elements are removed, as opposed to measures using many of the same data elements as other RHQDAPU measures. We are also continuing to consider how we may be able to develop a process to decide when to retire a performance measure that has truly topped out.

5. Procedures for the RHQDAPU Program for FY 2008 and FY 2009

a. Procedures for Participating in the RHQDAPU Program

The "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist" section of the QualityNet Exchange Web site contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative for FY 2008, hospitals must follow these steps:

● Identify a QualityNet Exchange Administrator who will follow the registration process and submit the information through the QIO Clinical Warehouse. 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. Hospitals must send this form to their QIO, no later than August 15, 2007. In an effort to alleviate the burden associated with submitting this form annually, we consider that a hospital that submits this form is an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.

In addition, before participating hospitals initially begin reporting data, they must register with the QualityNet Exchange, regardless of the method used for submitting data.

● Collect and report data for each of the required measures except the Medicare mortality measures (Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-day Mortality for Medicare Patients). A hospital must report these data for discharges occurring in or after first quarter CY 2007. Hospitals must submit the data to the QIO Clinical Warehouse 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. All submissions will be executed 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. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.

● For each quality measure that requires hospitals to collect and report data, submit complete data regarding the quality measures in accordance with the joint CMS/Joint Commission 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 the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.

● Submit to CMS on a quarterly basis aggregate population and sample size

counts for Medicare and non-Medicare discharges for the four topic areas (AMI, HF,

PNE, and SCIP)).

● Continuously collect HCAHPS data, beginning with July 2007 discharges, in

accordance with the HCAHPS Quality Assurance Guidelines, Version 2.0, located at

www.hcahpsonline.org. The CY 2007 OPPS rule required HCAHPS-eligible hospitals to

participate in the March 2007 dry run of the HCAHPS survey, if they had not already

participated in a previous dry run. Hospitals must submit HCAHPS dry run data to the

QIO Clinical Warehouse by July 13, 2007. As part of the March 2007 dry run, hospitals

were required to survey HCAHPS-eligible discharges between 48 hours and 6 weeks

following hospital discharge. CMS has become aware that, because they treat very few

patients, a very small percentage of hospitals might not have had any HCAHPS-eligible

discharges in March 2007. Similarly, such hospitals might not have any HCAHPS-

eligible discharges in any month from July 2007 forward. The clinical data warehouse is

being modified to accept zero HCAHPS-eligible discharges in the future but until this

modification is complete, these hospitals should contact CMS by sending an email to

hcahps@azqio.sdps.org.

● For the AMI 30-day and HF 30-day mortality measures, CMS uses Part A and

Part B claims for Medicare fee-for-service patients to calculate the mortality measures.

For FY 2008, hospital inpatient claims (Part A) from July 1, 2005 to June 30, 2006, will

be used to identify the relevant patients and the index hospitalizations. Inpatient claims

for the index hospitalizations and Part A and Part B claims for all inpatient, outpatient,

and physician services received 1 year prior to the index hospitalizations are used to

determine patient comorbidity, which is used in the risk adjustment calculation (see

http://www.qualitynet.org/dcs/ContentServer?cid=1163010398556&pagename=QnetPubl

ic%2FPage%2FQnetTier2&c=Page). No other hospital data submission is required to

calculate the mortality rates.

Comment: Several commenters stated that CMS needs to release new and revised

measure and programming specifications in an expedited manner. Specifically, the data

specifications need to be articulated well in advance of the start of data collection so that

both the vendors that assist hospitals in collecting and formatting data for submission and

the QIO Clinical Warehouse have an appropriate amount of time to adjust their software

and test it to ensure it functions properly.

Response: The current 120 day advance release of the specification manual is

jointly implemented by CMS and the Joint Commission. We will consider adding more

time to this advance release in the future. Additionally, we will strive to minimize the

number of post-update clarifications that further reduce the lead time needed for vendor

software programming. We believe that a continued coordination with the Joint

Commission is the most efficient and feasible method to ensure that hospitals and data

vendors receive measures specifications with sufficient advance notice.

Comment: One commenter supported coordination among vendors, CMS, and

the Joint Commission, including the need for clear and definitive alignment. Hospitals

and vendors will require extremely detailed guidance on what should be included in each

reporting period. The commenter urged CMS to recognize the time constraints in

applying the validation requirement for the FY 2008 update for the three SCIP measures

that are to be included in the RHQDAPU measure set.

Response: We are continuing to work on coordinating measures updates and

selection with the Joint Commission in an effort to minimize the reporting burden on

hospitals. We understand the need to coordinate measure selection and corresponding

abstraction and processing burden on vendors and hospitals. However, measures

selection must also consider the requests by consumer groups, purchasers, and other

stakeholders to increase the public reporting measure set. We also appreciate the

comment on applying the validation requirement for the FY 2008 update.

Comment: Two commenters stated that when amending measures, CMS should

take into account the ability of hospitals, the QIO Clinical Warehouse, and data vendors

to successfully and quickly implement changes in reporting measures and that CMS

should seek input from hospital data collection personnel as a part of the measure review

process to understand the effects that reporting changes have on hospitals.

Response: We understand the need to consider the abstraction and processing

burden on vendors and hospitals when selecting measures for the RHQDAPU program.

We will consider greater vendor and hospital participation into our measure testing and

development program in the future.

b. Procedures for Participating in the RHQDAPU Program for FY 2009

In the FY 2008 IPPS proposed rule (72 FR 24807), we stated that for FY 2009,

the requirements for FY 2008 discussed above would apply, except that hospitals would

be required to collect and report data on any additional measures that we finalize through

the rulemaking process, and for which we specify that data submission is required. We

also stated that mortality measures will be expanded to include pneumonia when this

measure received final NQF endorsement. This measure has received NQF endorsement

and, as we discussed above, we are adopting as final in this FY 2008 IPPS final rule the

proposed pneumonia 30-day mortality measure for Medicare patients for the FY 2009

RHQDAPU program.

c. Chart Validation Requirements

(1) FY 2008 Chart Validation Requirements

        In the FY 2008 IPPS proposed rule (72 FR 24808), we stated that for the FY 2008

update, and until further notice, we would continue to require that hospitals meet the

chart validation requirements that we implemented in the FY 2006 IPPS final rule. 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, continue and are being placed on the QualityNet

Exchange Web site.

        We also stated that for the FY 2008 payment update, and until further notice,

hospitals must pass our validation requirement that requires a minimum of 80 percent

reliability, based upon our chart-audit validation process, for the first three quarters of

data from CY 2006. These data were due to the QIO Clinical Warehouse by

August 15, 2006 (first quarter CY 2006 discharges), November 15, 2006 (second quarter

CY 2006 discharges), and February 15, 2007 (third quarter CY 2006 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 will 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 proceed to the second

step and restrict the comparison to those variables associated with payment. For first and

second quarter CY 2006 discharges (1Q06, 2Q06), that means we limit the calculations to

the 10-measure starter set. For third quarter CY 2006 discharges (3Q06), we include 21

measures. We recalculate the percent agreement and the estimated 95-percent confidence

interval, and again compare the sum 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.

Due to time constraints, we will not apply the validation requirement for the

FY 2008 update to 3 SCIP measures that are included in the RHQDAPU measure set:

Infection 2, VTE 1 and VTE 2.

Comment: Three commenters stated that improvements need to be made to the

validation process. They indicated that many hospitals have been notified that there have

been problems validating the data they submitted. The commenters stated that in several

instances, these validation problems have been due to inconsistencies in the definitions of

some variables used by CMS' contractors who are re-abstracting patient-level data and

comparing it to the data submitted by the hospitals. They believed that while the

re-abstraction of five charts per quarter for each hospital may have been a sufficient

validation strategy when only 10 measures were being collected and reported, it is

insufficient to ensure the reliability of the data as we continue to expand the number of

measures and the number of patients on whom data are being collected. The commenters

believed that a more resilient and less resource intensive method of validation is needed.

The commenters indicated that they are working with a well known research and data

enterprise to explore alternatives and will share their recommendations about more

effective, less cumbersome validation processes with CMS in the next few weeks.

Response: We appreciate this comment and are interested in receiving alternative

proposals to improve the validation process in terms of burden and accuracy of abstracted

data. The current validation process has been in place for several years, and we believe

that improvements should be thoroughly tested and submitted to hospitals before we

adopt them for the RHQDAPU program. We are currently considering these options and

others for their burden of hospitals, resource implications for CMS, and impact on

accuracy of the data.

Comment: In the event hospitals are notified of problems with their data

submissions, one commenter suggested that it should have the ability to appeal those

notices. The commenter stated that often these problems are a result of inconsistencies in

some of the variables used by CMS' contractors and abstractors. The commenter

believed that the small number of charts being abstracted also is insufficient to ensure

reliability. Consequently, the commenter suggested that hospitals should be permitted to

file an appeal if there is a validation problem. Any appeals process should also be timely

with a clearly defined process that is published in the final rule.

Response: Hospitals falling below 80 percent agreement rate for quarterly

validation are eligible to appeal their mismatched elements if they believed that the CMS

CDAC contractor incorrectly abstracted the data element. This validation appeals

process is outlined on the QualityNet Web site (www.qualitynet.org), and contains

clearly defined timeframes for hospital appeals request and subsequent QIO appeals

review.

Comment: One commenter stated that the quarterly submission of data would be

a hardship on small providers that only have one person collecting and reporting quality

measures. Nonetheless, the commenter believed that quarterly submission makes sense.

Response: We appreciate and understand the abstraction and submission burden

of smaller hospitals. The quarterly submission deadline weighs the need to frequently

update the publicly reported data, data reliability, against the abstraction and submission

burden placed on hospitals. We continue to coordinate these requirements with The Joint

Commission for their accredited hospitals to attempt in minimizing the incremental

burden placed on Joint Commission accredited hospitals, which comprise over 80 percent

of all hospitals operating under the hospital IPPS payment system.

Comment: With respect to validation of data being submitted by hospitals, one

commenter understood that in FY 2008, CMS would not be applying the validation

requirement to three SCIP anti-infection measures (Infection 2, VTE 1 and 2). The

commenter stated that since these data come from the hospitals and it can impact their

business, it is imperative to include validation for these measures to assure the public that

the information is accurate.

Response: We appreciate the comment. CMS proposed in the FY 2008 IPPS

proposed rule (72 FRE 24808) to apply the validation requirements to these measures

using 2nd quarter 2007 and 3rd quarter CY 2007 discharges.

Comment: One commenter stated that CMS should consider alternative methods

of data validation such as using monthly data points of each clinical measure and not

relying on chart abstraction. The commenter indicated that such a method of validation

might employ a process similar to the quarterly Outlier validation that the Joint

Commission requires of its core measure vendors. A monthly data point that exceeds

three (3) standard deviations is considered an outlier. When an outlier is identified, the

hospital is requested to verify that the data are accurate. This validation process relies on inter-hospital variability.

Response: We appreciate this comment and are interested in incorporating the Joint Commission's outlier validation methodology into our current chart audit validation process of abstracted data. The two methodologies assess important and different aspects of data quality. CMS' validation methodology assesses abstraction accuracy at the element level, and The Joint Commission's methodology assesses aberrant aggregate data patterns. The current CMS validation process has been in place for several years, and we believe that improvements should be thoroughly tested and submitted to hospitals through advance notice in future proposed rules posted in the Federal Register..

Comment: One commenter stated that validation frequently does not relate to the quality of care provided, especially for many of the validation failures that are keying error. The commenter stated that these errors are classified as "invalid record selections" which are not abstracted by CMS and not subject to appeal.

Response: The current validation methodology is designed to measure the abstraction accuracy of the hospital, not the quality of care provided. All elements that are part of the RHQDAPU measures are subject to validation. However, before validating the data elements, CMS must ensure that the chart submitted by the hospital represents the patient sampled for validation. CMS does not abstract charts in cases where the information used to identify the patient's stay contradicts the electronic submission data. CMS must definitively determine that the submitted medical record is the patient as identified in the submitted data. The patient name, admission or discharge

date must match for CMS to definitively determine the medical record is the same

episode of care as the submitted patient level data.

Comment: One commenter stated that all hospitals should have the ability to

appeal all validation cases regardless of whether scores are below 80 percent, whenever

the validation scores could affect a potential loss of the APU. The commenter believed

that hospitals must have the opportunity to appeal human errors in transcription, copying

or mailing medical records to the CDAC for validation.

Response: We appreciate this comment, but resources do not allow CMS to

review requests from all 3,500 hospitals that participate in the RHQDAPU program for

reconsideration regarding validation results if those results did not affect payment. We

restrict our review to only hospitals not meeting the 80 percent threshold because

payment is much more likely to be affected for these hospitals.

Comment: One commenter agreed with including "measure match" accuracy as

part of the validation process but also asked if the hospital can correctly identify which

cases received the process of care (i.e., the numerator) and belong in the process of care

(i.e., the denominator), which is how the data is displayed on Hospital Compare, what

additional value does verification of individual data element match provide? The

commenter recommended that CMS evaluate only the verification of the accuracy of the

cases placed into the numerator and denominator. From a patient care perspective, the

commenter was interested in knowing if a patient received antibiotics in a timely manner,

not if the abstractor correctly entered a specific data element.

Response: We appreciate this comment. We will consider this proposed

approach in the future for the RHQDAPU program, and the lessened burden associated

with this proposal. We must also consider the relative amount of information that CMS

is able to provide hospital under the proposed approach, because CMS would not be

definitively able to provide the hospital with the exact data element that resulted in the

validation failure for that measure. We must evaluate the need to provide this detailed

information to the hospitals in our future RHQDAPU proposed validation methodology.

After careful consideration of the comments received, we are adopting in this

FY 2008 IPPS final rule the validation process we proposed in the FY 2008 IPPS

proposed rule. However, we will further address the final list of process measures which

will be validated for the FY 2009 RHQDAPU program in the CY 2008 OPPS final rule.

For HCAHPS, hospitals and survey vendors must participate in a quality

oversight process conducted by the HCAHPS project team. Prior to July 2007, the

purpose of the oversight activities was to provide feedback to hospitals and survey

vendors on data collection procedures. Starting in July 2007, we ask hospitals/survey

vendors to correct any problems that are found and provide follow-up documentation of

corrections for review within a defined time period. If the HCAHPS project team finds

that the hospital has not made these corrections, CMS may determine that the hospital is

not submitting HCAHPS data that meets the requirements for the RHQDAPU program.

As part of these activities, HCAHPS project staff will review and discuss with survey

vendors and hospitals self-administering the survey their specific Quality Assurance

Plans, survey management procedures, sampling and data collection protocols, and data

preparation and submission procedures. This review may take place in-person or through other means of communication.

(2) FY 2009 Chart Validation Requirements

In the FY 2008 IPPS proposed rule (72 FR 24808), we indicated that for the FY 2009 update, all FY 2008 requirements would apply, except for the following modifications. We would modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges. We would also expand the list of validated measures in the FY 2009 update to add SCIP Infection-2, SCIP VTE-1, and SCIP VTE-2 starting with 4th quarter CY 2006 discharges. We would also drop the current two-step process to determine if the hospital is submitting valid data. We proposed for the FY 2009 update to pool validation estimates covering the 4 quarters (4th quarter CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the current 3 quarter pooled confidence interval.

Comment: One commenter recommended that CMS go to a four (4) quarter validation instead of three (3) quarters. The commenter suggested that the approach needs to be consistent for all measures, otherwise it will be administratively very difficult for the vendors.

Response: We appreciate this comment, and proposed in the FY 2008 IPPS proposed rule that we would use four quarters of validation results starting with the FY 2009 update. We made this proposal a year in advance to give hospitals ample notice of this new requirement. We will consider the consistency of our validation approach as we make improvements to this process in future years.

(3) Validation and Submission Requirements

In the FY 2008 IPPS proposed rule (72 FR 24808), we stated that we planned to apply the validation and submission requirements for the FY 2008 and FY 2009 payment determination to the quality measures. For the validation and submission requirements for the FY 2008 payment year, we stated that we plan to use the following criteria:

● The 10 measure starter set for both submission and validation for 1st through 3rd quarters CY 2006 discharges.

● The additional 11 measures that make up the expanded measure set for both submission and validation for 3rd quarter CY 2006 discharges.

● SCIP VTE 1, 2, and SCIP Infection 2 submissions only for 1Q 2007 discharges only.

● HCAHPS measures, both submission of dry run data and continuous submissions beginning with July 2007 discharges.

● AMI and HF 30-day mortality measures as described previously.

For FY 2009 payment year, we plan to use the following criteria:

● The 21 expanded measure set for submission and validation starting with 4th quarter CY 2006 (4Q06) through 3rd quarter CY 2007 (3Q07) discharges.

● SCIP VTE 1, 2, and SCIP Infection 2 submission and validation for 2nd quarter CY 2007 and 3rd Quarter CY 2007 discharges.

● HCAHPS measures, continuous submission.

● AMI, HF, and PN 30-day mortality measures as described previously.

As we have previously stated, at this time we are not finalizing the SCIP Infection 4, SCIP Infection 6, SCIP Infection 7 and SCIP Cardiovascular-2 measures for the FY 2009 RHQDAPU program because they have not yet been endorsed by the NQF. We anticipate that three of these measures will be endorsed by the NQF in the next few months (SCIP Infection 4, SCIP Infection 6 and SCIP Cardiovascular -2) and, if they are, we intend to adopt these measures in the CY 2008 OPPS final rule. We will await NQF action on SCIP Infection 7, and if it is endorsed and we determine to adopt this measure, we will do so through the rulemaking process.

As additional measures are finalized for inclusion in the FY 2009 payment decision, we stated that we would anticipate making further changes to the above plan to incorporate those measures.

Comment: Several commenters urged immediate adoption of an effective mechanism for allowing hospitals and their vendors to resubmit quality measure data if they discover an error.

Response: Quality measure data can be resubmitted before the data submission deadline; however, measure data resubmissions after the deadline and the QIO Clinical Warehouse lockdown are currently rejected. We will, however, take into consideration the commenter's suggestion to allow quality measure resubmissions to occur after the data submission deadline for public reporting purposes. For payment purposes, we believe that the requirement of submission deadlines is necessary to ensure a proper audit trail to ensure that annual requirements were accurately calculated in a timely manner.

Comment: One commenter continued to support expanding the number of measures to be included in the RHQDAPU program. However, the commenter was concerned that the program is constrained in how quickly it can expand given the capacity and capability of the current QIO Clinical Warehouse. The commenter suggested that CMS should give serious consideration to competitively bidding the QIO Clinical Warehouse to an entity with greater capacity. The commenter indicated that, ideally, the entity must be able to receive, aggregate, and calculate reliable and valid data on performance measures across all patient populations on a timely basis, supply such data to CMS, public and private payers, accreditation organizations, and entities representing providers, practitioners, and consumers, conduct ongoing assessments and make adjustments and changes to address any deficiencies. The commenter also recommended that this entity should provide effective technical assistance to entities submitting data to, and entities using data from, the QIO Clinical Warehouse.

Response: We are continuing to evaluate the capacity of our data infrastructure and contractor resources and will continue to assess and make adjustments to the QIO Clinical Warehouse in order to provide an efficient system, in a timely manner, for the submission, storage, and calculation of quality measure data. CMS will consider the commenter's suggestion as we evaluate the warehouse.

Comment: One commenter urged CMS to allow vendors access to the data during the CDAC validation process so that the vendors and hospitals together can analyze the data. The commenter indicated that shortened timeframe for reporting is acceptable so long as CMS communicates technical changes in programming in a timely

manner and coordinates with the QIOs so that messages are consistent across all aspects

of the agency.

Response: We will investigate and study the issues related to the possibility of

allowing vendors access to these data.

Comment: Two commenters requested that CMS continue improving the ability

of vendors to help their hospital clients to the fullest extent by permitting vendors to

access the data of their client hospitals on Q-net with a single sign on. The commenters

also believed that hospitals and vendors should be able to resubmit data in the event a

problem is found during the validation process and assuming the resubmission can take

place prior to the closing of the reporting period. Often the problems are technical in

nature and are related to straight programming errors, not to errors or omissions by

hospitals.

Response: We agree that vendors should provide efficient data submission for

their hospitals. Currently, there is a single sign on for a vendor to upload data for all

those providers for which the vendor is authorized to submit data. There is also a single

sign on to access the submission reports for all those providers who have given their

vendor authorization to view their reports.

Regarding resubmission of data, if an error is found before the data submission

deadline, hospitals and vendors can resubmit their data.

Comment: One commenter noted that recently, many hospitals have had

difficulties with their data submission. The commenter indicated that these problems

commonly have been due to errors in the software at the QIO Clinical Warehouse, and

have caused an undue administrative burden for hospitals. The commenter believed that

these difficulties have focused staff attention on data collection and reporting and away

from quality improvement initiatives to provide better care to patients.

Response: The contractor responsible for the QIO Clinical Warehouse is

continuing its efforts to improve warehouse processes and has added an independent

verification and validation step to the testing phase in order to further ensure accuracy

and reliability.

Comment: One commenter stated that it is not clear from the proposed rule what

data transmission mechanism hospitals should use if they do not use the CART

application. The commenter encouraged consideration of ORYX performance

measurement systems for data processing and abstraction software as an existing, well-

established reporting infrastructure.

Response: CART (CMS Abstraction & Reporting Tool) is a software application

created by CMS, and is designed to allow hospitals, QIOs, and other organizations to

abstract, edit, export, and report on the quality measures. CART and the QIO Clinical

Warehouse infrastructure may be used across data collection programs and is available at

no charge. Hospitals are allowed to use CART or to use ORYX vendor software to

abstract data. ORYX vendor software and data processing must be purchased by

hospitals.

d. Data Validation and Attestation

In the FY 2008 IPPS proposed rule we stated that for the FY 2008 update and in

subsequent years, we would revise and post up-to-date confidence interval information on

the QualityNet 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.

We also stated that we would require for FY 2008 and subsequent years that

hospitals attest each quarter to the completeness and accuracy of their data, including the

volume of data, submitted to the QIO Clinical Warehouse in order to improve aspects of

the validation checks. We proposed to provide additional information to explain this

attestation requirement, as well as provide the relevant form to be completed on the

QualityNet Exchange Web site at the same time as the publication of this final rule with

comment period.

Comment: One commenter supported the attestation process for the new SCIP

measures. Another commenter stated that it is critical that CMS gives every provider the

opportunity to attest each quarter to the completeness and accuracy of their data.

Response: We appreciate the comments. We believe that the attestation

requirement for all measures for which hospitals submit data under the RHQDAPU

program will increase awareness among hospitals about the abstraction and submission of

accurate data because it demands explicit acknowledgement from hospitals that its data is

complete and accurate. At this time, we are not finalizing the SCIP Infection 4, SCIP

Infection 6, SCIP Infection 7, and SCIP-Cardiovascular-2 measures. We plan to address

the status of these measures in the CY 2008 OPPS final rule.

Comment: One commenter stated that without automated electronic records that interface with the billing system, the quarterly attestation of data completeness is difficult to ensure.

Response: We appreciate this comment. We will consider this comment in our future efforts to improve the attestation component of the RHQDAPU program.

e. Public Display

We proposed that we would continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

Currently, hospitals that share the same Medicare Provider Number (MPN) must combine data collection and submission across their multiple campuses (for both clinical measures and for HCAHPS). These measures are then publicly reported as if they apply to a single hospital. We estimate that approximately 5 to 10 percent of the hospitals reported on the Hospital Compare Web site share MPNs. For FY 2008 and subsequent years, we proposed that we would require hospitals to begin to report the name and address of each hospital that shares the same MPN. This information would be gathered through the RHQDAPU program Notice of Participation form, which hospitals would submit to their QIOs by August 15, 2007. To increase transparency in public reporting and improve the usefulness of the Hospital Compare Web site, we would note on the Web site where publicly reported measures combine results from two or more hospitals.

Comment: One commenter supported CMS' efforts to increase transparency in

public reporting and the disclosure of hospitals that collectively report quality data under

the same MPN and supported CMS' proposals regarding new hospital participation under

the RHQDAPU program as well as the expanded quality measures for FY 2009.

Response: We agree that, by collecting information about which MPNs are being

shared by multiple hospitals and publicly reporting where the quality indicators combine

the experience of two or more hospitals, it can create greater transparency and increase

the utility and value of the Hospital Compare Web site.

Comment: Two commenters stated that CMS should provide comparative

performance at a hospital level on the Hospital Compare Web site. The commenters

believed that the proposal to indicate which data reflect the performance of two or more

hospitals is inadequate to aid in provider selection.

Response: We agree that, to increase the utility and value of the hospital quality

information on the Hospital Compare Web site, information should be collected and

reported at the hospital campus level. Our first step in this direction is to determine which

hospitals share the same MPN. This will allow us to indicate on the Web site where the

quality indicators currently combine the experience of two or more hospitals. Eventually,

we intend to collect and report hospital quality information at the campus level.

Comment: One commenter believed that CMS' proposal to require hospitals to

begin to report the name and address of each hospital campus that shares the same MPN

would be extremely cumbersome in practice and strongly encouraged CMS to be

consistent across all environments and data requirements within CMS. The commenter,

therefore, recommended that only the main campus address be listed, for consistency.

Although it recognized the constraints this places on <u>Hospital Compare</u> Web site and the

ability to compare specific hospital measures; the commenter believed that just including

a note on the Web site where hospital scores have been combined will avoid much of the

current confusion.

<u>Response</u>: Currently, we do not have information about which hospitals share an

MPN. Thus, we cannot note that hospitals share an MPN on <u>Hospital Compare</u> without

gathering this information from hospitals.

<u>Comment</u>: With respect to public reporting, one commenter stated that

combining data across multiple campuses hides from consumers serious quality problems

at a single facility. The commenter believed that as long as this grouping is in place, the

public must be informed as to which facilities are falling into these groups. However, the

commenter added, it is ultimately more important to address the underlying problem that

is preventing CMS from reporting the performance of each individual hospital. The

commenter urged CMS to report the quality measure for each specific hospital campus.

<u>Response</u>: We agree that ultimately to make the information most useful it should

be collected and reported at the campus level. Our first step in this direction is to

determine which hospitals are combining data across hospitals on <u>Hospital Compare</u>.

This will allow us to indicate on the Web site where the quality indicators currently

combine the experience of two or more hospitals. Eventually, we intend to collect and

report hospital quality information at the campus level.

f. Reconsideration and Appeal Procedures

In the FY 2008 IPPS proposed rule, we stated that if we deny a hospital the full

market basket update, the hospital may submit a request that we reconsider our decision

that the hospital did not meet the RHQDAPU program requirements. For FY 2008, a

hospital must submit such a request for reconsideration on or before November 1,

2007.   We also are establishing additional procedural rules that will govern RHQDAPU

program reconsiderations. We will post these rules on the QualityNet Exchange Web site

at the same time as the publication of this final rule with comment period.

In the FY 2008 IPPS proposed rule (72 FR 24809), we again solicited public

comment and suggestions related to reconsideration decisions.

Comment: Three commenters stated that CMS should use the experience in

FY 2007 to construct a process (reconsideration) for adjudicating appeals in a timely

fashion and should clearly lay out that process for all hospitals to see prior to publication

of the final rule.

Response: We will use the experience from the FY 07 reconsideration period to

develop a process that will streamline and expedite this annual process that potentially

affects hospital payment.

We are concurrently posting more detailed procedural rules regarding the

FY 2008 reconsideration process on the QualityNet Exchange Web site. We are also

describing these rules below in this final rule with comment period.

In order to receive a reconsideration, the hospital must:

● Submit via QualityNet Exchange a Reconsideration Request form (available on

the QualityNet Exchange Web site), containing the following information, to CMS:

○ Hospital Medicare ID number

○ Hospital Name

○ CMS identified reason for failure (as provided in the CMS notification
of failure letter to the hospital)

○ Hospital basis for requesting reconsideration;

▪ This must identify the hospital's specific reason(s) for believing it met
the RHQDAPU requirements and should receive the full FY 2008 IPPS annual payment
update.

○ CEO contact information, including name, email address, telephone
number, and mailing address (must include physical address, not just PO box)

○ QualityNet System Administrator contact information, including name,
email address, telephone number, and mailing address (must include physical address, not
just PO box)

▪ The request must be signed by the hospital's CEO.

For FY 2008, a hospital must submit via QualityNet Exchange such a request for
reconsideration on or before November 1, 2007.

Following receipt of a request for reconsideration, CMS will:

● Provide an email acknowledgement, using the contact information provided in
the reconsideration request, to the CEO and the QualityNet Administrator that the letter
has been received.

● Provide a formal response to the hospital CEO, using the contact information
provided in the reconsideration request, notifying the facility of the outcome of the

reconsideration process. CMS expects the process to take 60-90 days from the due date

of November 1, 2007.

        If a hospital is dissatisfied with the result of a RHQDAPU program

reconsideration decision, the hospital may file a claim under 42 CFR Part 405, Subpart R

(a Provider Reimbursement Review Board (PRRB) appeal).

g. RHQDAPU Program Withdrawal Requirements

        For the FY 2008 update, hospitals may withdraw from the RHQDAPU program at

any time up until August 15, 2007. If a hospital withdraws from the program, it will

receive a 2.0 percentage point reduction in its annual payment update.

6. 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;

taking measures to ensure that the data necessary for quality measures is captured.

Ideally, such systems will also provide point-of-care decision support that enables

detection of high levels of performance on the measures. Hospitals using 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 public comment on these requirements and related options. In the FY 2007

IPPS final rule (71 FR 48045), we summarized and addressed the additional comments

we received. In the FY 2008 IPPS proposed rule (72 FR 24809), we noted that we would

welcome additional comments on this issue.

Comment: One commenter supported encouraging the use of electronic medical

records (EMRs). The commenter indicated that the use of the EMR could assist in the

initial collection of information. However, the commenter added, CMS must recognize

the clear distinction between tools that are used at the point of care to record and improve

medical interventions and those that are used to report and validate quality measures. At

this point, EMRs are best suited to only the former functions and not the latter of the

functions. The reality is that the specifications for reporting measures change too quickly

to enable EMRs to be the vehicle for quality data and reporting. Moreover, the appetite

among EMR vendors to constantly update their products to incorporate new

specifications is costly in terms of both time and dollars. The commenter was pleased to

continue to work with CMS through the American Health Information Community

(AHIC) and other agencies to develop processes through which an EMR could speed the

collection and minimize the resources necessary for quality reporting.

Response: We appreciate the feedback from the commenter. We note that the

AHIC is a federal advisory body, chartered in 2005 to make recommendations to the

Secretary of the HHS on how to accelerate the development and adoption of health

information technology. CMS plans to continue working through the AHIC and other

entities to develop processes through which an EMR could speed the collection and

minimize the resources necessary for quality reporting.

        We acknowledge the current differentiation between tools used to record and

medical intervention and the current tools used to report and validate quality

measures. CMS will continue to participate in appropriate HHS studies and workgroups,

as mentioned by the GAO report about hospital quality data and their use of information

technology. As appropriate, CMS will inform interested parties regarding progress in the

implementation of HIT for the collection and submission of hospital quality data as

specific steps, including timeframes and milestones, are identified. Current mechanisms

include publication in the Federal Register as well as ongoing collaboration with external

stakeholders such as the Hospital Quality Alliance, the American Hospital Association,

the Federation of American Hospitals, the Association of American Medical Colleges;

and The Joint Commission. We further anticipate that as HIT is implemented, a formal

plan, including training, will be developed to assist providers in understanding and

utilizing HIT in reporting. In addition, we will assess the effectiveness of our

communications with providers and stakeholders as it relates to all information

dissemination pertinent to collecting hospital quality data as part of an independent and

comprehensive external evaluation of the RHQDAPU program.

7. New Hospitals

In the FY 2008 IPPS proposed rule (72 FR 24809), we also proposed a minor change to our policies regarding new hospitals. In the FY 2006 IPPS final rule, we noted that a new hospital should begin collecting and reporting data immediately, and to complete the registration requirements for the RHQDAPU program quality measures (70 FR 47421 and 47428). We also explained that a new hospital would be held to the same standards as other established facilities when determining the expected number of discharges for the calendar quarters covered for each fiscal year. We also stated that fiscal intermediaries would provide information on new hospitals to the QIO in the state in which the hospital opened for operations as a Medicare provider, as soon as possible, so that the QIO could enter the provider information into its Program Resource System (PRS), and follow through with ensuring provider participation as the requirements for quality data reporting under this rule stipulate.

We believe that some new hospitals have found it difficult to start reporting RHQDAPU measures immediately after signing up to participate in the RHQDAPU program. Therefore, we proposed to modify our policy to reduce the burden on new hospitals. We proposed that fiscal intermediaries would continue to provide information on the new hospital to the QIO in the state in which the hospital is located, as soon as possible, so that the QIO can enter the provider information into its PRS, and follow through with ensuring provider compliance with the requirements for quality data reporting. For a new hospital that receives a provider number on or after October 1 of each year (beginning with October 1, 2007), we proposed that the hospital be required to

report RHQDAPU data beginning with the first day of the quarter following the date the

hospital registered to participate in the RHQDAPU program. For example, a hospital that

receives its MPN on October 2, 2007, and signs up to participate in RHQDAPU on

November 1, 2007, will be expected to meet all of the data submission requirements for

discharges on or after January 1, 2008.

In addition, for HCAHPS we strongly recommend the hospital participants in a

dry run, if feasible, prior to beginning to collect HCAHPS data on an on-going basis to

meet the RHQDAPU requirements. We refer readers to the Web site at

http//www.hcahpsonline.org for a schedule of upcoming dry runs.

Comment: One commenter supported the plan for new hospitals joining the

RHQDAPU program. It is reasonable to have the hospitals begin reporting the first full

quarter after inclusion in the program. The commenter recommended, however, that a

clear appeals process be established should a hospital be unable to meet this standard.

Response: We appreciate the commenter's support. As we continue to assess the

RHQDAPU program, we plan to consider the commenter's suggestion.

In summary, for the validation and submission requirements for the FY 2008

payment year, we plan to use the following criteria:

● The 10 measure starter set for both submission and validation for 1st through

3rd quarters CY 2006 discharges

● The additional 11 measures that make up the expanded measure set for both

submission and validation for 3rd quarter CY 2006 discharges

● SCIP VTE 1, 2, and SCIP Infection 2 submissions only for 1Q 2007 discharges only

● HCAHPS measures, both submission of dry run data and continuous submissions beginning with July 2007 discharges

● AMI and HF 30-day mortality measures

For FY 2009 payment year, we plan to use the following criteria:

● The 21 expanded measure set for submission and validation starting with 4th quarter CY 2006 (4Q06) through 3rd quarter CY 2007 (3Q07) discharges

● SCIP VTE 1, 2, and SCIP Infection 2 submission and validation for 2nd quarter CY 2007 and 3rd Quarter CY 2007 discharges

● HCAHPS measures, continuous submission

● AMI, HF, and PN 30-day mortality measures

As we previously stated, we are not finalizing at this time the following measures that we proposed in the proposed IPPS FY 2008 rule:

● SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

● SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

● SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia

● SCIP Cardiovascular-2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period

As previously stated, we are adopting the validation process we proposed in the

FY 2008 IPPS proposed rule in this FY 2008 IPPS final rule. We are also finalizing the

proposed chart validation requirements covering FY 2009 discharges for all of the

FY 2009 measures that we are finalizing in this final rule with comment period.

Specifically, we will drop the current two-step process to determine if the hospital is

submitting valid data starting with 1st quarter 2007 discharges. Starting with FY 2009,

we will also begin to pool validation estimates covering the 4 quarters (4th quarter

CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the

current 3 quarter pooled confidence interval.

We will include the SCIP Infection 4, SCIP Infection 6, and SCIP

Cardiovascular-2 measures in our chart validation requirements for FY 2009 if we

finalize those measures in the CY 2008 OPPS final rule to be published in the **Federal**

Register later this year. As discussed above, we also intend to adopt proposed SCIP

Infection 7 if it is endorsed by NQF. When we determine to adopt this measure, we will

do so through the rulemaking process.

For FY 2008 and subsequent years, we are finalizing our proposal to require

hospitals to begin to report the name and address of each hospital that shares the same

MPN. This information would be gathered through the RHQDAPU program Notice of

Participation form, which hospitals would submit to their QIOs by August 15, 2007. To

increase transparency in public reporting and improve the usefulness of the Hospital

Compare Web site, we will note on the Web site where publicly reported measures

combine results from two or more hospitals.

For FY 2008, a hospital must submit such a request for reconsideration on or

before November 1, 2007. We are also establishing additional procedural rules that will

govern RHQDAPU program reconsiderations. In addition to including information in

this final rule with comment period, we will also post these rules on the QualityNet

Exchange Web site at the same time as the publication of this final rule with comment

period.

If a hospital is dissatisfied with the result of a RHQDAPU program

reconsideration decision, the hospital may file a claim under 42 CFR Part 405, Subpart R

(a Provider Reimbursement Review Board (PRRB) appeal).

We are also finalizing our proposal that fiscal intermediaries will continue to

provide information on the new hospital to the QIO in the state in which the hospital is

located, as soon as possible, so that the QIO can enter the provider information into its

PRS, and follow through with ensuring provider compliance with the requirements for

quality data reporting. For a new hospital that receives a provider number on or after

October 1 of each year (beginning with October 1, 2007), we are finalizing our proposal

that the hospital will be required to report RHQDAPU data for clinical and outcome

measures beginning with the first day of the quarter following the date the hospital

registered to participate in the RHQDAPU program. For example, a hospital that

receives its MPN on October 2, 2007, and signs up to participate in RHQDAPU on

November 1, 2007, will be expected to meet all of the data submission requirements for

discharges on or after January 1, 2008. In addition, for HCAHPS we strongly

recommend the hospital participates in a dry run, if feasible, prior to beginning to collect

HCAHPS data on an on-going basis to meet RHQDAPU requirements. We refer readers

to the Web site at http://www.hcahpsonline.org for a schedule of upcoming dry runs.

B. Development of the Medicare Hospital Value-Based Purchasing Plan

Section 5001(b) of the Deficit Reduction Act of 2005 (DRA) requires the

Secretary of Health and Human Services to "develop a plan to implement a value-based

purchasing program for payments under the Medicare program for subsection (d)

hospitals beginning with fiscal year 2009." Congress specified that the plan include

consideration of the following issues:

● The ongoing development, selection, and modification process for measures of

quality and efficiency in hospital inpatient settings.

● The reporting, collection, and validation of quality data.

● The structure of value-based payment adjustments, including the determination

of thresholds or improvements in quality that would substantiate a payment adjustment,

the size of such payments, and the sources of funding for the value-based payments.

● The disclosure of information on hospital performance.

In developing the plan, the Secretary must consult with relevant affected parties,

and consider experience with demonstrations that are relevant to the value-based

purchasing program.

To develop the mandated plan on behalf of the Secretary, CMS created an internal

Hospital Value-Based Purchasing (VBP) Workgroup. The Workgroup was organized

into four subgroups to address each of the required planning issues: (1) measures; (2)

data collection and validation; (3) incentive structure; and (4) public reporting.

CMS hosted two public "Listening Sessions" in early 2007 to solicit comments from relevant affected parties on outstanding questions associated with the development of a plan. The first Listening Session was held on January 17, 2007, to consider design questions. The second Listening Session was held on April 12, 2007, to consider plan options. The perspectives expressed by stakeholders, including hospitals, consumers, and purchasers, during these sessions and in writing were used to assist the Workgroup in drafting the Medicare Hospital VBP Plan Report to Congress. Once the Report is submitted to Congress, CMS will post it on the CMS Web site.

Comment: Numerous commenters were supportive of the basic concepts included in the plan options and many commended CMS on its efforts to obtain stakeholder input during the planning process. The commenters urged CMS to continue this active dialogue once the Medicare Hospital VBP Plan is publicly released.

The commenters addressed five principal themes:

● Proposed Measure Set. Several commenters stressed the importance of maintaining a stable measure set and measure specifications to provide a consistent basis for measuring improvement. A few commenters addressed the value of focusing on health outcomes and on evaluating resource consumption in achieving desired outcomes. A number of commenters made recommendations on specific measures and on establishing thresholds and benchmarks.

● Data Submission and Validation Process. A few commenters expressed concern about the proposed accelerated timeframe for data submission, and several

commenters had suggestions for further strengthening the proposed new approach to data

validation.

● Phased Approach to Transition from RHQDAPU to VBP. A number of

commenters stressed the importance of a phased transition so that hospitals will have

notice before the first "measurement year" begins.

● Proposed Incentive Structure. Several commenters urged that the dollars at

risk be limited, given the limited experience with VBP and encouraged CMS to distribute

all unearned incentives to hospitals.

● Possible Roles for Medicare Quality Improvement Organizations (QIOs) in

VBP. A few commenters recommended that QIOs support performance improvement in

lower-performing hospitals to ensure that successful practices are shared.

Response: These comments are similar to those that CMS received on the plan

options during the April 12, 2007 Listening Session and in written comments. We

appreciate the careful thought, and in one instance detailed analysis, devoted to providing

these comments. The comments will be useful as we consider a Medicare Hospital VBP

Plan. We welcome continued dialog with stakeholders regarding the challenges and

opportunities in the development of a plan to implement a Medicare VBP program for

hospitals.

C. Rural Referral Centers (RRCs) (§412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at

§412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS

as an RRC. For discharges occurring before October 1, 1994, RRCs received the benefit

of payment based on the other urban standardized amount rather than the rural

standardized amount. Although the other urban and rural standardized amounts are the

same for discharges occurring on or after October 1, 1994, RRCs continue to receive

special treatment under both the DSH payment adjustment and the criteria for geographic

reclassification.

Section 402 of Pub. L. 108-173 raised the DSH adjustment for other rural

hospitals with less than 500 beds and RRCs. Other rural hospitals with less than 500

beds are subject to a 12-percent cap on DSH payments. RRCs are not subject to the

12-percent cap on DSH payments that is applicable to other rural hospitals (with the

exception of rural hospitals with 500 or more beds). RRCs are not subject to the

proximity criteria when applying for geographic reclassification, and they do not have to

meet the requirement that a hospital's average hourly wage must exceed 106/108 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 an

RRC by the Secretary . . . for fiscal year 1991 shall be classified as such an RRC for

fiscal year 1998 and each subsequent year." In the August 29, 1997 final rule with

comment period (62 FR 45999), we reinstated RRC status for all hospitals that lost the

status due to triennial review or MGCRB reclassification, but did not reinstate the status

of hospitals that lost RRC status because they were now urban for all purposes because of

the OMB designation of their geographic area as urban. However, subsequently, in the

August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that

decision. Specifically, we stated that we would permit hospitals that previously qualified

as an RRC and lost their status due to OMB redesignation of the county in which they are

located from rural to urban to be reinstated as an RRC. Otherwise, a hospital seeking

RRC status must satisfy the applicable criteria. We used the definitions of "urban" and

"rural" specified in Subpart D of 42 CFR Part 412.

1. Annual Update of RRC Status Criteria

        One of the criteria under which a hospital may qualify as a RRC is to have 275 or

more beds available for use (§412.96(b)(1)(ii)). A rural hospital that does not meet the

bed size requirement can qualify as an RRC if the hospital meets two mandatory

prerequisites (a minimum CMI and a minimum number of discharges), and at least one of

three optional criteria (relating to specialty composition of medical staff, source of

inpatients, or referral volume) (§412.96(c)(1) through (c)(5) and the September 30, 1988

Federal Register (53 FR 38513)). With respect to the two mandatory prerequisites, a

hospital may be classified as an RRC if--

        ● The hospital's CMI is at least equal to the lower of the median CMI for urban

hospitals in its census region, excluding hospitals with approved teaching programs, or

the median CMI for all urban hospitals nationally; and

        ● The hospital's number of discharges is at least 5,000 per year, or, if fewer, the

median number of discharges for urban hospitals in the census region in which the

hospital is located. (The number of discharges criterion for an osteopathic hospital is at

least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

a. Case-Mix Index

Section 412.96(c)(1) provides that CMS establish updated national and regional

CMI values in each year's annual notice of prospective payment rates for purposes of

determining RRC status. The methodology we used to determine the national and

regional CMI values is set forth in the regulations at §412.96(c)(1)(ii). The national

median CMI value for FY 2008 includes all urban hospitals nationwide, and the regional

values for FY 2008 are the median CMI 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 2006 (October 1, 2005

through September 30, 2006), and include bills posted to CMS' records through March

2007.

In the FY 2008 IPPS proposed rule (72 FR 24811), we proposed that, in addition

to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for

initial RRC status for cost reporting periods beginning on or after October 1, 2007, they

must have a CMI value for FY 2006 that is at least--

• 1.2258; 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.

Based on the latest available data (FY 2006 bills received through March 2007),

in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to

qualify for initial RRC status for cost reporting periods beginning on or after

October 1, 2007, they must have a CMI value for FY 2006 that is at least--

- 1.4049; 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)	1.2348
2. Middle Atlantic (PA, NJ, NY)	1.2665
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3515
4. East North Central (IL, IN, MI, OH, WI)	1.3393
5. East South Central (AL, KY, MS, TN)	1.2904
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2869
7. West South Central (AR, LA, OK, TX)	1.4010
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4260
9. Pacific (AK, CA, HI, OR, WA)	1.3772

Hospitals seeking to qualify as RRCs or those wishing to know how their CMI

value compares to the criteria should obtain hospital-specific CMI values (not transfer-

adjusted) from their fiscal intermediaries. 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.

b. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional

numbers of discharges in each year's annual notice of prospective payment rates for

purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act,

the national standard is set at 5,000 discharges. In the FY 2008 IPPS proposed rule, we

proposed to update the regional standards based on discharges for urban hospitals' cost

reporting periods that began during FY 2004 (that is, October 1, 2003 through

September 30, 2004), which was the latest available cost report data we had at that time.

Therefore, in the FY 2008 IPPS proposed rule (72 FR 24811), we proposed that,

in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for

cost reporting periods beginning on or after October 1, 2007, must have as the number of

discharges for its cost reporting period that began during FY 2004 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 2008 IPPS proposed rule

at 72 FR 24811.)

Based on the latest discharge data available at this time, that is, for cost reporting

periods that began during FY 2004, the final median number of discharges for urban

hospitals by census region are set forth in the following table:

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,758
2. Middle Atlantic (PA, NJ, NY)	10,603
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,627

Region	Number of Discharges
4. East North Central (IL, IN, MI, OH, WI)	9,325
5. East South Central (AL, KY, MS, TN)	7,966
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,986
7. West South Central (AR, LA, OK, TX)	7,225
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,082
9. Pacific (AK, CA, HI, OR, WA)	8,439

We note that the median number of discharges for hospitals in each census region

is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is

the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost

reporting periods beginning on or after October 1, 2007, the hospital would be required to

have at least 3,000 discharges for its cost reporting period that began during FY 2004.

Comment: Two commenters asked about the CMI values, stating that the values

seem to have risen inexplicably in recent years, and the proposed FY 2008 national value

is higher than the regional values, which is counter-intuitive given the national value

includes teaching hospitals and the regional values do not.

Response: The method for calculating the CMI values for the RRC criteria has

not changed. The rise in CMI values over the years may be due to an increase in the

severity of inpatient cases and perhaps to improvements in the coding of such cases.

Regarding the proposed FY 2008 national CMI value being lower than the regional CMI

values, the national CMI value in the proposed rule was erroneous. The proposed

FY 2008 national median CMI value should have read 1.4039. The final FY 2008

national median CMI value (1.4049) is higher than each of the regional median CMI

values, except the Mountain region median CMI value, set forth in the table above. With

respect to the national median CMI value being slightly lower than the Mountain region

CMI value, we note that these values are medians, not means. Therefore, the national

and regional medians are affected by the distribution of each hospital's CMI within each

region and nationally.

2. Acquired Rural Status and RRCs (§412.103(g))

        With the following exceptions, a hospital must be rural to qualify as an RRC:

        ● Consistent with section 4202(b) of Pub. L. 105-33, any hospital designated as

an RRC in FY 1991 retains that status for FY 1998 and each subsequent year.

        ● Hospitals located in a rural county that would have lost their RRC status as a

result of an OMB redesignation of the area from rural to urban were permitted to remain

as RRCs (69 FR 49056).

        ● Hospitals located in urban areas that apply for reclassification as rural under

§412.103 (that is, the hospital is located in an urban area but it "acquires" rural status

under the regulations) also may qualify as an RRC.

        Under §412.103(g), a hospital may cancel its rural reclassification by submitting a

written request to the CMS Regional Office no less than 120 days prior to the end of its

current cost reporting period. A hospital may choose to cancel its acquired rural status if

it determines that it may be more financially beneficial to return to urban status and the

associated IPPS payments rather than remain rural and receive the special treatments of

certain rural providers such as RRCs, SCHs and CAHs. The hospital's acquired rural

status is canceled beginning with its next cost reporting period. We have received

inquiries asking whether a hospital retains its RRC status once it voluntarily cancels its

acquired rural status.

As indicated above, a hospital generally must be rural to be classified as an RRC.

However, a hospital may retain its RRC status in the special circumstances where it

would have lost status due to OMB redesignation of its area from rural to urban, or where

it was already designated as an RRC in 1991. In these situations, there were either

special statutory provisions that require the hospital to retain its RRC status or the

hospital's geographic status changed from rural to urban through no action of its own.

We do not believe that an urban hospital that acquires rural status under §412.103

and subsequently is approved as an RRC should be able to retain the benefits of being an

RRC when it voluntarily cancels that acquired rural status. In our view, it follows from

the requirement that an RRC must be located in a rural area that cancellation of acquired

rural status negates a hospital's RRC designation. Therefore, we believe that Medicare's

policy should be that a hospital cannot continue to be classified as an RRC once it cancels

acquired rural status under §412.103. For this reason in the FY 2008 IPPS proposed rule

(72 FR 24812), we stated that a hospital that cancels its acquired rural status, received

under §412.103, would also lose its RRC designation under §412.96. In this situation,

the hospital would lose its RRC designation under §412.96 as of the date the cancellation

of its acquired rural status takes effect.

As indicated above, RRCs are not subject to a maximum DSH adjustment of 12

percent that applies to other rural hospitals with less than 500 beds. Further, RRCs are

not subject to the proximity criteria when applying for geographic reclassification

(§412.230(a)(3)), and they do not have to meet certain wage comparison tests for

reclassification (§412.230(d)(1)(iii)). A hospital located in an urban area that cancels its

acquired rural status under §412.103 would lose its RRC status and become subject to a

12-percent cap on the DSH adjustment applicable to urban hospitals with less than 100

beds (if the hospital has 100 beds or more, it would not be subject to the cap on the DSH

adjustment). Further, the hospital would also have to meet the proximity requirement for

geographic reclassification at §412.230(a)(3). We note that the hospital would maintain

the benefit of being exempt from the average hourly wage criterion for geographic

reclassification requiring the comparison of the hospital's wages to the wages of the area

in which it is located, as stated in section 1886(d)(10)(D)(iii) of the Act.

Comment: One commenter stated that a hospital located in an urban area may

also qualify as an RRC if it meets the criteria set forth in 42 CFR 412.96(b)(2). These

criteria specify referral patterns the hospital's patients must meet in order for an urban

hospital to be a referral center. The commenter requested that the final rule confirm that

an urban hospital may also qualify as an RRC under §412.96(b)(2).

Response: The regulations at §412.96(b)(2) do specify criteria for a hospital to

qualify as a "referral center," with no requirement to be rural. However, an urban

hospital that qualifies as a referral center under §412.96(b)(2) is not a "rural" referral

center (RRC). Section 1886(d)(5)(C)(i) of the Act states that a hospital that is classified

as a "rural hospital" may apply to the Secretary to be classified as an RRC. Thus, an

urban hospital that meets the criteria under §412.96(b)(2) qualifies as a referral center but

does not qualify as an RRC because it is not rural (unless it first reclassifies as rural under

§412.103).

Comment: One commenter stated that this policy would prohibit urban hospitals

that acquire rural status from maintaining their RRC designation if they are subsequently

reclassified as urban by the MGCRB. The commenter indicated that the policy creates a

significant disadvantage for urban hospitals that acquire rural status and to the Medicare

beneficiaries they serve, relative to their RRC counterparts that retain the status of RRC

even though physically located in an urban area.

Response: We believe the commenter is generally concerned with the policy that

an urban hospital that has acquired rural status cannot retain its RRC designation once it

cancels its acquired rural status. As indicated above, a hospital generally must be rural to

be classified as an RRC. For this reason, we believe that Medicare's policy should be

that a hospital cannot continue to be classified as an RRC once it cancels acquired rural

status under §412.103. In our view, it follows from the requirement that an RRC must be

located in a rural area that cancellation of acquired rural status negates a hospital's RRC

designation. As discussed above, a hospital may retain its RRC status in the special

circumstances where it would have lost status due to OMB's designation of its area from

rural to urban, or where it was already designated as an RRC in 1991. In these situations,

there were either special statutory provisions that require the hospital to retain its RRC

status or the hospital's geographic status changed from rural to urban through no action of

its own. Again, we do not believe that an urban hospital that acquires rural status under

§412.103 and subsequently is approved as an RRC should be able to retain the benefits of

being an RRC when it voluntarily cancels that acquired rural status.

Furthermore, in response to the commenter's statement that this policy prohibits

urban hospitals that acquire rural status from maintaining their RRC designation if they

are subsequently reclassified as urban by the MGCRB, we note that §412.230(a)(5)(iii) of

the regulations prohibits an urban hospital that has been granted rural status under

§412.103 from receiving an additional reclassification by the MGCRB based on this

acquired rural status for a year in which such redesignation under §412.103 is in effect.

Therefore, under our current regulations, an urban hospital that has acquired rural status

cannot be reclassified by the MGCRB. As discussed above, if an RRC with acquired

rural status cancels its acquired rural status so that it can be reclassified by the MGCRB,

the hospital would lose its RRC status once it cancels its acquired rural status.

Comment: Some commenters pointed to language in the **Federal Register**

(August 1, 2000; 65 FR 47087) regarding section 401 of Pub. L. 106-113, on which the

regulations at 42 CFR 412.103 are based. The commenters stated that certain discussions

in the preamble to that August 1, 2000 rule demonstrate that a hospital acquiring rural

status should retain RRC status for all purposes, even if it subsequently cancels the

acquired rural status. In addition, the commenters stated that our previous amendment of

§412.96 to eliminate the triennial review requirement indicates an intent to allow all

hospitals to retain RRC status indefinitely once obtained under §412.96.

Response: The discussion in the August 1, 2000 **Federal Register** referenced by

the commenters was targeted at hospitals that had lost their RRC status through an OMB

change in geographic area definitions, through triennial review, or through an MGCRB

reclassification for purposes of the standardized amount. Thus, in the August 1, 2000

Federal Register, we discussed grandfathering into RRC status any hospital that lost

RRC designation as a result of OMB's new geographic areas, due to an MGCRB

standardized amount reclassification, or through triennial review. At the time, the

discussion did not address hospitals that, in the future, would acquire rural status under

§412.103, only to voluntarily cancel such acquired status at a later date.

In addition, the discussion addressed the rule that hospitals acquiring rural status

under §412.103 cannot receive an additional reclassification by the MGCRB based on

this acquired rural status for a year in which such a redesignation is in effect. This rule

prevents an urban to rural reclassification under §412.103 from becoming a vehicle by

which a hospital navigates from one geographic location and special status as a rural

provider for the purpose of a more advantageous reclassification via the MGCRB

process. The prohibition against a hospital that acquires rural status from exploiting such

status to further seek an MGCRB reclassification demonstrates our longstanding view

that section 401 of Pub. L.106-113 should not be used as a way of acquiring special status

solely to benefit from MGCRB rules. Similarly, we do not believe that acquiring rural

status and then subsequently canceling it should be used as a way to exploit MGCRB

reclassification rules.

Rather, in the August 1, 2000 rulemaking, we implemented section 401 of

Pub. L. 106-113 by specifying three categories of hospitals which would essentially be

grandfathered in as RRCs: those that lost RRC status due to (a) triennial review, (b)

MGCRB standardized amount reclassification, or (c) OMB redesignation of the county in

which they were located from rural to urban. The first and second categories of hospitals

no longer exist, as we do not conduct triennial review and there are no MGCRB

reclassifications for purposes of the standardized amount. As for the third category of

hospitals, we have retained the rule that hospitals redesignated as urban through no action

of their own, and solely through an OMB redesignation of an area as urban would

continue to be considered RRCs if they were RRCs prior to the change in geographic

areas. Our rulemaking from August 1, 2000 was intended to ensure that the hospitals for

which Congress intended to preserve RRC status (that is, those that lost RRC designation

through an OMB geographic area redefinition, triennial review, or MGCRB standardized

amount reclassification) would continue their RRC status. However, it was not intended

to allow hospitals to exploit acquired rural status in order to seek the most advantageous

MGCRB reclassification. Indeed, the rule we added to §412.230 limiting hospitals that

reclassify under §412.103 from further reclassifying (65 FR 47087 through 47089)

demonstrates this policy. Therefore, we believe the policy we discussed in this year's

proposed rule--that a hospital that voluntarily cancels acquired rural status can no longer

be considered a "rural" referral center--is fully consistent with our August 1, 2000

rulemaking.

Furthermore, our amendment to the regulations eliminating the triennial review

requirement was not intended to allow hospitals to retain RRC status indefinitely once

obtained under §412.96. We eliminated the triennial review requirement in the

August 29, 1997 final rule (62 FR 45998 through 46000). In that rule, we addressed

section 4202(b)(1) of Pub. L. 105-33, which states in part, "Any hospital classified as a

rural referral center by the Secretary * * * for FY 1991 shall be classified as such a rural

referral center for fiscal year 1998 and each subsequent fiscal year." In the

August 29, 1997 rule, we noted that section 4202(b)(1) of Pub. L. 105-33 provided

reinstatement to only those hospitals that were classified as RRCs during FY 1991. As a

result, those hospitals that were RRCs in FY 1991 and lost RRC status due to triennial

review would be reinstated to RRC status; whereas, those hospitals that were classified as

RRCs after FY 1991 and lost that status due to triennial review would not be protected.

We stated that we did not believe that it was equitable or administratively practical to

maintain two lists of referral centers; that is, (a) a list of those hospitals that lost RRC

status due to triennial review but were then reinstated under section 4202(b)(1) of

Pub. L. 105-33 because they were approved as RRCs in FY 1991; and (b) a list of those

hospitals that lost RRC status due to triennial review, but were not protected by section

4202(b)(1) because they were approved as RRCs after FY 1991. Therefore, we

terminated the triennial review requirement and reinstated all hospitals that lost RRC

status due to triennial review. In addition, in the August 29, 1997 final rule, we stated

that we could still reinstate some type of annual or periodic qualifying criteria and

remove a hospital's RRC status if we discovered that some hospital or class of hospitals

should not be allowed to retain referral center status because they fail to meet some basic

requirement that we believe is essential to receiving this special designation. As

indicated above, a hospital generally must be rural to be classified as an RRC. It follows

from the requirement that an RRC must be located in a rural area that cancellation of acquired rural status negates a hospital's RRC designation.

Comment: One commenter agreed with the policy discussed in the proposed rule that a hospital that cancels its acquired rural status should no longer qualify to be an RRC.

Response: We appreciate the commenter's support.

In this FY 2008 IPPS final rule, we are again announcing our policy that a hospital that cancels its acquired rural status under §412.103 would also lose its RRC designation under §412.96. Under this final policy, any hospital that submits a written request on or after October 1, 2007, to cancel its acquired rural status under §412.103(g) will lose RRC status (obtained based on rural status acquired under §412.103) as of the same date that the cancellation of acquired rural status under §412.103(g) takes effect. We are amending the regulations text at §412.96 by adding a paragraph (g)(4) that states: "A hospital that submits a written request on or after October 1, 2007, to cancel its reclassification under §412.103(g) is deemed to have cancelled its status as a rural referral center effective on the same date the cancellation under §412.103(g) takes effect. This provision of this paragraph (g)(4) applies to hospitals that qualify as rural referral centers under §412.96 based on rural status acquired under §412.103."

We note that the policy set forth in §412.96(g)(4) applies only to hospitals that obtain RRC status based on rural status acquired under §412.103. For example, in the FY 2001 IPPS final rule (65 FR 47089) and the FY 2005 IPPS final rule (69 FR 49056), we permitted a hospital that previously qualified as an RRC and lost its status as an RRC

due to OMB's redesignation of the county in which it is located from rural to urban to be

reinstated as an RRC (even though the area in which it is geographically located is now

urban). Section 412.96(g)(4) would not apply to a hospital that has RRC status based on

this policy regarding OMB redesignations and that also has acquired rural status under

§412.103 for other purposes (for example, to become an SCH). In this situation, the

hospital did not obtain RRC status based on acquired rural status under §412.103, but

instead based on the policies described in our FY 2001 and FY 2005 final rules regarding

OMB redesignations.

In the FY 2008 IPPS proposed rule (72 FR 24812), we also proposed to revise the

regulations at §412.103(g) with respect to when cancellation of acquired rural status

becomes effective. Currently, §412.103(g)(2) states, "The hospital's cancellation of the

classification is effective beginning with the hospital's next full cost reporting period

following the date of its request for cancellation." To address concerns that some IPPS

hospitals are acquiring rural status solely to benefit from reclassification rules applying to

hospitals that were once RRCs, and then canceling that rural status within a short period

of time, such as a few months, we proposed to require IPPS hospitals to retain acquired

rural status for at least one 12-month cost reporting period. In the FY 2008 IPPS

proposed rule, we stated that if the hospital chooses to cancel its rural reclassification, the

effective date of that cancellation would occur both after at least one 12-month cost

reporting period and at the start of the next Federal fiscal year. Thus, for example, if a

hospital with a cost reporting period from July 1, 2008 to June 30, 2009, becomes rural

on May 30, 2008, its acquired rural status under §412.103 would remain in effect from

May 30, 2008, through at least September 30, 2009 (that is, the date it acquired rural

status through the end of the fiscal year containing a 12-month cost reporting period).

We stated that we believed this policy was reasonable, given that acquired rural status for

IPPS hospitals should be a considered decision for hospitals that truly wish to be

considered as rural, and not purely as a mechanism for reclassifying. We did not propose

a duration requirement for hospitals paid under cost reimbursement because we are not

aware of similar manipulations of rural status in these cases.

        We proposed to change our current policy by revising §412.103(g) to specify that

a hospital's cancellation of its acquired rural status under §412.103 is effective for

hospitals under reasonable cost reimbursement (such as CAHs) with the hospital's next

cost reporting period and for hospitals under the IPPS after at least one 12-month cost

reporting period as rural, and not until the beginning of a Federal fiscal year following

both the request for cancellation and the 12-month cost reporting period. Under the

proposed revised regulations, an IPPS hospital (such as an RRC or SCH) that cancels its

acquired rural status would continue to be paid as rural until the beginning of the next

Federal fiscal year after at least one 12-month cost reporting period as rural. In addition,

for these IPPS hospitals, the deadline for seeking cancellation of the acquired rural status

would be no less than 120 days before the end of the fiscal year.

        Comment: One commenter raised concerns regarding the proposed requirement

that a hospital maintain rural status for at least a full 12 months, stating that the rate as a

rural SCH may be only slightly higher than the urban Federal rate. The commenter

believes that changes that positively impact the hospital's urban payment rate or

negatively impact the rural payment rate could cause a hospital the need to cancel its

rural status, and that in these cases, it seems that the proposed time lag/expansion could

cause a hospital to be harmed.

Response: After considering the commenter's concerns regarding hospitals that

acquire rural status to become SCHs, and considering that our primary purpose in

revising the policy is to address concerns regarding hospitals that acquire rural status to

become RRCs and then cancel RRC status after a brief period of time, such as a few

months, in order to take advantage of favorable reclassification rules under §412.230

applicable to hospitals that were ever RRCs, we have decided to limit our final policy to

IPPS hospitals that obtain RRC status based on rural status acquired under §412.103.

Therefore, in this final rule, we are requiring an IPPS hospital that is classified as an RRC

based on rural status acquired under §412.103 to maintain its acquired rural status under

§412.103 for at least one 12-month cost reporting period and until the next Federal fiscal

year following both its request for cancellation of acquired rural status and at least one

12-month cost reporting period as rural.

RRCs benefit only from special provisions in the statute relating to geographic

reclassification and DSH. A hospital that is in acquired rural status cannot be

geographically reclassified by the MGCRB (§412.230). Therefore, the only benefit to an

RRC in acquired rural status relates to DSH (and only if the hospital has less than 100

beds). Thus, there is limited or no benefit to a hospital acquiring rural status in order to

become an RRC, except when the acquired rural status is subsequently canceled. Thus,

the issue is that hospitals should not be permitted to obtain rural status solely for the

purpose of canceling such status as soon as possible in order to benefit from favorable

MGCRB reclassification rules, but, rather, should be required to retain rural status for a

reasonable period of time. Therefore, we believe that a policy requiring an IPPS hospital

that acquires rural status under §412.103, in order to become an RRC, to maintain

acquired rural status for at least one 12-month cost reporting period and until the next

Federal fiscal year is reasonable.

Comment: Two commenters questioned the CMS statement that this proposed

change would be consistent with IPPS policy that makes changes prospectively based on

the Federal fiscal year. They stated that many rural elections under IPPS are not based on

the Federal fiscal year, such as acquiring SCH or MDH status, among others. They stated

they do not see how this proposed revision serves the Medicare program, and do not

believe CMS has adequately explained the need for such a revision. They requested

CMS not adopt this provision in the final rule.

Response: Section 1886(d)(8)(E) of the Act specifies that the effective date of

acquired rural status is not later than 60 days after the receipt of the hospital's

application. Therefore, under the statute, a hospital paid under the IPPS may acquire

rural status in the middle of a Federal fiscal year, and then receive any payment

advantages (or disadvantages) that accompany rural status. In most cases, a hospital will

acquire rural status because of the long-term financial benefits it expects to reap. We

recognize that for hospitals paid under the IPPS system, there may be a short-term cost if

the hospital must accept a lower rural wage index from the time the hospital acquires

rural status to the time the hospital is approved as an RRC, SCH or MDH. However, we

note that acquiring rural status is a voluntary choice, and presumably hospitals balance

the long-term financial benefits that accrue from RRC, SCH or MDH status against the

costs arising from a lower rural wage index.

As we discussed above, our primary concern is with IPPS hospitals that acquire

rural status to become RRCs and then cancel acquired rural status after a brief period of

time in order to take advantage of special MGCRB reclassification rules. Therefore, we

have decided to apply our new policy only to IPPS hospitals that obtain RRC status based

on acquired rural status under §412.103. As noted above, there is limited or no benefit to

a hospital acquiring rural status in order to become an RRC, except when the acquired

rural status is subsequently cancelled. Thus, the issue is that such hospitals should not be

permitted to obtain rural status solely for the purpose of canceling such status as soon as

possible in order to benefit from favorable MGCRB reclassification rules, but, rather,

should be required to retain rural status for a reasonable period of time. We believe that a

policy requiring an IPPS hospital that acquires rural status under §412.103 in order to

become an RRC, to maintain acquired rural status for at least one 12-month cost

reporting period and until the next Federal fiscal year is reasonable. As noted above,

acquiring rural status is a voluntary choice. A hospital should make a decision on

whether to acquire rural status to become an RRC based on its own assessment of the

financial impact on the hospital in the long term. There is administrative burden to both

the hospital and CMS from acquiring rural status, and we do not believe that such

hospitals should be able to change their status after only a short period of time, such as a

few months. Furthermore, we believe that requiring such hospitals to maintain acquired

rural status, and the associated wage index change, until the beginning of the next Federal

fiscal year (after at least one 12-month cost reporting period as rural), rather than the

beginning of the next cost reporting period, is consistent with the IPPS that generally

makes changes prospectively on a Federal fiscal year basis.

Finally, we note that while section 1886(d)(8)(E) of the Act governs the start-date

of acquiring rural status (that is, not later than 60 days after receipt of an application in a

form and manner determined by the Secretary), it does not address the end-date of such

acquired rural status. We believe we have the general rulemaking authority (including

under section 1871 of the Act) to specify the required longevity of acquired rural status,

especially when it has become apparent that hospitals may be acquiring rural status for a

very short period of time solely in order to take advantage of special MGCRB

reclassification rules that accrue to hospitals that were ever an RRC. Therefore, in light

of the comments and after further consideration, we are finalizing the policy announced

in the proposed rule with the revisions discussed above limiting the policy to IPPS

hospitals that become RRCs based on rural status acquired under §412.103.

We are finalizing a revision to §412.103(g) to specify that for a hospital that

obtains RRC status based on acquired rural status under §412.103, the hospital's

cancellation of its acquired rural status under §412.103 is effective after at least one

12-month cost reporting period as rural, and not until the beginning of a Federal fiscal

year following both the request for cancellation and the 12-month cost reporting period.

Under the revised regulations, if an IPPS hospital that obtained its RRC status based on

rural status acquired under §412.103 cancels its acquired rural status, it would continue to

be paid as rural until the beginning of the next Federal fiscal year after at least one

12-month cost reporting period as rural. In addition, for these RRCs, the deadline for

seeking cancellation of the acquired rural status would be no less than 120 days before

the end of the current Federal fiscal year.

This rule applies to all such hospitals (that is, hospitals that became RRCs based

on rural status acquired under §412.103) that submit a written request on or after

October 1, 2007, to cancel their acquired rural status, whether they are in acquired rural

status before October 1, 2007, or acquire rural status on or after October 1, 2007. Thus, if

such a hospital submits a written request on or after October 1, 2007, to cancel its

acquired rural status, the effective date of cancellation would be after at least one

12-month cost reporting period as rural and at the beginning of the next Federal fiscal

year. If such a hospital submits a written request before October 1, 2007, to cancel its

acquired rural status, the hospital is subject to the pre-FY 2008 rule, and the effective

date of cancellation would be the beginning of its next cost reporting period (given it

submits the written request not less than 120 days prior to the end of its current cost

reporting period).

For all other hospitals (that is, hospitals other than IPPS hospitals that became

RRCs based on acquired rural status under §412.103), the effective date of cancellation

of acquired rural status under §412.103 will continue to be the beginning of the hospital's

next full cost reporting period following the date of its request for cancellation (given it

submits the written request not less than 120 days prior to the end of its current cost

reporting period).

D. Indirect Medical Education (IME) Adjustment (§412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at §412.105.

The Balanced Budget Act of 1997 (Pub. L. 105-33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2008

The IME adjustment to the DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is

traditionally described in terms of a certain percentage increase in payment for every

10-percent increase in the resident-to-bed ratio.

Section 502(a) of 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 final rule, we announced the schedule of formula

multipliers to be used in the calculation of the IME adjustment and incorporated the

schedule in our regulations at §412.105(d)(3)(viii) through (d)(3)(xii). In the FY 2008

IPPS proposed rule, we specified that, for any discharges occurring during FY 2008, the

statutorily mandated formula multiplier is 1.35. Previously, for discharges occurring

during FY 2007, the mandated formula multiplier was 1.32. We estimate that application

of the mandated formula multiplier for FY 2008 will result in an increase of 5.5 percent

in IME payment for every approximately 10-percent increase in the resident-to-bed ratio.

Comment: One commenter expressed satisfaction that CMS is increasing the

formula multiplier for FY 2008 and recommended that CMS maintain the formula

multiplier at 1.35.

Response: The provision for the IME formula multiplier for FY 2008 specified in

the proposed rule is mandated by section 1886(d)(5)(B) of the Act, which establishes

that, for discharges occurring during FY 2008 and thereafter, the formula multiplier is

1.35. As noted in the proposed rule and above, we have incorporated the statutorily

mandated schedule of formula multipliers in our regulations.

3. Time Spent by Residents on Vacation or Sick Leave and in Orientation

a. Background

In the FY 2007 IPPS final rule (71 FR 48080), we clarified our policy with

respect to the time that residents spend in nonpatient care activities (such as conferences

and seminars) as part of approved residency programs. We amended our regulations

concerning the FTE resident count at 42 CFR §412.105(f)(1)(iii)(C) to state, "In order to

be counted, a resident must be spending time in patient care activities, as defined in

§413.75(b) . . ." The regulations at §413.75(b) define patient care activities as "the care

and treatment of particular patients, including services for which a physician or other

practitioner may bill." In light of this clarification, during the past year, we have received

questions from the teaching hospital community as to whether the time that residents

spend on vacation or sick leave, and in orientation activities that typically occur at the

beginning of a residency training program, is counted for IME payment purposes.

Historically, time spent by residents on vacation or sick leave and in initial

orientation activities has been included in the FTE resident count for IME and direct

GME. (The sick leave we are referring to throughout this discussion is sick leave that

does not require the resident to make up for his or her absence by adding additional

training time at the end of the program.) The practice of allowing vacation and sick leave

to be included in the IME count appears to be based on a provision in the Provider

Reimbursement Manual, Part I, at section 2405.3.H.2. This manual provision discusses

the treatment of residents who are on vacation or sick leave in the context of our prior

"one day count" policy for counting residents for IME payment. Generally, effective

with cost reporting periods beginning on or after October 1, 1984, and before

July 1, 1991, residents were counted for IME purposes on a uniform reporting date of

September 1. A hospital's FTE residents were counted based on their assignment to that

hospital's IPPS or outpatient areas on September 1 of an academic year. Because it was

possible that a resident might not actually be present in the hospital on September 1

because he or she was on approved vacation or sick leave, to ensure that the hospital's

IME FTE count would not be understated for the entire year, section 2405.3.H.2 of the

PRM-I states that "interns and residents using vacation and sick leave on the day of the

count may be included in the count." Although the regulations were changed effective

for cost reporting periods beginning on or after July 1, 1991 (55 FR 36059) to reflect the

current resident-counting methodology (that is, to count the number of FTE residents

based on the amount of time required to fill a residency slot as specified at

§412.105(f)(1)(iii)(A)), the fiscal intermediaries (or, if applicable, the MAC) have

continued to include time spent by residents on vacation and sick leave in the FTE

resident counts for purposes of both IME and direct GME payments.

Orientation time is time spent by residents in activities that typically take place at

the beginning of a resident's training program, and include orientation regarding hospital

employment, the hospital's policies and procedures in general, as well as policies and

procedures specific to the residency training program. As is the case for vacation and

sick leave, time spent by residents in orientation has continued to be included by fiscal

intermediaries/MAC in the FTE resident counts for purposes of both IME and direct

GME.

We understand why we have received numerous questions regarding whether FTE

resident time spent on vacation or sick leave, or in orientation activities, should be

counted for purposes of IME payment. The time a resident spends on vacation or sick

leave is not addressed within the current definition of "patient care activities" at

§413.75(b). In fact, time spent on vacation or sick leave would not be spent at the

hospital location at all, so no patient care activities would occur during this time. Time

spent in orientation might be spent in the hospital complex (or at a nonhospital setting),

but would not involve the care and treatment of particular patients. Thus, although time

spent by residents on vacation or sick leave or in orientation has historically been

included in the IME and direct GME FTE counts, it seems apparent that this time should

be carefully considered in light of our clarified policy and current regulations. We

believe these types of activities (vacation time, sick leave, and orientation) are inherently

different from the types of "patient care activities" and "nonpatient care activities" we

have discussed in depth in previous rules, and most recently in the FY 2007 IPPS final

rule. We believe the aforementioned activities should be distinguished from other

activities, patient care or otherwise, in which the resident participates as part of the

approved program.

b. Vacation and Sick Leave Time

We believe that approved vacation time and sick leave are not appropriately

categorized as patient care activities, or as didactic, research, or other nonpatient care

activities. In addition, although the Accreditation Council for Graduate Medical

Education (ACGME) has some rules regarding resident duty hours and work

environment, the ACGME is not explicit regarding resident vacation and sick leave

policies. Rather, vacation and sick leave policies are determined by the resident's

employer and can vary by residency training program. Consequently, although vacation

and sick leave are fringe benefits to which every employee, hospital or otherwise, is

typically entitled, vacation and sick leave are not, in fact, part of the training time spent

by residents in an approved program. Therefore, we believe vacation and sick leave are

not properly considered as either patient care time or nonpatient care time, but are within

a distinct third category of time. As we noted above, it has been our policy to include the

time spent by residents on vacation or sick leave in the FTE resident count for IME and

direct GME. However, we do not believe the continuation of this policy is appropriate in

light of our current policy as clarified in the FY 2007 IPPS final rule, and expressed in

revised regulations, that permit only time spent by residents in patient care activities to be

counted for purposes of IME. We initially considered proposing a policy to no longer

count the time spent by residents on vacation or sick leave for purposes of IME on the

grounds that this time is not spent in patient care activities in accordance with our

regulations. However, we do not believe such a policy would have recognized the unique

character of vacation and sick time as time that is not spent in any aspect of residency

training—patient care or nonpatient care. Because we believe time spent by residents on

vacation and sick leave is not properly considered patient care time or nonpatient care

time, but fits within a distinct third category of time that is neither patient care nor

nonpatient care, we believe it would be more appropriate to remove the time altogether

from the FTE calculation for each resident for both IME and direct GME payment

purposes. Accordingly, in the FY 2008 IPPS proposed rule (72 FR 24814), we proposed

to remove vacation and sick leave from the total time considered to constitute an FTE

resident for purposes of IME payments, effective for cost reporting periods beginning on

or after October 1, 2007. Further, in order to have a consistent conception of an FTE

resident for purposes of IME and direct GME payment, we proposed to remove vacation

and sick leave from the total FTE resident time for purposes of direct GME payment as

well effective for cost reporting periods beginning on or after October 1, 2007. We

acknowledged that removing vacation and sick leave time from the denominator of the

FTE count for both IME and direct GME could have some impact on the FTE count, but

noted that the impact is fact-specific. In some cases, it would result in a lower FTE

count, and in some cases, it would result in a higher FTE count. In addition, we noted

that under our current policy, residents who are on maternity leave or other approved sick

leave of extended duration that prolongs the total time a resident is participating in the

approved program beyond the normal duration of the program are <u>not</u> counted while they

are out on extended sick or maternity leave. This is because the FTE time spent by such

residents is counted in accordance with our FTE counting policies during the training

time they spend to make up for their absence. For example, a resident in an internal

medicine program who takes 3 months of approved maternity leave, and therefore, must

stay an additional 3 months beyond the normal 3 years to complete her training, would

not be counted while she is on maternity leave for IME and direct GME payment

purposes. Rather, time spent during the additional 3 months of training in which she

must participate to make up for her 3 month absence will be counted in accordance with

our FTE-counting policies for IME and direct GME. We did not propose to change our

policy with respect to time spent by residents on maternity leave or other approved sick

leave of extended duration. We proposed to amend the regulations at

§§412.105(f)(1)(iii)(A) and 413.78(b) to specify that "Vacation and sick leave are not

included in the determination of full-time equivalency."

c. Orientation Activities

As discussed above, we believe that orientation activities in which residents

participate, often prior to the start of their residency training program, are also distinct

from the typical "patient care" and "nonpatient care" activities in which residents

participate as part of their training program. For example, before residents begin training

in an approved residency program, the hospital (or in many cases, the medical school as

the employer of the residents) is required to provide orientation for their residents. Most

of these orientation activities involve neither patient care nor the typical didactic or

research activities that comprise the residency training program. Instead, such orientation

activities consist of basic informational sessions in which all new employees, residents,

and other staff must participate at the beginning of employment. There could also be

other orientation activities designed specifically to prepare residents to furnish patient

care in a particular setting, or to participate in a particular approved residency training

program. We recognize that certain portions of orientation activities are specific to

residents in particular approved programs and are required by the accrediting

organizations. Other components of orientation activities relate to employment and are common to all employees. Still other components of orientation activities may involve training regarding particular hospital policies and procedures, some of which would relate to patient care and safety. In many ways, these orientation activities resemble "didactic" activities. However, we believe there are important differences between the "didactic" activities that are part of orientation and the other conferences and seminars in which the residents engage throughout the course of their training. That is, we do not envision orientation activities as including scholarly didactic activities such as conferences or seminars that may occur throughout a residency training program. Rather, we believe orientation activities would occur either at the beginning of a particular specialty program, or when a resident goes to another facility for training. In orientation sessions, much of the information being imparted to the residents is essential knowledge for the residents in order to furnish patient care services in a particular hospital facility or approved program. Thus, the information furnished during orientation is not information that merely enhances the resident's patient care delivery knowledge and skills during the residency program, but it is a necessary prerequisite for the residents as they commence (or continue) their training program, and is often required as a term of employment. Because we recognize the distinct character of orientation activities as essential to the provision of patient care by residents, and the fundamental differences between orientation and the typical didactic activities in which a resident may participate throughout a residency training program, in the FY 2008 IPPS proposed rule (72 FR 24814), we proposed to continue to count the time spent by residents in

orientation activities, whether they occur in the hospital or nonhospital setting, and

proposed to amend our regulations accordingly. (We note that orientation activities in the

hospital setting have historically been counted for direct GME payment purposes in

accordance with the regulations at §413.78(a) which states "Residents in an approved

program working in all areas of the hospital complex may be counted.") We also

proposed to amend §413.75(b) to add a definition of the term "orientation activities," to

mean "activities that are principally designed to prepare an individual for employment as

a resident in a particular setting, or for participation in a particular specialty program and

patient care activities associated with that particular specialty program." We understand

that orientation activities typically occur at the beginning of a resident's first program

year. However, in the FY 2008 IPPS proposed rule, we noted that we were interested in

hearing from commenters on whether orientation activities typically occur during other

times during an approved residency training program. We proposed to amend the

definition of "patient care activities" at §413.75(b) as follows: "the care and treatment of

particular patients, including services for which a physician or other practitioner may bill,

and orientation activities as defined at §413.75(b)."

Comment: Many commenters expressed appreciation of CMS' efforts to clarify

its policies concerning the time that residents spend in orientation activities in the

determination of an FTE. Several commenters also stated their appreciation that CMS

did not attempt to penalize hospitals for offering vacation and sick leave; that is, they

were appreciative that CMS did not propose to remove vacation and sick leave from only

the numerator of the FTE. One commenter stated "We can agree with the proposed

removal of vacation and sick time from both the numerator and denominator in the FTE

calculation." The commenter stated that any benefit time such as holidays should also be

removed. The commenter also stated that CMS should clarify its expectations in order to

"…eliminate an overzealous reading…" of policy so that between the effective date of

FY 2007 final rule and this year's final rule, days spent by residents on vacation or sick

leave would not be viewed as days spent in nonpatient care and, therefore, removed from

the numerator of the FTE count. The commenter further requested that the policy change

be made retroactive to FY 2007 to coincide with CMS' clarification in the FY 2007 final

rule concerning nonpatient care activities. The commenter also indicated that other

benefit time should be removed from the numerator and denominator so as to avoid

leaving a gap in policy that is open to interpretation for FY 2007 FTE resident counts.

However, numerous commenters viewed the proposed policy as "operationally

impractical" and stated that it would impose significant documentation and administrative

burdens. Many commenters requested that the regulations remain unchanged--that

vacation and sick leave continue to be included in the determination of an FTE.

Commenters also asserted that there are many issues and questions that CMS must

consider and determine before finalizing such a policy; otherwise, the policy will be

subject to interpretation and could be applied inconsistently by providers.

Several commenters stated that the proposed rule would be administratively

burdensome for the following reasons: each hospital would be required to track vacation

and sick time for each resident and allocate that vacation and sick leave time for every

hospital in which the resident is training; it is difficult for hospitals that share residents to

discern whether the residents actually take their allotted vacation time; and residents may

rollover their unused vacation from one year to another. One commenter expressed

concerns regarding the "intellectual and administrative difficulty" of trying to parse

resident time and indicate whether it should be included in the FTE count with orientation

or be removed from the FTE count with vacation and sick leave. Several commenters

stated that hospitals do not have sick leave and vacation records for each resident for the

entire year, and hospitals would have to communicate up front and on a continual basis

with all other hospitals in which an individual resident is training in order to determine

the correct FTE count for that particular resident.

One commenter stated that records of sick time and vacation are kept by the

sponsoring institution and actual scheduling and tracking of time off is organized at the

department level. Another commenter stated that up to this point, sick leave has not been

recorded, while another commented that hospitals often require residents to make up sick

days due to the educational demands of the residency program, and that residents may

also swap days to cover for someone who is sick. One commenter stated that hospital

record keeping requirements should be established prior to the implementation of the

proposed policy so that both hospitals and fiscal intermediaries have a consistent

understanding of what documentation is required to comply with the policy. Another

commenter stated that the purpose of the rotation schedule is to identify and document

residency training and not to duplicate the detail kept by the payroll system. Several

commenters also stated that the proposed policy would prove to be burdensome because

vacation time is usually decided between the resident and supervising physician and,

therefore, the recordkeeping requirements would need to be modified. In addition,

commenters noted that vacation days are allotted based on the residency program year

which may be different than the cost reporting year. Commenters also noted that

residents may rotate to different hospitals which have different fiscal year ends.

Therefore, the other hospitals to which the residents rotate, may not know the residents'

vacation and sick leave until each hospital's cost report has been filed. One commenter

stated "[t]he Graduate Medical Education Committee's (GMEC) responsibilities as stated

in the Accreditation Council for Graduate Medical Education (ACGME) 'Green' book

indicate that monitoring of duty-hours and call schedules for excessive service demands

and/or resident fatigue must be included. It also states that each program must ensure

that adequate time for rest and personal activities must be provided."

Several commenters expressed concerns that the proposed rule will lead to other

areas of time being reviewed, to the point where residents will be spending more time

tracking their time for lunches and meetings than being involved with patient care. One

commenter noted that CMS' proposed policy will be a significant challenge for the

teaching hospital community because of the fluid nature of residency training. One

commenter stated that CMS did not provide a policy justification for why vacation and

sick time should be removed from the FTE count for direct GME. The commenter

mentioned that although CMS may be trying to reduce the administrative burden, a

simpler way of reducing the administrative burden would be to retain the current policy.

The commenter noted that, in the last few years, the administrative burdens associated

with receiving Medicare payments for GME "have grown exponentially" and that with

the proposed rule on vacation, sick leave, and orientation, the teaching hospital

community has reached a "breaking point." Commenters also noted that the

administrative cost of instituting the proposed policy would exceed the potential savings.

One commenter requested that CMS confirm and clarify that the proposal is to

remove vacation and sick time from both the numerator and denominator. Another

commenter stated that CMS' proposed policy "…suggests CMS is interested in

supporting [the resident's] role on an hourly basis and if this is correct, hospitals should

be able to count all after-hours, weekend and holiday time the residents spend with

patients." The commenter maintained that if CMS supports GME on an hourly basis, the

commenter would expect a net increase in its FTE count because of the long hours of

resident-related patient care.

One commenter stated that CMS correctly noted that the outcome of the proposed

rule would depend on specific facts. However, the commenter noted that CMS failed to

acknowledge that the effect of the proposed rule would be to decrease FTE counts in

every instance in which the FTE resident is counted at less than one FTE; that is, in every

instance where there is also disallowed time, such as didactic time. The commenter also

noted that "[e]liminating time spent in didactic teaching from the denominator of the

fraction prior to removing vacation time from the equation would exacerbate even further

this drop in hospital FTE counts." Commenters also provided examples of cases where a

resident rotates to more than one hospital and takes vacation while assigned to one of the

hospitals. The commenters noted that each hospital to which the resident rotates, as a

result of the proposed policy, would experience a change in its FTE count even though no hospital has modified its rotation arrangement.

Commenters were concerned that although the proposed policy would have minimal effects nationally, the policy has major implications at the local level. A number of commenters noted their facilities provided training for hundreds of interns and residents, and stated the cost of tracking the vacation and sick time of interns and residents at their facilities would be in the thousands of dollars, and, in some cases, would decrease a provider's reimbursement.

Many commenters stated that if the proposed policy is finalized, it cannot be done until the IRIS system is modified to change the denominator of an FTE, since the commenter believes IRIS currently is based on a denominator of 365 days. One commenter stated that in order to document that no double counting is occurring, hospitals use up to 60 lines on IRIS to document each resident's time. However, hospitals have noted that 60 lines is not enough to account for the residents' time and therefore hospitals must "…consolidate training time frames which can create additional overlap potentials which must be investigated by the hospitals involved." The commenter stated if hospitals need to account for vacation and sick leave, IRIS will require significant modification. The commenter noted that CMS needs to further study the impact of its proposed policy on IRIS submissions and it would be unfair and wrong for CMS to "prematurely implement" the vacation and sick leave policy if IRIS cannot accommodate it. Another commenter stated that it had previously commented on the need to update IRIS and that teaching hospitals have needed to purchase "workaround

software," "Compu-max," to meet the regulatory and audit requirements of Medicare.

The commenter further stated that "Compu-max" software generates FTE counts on the

basis of a 365 day year and this process is how most of the teaching hospitals generate

IRIS reports for Medicare purposes. Because vacation and sick leave varies among

hospitals and among residents, IRIS would now require an additional field for each

resident which would include a resident-specific number of countable days. The

commenter questioned where this information would be stored since IRIS currently has

both a Master Record database and an Assignment Record database. The commenter

believed that "extensive updating and testing of a new version" of IRIS will be required

to make certain that providers and fiscal intermediaries can use the program, and that

provider payments will not be jeopardized. The Master Record includes demographic

and other permanent information and remains unchanged during the residents' training

years, while the Assignment Record database includes the residents' assignments (with

beginning and end dates) at the hospital which is completing the IRIS report. The

commenter stated that the denominator could not be locked in the databases because it

would differ among hospitals depending on the cost reporting year and it would change

when the resident changes programs. As previously noted, the commenter maintained

that the administrative burden would be significant when the cost reporting year differs

from the residency training year and the resident is training at more than one hospital.

Another commenter stated that the commenter's facility, prior to instituting a costly

resident tracking system, had to devote over 300 personnel hours to entering over 1,000

residents into IRIS. The commenter urged CMS to review the IRIS program and make

recommendations for updating the software. The commenter further noted that IRIS has

not changed significantly since it was updated for Y2K in 1999, and that it currently uses

MS-DOS which is no longer the industry standard and needs to be updated to reflect

"current operating environments."

Response: We believe our proposed policy on the exclusion of vacation and sick

leave from both the numerator and denominator of the FTE calculation is consistent with

the clarification of our policy regarding patient care activities expressed in the FY 2007

IPPS final rule, that permits only time spent by residents in patient care activities to be

counted for purposes of IME for training that occurs in hospital settings and for purposes

of both IME and direct GME for training that occurs in nonhospital settings

(71 FR 48080). We believe that approved leave, including vacation time and sick leave,

are not appropriately categorized as patient care activities, or as didactic, research, or

other nonpatient care activities. Rather, these activities fall into a distinct third category

that is neither patient care nor nonpatient care. Furthermore, vacation, sick leave, and

other types of approved leave are discrete periods of time that are not spent as training

time in the approved residency program and do not take place in either the hospital

complex or a nonhospital site. Therefore, we believe vacation, sick leave, and other types

of approved leave should be removed from the FTE calculation for direct GME purposes,

and not just for IME purposes.

Despite our continued belief that vacation, sick leave, and other approved leave is

neither a patient care nor a non-patient care activity, we acknowledge the significant

concerns raised by the commenters regarding the administrative burdens associated with

the implementation of the proposed policy. Therefore, we will <u>not</u> be finalizing the

proposed policy to remove vacation and sick leave from the FTE calculation at this time.

However, we will continue to consider ways to finalize the proposed policy, or something

similar to it, but in a more administratively feasible manner. For example, since

commenters pointed out that one major difficulty with the proposed policy is that it

would require hospitals that cross-train residents to obtain information regarding the

amounts of time off taken by each resident from the other hospital(s), such that the same

denominator would be used for the resident at each hospital in which he/she trains, we are

considering a policy that would require a hospital to be aware of only the vacation, sick

leave, and other types of approved leave a resident takes while training at that specific

hospital. That is, under the approach we are considering, hospitals would <u>not</u> be required

to account for vacation, sick leave, and other types of approved leave occurring at another

hospital(s). Each hospital would only be responsible for excluding time off from the

numerator and denominator that occurred while the particular resident was assigned to its

hospital. Hospitals that train the same resident would not need to obtain information

about the time off taken by the resident at the other hospital(s), nor would the same

denominator need to be used by both hospital(s) for that FTE resident. However, in no

case would a resident be counted as more than 1.0 FTE in total. Another option we are

considering is, given that all residents take vacation and most take some sick leave, to

establish a standard amount of "approved leave" which must be excluded from the FTE

calculation of all residents. We are interested in receiving feedback on these alternative

approaches to implementing this policy.

With respect to time spent in orientation activities, the current policy on orientation activities occurring in the hospital complex will continue to be effective for IME and direct GME payment purposes, and a new policy with respect to orientation occurring in certain nonhospital settings (explained in greater detail in response to comments below) will be effective for cost reporting periods beginning on or after October 1, 2007. That is, time spent in orientation activities (as that term is defined in the revised regulation at §413.75(b)) occurring in the hospital complex is currently counted, and will continue to be counted on or after October 1, 2007. Time spent by residents in orientation activities occurring in nonhospital settings such as physicians offices or clinics where patient care is routinely provided and a hospital is permitted to count the time spent by residents in accordance with §§412.105(f)(1)(ii)(C) and 413.78(f) may be counted only for cost reporting periods beginning on or after October 1, 2007.

We would also like to note that in response to the statement by a commenter that "[e]liminating time spent in didactic teaching from the denominator of the fraction prior to removing vacation time from the equation would exacerbate even further this drop in hospital FTE counts," under CMS' policy as expressed in the August 18, 2006 **Federal Register**, entire workdays that are spent in didactic activities must be identified and removed only from the *numerator* of the FTE calculation, and not from the denominator.

Comment: One commenter described a methodology using an example for counting residents which the commenter believes, from a mathematical standpoint, is the correct way to implement CMS' proposed policy. The applicable portion of the example is as follows:

Dr. Z spends 334 days in total of the 365-day cost reporting period at Hospital A.

This time at Hospital A includes 261 days of non-vacation/non-sick time, 28 days

of vacation time, and 45 days of Medicare time nonreimbursable for IME

purposes. Under current rules, Hospital A's reporting of its resident FTE count for

IME purposes for Dr. Z would usually be represented as 289 days/365 days =

0.792 FTE. However, this can be thought of as comprised of the following two

components as noted in the formula

$$(a/b) \times (c/a)$$

The first term represents the hospital's share of the resident's total time in the cost

reporting period and the second term represents the resident's share of

reimbursable days at that hospital. In the formula, a = # of countable days at the

hospital, b = # of days in the cost reporting period, and c = number of Medicare-

reimbursable days. Applying this formula in the case of Dr. Z training at Hospital

A,

$$(334/365) \times (289/334) = 0.792 \text{ FTE.}$$

Applying this formula yields the same result as the usual formula (289 days/365

days). Now, if one were to implement the CMS proposed policy on a hospital-

specific basis and remove the 28 vacation days from a, the "# of countable days at

the hospital," which is represented in the numerator of the first term and the

denominator of the second term above, it would yield the following calculation:

$$(306/365) \times (289/306) = 0.792 \text{ FTE.}$$

One can see that the calculation yields exactly the same resident FTE count for

Hospital A as performing the calculation while including the vacation time. So, by

removing the vacation days from the numerator and denominator in this manner,

which would be the correct way to do it mathematically, Hospital A's resident

FTE count has been preserved from its previous level. While the financial impact

of this methodology would be neutral, if CMS were to still require that vacation

and sick time be tracked, we believe it should be rejected because of the

significant administrative challenges that would be imposed on the teaching

hospital community. Imposing such additional burdens to implement a policy that

has zero effect on resident FTE counts at teaching hospitals makes no sense and

should be rejected.

Response: We appreciate the commenter sharing this proposed methodology with

us. However, we do not agree with the commenter that the methodology presented in the

example above would be the correct way, from a mathematical standpoint, to implement

CMS' proposed policy. The commenter provided the following equation: (306/365) x

(289/306) = 0.792 FTE. We do not agree that 289 should be the numerator of the second

part of the equation because, although it excludes the 45 days of nonreimbursable time, it

still includes vacation time; the correct number to use for the numerator would be 261.

Furthermore, the denominator that should be used is 337, which is calculated by

subtracting the 28 days of vacation from the total of 365 days. We believe the

mathematically correct interpretation of the proposed policy would be to calculate the

FTE resident's time as 261/337, which results in .774 FTE

Comment: One commenter stated that, in regard to the vacation and sick leave policy, the commenter can only see examples where providers' FTE resident counts would be reduced, not increased. Another commenter stated that the proposed rule did not include examples of calculations which illustrate CMS' thinking. The commenter also provided examples where FTE resident counts changed for both hospitals at which a resident trains despite the fact that neither party modified the rotation arrangement in any way.

Response: Since we are not finalizing the proposed policy on vacation and sick leave, we will not be providing any detailed examples to illustrate how the proposed policy would have been implemented. However, as previously mentioned, we are considering a policy alternative under which a hospital would only have to keep track of vacation, sick leave, and other types of approved leave that the residents take while training at that specific hospital (or while training at a nonhospital site for which that hospital is counting the FTE residents in accordance with §413.78(f)). For example, assume the total number of days in a certain residency program is 320 days and the resident is assigned for 200 days at Hospital A and 120 days at Hospital B. The resident takes 10 days of vacation while assigned to Hospital B. Under the alternative policy we are considering, the resident's time could be calculated as follows: Hospital A: 200/320 = 0.625, Hospital B: (120-10)/(320-10)=0.355. If the hospitals track time off in hourly increments, rather than days, another example of this alternative policy would be: Assume that the resident is now taking 36 hours of vacation while assigned to Hospital B and the specific residency program in which the resident is training considers each

workday to be 12 hours. Again, as in the previous example, there are 320 days during the

residency training year. The resident is assigned for 200 days at Hospital A and 120 days

at Hospital B. The resident's time under the alternative policy could be calculated for

each hospital as follows: Hospital A: 2400/3840 = 0.625, Hospital B: (1440-

36)/(3840-36) = 0.369. We are interested in hearing feedback on this alternative policy

approach.

Comment: One commenter stated that an FTE is determined by "…the amount of

time it takes to fill one approved slot"; thus, the FTE resident denominator may differ for

different specialty training programs. The commenter also asked how one day of sick

leave would be removed from the FTE count when the FTE resident may be measured in

terms of days, weeks, or months. The commenter noted that the resulting "FTE" could be

different based on how the denominator is determined.

Response: The commenter is correct that an FTE is determined based on the total

time necessary to fill a residency slot (see §412.105(f)(1)(iii)(A) and also §413.78(b)),

and therefore, an FTE resident's denominator could vary for different specialty programs.

We refer the commenter to the examples in the previous response to see how time off in

daily or hourly increments might be removed from the FTE count. For a program that

uses 52 weeks as the program year, the time off would be identified in weekly increments

and excluded from the 52 weeks in the numerator and denominator. We note that it is

possible to deduct fractions of days or weeks from the FTE calculation as well (i.e., if a

resident takes 10.5 days off, or 2.5 weeks off, then these amounts would be removed

from the numerator and denominator of the applicable FTE calculation).

Comment: Several commenters stated that residents work more than 40 hours a week, and CMS should take residents' actual work week hours into consideration when determining whether vacation and sick leave should be removed from the determination of an FTE. One commenter specifically stated that CMS has not yet defined a "work week," and because a resident usually works more than 40 hours per week, that time should be taken into consideration in the proposal to remove vacation and sick leave. The commenter further noted that hospitals continue to compensate the residents when they are on vacation and therefore they should be able to count that time. Another commenter asked whether an FTE consists of 40 hours per week or 60 hours per week and stated that it is difficult to determine an FTE because there is no consistent regulatory definition of what amount of work/training is required to count a resident as 1.0 FTE or how the appropriate amount of time can be substantiated with a Medicare auditor. Several commenters asserted that vacation and sick leave provides time away from the stress and rigors of the residency program and allows residents to focus on patient care. One commenter contended that hospitals would be incentivized to offer minimal vacation and restrict maternity and paternity leave, and that the proposed policy would burden residents who are already overworked. The commenter noted further that the proposed policy would also negatively affect female residents because they are more likely to carry over vacation time from year to year to be used as a maternity benefit. One commenter stated that hospitals cannot attract quality employees if they do not offer vacation and sick leave, and that the same goes for residents. Another commenter stated that vacation leave and sick leave are an essential element of hospital employment and therefore "…an

integral part of the patient care process." The commenter stated that CMS has interpreted

the term "patient care activities" without considering any complementary activities that

contribute to effective "patient care activities." Commenters stated that teaching

hospitals accept patients for medical treatment contingent on their ability to provide

medical coverage with both staff physicians and residents, and that teaching hospitals

will continue to have the additional financial burden of providing coverage when

residents are on vacation and sick leave. The commenters stated that by including

vacation and sick leave in the determination of an FTE, CMS would be "…ensuring a

'minimal' payment to help offset costs for care coverage that must be provided by

another medical professional." Another commenter stated the context for CMS' proposal

is flawed because the government should not be tampering with employee benefits, and

the proposal may cause providers to consider changing their benefit rules because of

potential loss of funds due to maintaining benefits.

        Response: As we have stated in response to comments above, there is a

consistent regulatory definition of what constitutes 1.0 FTE, and this should be used by

hospitals and fiscal intermediaries/MAC alike to determine the unit of an FTE for each

specialty program. In terms of calculating a resident's "work week," a hospital's

allowable FTE count is "based on the total time necessary to fill a residency slot"

(§412.105(f)(1)(iii)(A)). The regulations at §413.78(b) add that "a part time resident

counts as a partial FTE based on the proportion of allowable time worked compared to

the total time necessary to fill a full-time internship or residency slot." 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, among all the

hospitals and nonhospital sites in which the resident is training, the resident is not

working the number of hours necessary to fill a residency slot, 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. Therefore, we would consider a "work

week" to be dependent on the specific residency program in which the resident is training

and the resident's full or part-time status. For example, if 60 hours per week (including

vacation time) is established as the total time necessary to fill the residency slot for a

particular program, and a resident in this program works 60-hour weeks (full time)

consisting of 30 hours per week at each of two hospitals, in allowable/countable activities

or areas, then each hospital would count "0.5" of an FTE for this resident. Since in this

example, the time necessary to fill a residency slot is 60 hours per week (including

vacation time) rather than 40 hours per week, any leave taken would be excluded from

the FTE unit based on a 60 hour work week (or a program year consisting of 3,120 hours

(that is, 52 weeks x 60 hours)).

In response to the commenters' concerns regarding maternity leave and the

provision of leave as essential to attracting quality employees and providing quality

patient care, maternity leave is typically a leave of extended duration and we did not

propose any changes to policies concerning leave of extended duration in the proposed

rule. Furthermore, it is important to note that the intent of the proposed rule was not to

suggest that hospitals should change their benefit policies. We see no reason that

hospitals would not continue to offer the same benefits they offered prior to our proposed

policy. Additionally, we note that the proposed rule would not have <u>disallowed</u> vacation, sick leave, and other types of approved leave, which would have required the time to be excluded only from the numerator of the FTE calculation; it proposed to exclude the time from both the numerator and denominator of the FTE calculation. In response to the comment that hospitals accept patients for treatment contingent on their ability to provide medical coverage, other commenters have stated that residents often cover for each other when a resident is sick or on vacation; therefore, we do not agree that the exclusion of vacation, sick leave, and other types of approved leave from the numerator and denominator of the FTE calculation would limit the hospital's ability to provide medical coverage. However, as we stated in response to previous comments, we are not finalizing the proposed policy to remove vacation and sick leave from the FTE calculation at this time.

Comment: Several commenters stated that vacation and sick leave were included in the base year costs for determination of PRAs. Therefore, in order to maintain consistency between base year and current year FTE counts, the commenter suggested that vacation and sick leave should be included in the determination of an FTE.

Response: We acknowledge that the costs and FTEs associated with vacation and sick leave were included in the determination of the base year PRAs. This is because prior to the implementation of the IPPS, under the reasonable cost system of reimbursement, vacation leave and sick leave were reimbursed as a Medicare allowable cost. Since implementation of the IPPS, however, we have only permitted hospitals to count for purposes of direct GME the time spent by residents training in GME activities

within the hospital complex. Since the time spent by residents on approved leave is not

spent in the hospital complex, we believe that, from a policy perspective, it would be

appropriate to not include vacation and sick leave in the FTE count for direct GME

purposes. However, as we noted above, we have decided not to finalize our proposal to

remove vacation and sick leave from the FTE calculation at this time.

Comment: Many commenters disagreed with removing vacation and sick leave

from the determination of an FTE because these fringe benefits are included under other

forms of hospital reimbursement. For example, several commenters stated that Medicare

regulations allow fringe benefits for all employees as Medicare allowable costs and there

should be no exception made for residents. Another commenter stated that when CMS

requires hospitals to pay for the costs of residents in nonhospital settings, CMS requires

that fringe benefits such as vacation and sick leave be included. The commenter

requested "…clarification on the justification for considering vacation and sick time non-

patient care related given the apparent inconsistency this proposal would create with

respect to both…" the GME nonhospital site policy and non-GME policies. Commenters

also recommended that, because vacation and sick leave are included in wage index

calculations, they should be included in the determination of an FTE. One commenter

specifically stated the Provider Reimbursement Manual (CMS Pub 15-2) Section 3605.2,

treats amounts paid for vacation and sick leave as included in wages and salaries.

Therefore, to maintain consistency between wage index and GME, the commenter

indicated that vacation and sick leave should be included. The commenter further noted

that 42 CFR 412.105(f)(1)(iii)(A) states FTE status "…is based on the total time

necessary to fill a residency slot," and therefore vacation and sick leave should continue

to be included in the determination of an FTE. Another commenter provided additional

reasons as to why the commenter believed the determination of an FTE should include

vacation and sick leave, including: CMS recognizes vacation and sick leave when paid to

an outside supplier as stated in PRM-I, section 1402.2; the American Medical Group

Association's (AMGA) 2006 Compensation Survey Data Report includes fringe benefits

in compensation; and there are several instances "…where CMS recognizes that fringe

benefits (including vacation and sick leave) are an allowable cost when services being

provided are related to patient care activities"--for example: CMS Pub. 15, Part I, Section

2144.4; CMS Pub. 15, Part I, Section 2182.6; CMS Pub. 15, Part I, Section 2144.9; CMS

Pub. 15, Part I, Section 1402.2; and CMS Pub. 15, Part II, Section 3605.2. The

commenter also noted that in establishing reasonable compensation equivalents (RCEs),

CMS recognized compensation for a full-time physician at 2,080 hours per year,

"…including a reasonable amount of time devoted to vacation and sick leave…" as stated

in PRM-I, Section 2182.6. The commenter further noted that the PRM "…goes on to

note that the intermediary considers the general practice of the hospitals it serves in

determining the reasonableness of a hospital-compensated physician's time devoted to

vacation and sick leave" and includes CMS' response to a comment regarding the

development of the RCE in the March 2, 1983 **Federal Register** (48 FR 8902). The

commenter stated that, based on the comment and response, it was evident that CMS

believed vacation time should be included in compensation for hospital-based physicians.

Response: We agree with the commenters that the costs of vacation and sick

leave have always been considered allowable under Medicare, for both hospital

employees in general, and for residents and teaching physicians. However, with respect

to the treatment of vacation, sick leave, and other types of approved leave in the GME

context, the issue is not the allowability of the cost, but rather whether this time should be

included in the determination of an FTE, considering that such time is not spent in any

aspect of residency training. From a policy perspective, we do not believe that vacation,

sick leave, and other types of approved leave, where the residents are not engaged in

activities that are part of the approved program, and are not even present in the hospital

or any nonhospital site, should be included in the determination of an FTE, for both IME

and direct GME purposes. However, as we stated previously, because of the concerns

regarding the administrative burden surrounding implementation of this policy, we have

decided not to finalize the proposed policy to remove vacation, sick leave, and other

approved leave from the FTE calculation as proposed, and we are asking for feedback on

a method of dealing with some of the "burden." With respect to the inclusion of vacation

and sick leave in the wage index calculations, we note that salaries and hours of residents

and teaching physicians are carved out of the IPPS wage index. Also, as explained in the

August 18, 2006 **Federal Register** (71 FR 48085), the salaries and hours of residents

historically used in the wage index calculation are irrelevant for purposes of determining

a GME FTE count. We also note that for purposes of counting FTE time for determining

direct GME and IME payments, a resident that trains in a hospital is counted by that

hospital regardless of whether that hospital makes *any* payments for the resident's salary

and fringe benefits. Therefore, we do not find persuasive the commenter's argument that vacation and sick time should be counted by the hospital that pays for that time. Our policy is consistent in that FTE counts at each hospital are based on what the resident is doing and not on whether the hospital is paying for the resident's salary and fringe benefits.

Comment: Several commenters expressed additional concerns regarding the removal of vacation and sick leave for purposes of the FTE resident count for IME. One commenter stated that academic centers are dependent on direct and indirect GME payments to cover the costs of the residents' education, salaries, and research, and they must also face the increased burden of indigent care and "medically complex" patients. The commenter further noted that IME covers fixed costs such as employee benefits which are in place even when the resident is on sick leave. A couple of commenters stated that residents' participation in research and other academic activities will be adversely affected by the proposed policy and more dialogue and stakeholder input is needed on such a rule. Another commenter asked whether Medicare may potentially disallow vacation and sick leave from cost reporting in totality. The commenter suggested that if CMS' intent is to reduce payments to hospitals, CMS should use mechanisms found on the cost report to achieve its goals – such as adjustments to the PRA for GME and the formula multiplier for IME.

Response: We note, again, that we did not propose to disallow vacation, sick leave, and other types of approved leave from the IME count (or direct GME count) and that the intent of the proposed rule was not to reduce Medicare GME payments to

teaching hospitals. A disallowance would mean excluding the vacation, sick leave, and

other types of approved leave from the numerator of the FTE calculation, but not the

denominator, as is done for IME for research and for time spent in distinct part units that

are excluded from the IPPS. By excluding vacation, sick leave, and other types of

approved leave from both the numerator and denominator of the FTE resident

calculation, the effect on the FTE resident count for a hospital would be limited, if there

would be any at all.

Comment: Several commenters expressed their concerns regarding the effect of

the proposed policy on hospitals that rotate residents and participate in Medicare GME

affiliation agreements. One commenter stated that the proposed policy does not resolve

the inequalities that result when residents rotate to different hospitals. The commenter

further maintained that the proposed policy may unfairly increase FTE time at another

hospital to which a resident rotates because time off is allocated to the hospital in which

the resident was assigned. One commenter stated "[s]ince the receiving institution

usually is accepting the residents because of a desire to provide more medical staff

coverage, they will not allow residents to take vacations when scheduled at their facility.

Then, if the resident's vacation is excluded from the FTE calculation (as proposed), the

receiving facility will be getting more of an FTE than they are paying for." The

commenter suggested that the proposed policy is "inherently flawed" because it would

produce a redistribution of FTE residents that is inconsistent with multiple base year

policies. Other commenters provided an example where there is an affiliation agreement

between Hospital A and Hospital B, Hospital A rotates a different resident to Hospital B

each month, and each resident does <u>not</u> take vacation while training a Hospital B. In this case, Hospital B's total resident FTE count for the entire year would be greater than one, since the vacation time would be excluded from the denominator of Hospital B and not from the numerator. The commenter stated that this is a fundamental problem of CMS' proposal because a hospital that was at its hospital-specific cap may now find itself training over its cap while another hospital may find itself training under its cap. The commenter noted that an additional burden would be created because a hospital would probably not know its resident FTE count until the very end of the training year and would have to wait until the last minute to amend its Medicare GME affiliation agreements. Another commenter stated that the rule is not clear on which hospital should claim the sick or vacation time when a resident rotates between hospitals. The commenter recommended that if vacation or sick leave occurs during an assigned rotation at a specific hospital, that hospital should claim the vacation and sick time. However, if the vacation and sick leave occurs between rotations, the hospital claiming the time associated with the rotation immediately prior to the vacation or sick leave should account for the sick or vacation leave. If the sick leave or vacation occurs during the residents' rotation to a nonhospital site, the hospital counting the resident's time at the nonhospital site should account for the vacation and sick time. Another commenter stated that a hospital that absorbs the vacation payment will be hurt by the proposed rule, "…thereby not matching third party reimbursement to the cost incurred. The policy of matching costs to reimbursement is an inherent principle of third party reimbursement and should have been considered when CMS proposed this change."

Response: We are sympathetic to the points raised by the commenters concerning shifts in FTE counts among hospitals that cross-train resident, and we will explore options of mitigating this effect in the context of reducing the overall administrative burden of the proposed policy. In the interim, as we stated above, we are not finalizing the proposed policy.

Comment: Several commenters stated that the proposed rule is not clear as to whether a change would relate to scheduled time off or actual time off. One commenter stated that it would be inappropriate to exclude all scheduled time off since residents usually do not take all of their vacation or sick time. The commenter further noted that, if the hospital were to exclude time from the denominator of the FTE calculation because that time was scheduled time off, but include that time in the numerator of the FTE calculation because other documentation shows that the resident actually worked during that time, the resulting FTE would be greater than 1.0 and disallowed by the fiscal intermediary on that basis. However, the commenter also asserted that if CMS were to require that actual time off be excluded, this would be a substantial administrative burden because the hospital would have to determine: whether the resident actually used scheduled vacation leave, or whether the resident worked at the hospital, even for a brief period of patient care, during the vacation period; and whether the resident switched days off with another resident so that the time was made up at a later point. We also received comments regarding the mathematical counting of FTEs, particularly when a resident takes a half day of vacation or sick leave. Another commenter stated that vacation time of one or more weeks is likely to be documented on the rotation schedule, while one or

two days of vacation may not always be included. One commenter stated that the

American Board for Internal Medicine requires that residents make up sick time but CMS

does not allow this make-up time to be reflected in the cost report.

Response: The commenters pointed out correctly that we did not specify in the

proposed rule whether we intended that scheduled time off or actual time off should be

removed from the calculations of an FTE. In considering this, we agree that had we

finalized the proposed policy in this final rule, it would be more appropriate to instruct

hospitals to only exclude actual vacation, sick leave, and other types of approved leave

taken, since it is understandable that residents may not use all of their allotted approved

leave. Accordingly, under the alternative approach on which we are considering and

seeking feedback, a hospital would track *actual* time off taken by residents assigned to it

(but not be responsible for deducting time off while the resident is assigned to another

hospital). Concerning the comment about the requirements of the American Board of

Internal Medicine, we are not sure if the commenter is referring to leave of short duration

or extended leave. However, we note that the proposed rule did not include any

proposals regarding extended leave.

Comment: Several commenters disapproved of CMS' recent rules on GME,

including the recent proposed rule on Medicaid GME. Commenters expressed their

concern regarding how these rules have disallowed pieces of residents' training time and

imposed significant administrative burdens. One commenter requested that CMS limit its

application of policy regarding "patient care activities" to that of didactic activities "…to

prevent going down a policy 'slippery slope' that ends up with parsing every aspect of

residents' training time into a 'patient care,' or 'nonpatient care' bucket." The

commenter noted that the proposed policy on vacation and sick leave illustrates "…the

downward spiral that starts to occur if CMS attempts to extend its 'patient care' analysis

beyond didactic activities." One commenter stated that with the exception of bench

research, all other resident training time should be included in the determination of an

FTE for Medicare direct GME and IME payment purposes. The commenter stated that

CMS should discontinue its efforts to parse out residents' time; instead the goal should be

for Medicare to pay its fair share of GME costs. Another commenter stated that CMS'

policy that only permits residents to be counted for IME payment purposes if they are

involved in patient care has no statutory basis, and CMS "…apparently excludes time

spent in didactic activities based on assumption that because IME is an adjustment to the

DRG system, it is inherently related to patient care."

Response: We do not believe that the proposed rule, if finalized, would have

contributed to an inappropriate "parsing" of a resident's training into patient care and

nonpatient care time. Particularly for IME purposes, this is an important distinction to

make, given that the IME adjustment is intended to account for the higher patient care

costs experienced by teaching hospitals relative to nonteaching hospitals. We refer

readers to the August 18, 2006 **Federal Register** (71 FR 48080) for a more detailed

discussion on the distinction between patient care and nonpatient care activities. With

respect to the proposed policy to exclude vacation and sick leave from the FTE resident

calculation, as we stated above, we believe vacation, sick leave, and other types of

approved leave are neither patient care nor nonpatient care, but fall into a third category

of time that is not spent in any aspect of residency training.

Comment: One commenter stated that "[i]n *University Medical Center v. Blue*

Cross/Blue Shield Association, 2005-D36, June 7, 2005, the CMS Administrator

concurred with the findings of the Provider Reimbursement Review Board (PRRB

Decision No. 2005-D36, dated April 12, 2005) that held that the critical factor related to

vacation time was 'consistency' in its treatment by the fiscal intermediary for each

provider." The commenter stated that, currently, the provider includes vacation time

when the resident's rotation is to a site owned by the provider and excludes vacation time

when the resident's rotation is to a site not related to the provider. The commenter stated

that its fiscal intermediary has accepted this process and that this method is consistent

with the Administrator's decision in the aforementioned case. Furthermore, the

commenter asserted that treating vacation and sick leave differently from orientation, is

inconsistent with the Administrator's decision in *University Medical Center v. Blue*

Cross/Blue Shield Association.

Response: We believe the commenter has confused the Administrator's findings

in the case of *University Medical Center v. Blue Cross/Blue Shield Association* with

respect to the vacation time at issue. In that case, the Provider (plaintiff) believed that

since it continued to pay the residents' salaries while the residents were assigned and took

vacation time while at another hospital, the Provider should be allowed to include those

FTEs in its direct GME and IME FTE count. The fiscal intermediary disagreed with the

Provider, asserting that "it is common practice to include vacation time in the resident

count for the hospital where residents are assigned and working when the vacation time is

taken." The Provider Reimbursement Review Board (the Board) concluded that the

fiscal intermediary's methodology was proper, but that "…the critical factor is

consistency. As long as vacation time is accounted for in the same manner for each

hospital, as presented by the Intermediary, each hospital will be properly reimbursed."

We stated that we "acknowledge and concur with the Board's conclusion that *the*

Intermediary properly disallowed the FTE time spent on vacation…" (emphasis added).

In this case, we did *not* state that we agree with the Board that the most important factor

is <u>consistency</u>. The fiscal intermediary was correct to disallow from the provider's FTE

count the vacation time that occurred at another hospital because of the longstanding

Medicare policy that "a hospital cannot claim the time spent by residents training at

another hospital" (42 CFR 412.105(f)(1)(iii)(A) for IME and §413.78(b) for direct GME).

A method for counting FTEs is <u>not</u> correct merely because hospitals, or fiscal

intermediaries, for that matter, apply it consistently. As the Administrator concluded in

the case, "the Intermediary properly disallowed the vacation time from the Provider's

FTE counts, since that FTE was not spent training at the Provider, nor were those FTEs

assigned to the Provider during the vacation time in question." Thus, under our <u>previous</u>

policy (and current policy, since we are not finalizing our proposal at this time),

regardless of which hospital is paying the resident's salaries and fringe benefits, the

hospital to which the resident is assigned during the time the vacation was taken is the

hospital that counts that FTE time for direct GME and IME. If the rotation schedule does

not clearly indicate where the resident is assigned during the time the vacation is taken,

the hospitals to which the resident rotates over the course of the academic year would

divide and count that vacation time proportionately based on the amount of time spent in

actual training at the respective hospitals. For example, if during the course of the

academic year, a resident spends 25 percent of his time at Hospital A, and 75 percent of

his time at Hospital B, and there are two weeks of vacation in which the resident was not

assigned to either Hospital A or Hospital B, then it is appropriate for Hospital A to count

25 percent of that vacation time and Hospital B to count 75 percent of the vacation time

for that FTE resident.

Comment: One commenter noted that, unlike the ACGME, the AOA has adopted

a clear policy on resident vacations and other leaves of absence; osteopathic programs are

required to give interns and residents a minimum of 10 business days of vacation time

during each year of training. The commenter stated that the AOA's policy is in place to

protect residents and ameliorate stress and fatigue and that CMS' proposal contradicts

efforts aimed at establishing limits on time spent in the training environment which have

been established to protect the health, safety, and well being of residents and their

patients and disregards the need for residents to have personal time away from their

program. Another commenter disagreed with the argument for removing vacation and

sick leave because the ACGME and Residency Review Committees are not explicit

regarding this time which causes the amount of vacation and sick leave to vary from

program to program. The commenter stated that there are numerous cases where

Residency Review committees "…are open-ended or not explicit in number or content,

leaving programs to interpret within a range of behavior or activities, what is acceptable

for accreditation."

Response: Regardless of whether a clear policy on vacation, sick leave, and other

types of approved leave has been adopted by any of the accrediting bodies, we believe

that vacation, sick leave, and other types of approved leave for purposes of counting

residents for Medicare direct GME and IME fit into a third category that is neither patient

care nor nonpatient care. Furthermore, under the proposed rule, we were <u>not</u>

"<u>disallowing</u>" vacation, sick leave, and other types of approved leave, but rather

excluding the time spent by residents on vacation, sick leave, and other types of approved

leave from the calculation of an FTE.

Comment: One commenter requested that if CMS finalizes the proposed policy,

it should be made date specific to October 1, 2007, instead of for cost reporting periods

beginning on or after October 1, 2007, because hospitals with cost reporting periods

beginning October 1, 2007, would be disadvantaged for a longer period of time than

hospitals with different cost reporting periods.

Response: As previously stated, we are <u>not</u> finalizing our proposed policy with

respect to vacation and sick leave at this time.

Comment: One commenter asked CMS to comment on the statement that "[t]he

hospital complex consists of the hospital and any hospital based providers…and

subproviders…Therefore, if the orientation takes place in a related medical school, such

time could not be counted for GME purposes."

Response: The commenter is correct that the hospital complex consists of the

hospital, hospital-based providers, and subproviders; that is, facilities that meet the

provider-based criteria at § 413.65. The commenter is also correct that orientation

activities in a related medical school cannot be counted. As we stated on page 24814 of

the May 3, 2007 proposed rule, "Because we recognize the distinct character of

orientation activities as essential to the provision of patient care by residents, and the

fundamental differences between orientation and the typical didactic activities in which a

resident may participate throughout a residency training program, we are proposing to

continue to count the time spent by residents in orientation activities, whether they occur

in the hospital or nonhospital setting, and are proposing to amend our regulations

accordingly" (emphasis added). However, the nonhospital settings we were referring to

in which orientation may be counted are those nonprovider settings such as physicians'

offices or clinics, where patient care is routinely provided and a hospital is permitted to

count the time spent by residents in accordance with our regulations at

§§412.105(f)(1)(ii)(C) and 413.78(f), not other nonhospital settings where time spent by

residents is not permitted to be counted for purposes of direct GME and IME. We note

that the policy to allow time spent by residents in orientation activities to be counted if it

occurs in nonhospital sites where patient care is routinely provided is new, and will be

effective for cost reporting periods beginning on or after October 1, 2007. (In order to

count resident training time in orientation activities for IME and direct GME purposes at

the nonhospital site, hospitals must comply with the regulations at §§413.78(f) and

412.105(f)(1)(ii)(C)). Prior to cost reporting periods beginning on or after

October 1, 2007, the effective date of this policy, time spent by residents in orientation

was permitted to be counted for direct GME and IME only if it occurred in the hospital

complex.

Comment: One comment addressed Medicare's rules regarding shared programs

and residency training at nonhospital sites, when the shared programs are operated by a

foundation. The commenter stated that because at least two hospitals may be involved

with the foundation, the interns and residents keep time studies to document time spent in

patient care in each location so that each hospital is aware of its financial commitment.

The foundation bills the hospital monthly for the total costs of educating the interns and

residents for training in the hospital and nonhospital site. The commenter stated that its

fiscal intermediary considers this a shared program (neither hospital is paying for "all or

substantially all" of the costs) and has disallowed the time spent in nonhospital settings.

Another commenter urged CMS to "…continue to fund, to the best of your ability, the

ongoing education of newly graduated physicians and allow the dedicated medical

education professionals the opportunity to continue to make a difference in the future of

health care." We also received comments concerning the counting of didactic time.

Response: We did not propose to make any changes to our regulations

specifically regarding residency training at nonhospital sites or general GME funding

mechanisms and counting of didactic time. Therefore, we believe the comments are

outside the scope of this rule and we are not responding to them at this time.

d. Regulation Changes

In the FY 2008 IPPS proposed rule (72 FR 24815), we proposed, for cost

reporting periods beginning on or after October, 1, 2007, for direct GME and IME

payments, that time spent by residents on vacation or sick leave would not be included in

the determination of what constitutes an FTE resident (or would be removed from both

the numerator and denominator of the FTE count) for both IME and direct GME payment

purposes. In addition, we proposed to continue to count time spent by residents in

orientation activities for both IME and direct GME payment purposes. We proposed to

amend the regulations at §§412.105(f)(1)(iii)(A) and 413.78(b). Lastly, we proposed to

amend §413.75(b) to include the definition of the term "orientation activities" and to

amend the definition of "patient care activities" to add "orientation activities."

After consideration of the public comments received, at this time we are <u>not</u>

finalizing our proposed policy to remove vacation and sick leave from the determination

of the FTE calculation. However, we are adopting as final our proposed policy to

continue counting time spent by residents in orientation activities for IME and direct

GME in the hospital complex; and, effective for cost reporting periods beginning on or

after October 1, 2007, we are finalizing the policy that orientation activities occurring in a

nonhospital site where patient care is routinely provided and the hospital complies with

the regulations set for at §§413.78 (f), and 412.105(f)(1)(ii)(C)) may be counted. We are

also finalizing our proposal to define "orientation activities" the regulations text at

§413.75(b) as "activities that are principally designed to prepare an individual for

employment as a resident in a particular setting, or for participation in a particular

specialty program and patient care activities associated with that particular specialty

program." We are also finalizing our proposal to modify the definition of "patient care

activities" to mean "the care and treatment of particular patients, including services for

which a physician or other practitioner may bill, and orientation activities as defined in

this section."

E. Payments to Disproportionate Share Hospitals (DSHs): Technical Correction

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.

DSH Patient Percentage	=	Medicare, SSI Days / Total Medicare Days	+	Medicaid, Non-Medicare Days / Total Patient Days

2. Technical Correction: Inclusion of Medicare Advantage Days in the Medicare

Fraction of the Medicare DSH Calculation

In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our

policy change to reflect the inclusion of the days associated with Medicare + Choice

(now Medicare Advantage) beneficiaries under Medicare Part C in the Medicare fraction

of the DSH calculation. In that rule, we indicated that we were revising the regulation

text at §412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not

make a change in the regulation text to conform to the preamble language. We also

inadvertently did not propose to change §412.106(b)(2)(iii) in the FY 2005 final rule,

although we intended to do so. Section 412.106(b)(2)(i) of the regulations discusses the

numerator of the Medicare fraction of the Medicare disproportionate patient percentage

(DPP) calculation while §412.106(b)(2)(iii) of the regulations discusses the denominator

of the Medicare fraction of the Medicare DPP. We intended to amend the regulation text

with respect to both the numerator and the denominator of the Medicare fraction of the

Medicare DPP. Therefore, in this final rule with comment period, we are making this

technical correction to §412.106(b)(2)(i) and to §412.106(b)(2)(iii) to make them

consistent with the preamble language of the FY 2005 IPPS final rule and to effectuate

the policy iterated in that rule.

With respect to the technical correction that we are making to §412.106(b)(2)(iii),

we note that we ordinarily publish a notice of proposed rulemaking in the

Federal Register to provide for a period for public comment before a provision such as

this would take effect. However, we can waive this procedure 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 notice

issued. We find it unnecessary to undertake notice and comment rulemaking in this

instance for the additional change to §412.106(b)(2)(iii) because this notice merely

provides technical corrections to the regulations and does not make any substantive

changes to the regulations or our existing policy. Therefore, under 5 U.S.C. 533(b)(B),

for good cause, we waive notice and comment procedures.

F. Hospital Emergency Services under EMTALA (§489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific

obligations on certain Medicare-participating hospitals and CAHs. (Throughout this

section of this final rule with comment period, 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 incorporated these antidumping provisions within 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. Recent Legislation Affecting EMTALA Implementation

a. Secretary's Authority to Waive Requirements During National Emergencies

Section 1135 of the Act authorizes the Secretary to temporarily waive or modify

the application of several requirements of titles XVIII, XIX, or XXI of the Act (the

Medicare, Medicaid, and State Children's Health Insurance Program provisions), and

their implementing regulations in an emergency area during an emergency period.

Section 1135(g)(1) of the Act defines an "emergency area" as the geographical area in

which there exists an emergency or disaster declared by the President pursuant to the

National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency

Assistance Act (subsection A) and a public health emergency declared by the Secretary

pursuant to section 247d of Title 42 of the United States Code. Section 1135(g)(1) of the

Act also defines an "emergency period" as the period during which such a disaster exists.

Section 1135(b) of the Act lists the actions for which the otherwise applicable statutory

provisions and implementing regulations may be waived. Included among these actions

are, in subparagraph (b)(3)(A), a transfer of an individual who has not been stabilized in

violation of the EMTALA requirements restricting transfer until an individual has been

stabilized (section 1867(c) of the Act) and, in subparagraph (b)(3)(B) , the direction or relocation of an individual to receive medical screening in an alternate location, in accordance with an appropriate State emergency preparedness plan.

Section 1135(b) of the Act further states that a waiver or modification provided for under section 1135(b)(3) of the Act shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. All other waivers arising out of section 1135(b) of the Act (except for section 1135(b)(7)) ordinarily may continue in effect for the duration of the declaration of emergency or disaster, or the declaration of a public health emergency, or for 60-day periods as described in section 1135(e)(1) of the Act.

To take into account the effect of section 1135(b)(3)(A) waivers on the EMTALA requirements, §489.24(a)(2) of our regulations specifies that sanctions under the EMTALA regulations for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. However, the current regulations do not address the Secretary's authority to waive sanctions associated with the direction or relocation of an individual to receive a medical screening examination.

For further information about section 1135 of the Act and its applicability, we refer readers to the CMS Web site:

http://www.cms.hhs.gov/Emergency/02_Hurricanes.asp.

b. Provisions of the Pandemic and All-Hazards Preparedness Act

On December 19, 2006, Congress enacted the Pandemic and All-Hazards

Preparedness Act, Pub. L. 109-417. Section 302(b) of Pub. L. 109-417 makes two

specific changes that affect EMTALA implementation in emergency areas during an

emergency period.

As noted above, section 1135(b)(3) of the Act authorized the Secretary to waive

sanctions for either the transfer of an unstabilized individual in violation of the

requirements of section 1867(c) of the Act where such transfer is necessitated by the

circumstances of the declared emergency in the emergency area during the emergency

period or the direction or relocation of an individual to receive medical screening in an

alternate location in accordance with an appropriate State emergency preparedness plan.

Section 302(b)(1)(A) of Pub. L. 109-417 amended section 1135(b)(3)(B) of the Act to

state that sanctions for the direction or relocation of an individual for screening may be

waived where, in the case of a public health emergency that involves a pandemic

infectious disease, that direction or relocation occurs pursuant to a State pandemic

preparedness plan, or to an appropriate State emergency preparedness plan. In addition,

sections 302(b)(1)(B) and (b)(1)(C) of Pub. L. 109-417 amended section 1135(b) of the

Act to further state that "if a public health emergency involves a pandemic infectious

disease (such as pandemic influenza), the duration of a waiver or modification for such

emergency shall be determined in accordance with section 1135(e) of the Act as such

subsection applies to public health emergencies." The amendments to section 1135(b) of

the Act made by section 302(b) of Pub. L. 109-417 are effective as of the date of

enactment of that legislation (December 19, 2006) and apply to public health

emergencies declared pursuant to section 247d of Title 42 of the United States Code.

c. Revisions to the EMTALA Regulations

Currently, the EMTALA regulation at 42 CFR 489.24(a)(2) specifies that

sanctions under this section (§489.24) for inappropriate transfers during a national

emergency do not apply to a hospital with a dedicated emergency department located in

an emergency area, as specified in section 1135(g)(1) of the Act. To implement the

changes made by section 302(b) of Pub. L. 109-417 and to ensure that our regulations

accurately reflect section 1135 of the Act, in the FY 2008 IPPS proposed rule

(72 FR 24816), we proposed to make two changes to paragraph (a)(2) of §489.24. First,

we proposed to specify that the sanctions that do not apply are those for either the

inappropriate transfer of an individual who has not been stabilized, or those for the

direction or relocation of an individual to receive medical screening at an alternate

location. We also proposed to revise §489.24 by adding a second sentence to paragraph

(a)(2) to state that a waiver of these sanctions for EMTALA violations is limited to a

72-hour period beginning upon the implementation of a hospital disaster protocol, except

that if a public health emergency involves a pandemic infectious disease (such as

pandemic influenza), the duration of the waiver will be determined in accordance with

section 1135(e) of the Act as it applies to public health emergencies. This proposed

change would clarify that, in the case of public health emergencies involving pandemic

infectious diseases, the waiver of EMTALA sanctions is not limited to 72 hours, but will

remain in effect until the termination of the applicable declaration of a public health

emergency as described in section 1135(e)(1)(B) of the Act.

We received several public comments that generally supported the updating of the

regulations to reflect the new legislation. These comments did not include any specific

recommendations for change. Therefore, we are adopting as final, without modification,

the proposed revision to §489.24 to specify that the sanctions that do not apply are those

for either the inappropriate transfer of an individual who has not been stabilized, or those

for the direction or relocation of an individual to receive medical screening at an alternate

location and to add a second sentence to paragraph (a)(2) to state that a waiver of these

sanctions for EMTALA violations is limited to a 72-hour period beginning upon the

implementation of a hospital disaster protocol, except that if a public health emergency

involves a pandemic infectious disease (such as pandemic influenza), the duration of the

waiver will be determined in accordance with section 1135(e) of the Act as it applies to

public health emergencies.

G. Disclosure of Physician Ownership in Hospitals and Patient Safety Measures

1. Disclosure of Physician Ownership in Hospitals

Section 1866 of the Act states that any provider of services (except a fund

designated for purposes of section 1814(g) and section 1835(e) of the Act) shall be

qualified to participate in the Medicare program and shall be eligible for Medicare

payments if it files a Medicare provider agreement and abides by the requirements

applicable to Medicare provider agreements. These requirements are incorporated into

our regulations in 42 CFR Part 489, Subparts A and B (Provider Agreements and

Supplier Approval). Section 1861(e) of the Act defines the term "hospital." Section

1861(e)(9) of the Act defines a hospital and authorizes the Secretary to establish

requirements as he finds necessary in the interest of patient health and safety. Section

1820(e)(3) of the Act authorizes the Secretary to establish criteria necessary for an

institution to be certified as a CAH.

Section 5006 of Pub. L. 109-171 (DRA) required the Secretary to develop a

"strategic and implementing plan" to address certain issues related to physician

investment in "specialty hospitals." In the strategic and implementing plan included in

our "Final Report to the Congress and Strategic and Implementing Plan Required under

Section 5006 of the Deficit Reduction Act of 2005" issued on August 8, 2006 (page 69),

available on our Web site at:

http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp (hereinafter

referred to as the "DRA Report to Congress"), we stated that our plan for addressing

issues related to physician investment in specialty hospitals involved promoting

transparency of investment. Consistent with that approach, we stated that we would

adopt a disclosure requirement that would require hospitals to disclose to patients

whether they are physician-owned, and if so, disclose the names of the physician owners.

Accordingly, in the FY 2008 IPPS proposed rule (72 FR 24816), we proposed changes to

regulations governing Medicare provider agreements to effectuate this change, under our

authority at sections 1861(e)(9), 1820(e) and 1866 of the Act, and under our rulemaking

authority at sections 1871 and 1102 of the Act. We sought comment as to whether these

changes would be best effectuated through changes to the Medicare provider agreement

regulations or whether it would be more appropriate to include these changes in the conditions of participation (CoPs) applicable to hospitals and CAHs.

Specifically, we proposed to amend §489.3 to define a "physician-owned hospital" as any participating hospital (which, as defined in §489.24 includes any CAH) in which a physician or physicians have an ownership or investment interest. We solicited comments on whether, for purposes of the ownership disclosure requirements only, the definition of "physician-owned hospital" should exclude certain physician ownership or investment interests based on the nature of the interest, or the relative size of the interest, or the entity's assets (for example, whether the interest would satisfy the exceptions at §§411.356(a) and (b) for physician ownership or investment interest in publicly-traded securities and mutual funds).

We proposed to add a new provision at §489.20(u)(1) to require that patients be given written notice that a hospital is physician-owned and that the list of physician owners is available upon request. We proposed to require that the notice, in a manner reasonably designed to be understood by all patients, disclose the fact that the hospital meets the Federal definition of a "physician-owned hospital" and that patients will be provided the list of the hospital's physician owners upon request. In addition, we proposed to add a new provision at §489.20(u)(2) that would require hospitals to require that all physician owners who are also members of the hospital's medical staff to disclose, in writing, their ownership interest in the hospital to all patients they refer to the hospital, as a condition of continued medical staff membership. Patient disclosure would be required at the time a physician makes a referral. We stated that we believed that

these provisions are in the interest of the health and safety of individuals who are furnished services in these institutions. The proposed notice requirement would permit individuals to make more informed decisions regarding their treatment, and to evaluate whether the existence of a financial relationship, in the form of an ownership interest, suggests a conflict of interest that is not in their best interest.

In order to enforce these proposed requirements, we proposed to amend §489.12 to permit CMS to deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital. In addition, we proposed to amend §489.53 to permit CMS to terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with the requirements of §489.20(u).

We received a number of comments concerning our proposal. Most came from national and state hospital associations, and a few were received from individual hospitals, and two associations representing physician-owned hospitals.

Comment: Commenters representing hospital associations were generally supportive of the physician ownership disclosure proposal, but recommended that CMS except from the definition of a "physician-owned hospital" those hospitals in which the physician ownership is limited to holding publicly traded securities or mutual funds that satisfy the requirements of the exceptions under §§411.356(a) or (b).

Response: We agree and are revising the regulatory text at §489.3 accordingly.

Comment: Several commenters requested that CMS revise the timing of the hospital's written notice of the disclosure of physician ownership to patients. The

commenters requested that CMS clarify that the written notice be given to patients, not

only with the provision of a package of information regarding preadmission testing and

registration, but also at the time of scheduling.

Response: We believe that the specific revisions suggested by the commenters

would not be feasible. The scheduling of most inpatient or outpatient services is

performed by a staff member in the physician's office, rather than the patient. Therefore,

the first contact between the hospital and the patient usually will be when the hospital

sends a package of information regarding scheduled preadmission testing and registration

for a planned hospital admission for inpatient care or outpatient service. We do

recognize the benefit to patients of receiving this information at the earliest opportunity,

and in those instances where the patient and the hospital are scheduling the inpatient

admission or outpatient services, we encourage hospitals to provide the notice at that

time.

Comment: Several commenters noted that the proposal requires physician-owned

hospitals to provide patients with a list of the hospital's physician owners or investors

upon request, but does not establish any timeframe for the hospital to furnish the list to

the patient. The commenters suggested that the list be provided to the patient at the time

the request is made.

Response: While we expect a hospital to make this list available to a patient upon

request, and that this should be done at the earliest possible opportunity, we believe that it

is important to allow the hospital some degree of flexibility regarding the manner and

form by which it meets this requirement. Therefore, we are not revising the provision to include any specific timeframe for making the list available.

Comment: Many comments addressed the appropriateness of our decision to propose a physician ownership disclosure requirement for all hospitals. Although most commenters supported our proposal, two commenters recommended that the proposed ownership disclosure requirement be limited to those facilities that meet the specialty hospital definition under section 1877(h)(7) of the Act. The commenters contended that the research to date raises concerns about ownership and referrals related to specialty hospitals only, and that similar concerns have not been raised about other types of hospitals with physician ownership.

Response: We are not adopting the commenters' suggested changes. We believe that it is in the best interests of patients to have available physician ownership information concerning all hospitals.

Comment: Most commenters agreed with our proposal to effectuate a hospital physician ownership disclosure requirement through changes to the regulations governing Medicare provider agreements. However, one commenter recommended that the proposal be effectuated through changes to the CoPs applicable to hospitals and CAHs. The commenter believed that the use of the CoPs is more practical for enforcement purposes and states that the provider agreement rules are only referenced when a healthcare facility initially enrolls, with no subsequent review of compliance.

Response: We are finalizing the hospital physician ownership disclosure requirements through the regulations governing Medicare provider agreements. We

believe that this approach is better than using the Medicare CoPs, which are centered on quality of care. We also disagree with the commenters' assertion that there is no subsequent review of compliance with the provider agreement rules after initial enrollment. CMS reviews compliance with the provider agreement rules after initial enrollment, and, if a provider is out of compliance, CMS may terminate its provider agreement.

Comment: One commenter urged CMS to make the disclosure requirement applicable to all financial arrangements between physicians and all hospitals, not just ownership and investment interests by physicians in physician-owned hospitals. The commenter encouraged CMS to require disclosure of financial interests such as salaries, bonuses, medical directorships, and consulting arrangements, as well as any other arrangements conferring a material financial benefit upon a physician by a hospital.

Response: We are not adopting the commenter's suggestions. We believe the physician ownership disclosure proposal focuses on those hospitals whose ownership or investment interests might be most relevant to patients in deciding whether and where to undergo medical treatment. The voluminous amount of information suggested by the commenter would be of little additional benefit to patients in making such decisions. In addition, we believe that our proposal strikes the appropriate balance between providing useful information to the patient and not unnecessarily burdening physicians and hospitals.

Comment: One commenter strongly opposed physician ownership disclosure as a condition of continued medical staff membership and stated that hospitals have no

effective means to police medical staff members in this manner. Another commenter

believed that changes must be made to §482.22(c), which lists requirements for medical

staff bylaws, to provide that bylaws of physician-owned hospitals must contain a

provision requiring physician ownership disclosure as condition of continued medical

staff membership.

Response: We believe that the overall intent of this physician ownership

disclosure requirement is to provide patients with the information that they need to decide

whether the existence of a financial relationship, in the form of a physician ownership

interest, is in their best interests as a potential patient of the hospital. Therefore, we are

not finalizing the proposed provision at §489.20(u)(2), which ties a physician's continued

medical staff membership to this disclosure of ownership, because it would not provide

any additional protections for patients that are not already contained under §489.20(u)(1).

Furthermore, the provision at §489.20(u)(1) allows hospitals much greater flexibility in

meeting this disclosure requirement than would be provided by the inclusion of

§489.20(u)(2).

For similar reasons, we disagree with the commenter who believed that changes

must be made to the medical staff bylaws provision under the CoPs at §482.22(c). As

previously stated, we believe that the appropriate area for the hospital physician

ownership disclosure requirement is in the regulations governing Medicare provider

agreements.

Comment: One commenter asserted that the disclosure of physician ownership

interests provides no useful information to the patient unless the notice is done in concert

with an outreach and educational initiative for patients that provides other information

about the hospital so the patient can make an informed decision.

Response: We believe the disclosure of physician ownership interests does

provide useful information. However, we will carefully consider the recommendation to

conduct an outreach and educational initiative for patients.

Comment: One commenter recommended that CMS establish a de minimis level

of physician investment below which no notification would be necessary.

Response: We are not establishing a de minimis level of physician investment.

Rather than establishing an arbitrary threshold, we believe that patients should be

informed about any level of physician investment. However, as discussed above, we

have excluded ownership interests that satisfy the exceptions found in §§411.356(a) and

(b) from the definition of a physician-owned hospital found at §498.3.

Comment: One commenter (a healthcare system) recommended that instead of

revoking hospital privileges of physician investors or owners that fail to provide the

required disclosure, CMS should deny payments to physicians who fail to disclose their

ownership in a hospital at the time the referral is made.

Response: We are not adopting the commenter's suggestion. We do not believe

that we have the statutory authority to take such action.

After consideration of the public comments we received, we are revising the

proposed changes to §489.3 by adding a provision to except from the definition of a

"physician-owned hospital" those hospitals in which the physician ownership is limited

to holding publicly traded securities or mutual funds that satisfy the requirements of the

exception under§ 411.356(a) or (b). We are adopting as final, without modification, the proposed revisions to §§489.12 and 489.53. We are redesignating proposed paragraph (u)(1) of §489.20 as paragraph (u) and revising it to specify that the hospital should furnish a list of physician owners to patients at the beginning of their hospital stay or outpatient visit. We are not adopting the proposed regulatory text under §489.20(u)(2).

2. Patient Safety Measures

In the DRA Report to Congress (page 67), we stated that it was appropriate to issue further guidance on what we expect of all hospitals with respect to the appraisal, initial treatment, and referral, when appropriate, of patients with medical emergencies. The Medicare hospital CoP regulations at 42 CFR Part 482 impose requirements on hospitals that have emergency departments, as well as requirements on hospitals without emergency departments. We believe that hospitals should be required to disclose to patients at the time of inpatient admission or registration for an outpatient service information concerning whether a physician is available on the premises 24 hours per day, 7 days per week. In the FY 2008 IPPS proposed rule (72 FR 24817), under the authority at sections 1861(e)(9), 1820(e)(3), 1866, 1871, and 1102 of the Act (described previously), we proposed to add a new provision at §489.20(v) to require that hospitals furnish all patients notice at the beginning of their hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, and to describe how the hospital will meet the medical needs of any patient who develops an emergency medical condition, at a time when no physician is present in the hospital. We sought comment as to whether this change would be best

effectuated through changes to the Medicare provider agreement regulations or whether it would be more appropriate to include this change in the CoP requirements applicable to acute care hospitals and CAHs.

It has also come to our attention that some hospitals have called 9-1-1 when a patient has gone into respiratory arrest, a physician has not been on the premises, and the onsite clinical personnel have lacked the requisite equipment or training to provide the required assessment, initial treatment, and referrals that are required of all hospitals. In some cases, required interventions to initiate emergency treatment may be outside the scope of practice of the clinical personnel onsite. This has occurred even in hospitals that operate emergency departments. Therefore, in the FY 2008 IPPS proposed rule (72 FR 24817), we solicited comments on whether current requirements for emergency service capability in hospitals with or without emergency departments should be strengthened in certain areas. Specifically, we sought feedback on whether present regulatory provisions should be expanded with respect to the type of clinical personnel that must be present at all times in hospitals with and without emergency departments; the competencies that such personnel must demonstrate, such as training in Advanced Cardiac Life Support, or successful completion of specified professional training programs; the type of emergency response equipment that must be available and the manner in which it must be available, such as in each emergency department, or inpatient unit, among others; and whether emergency departments must be operated 24 hours per day, 7 days per week. We indicated that after evaluating the comments we received, we

would consider whether we should amend the Medicare hospital CoPs related to the

provision of emergency services in hospitals with and without emergency departments.

We received a number of public comments on our proposal. Our response

follows each comment summary below.

Comment: Most of the commenters stated that only physician-owned specialty

hospitals should be required to disclose to patients whether or not a physician is on site at

all times and how emergencies are handled when a physician is not on-site. The

commenters stated that physician-owned specialty hospitals are generally not part of a

larger system of care, most often have no transfer agreements with other hospitals, and

tend to specialize in one type of care delivery, and that these factors create challenges to

their ability to treat the unexpected emergency. The commenters also stated that "full-

service community" hospitals are part of a network of care in their community that

involves referrals from local physician practices, reliance on local trauma support

networks, participation in local emergency medical transport systems, and transfer

agreements among facilities. The commenters stated that applying additional

requirements to full-service community hospitals is unnecessary and costly. However,

they stated that applying them to physician-owned specialty hospitals could be used to

assure that such hospitals, in the absence of being part of the broader care network, meet

minimum standards for patient safety.

In contrast, several other commenters stated that they supported a requirement to

disclose onsite physician coverage, so long at it applies to all hospitals, regardless of

whether they are physician-owned. Another commenter supported extending the

physician onsite disclosure requirement to all hospitals and CAHs, stating that ideally all patients should be informed regarding the level of physician staffing present in the hospital. This commenter stated that patients should know, for example, whether a physician will remain in the hospital until all patients have recovered from anesthesia and are fully conscious. The commenter also stated that patients should be informed of the hospital's emergency response plan when a physician is not on the premises 24 hours per day, 7 days per week.

Response: Fully informed consumers of hospital and CAH services play an essential role in assuring the quality of health care services. It is important to provide patients information about whether a hospital or CAH has a physician on site at all times, and the provisions for handling emergencies when a physician is not on site. Consumers may have an expectation that a hospital or CAH, as a health care facility that operates 24 hours per day, 7 days per week, always has a physician on site. Therefore, it is important to ensure that consumers are provided accurate information on the availability of physician services at the point when they are about to become patients of a hospital or CAH. All hospitals and CAHs are required to have the basic capabilities to address medical emergencies within their facilities, regardless of whether a physician is always on-site and, in the case of hospitals, regardless of whether or not the hospital offers an emergency department or service. (All CAHs are required to offer emergency services.)

In order to be fully informed, consumers also should be made aware of the hospital's or CAH's process for addressing medical emergencies that may occur when a physician is not on-site. Therefore, we have not adopted the suggestion of those

commenters who would condition consumers' access to this information on the basis of

the ownership structure of the hospital or CAH. Medicare hospital health and safety

regulations are the same for all participating hospitals, regardless of their type of

ownership. The same is true for the Medicare CAH health and safety regulations. For

example, all hospitals are expected to have the capability to assess a medical emergency,

provide initial treatment, and refer, or transfer, a patient to another hospital when

appropriate. Given the uniform applicability of hospital and CAH requirements to all

hospitals or CAHs, there is no basis for requiring only those hospitals or CAHs that are

physician-owned to make the proposed physician availability-related disclosures. The

disclosure requirement is appropriately triggered when a hospital or CAH does not have a

physician on-site 24 hours per day, 7 days per week.

As discussed in the regulatory impact statement, this final rule with comment

period change will not have any significant economic impact on hospitals or CAHs.

Therefore, we disagree with those commenters who stated that the physician-availability

disclosure requirement would be costly for hospitals and CAHs.

Comment: Several commenters addressed whether the physician-availability

disclosure requirement should apply to CAHs as well as hospitals. One commenter stated

that the problem of hospitals ill-prepared to handle patient emergencies seems confined to

specialty hospitals. This commenter stated that the physician-availability disclosure

requirement would affect numerous rural hospitals and CAHs, which often do not have

physicians on site, and often utilize physician assistants or nurse practitioners, or both,

with a supervising physician available by telephone. The commenter stated that, because

these hospitals have established referral systems and often serve as staging areas where

patients are stabilized for transport, additional requirements would be unnecessary and

costly. The commenter also stated that limiting rural hospitals' and CAHs' ability to

utilize physician assistants and nurse practitioners would create substantial access

problems.

Similarly, another commenter stated that the proposed change would be a

particular problem for CAHs. This commenter stated that the CAH CoPs have been

written expressly to provide flexibility for CAHs so they can meet the needs of patients in

isolated, rural communities without having a physician in the building at all times.

In contrast, another commenter stated that the physician-availability disclosure

requirement should include CAHs because there is no clear distinction between the

services offered by physician-owned specialty hospitals and CAHs. This commenter

stated that, while most CAHs are nonprofit hospitals that provide a range of services to

small rural communities, some CAHs are for-profit hospitals and some offer specialty

services. The commenter stated he was aware of one CAH with a hand surgery focus and

another with a cardiac catheterization laboratory. The commenter stated that, because

CAHs are not restricted in the services they offer, they should have the same physician-

availability disclosure requirements as other hospitals.

Response: We agree that the physician-availability disclosure requirement should

apply equally to hospitals and CAHs. Although we agree with those commenters who

stated that many CAHs do not have physicians on-site at all times, and thus would be

required to disclose this information to patients, we do not agree that this alone is

sufficient reason to exempt CAHs from the physician-availability disclosure requirement.

It would not be appropriate to condition patients' access to information on physician

availability on whether or not the patients reside in a rural area. Because we do not

require either hospitals or CAHs to have a physician on-site at all times, there is no basis

to require only hospitals, but not CAHs, to disclose this information. As one commenter

stated, the CAH CoPs provide greater flexibility in many areas when compared to the

hospital CoPs. However, this is not the case in all areas. CAHs, for example, must

provide emergency services to the public 24 hours per day, while hospitals have the

option of operating an emergency department or not. Furthermore, as one commenter

stated, there is no restriction on the types of services a CAH may offer. Thus, it may be

difficult for consumers to distinguish whether a given provider is a hospital or a CAH.

Consumers may not be aware that there are different requirements for CAHs than for

facilities participating in Medicare as hospitals. Consumers may make assumptions about

physician availability in any "hospital," because the facility provides services 24 hours

per day, 7 days per week, regardless of whether that facility is a CAH or hospital for

Medicare purposes. Therefore, it is important for consumers to be informed whether a

physician is always on site, and how emergencies will be handled when no physician is

available. We do not agree that this requirement limits the ability of rural hospitals or

CAHs to utilize physician assistants and nurse practitioners. There is no change to the

current requirements in the CoPs for hospitals or CAHs regarding utilization of physician

assistants and nurse practitioners.

Comment: One commenter stated a physician-availability disclosure requirement should apply only to facilities that provide inpatient care 24 hours per day, 7 days per week. The commenter stated that CMS should clarify in the FY 2008 IPPS final rule that the requirement does not apply to provider-based settings that are not open at all times and/or are not providing inpatient services. The commenter stated that disclosure of emergency services capabilities in the registration process will create greater confusion for patients.

Response: Because the requirement in this final rule with comment period applies to hospitals and CAHs, and because both hospitals and CAHs are required to make inpatient care available on a 24 hours per day, 7 days per week basis, we do not agree that the requirement would be narrowed to fewer facilities by applying it only to facilities providing inpatient care. We do not agree that provider-based locations are subject to a separate standard because they do not participate separately in Medicare. The health and safety standards apply to provider-based locations of hospitals or CAHs. All provider-based locations of a hospital or CAH are considered part of the hospital or CAH, and the provider-based location's clinical services, including the provision of emergency services, must be integrated into those of the hospital or CAH.

Comment: One commenter stated that the proposed requirement fails to provide timely or useful information to the patient, indicating that the physician-availability disclosure occurs post-admission. The commenter stated that CMS should undertake a comprehensive consumer education initiative prior to imposing this requirement, so that the patient could make an informed choice about any particular facility.

Response: We do not agree that the patient would in every instance already have been admitted before the required physician-availability disclosure would take place. We proposed that, for purposes of this disclosure requirement, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or the provision of a package of information regarding an outpatient service. It is our intent that this information be provided by the hospital to the consumer at the first point of contact related to a particular admission or episode of care, in order to enhance its usefulness.

CMS strives, as part of its overall commitment to increasing the transparency of the health care system to consumers, to equip consumers with information that enables them to make informed choices about their care. Education and outreach about our efforts are ongoing. We do not agree that implementation of the physician-availability disclosure requirement should be delayed until a specific educational campaign is concluded.

Comment: One commenter stated that hospitals are currently required to have a plan in place for how they will provide care, including emergency care. The commenter stated that the physician-availability disclosure requirement is therefore redundant and places an unnecessary burden on the facility.

Response: We do not agree that having a plan in place for providing emergency care is the same as informing consumers about the availability of physician services and how emergency care will be provided to them when a physician is not on the premises.

The physician-availability disclosure required by this final rule with comment period is intended to assure provision of important information to consumers making healthcare decisions. This requirement is separate and distinct from any requirements contained in the hospital and CAH CoPs regarding the provision of emergency services and the care planning for each patient, among others.

Comment: One commenter stated that the required disclosure "arguably" should be extended to cover the presence or absence of particular equipment, or the level of expertise of the facility's staff, so the patient can understand what to expect depending on the nature of the emergency and the capabilities of the facility, and the likelihood of transfer to another hospital for any particular medical emergency.

Response: Ideally, an informed consumer would have a comprehensive understanding of the capabilities of any hospital and/or CAH, in terms of both specialized equipment and staff, that the consumer considers using. However, the commenter's suggestion would greatly expand the impact of the physician-availability disclosure requirement. Instead of affecting only those hospitals and CAHs that do not have a physician present 24 hours per day, 7 days per week, the commenter's suggested approach would affect all hospitals and CAHs. It would not only increase the number of hospitals and CAHs affected by the requirement, but would also require them to provide a much more detailed and lengthy disclosure. Therefore, at this time, we will not be mandating an expanded disclosure requirement. Hospitals have the flexibility to provide such additional information to consumers, either as a general policy or in response to questions from consumers.

Comment: One commenter did not object to informing patients when a physician is not always in the facility. However, the commenter hoped that the required notice of how emergency services would be provided would not imply that patients are receiving less than competent care. The commenter stated that a hospital could make an affirmative statement, such as the following: "This facility provides competent, fully trained staff who are available 24 hours per day. At times when there is no physician present, patients with health care emergencies will be assessed and treated by qualified medical personnel, with physician support available via telephone or pager, and will be transferred to another hospital, when necessary."

Response: We are requiring hospitals and CAHs that do not have a physician on site at all times to state this in the notice, as well as how the hospital will meet the needs of any patient who develops an emergency medical condition at a time when there is no physician present. We are not prescribing specific wording for the notice, since the content must be tailored to the circumstances of the individual hospital or CAH, but we note that the commenter's suggested wording lacks explicit notice that the hospital does not provide on-site availability of a physician 24 hours per day, 7 days per week. Adoption of this disclosure requirement does not imply anything about the competency of care provided by other types of practitioners.

Comment: One commenter stated that many long term care hospitals do not provide on-site, 24-hour physician coverage and asked whether such hospitals are expected to have such on-site physician services. The commenter stated that if this is CMS's interpretation, then this interpretation should be translated into the CoPs.

Response: In this final rule with comment period, we are requiring hospitals and

CAHs that do not have a physician on-site 24 hours per day, 7 days per week to disclose

this information to patients, along with information about how they would handle an

emergency when no physician is on-site. We are not making any changes to the hospital

or CAH CoPs in this final rule with comment period. The current hospital and CAH

CoPs do not include a requirement for a physician to be on site at all times.

Comment: One commenter stated that CMS should clarify whether the disclosure

would be required only on those days when a physician is not on-site, or at all times if

there is a possibility that a physician might not be on-site. The commenter also stated

that CMS should indicate whether it expects a separate, signed notice to be provided to

patients or a general notice to be included with other registration/admission documents

outlining basic provisions for unexpected emergency care.

Response: This final rule with comment period requires any hospital or CAH that

does not provide for a physician to be on-site 24 hours per day, 7 days per week to

disclose this to patients, regardless of whether or not it happens to have 24-hour on-site

coverage at the beginning of the patient's hospital or CAH inpatient stay or outpatient

visit. A hospital or CAH that is required under this final rule with comment period to

make a physician-availability disclosure must do so via a written notice provided to each

patient. The required notice must indicate that a physician is not on-site 24 hours per

day, 7 days per week, and how the hospital or CAH handles medical emergencies that

arise when a physician is not on-site. This final rule with comment period does not

require that the hospital have the patient sign the notice.

Comment: Most of the commenters stated that they supported strengthening

requirements concerning emergency services capabilities only for physician-owned

specialty hospitals. The commenters stated that applying additional requirements for

"full-service community hospitals" is unnecessary and costly, but that applying them to

physician-owned facilities could be used to assure that such hospitals, in the absence of

being part of the broader care network, meet minimum standards for patient safety.

Another commenter also stated that any additional measures should be applied

only to physician-owned facilities and not to "full-service community hospitals." This

commenter also stated that State and Federal rules for CAHs already delineate in detail

the emergency equipment that must be provided on site, mechanisms to contact on-call

practitioners, timeframes within which these practitioners must be available, and written

agreements and protocols for transferring patients for further treatment when indicated.

In contrast, several other commenters stated that, in the interest of patient safety,

they would support a requirement that standardized the type and training of clinical

personnel available in any Medicare-certified hospital. These commenters also stated

that they endorse setting minimum requirements for equipment.

Another commenter stated that the condition of participation for emergency

services in both hospitals and CAHs should be strengthened, stating that a hospital should

be capable of handling any situation that can reasonably be expected to occur. This

commenter also stated that, to develop the precise regulatory provisions in the revised

CoPs, CMS should convene an expert panel or, at a minimum, consult with the State

agencies and recognized national accrediting bodies, as required by section 1863 of the
Act.

Finally, one commenter, while stating support for CMS setting minimum
emergency service standards, also stated concern that such standards might conflict with,
duplicate, or exceed current State requirements. The commenter stated CMS should
coordinate development of minimum emergency medical response standards with
interested professional organizations as well as State authorities overseeing medical
emergency response.

Response: We disagree with those commenters who supported expanded
regulatory requirements for emergency services capabilities only for physician-owned
facilities, because Medicare hospital health and safety standards apply to all participating
hospitals, regardless of their type of ownership. The same is true for the Medicare CAH
health and safety standards. We are not aware of any evidence to support the view that
patient safety concerns arise only in physician-owned facilities, and that what the
commenters call "full-service community hospitals" always assure that care is provided
to patients in the right time and setting, due to these hospitals' participation in a
community network of care. Our oversight experience suggests that patient safety
problems can occur in hospitals with any type of ownership structure, or any type of
service mix, whether general or specialized. For this reason, any changes to the hospital
CoPs that we might propose would apply to all hospitals, and likewise any changes to the
CAH CoPs that we might propose would apply to all CAHs.

We also note the support of several commenters for a requirement that would standardize the type and training of clinical personnel, as well as minimum requirements for equipment that must be available in any Medicare-certified hospital. With respect to whether strengthening the minimum Medicare requirements related to emergency services would raise issues of conflict with or exceeding State requirements, this potential situation is not unique to emergency services standards. Medicare health and safety standards, unless the regulations specifically state to the contrary, preempt conflicting State requirements. We will consider the commenters' views, including the suggestions about consultation, in undertaking any future rulemaking to strengthen emergency services minimum requirements.

We agree with the commenter who pointed out that the existing emergency services requirements for CAHs are detailed. For example, our current regulations at 42 CFR 485.618(a) require CAHs to make emergency services available on a 24-hour per day basis. Section 485.618(b) establishes the standard regarding availability of equipment, supplies, and medication used in treating emergency cases. Our regulations at §485.618(d) are specific as to the required CAH emergency services clinical personnel, including the types of personnel, as well as the mode and timeframe for their availability. These regulatory standards are more detailed than those found in the comparable hospital emergency services CoP (42 CFR 482.55), or in the applicable hospital standard at 42 CFR 482.12(f)(2) for hospitals that do not have emergency departments. Because hospitals tend to be larger health care facilities than CAHs, it might be reasonable to provide a comparable degree of specificity, appropriate to the hospital setting, in the

hospital CoPs. We will consider the commenters' views in undertaking any future

rulemaking on this issue.

Comment: One commenter stated that, if CMS chooses to expand the existing

regulatory provisions for clinical personnel that must be present at all times, CMS should

use broad terminology. The commenter provided the following examples: "qualified

medical personnel," or "practitioners with appropriate privileges," or "licensed

practitioners," including the phrase "with/and physician supervision to the extent required

by state law." The commenter also stated CMS should drop its current usage of the term

"licensed independent practitioner" in its regulations, stating that this causes "endless

headaches" for hospitals that wish to utilize physician assistants.

Response: We note that the terminology suggested by the commenter is very

broad and would not significantly expand upon existing requirements. We will consider

these comments in undertaking any future rulemaking on this issue.

Comment: Two commenters specifically addressed our request for comments on

whether we should require hospitals with emergency departments to provide these

emergency services 24 hours per day, 7 days per week. They stated that such a

requirement would best come from the State or EMS district in which the hospital is

located, because these authorities would be in the best position to judge the need for

emergency care.

Response: CAHs are currently required, under the provisions at

42 CFR 485.618(a), to make emergency services available on a 24 hours per day basis.

Because hospitals with emergency departments tend to be larger health care facilities than

CAHs, it might be reasonable to require hospital emergency departments to also be

available to the public on a 24-hour per day basis. We will consider these comments in

any future rulemaking on this issue.

Comment: Two commenters addressed the issue of locating the

physician-availability disclosure requirement in the provider agreement rules rather than

in the CoPs. One commenter stated it would be more appropriate to include the

requirement in the provider agreement rules. The other commenter stated that it would

be easier to ensure compliance if CMS implemented the physician-availability disclosure

requirement through the CoPs rather than the provider agreement regulations. This

commenter further stated that, unlike the CoPs referenced regularly, the provider

agreement rules are only referenced when a health care facility initially enrolls [in

Medicare], with no subsequent review of compliance. The commenter also stated that

placement of the requirement in the CoPs would facilitate the commenter's consultation

with Medicare requirements when developing its own practices and policies.

Response: We agree that the physician-availability disclosure requirement should

be included in the provider agreement regulations. We do not agree that the provider

agreement regulations are referenced only when a facility initially enrolls in Medicare.

Each participating provider must comply with all applicable provisions of the provider

agreement regulations found in 42 CFR Part 489, and CMS may terminate its provider

agreement if the provider is not in substantial compliance with these requirements. A

provider's compliance with applicable provider agreement regulations is reviewed

through a variety of means, including on-site investigation of complaints. An example of

this mode of compliance review is our enforcement of the special responsibilities of

Medicare hospitals in emergency cases, commonly known as EMTALA (EMTALA

requirements are addressed in §489.24, with certain related provisions found in §489.20).

Therefore, we do not agree that the regulatory language we proposed concerning

disclosure of physician on-site availability should be moved to the CoPs in order to

permit compliance reviews. We do not consider the ease of referencing the regulations

containing the CoPs, versus that of referencing those containing the provider agreement

regulations, a compelling reason to move the regulatory language from the provider

agreement regulations to the CoPs.

        After consideration of the public comments we received, we are adopting as final,

with one technical correction, the addition of a provision at §489.20(v) to require that

hospitals and CAHs furnish all patients written notice at the beginning of their hospital

stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present

in the hospital 24 hours per day, 7 days per week, and to describe how the hospital or

CAH will meet the medical needs of any patient who develops an emergency medical

condition at a time when no physician is present in the hospital. We are correcting a

typographical error that appeared in the proposed rule. The proposed regulatory text

stated that the required notice must indicate "…how the hospital will meet the medical

needs of any inpatient who develops an emergency medical condition…" We intended to

say "patient" instead of "inpatient," as is clear from the references to outpatient visits in

two other places within the regulatory text we originally proposed.

H. 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 2008.

(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 2008,

we are adjusting the national inpatient PPS rates by an amount sufficient to account for

the added costs of this demonstration program. We are applying budget neutrality across

the payment system as a whole rather than merely across the participants in this

demonstration program. As we discussed in the FY 2005, FY 2006, and FY 2007 IPPS

final rules (69 FR 49183; 70 FR 47462; and 71 FR 48100), 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 2008, 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 will be $9,681,893. This

estimated adjusted amount reflects the estimated difference between the participating

hospitals' costs and the IPPS payment based on data from the hospitals' cost reports. We

discuss the payment rate adjustment that is required to ensure the budget neutrality of the

demonstration program for FY 2008 in section II.A.4. of the Addendum to this final rule

with comment period.

We did not receive any public comments on the provisions of the demonstration

project discussed in the proposed rule.

V. Changes to the IPPS for Capital-Related Costs

(If you choose to comment on issues in this section, please include the caption

"Capital IPPS Payment Adjustments" at the beginning of your comment.)

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related

costs of inpatient acute hospital services "in accordance with a prospective payment

system established by the Secretary." Under the statute, the Secretary has broad authority

in establishing and implementing the IPPS for acute care hospital inpatient capital-related

costs. We initially implemented the IPPS for capital-related costs in the 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 (FY) 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for 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 the hospital (§412.348(c)), but were available only during the

10-year transition period. After the end of the transition period, eligible hospitals can no

longer receive this exception payment. However, even after the transition period, eligible

hospitals receive additional payments under the special exceptions provisions at

§412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of

its Medicare allowable capital-related costs provided that special exceptions payments do

not exceed 10 percent of total capital IPPS payments. Special exceptions payments may

be made only for the 10 years from the cost reporting year in which the hospital

completes its qualifying project, and the hospital must have completed the project no later

than the hospital's cost reporting period beginning before October 1, 2001. Thus, an

eligible hospital may receive special exceptions payments for up to 10 years beyond the

end of the capital IPPS transition period. Hospitals eligible for special exceptions

payments are required to submit documentation to the intermediary indicating the

completion date of their project. (For more detailed information regarding the special

exceptions policy under §412.348(g), 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 IPPS for capital-related costs, §412.300(b) of the regulations defines a

new hospital as a hospital that has operated (under current or previous ownership) for less

than 2 years. (For more detailed information, we refer readers to the August 30, 1991

final rule (56 FR 43418).) During the 10-year transition period, a new hospital was

exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of

its reasonable costs during that period. Originally, this provision was effective only

through the transition period and, therefore, ended with cost reporting periods beginning

in FY 2002. Because 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. (We refer readers 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 IPPS, we compute a separate payment rate specific to

Puerto Rico hospitals using the same methodology used to compute the national Federal

rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend

of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal

rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate

that consisted of 75 percent of the capital IPPS Puerto Rico specific rate and 25 percent

of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in

conjunction with the change to the operating IPPS blend percentage for hospitals located

in Puerto Rico required by section 4406 of Pub. L. 105-33, we revised the methodology

for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend

of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS

Federal rate. Similarly, in conjunction with the change in operating IPPS payments to

hospitals located in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108-173,

we again revised the methodology for computing capital IPPS payments to hospitals

located in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto

Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges

occurring on or after October 1, 2004.

B. Policy Change

As we have noted above, the Secretary has broad authority under the statute in

establishing and implementing the IPPS for hospital inpatient capital-related costs. We

initially exercised that authority in the August 30, 1991 IPPS final rule (56 FR 43358).

Among other provisions of that rule, we established the 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). The purpose of that lengthy transition was to allow hospitals sufficient

time to adjust to payment under a fully prospective system based on a uniform national

rate.   In that rule, we also established the initial standard Federal payment rate for

capital-related costs, as well as the mechanism for updating that rate in subsequent years.

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.

     In the FY 2008 IPPS proposed rule, we noted that since the implementation of the

IPPS for hospital inpatient capital-related costs, we have carefully monitored the

adequacy of the standard Federal payment rate for capital-related costs and the updates

provided under the existing regulations. On several occasions, the standard Federal

payment rate has been adjusted. Section 1886(g)(1)(A) of the Act required a 7.4 percent

reduction to the capital rate for discharges occurring after September 30, 1993. (We

implemented that reduction to the rate in §412.308(b)(2) of our regulations, effective in

FY 1994.) Section 412.308(b)(3) of the regulations 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 be reduced by 17.78 percent (above the

previous statutory reduction of 7.4 percent). (As a result of that reduction, the FY 1998

standard Federal payment rate for capital-related costs was $371.51, compared to $438.92

in FY 1997.) 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.

We also noted that, in general, under a PPS, standard payment rates should reflect

the costs that an average, efficient provider would bear to provide the services required

for quality patient care. Payment rate updates should also account for the changes

necessary to continue providing such services. Updates should reflect, for example, the

increased costs that are necessary to provide for the introduction of new technology that

improves patient care. Updates should also take into account the productivity gains that,

over time, allow providers to realize the same, or even improved, quality outcomes with

reduced inputs and lower costs. Hospital margins, the difference between the costs of

actually providing services and the payments received under a particular system, thus

provide some evidence concerning whether payment rates have been established and

updated at an appropriate level over time for efficient providers to provide necessary

services. All other factors being equal, sustained substantial positive margins may

suggest that payment rates and updates have exceeded what is required to provide those

services. It is to be expected, under a PPS, that highly efficient providers might regularly

realize positive margins, while less efficient providers might regularly realize negative

margins. However, a PPS that is correctly calibrated should not necessarily experience

sustained periods in which providers generally realize substantial positive Medicare

margins.

Under the capital IPPS in particular, it seems especially appropriate that there

should not be sustained significant positive margins across the system as a whole. Prior

to the implementation of the capital IPPS, Congress mandated that the Medicare program

pay only 85 percent of hospitals' inpatient Medicare capital costs. During the first

5 years of the capital IPPS, Congress also mandated a budget neutrality adjustment, under

which the standard Federal capital rate was set each year so that payments under the

system as a whole equaled 90 percent of estimated hospitals' inpatient Medicare capital

costs for the year. Finally, as we discussed in the proposed rule, Congress has twice

adjusted the standard Federal capital rate (a 7.4 percent reduction beginning in FY 1994,

followed by a 17.78 percent reduction beginning in FY 1998). On the second occasion in

particular, the specific congressional mandate was "to apply the budget neutrality factor

used to determine the Federal capital payment rate in effect on September 30, 1995… to

the unadjusted standard Federal capital payment rate" for FY 1998 and beyond. (The

designated budget neutrality factor constituted a 17.78 percent reduction.) This statutory

language indicates that Congress considered the payment levels in effect during

FYs 1992 through 1995, established under the budget neutrality provision to pay 90

percent of hospitals' inpatient Medicare capital costs in the aggregate, appropriate for the

capital IPPS. The statutory history of the capital IPPS thus suggests that the system in

the aggregate should not provide for continuous, large positive margins.

In preparation for the proposed rule, we analyzed the adequacy of the existing

capital IPPS rates by conducting a comprehensive review of hospital experience under

the IPPS for hospital inpatient capital-related costs, with particular attention to the

relationship between acute care hospital capital Medicare costs and payments under the

capital IPPS. Specifically, we examined the relationship between the Medicare inpatient

capital costs of hospitals that are paid under the IPPS for hospital inpatient capital-related

costs and their payments under that system over a number of years. We derived both cost

and Medicare payment data from the Medicare cost report. Specifically, cost data were

derived from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8, and

Medicare payment data from Worksheet E, Part A, Lines 9 and 10. We began our

analysis with FY 1996, the year in which the statutory budget neutrality provision

expired. (As we have discussed, for FYs 1992 through 1995, section 1886(g)(1)(A) of

the Act 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. As discussed in section III. of the Addendum

to the proposed rule and this final rule with comment period, we employed an 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 reasonable cost in order to determine the required budget neutrality adjustment.

As a result of the expiration of the budget neutrality provision, the standard Federal

payment rate for capital-related costs increased to $461.96 in FY 1996 from $376.83 in

FY 1995.) Our analysis in the proposed rule extended through FY 2004, the most recent

year for which we had relatively complete cost report information. We examined data

across all hospitals subject to the capital IPPS and across the categories of hospitals (for

example, urban and rural, and teaching and nonteaching) that we normally employ in

conducting impact analyses. Specifically, we looked at the difference between aggregate

hospital payments from the capital IPPS and hospitals' aggregate Medicare inpatient

capital costs. We determined the inpatient hospital Medicare capital margins for each

year of the period from FY 1996 through FY 2004. (A margin is calculated as the

difference between payments and costs, divided by payments.) We similarly calculated

the aggregate margins for the period FY 1996 through FY 2004 (the aggregate difference

between payments and costs over the period, divided by total payments over the period).

We also calculated aggregate margins for the period FY 1998 through FY 2004

(excluding FY 1996 and 1997). As a result of the expiration of the statutory budget

neutrality provision, the capital standard Federal rate increased to $461.96 in FY 1996

from $376.83 in FY 1995. The capital standard Federal rate was $438.92 in FY 1997,

before it was reduced to $371.51 in FY 1998 under section 4402 of Pub. L. 105-33,

which required that the unadjusted capital standard Federal rate be reduced by

17.78 percent. The capital standard Federal rates for FYs 1996 and 1997 were thus

substantially higher than the rates for the periods immediately preceding those years, and

in the subsequent years (FY 1998 and beyond). The margins for those years are

correspondingly higher than the margins for the other years in the period, and thus it

could be argued that the margins for FYs 1996 and 1997 are unrepresentative. The table

below summarizes the findings of this analysis for the proposed rule.

Hospital Inpatient Medicare Capital Margins											
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**Aggregate 1996-2004**	**Aggregate 1998-2004 (excluding 1996 and 1997)**
U.S.	17.5	13.4	7.0	6.8	7.3	7.9	8.7	7.7	5.1	9.0	7.2
URBAN	17.6	13.8	7.8	7.4	8.3	8.9	10.3	9.1	6.3	9.9	8.3
RURAL	17.2	11.1	2.0	2.7	1.3	1.5	-1.7	-1.2	-2.9	3.4	0.3
No DSH Payments	16.2	11.8	4.4	4.4	5.6	5.6	5.0	4.8	-0.9	6.9	4.2
Has DSH Payments	18.3	14.4	8.5	8.1	8.2	8.7	9.9	8.6	6.7	9.9	8.4
$1-$249,999	14.5	12.9	-0.4	3.1	1.6	4.2	2.5	0.6	-3.5	3.3	1.8
$250,000-$999,999	15.5	9.3	2.2	1.5	3.0	2.5	-1.2	0.2	-3.8	2.9	0.5
$1,000,000-$2,999,999	16.8	12.8	8.5	9.2	8.6	7.2	9.0	4.6	3.0	8.7	7.1
$3,000,000 or more	20.1	16.6	10.4	9.1	9.7	11.6	13.4	12.5	10.1	12.4	11.1
TEACHING	19.4	15.7	9.8	9.7	11.1	11.7	13.9	13.2	11.3	12.9	11.6
NON-TEACHING	15.3	10.5	3.3	2.9	2.2	2.8	1.6	0.2	-3.2	3.9	1.3
Census Division											
New England (1)	26.9	25.8	17.0	15.1	18.2	20.5	21.3	21.2	20.5	20.9	19.3
Middle Atlantic (2)	19.1	15.5	11.0	11.5	13.8	16.3	18.4	17.9	15.0	15.5	15.0
South Atlantic (3)	17.9	13.9	5.8	3.9	5.9	5.2	6.3	7.5	4.9	7.9	5.7
East North Central (4)	18.2	12.7	6.2	7.2	8.8	8.6	6.3	8.1	7.1	9.2	7.5
East South Central (5)	14.8	11.1	3.3	4.1	3.4	2.9	3.0	-1.8	-4.2	3.9	1.4
West North Central (6)	14.2	6.9	0.0	-0.4	-1.6	1.9	2.6	3.3	1.1	3.2	1.1
West South Central (7)	13.3	8.3	3.4	3.1	0.6	0.1	1.4	-1.2	-4.2	2.5	0.3
Mountain (8)	17.3	14.8	8.4	7.6	7.4	6.4	3.2	3.1	0.7	7.2	4.9
Pacific (9)	20.5	16.1	12.4	11.3	11.5	12.8	15.5	12.8	9.2	13.5	12.2
Code 99	24.1	26.1	14.9	16.7	20.0	20.9	20.6	25.2	22.3	21.4	20.3
Bed Size											

Hospital Inpatient Medicare Capital Margins											
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**Aggregate 1996-2004**	**Aggregate 1998-2004 (excluding 1996 and 1997)**
< 100 beds	17.7	13.0	4.7	3.5	2.8	2.5	-1.7	-1.3	-5.6	3.5	0.5
100-249 beds	15.1	10.6	3.5	4.5	4.7	6.0	6.1	4.5	1.1	6.2	4.4
250-499 beds	18.9	14.0	8.7	8.3	10.4	10.5	11.7	11.6	10.6	11.7	10.4
500-999 beds	19.7	17.5	11.1	10.3	10.7	10.4	12.5	10.3	6.8	12.0	10.2
>= 1000 beds	8.2	13.8	2.1	0.2	-6.6	-3.5	8.7	6.3	1.4	3.1	1.8

Notes:
Based on Medicare Cost Report hospital data updated as of the 4th quarter of 2006.
Medicare payment is from Worksheet E, Part A, Lines 9 and 10.
Expenses are from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8.
We apply the outlier trimming methodology developed by MedPAC.
Code 99 applies when census division information was not specified in the Medicare Cost Report hospital data.

As the table showed, hospital inpatient Medicare capital margins have been very high across all hospitals during the period from FY 1996 through FY 2004. The margin for the entire period was 9.0 percent (7.2 percent, excluding FYs 1996 and 1997). For particular years, margins across all hospitals ranged from a high of 17.5 percent in FY 1996 to a low of 5.1 percent in FY 2004. While the margins fell after a high in FY 1996 of 17.5 to 6.8 percent in FY 1999, they rose again to 8.7 percent in FY 2002 before declining to 5.1 percent in FY 2004.

There were similar results among most types of hospitals and groupings of hospitals by geographic region. For example, teaching hospitals have realized margins of 12.9 percent (11.6 percent, excluding FYs 1996 and 1997) during the period from FY 1996 through FY 2004, with a high margin of 19.4 percent in FY 1996 and a low margin of 9.7 percent in FY 1999. Urban hospitals realized margins of 9.9 percent during the period from FY 1996 through FY 2004 (8.3 percent, excluding FYs 1996 and 1997). DSH hospitals realized margins of 9.9 percent over the period (8.4 percent, excluding FYs 1996 and 1997), while non-DSH had aggregate margins of 6.9 percent (4.2 percent, excluding FYs 1996 and 1997).

During the period from FY 1996 through FY 2004, every type of hospital and geographic grouping of hospitals has realized a positive aggregate margin from their capital IPPS payments. Of course, the aggregate capital margins for some types of hospitals have been lower than the margins for others. In particular, inpatient hospital Medicare capital margins for rural hospitals have lagged considerably behind the margins for urban hospitals. The aggregate margin for rural hospitals during the period from

FY 1996 through FY 2004 was 3.4 percent (0.3 percent, excluding FYs 1996 and 1997),

compared to 9.9 percent for urban hospitals and 9.0 percent for all hospitals. Rural

hospitals have even experienced negative margins during several years of the period (-1.7

percent in FY 2002, -1.2 percent in FY 2003, and -2.9 percent in FY 2004). Similarly,

nonteaching hospitals have experienced lower margins than teaching hospitals. Teaching

hospitals have experienced an aggregate margin of 12.9 percent during the period from

FY 1996 through FY 2004 (11.6 percent, excluding FYs 1996 and 1997). However,

nonteaching hospitals have experienced an aggregate margin of 3.9 percent during that

period (1.3 percent, excluding FYs 1996 and 1997).

   As we discussed in the proposed rule, there may be various factors reflected in

these margins. For example, one factor in the lower margins experienced by rural

hospitals may be the transition of many rural hospitals to CAHs that are paid outside the

IPPS. The number of rural hospitals in our analysis fell from 2,243 in FY 1996 to 1,211

in FY 2004, as the inpatient Medicare capital margins realized by rural hospitals fell from

17.2 percent to -2.9 percent. This suggests that more rural hospitals with relatively

higher inpatient Medicare capital margins have made the transition to CAH status.

However, it remains to be seen whether this trend in inpatient Medicare capital margins

will continue as the relative numbers of CAHs and rural hospitals subject to the IPPS

stabilize. We believe that the low aggregate margin for nonteaching hospitals is largely a

function of the effect of the low, and for some years even negative, margin of the rural

hospitals, as discussed earlier.

As we also discussed in the proposed rule, there could be a number of reasons for the relatively high margins that most IPPS hospitals have realized under the capital IPPS. One possibility is that the updates to the capital IPPS rates have been higher than the actual increases in Medicare inpatient capital costs that hospitals have experienced in recent years. As we discuss in section III. of the Addendum to this final rule with comment period, we update the capital standard Federal rate 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. Under the framework that we have been using, we had proposed an update factor of 0.8 percent for FY 2008.

The final update factor for FY 2008 is 0.9 percent, based on the best data available at this time. That update factor is derived from a projected 1.3 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a -0.4 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We discuss this update framework, and the computation of the policy adjustment factors, in section III. of the Addendum to this final rule with comment period.

We continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also believe that the update framework successfully captures several factors that should be taken into account in determining appropriate updates for hospitals subject to the capital IPPS. However,

there may be factors affecting the rate-of-increase in capital costs that are not yet

captured in our analytical framework. For example, hospitals may be experiencing

productivity gains in their use of capital equipment. As productivity increases, hospitals

would be able to reduce the number of inputs required to produce a unit of service.

MedPAC has taken the position that the payment "rate for health care providers should be

set so that the Federal Government benefits from providers' productivity gains, just as

private purchasers of goods in competitive markets benefit from the productivity gains of

their suppliers." MedPAC has, therefore, included a productivity improvement target in

its framework for updating Medicare hospital payments on the grounds that "as a prudent

purchaser, Medicare should also require some productivity gains each year from its

providers." (MedPAC, Report to Congress, March 2006, p. 66) While we have not as

yet included a specific productivity factor, such as MedPAC's productivity improvement

target, in our analytical frameworks for updating the IPPS payment rates, we will

continue to study the appropriateness of adopting such a measure.

As we discussed in the proposed rule, another possible reason for the relatively

high margins of most capital IPPS hospitals may be that the payment adjustments

provided under the system are too high, or perhaps even unnecessary. Specifically, the

adjustments for teaching hospitals, disproportionate share hospitals, and large urban

hospitals appear to be contributing to excessive payment levels for these classes of

hospitals. Since the inception of the capital IPPS in FY 1992, the system has provided

adjustments for teaching hospitals (the IME adjustment factor, under §412.322 of the

regulations), disproportionate share hospitals (the DSH adjustment factor, under

§412.320), and large urban hospitals (the large urban location adjustment factor, under

§412.316(b)). The classes of hospitals eligible for these adjustments have been realizing

much higher margins than other hospitals under the system. Specifically, teaching

hospitals (11.6 percent for FYs 1998 through 2004), urban hospitals (8.3 percent), and

disproportionate share hospitals (8.4 percent) have significant positive margins. Other

classes of hospitals have experienced much lower margins, especially rural hospitals

(0.3 percent for FYs 1998 through 2004) and nonteaching hospitals (1.3 percent). The

three groups of hospitals that have been realizing especially high margins under the

capital IPPS are, therefore, classes of hospitals that are eligible to receive one or more

specific payment adjustment under the system.   We believe that the evidence indicates

that these adjustments have been contributing to the significantly large positive margins

experienced by the classes of hospitals eligible for these adjustments.

In the proposed rule, we therefore determined that the data on inpatient hospital

Medicare capital margins, as discussed above, provided sufficient evidence that some

adjustment of the updates under the capital IPPS was warranted at that time. In light of

the significant disparities in the margin performances of different classes of hospitals, we

did not believe at that time that an adjustment to the updates for FYs 2008 and 2009

should apply equally to all hospitals that are paid under the capital IPPS. In particular,

we believed that an adjustment to the updates should take into account the much lower

margins of rural hospitals (0.3 percent for the period from FY 1998 through FY 2004)

compared to urban hospitals (8.3 percent during that period). We also believed that any

initial adjustment to the rate should be relatively modest. One reason was that any

adjustment should avoid unwarranted disruption to hospital finances: because of the

nature of capital spending, long periods of time can be necessary for hospitals to adjust

adequately to significant changes in payment. Therefore, in the FY 2008 IPPS proposed

rule (72 FR 24822), for FYs 2008 and 2009 we proposed that the update to the capital

standard Federal rate for urban hospitals would be 0.0 percent, in place of the 0.8 percent

update that would have otherwise been provided in FY 2008 under the update framework

that we have been employing. (As discussed above, the final update to the capital

standard Federal rate under the capital update framework is 0.9 percent.) However, in

light of the margin analysis, we also proposed to give rural hospitals the full 0.8 percent

update determined by the update framework in FY 2008. We anticipated that we would

provide the full update only to rural hospitals in FY 2009 as well, once we had

determined what the update would be under the update framework. We proposed to

revise §412.308(c)(1) of the regulations accordingly. For purposes of the update in

FYs 2008 and 2009, we proposed that an urban hospital is any hospital located in an area

that meets the definitions under §412.64(b)(1)(ii)(A) or (b)(1)(ii)(B), or §412.64(b)(3). A

rural hospital is any hospital that does not meet those definitions, or that is reclassified as

rural under §412.103. For subsequent years, we stated that we would continue to

analyze the data concerning the adequacy of payments under the capital IPPS, and that

we may propose additional adjustments, positive or negative, as they were warranted.

We also stated that we would continue to study our update framework and to consider

whether adoption of additional or revised adjustments to account for other factors

affecting capital cost changes may be warranted.

In addition, we also proposed to eliminate, for FYs 2008 and beyond, one of the

payment adjustments that has been provided under the capital IPPS. Specifically, we

proposed to discontinue the 3.0 percent additional payment that has been provided to

hospitals located in large urban areas. In proposing to eliminate this adjustment, we cited

the consistent and significant positive margin of hospitals located in urban areas as strong

evidence that it was not necessary to continue this adjustment. Therefore, we proposed to

amend §412.316(b) of the regulations to provide that, effective for discharges on or after

October 1, 2007, there will no longer be any additional payment for hospitals located in

large urban areas, as currently provided under that section. When the payment

adjustments were instituted at the inception of the program, the initial standard Federal

payment rate was adjusted in a budget-neutral fashion to account for the expenditures that

would be required by these adjustments. However, in light of the strong overall positive

margins across the system, we proposed not to increase the standard capital rate to

account for expenditures otherwise payable due to this adjustment (approximately $147

million). Rather, in light of the excessive capital IPPS payments over the period of

FYs 1996 through 2004, we believed that it was appropriate for the program to realize

savings from this policy decision.

While we formally proposed an update of 0.0 percent for urban hospitals, an

update of 0.8 percent for rural hospitals in FY 2008, and elimination of the large urban

add-on payments, we also solicited public comment on additional adjustments to the

capital payment structure. As we noted in the proposed rule, the margin analysis

indicated that several classes of hospitals have experienced continuous, significant

positive margins. The analysis indicated that the existing payment adjustments for teaching hospitals and disproportionate share hospitals were contributing to excessive payment levels for these classes of hospitals. Therefore, we stated that it may be appropriate to reduce these adjustments significantly, or even to eliminate them altogether, within the capital IPPS. These payment adjustments, unlike the parallel adjustments under the operating IPPS, were not mandated by the Act. Rather, they were included within the original design of the capital IPPS under the Secretary's broad authority under sections 1886(g)(1)(A) and (g)(1)(B) of the Act to include appropriate adjustments and exceptions within a capital IPPS. We noted that it is difficult to justify indefinite continuation of these adjustments in the light of the continuous, substantial positive margins realized by the classes of hospitals that qualify for them. When the payment adjustments were instituted at the inception of the program, the initial standard Federal payment rate was adjusted in a budget-neutral fashion to account for the expenditures that would be required by these adjustments. Therefore, we indicated that we would also consider whether we should similarly adjust the Federal capital payment rate to account for all or a portion of these adjustments, effectively increasing the base payment rate for all hospitals (including rural, nonteaching, and non-DSH hospitals that do not benefit from these adjustments), while removing these special adjustments for the hospitals that have been eligible to receive them. We also indicated that we were considering whether, in light of the substantial positive margins experienced by these teaching and DSH hospitals, the discontinuation of these adjustments should not result in a change to the standard capital rate and should instead result in savings to the program.

We invited comments on these proposals and on other means of appropriately adjusting

and targeting payments under the capital IPPS, as well as on the proposals that we

formally made in the FY 2008 IPPS proposed rule.

     <u>Comment</u>: Numerous commenters addressed our proposals to eliminate the large

urban add-on and to provide a differential update to urban and rural hospitals for 2 years.

Many commenters also addressed our discussion about the possibility of significantly

reducing or eliminating the existing payment adjustments for teaching hospitals and DSH

adjustments within the capital IPPS. Commenters included numerous individual

hospitals, hospital associations, and MedPAC.

     Commenters from the hospital industry were strongly opposed to our proposals to

eliminate the large urban add-on and to provide a differential update to urban and rural

hospitals for 2 years. Many commenters contended that such reductions in capital

payments should not be made without explicit authorization from Congress. Many

commenters also objected that the proposals violated fundamental principles of the

capital IPPS. Specifically, many commenters asserted that the positive margins reflected

the operation of one such fundamental principle, that by responding to the incentives of

prospective payment, providers should be able to gain from conducting their operations

efficiently. Many of these commenters further contended that the proposals do not take

sufficient account of the cyclical nature of capital spending. These commenters pointed

out that, under the design of the capital IPPS, hospitals were expected to reserve capital

funds in anticipation of future capital needs, similar to how funded depreciation reserves

had been used under the prior cost reimbursement system. These funds would permit

future capital investment to be funded in part with equity financing rather than borrowing. Thus, it is only to be expected that hospitals would run positive margins during one phase of the capital cycle. Some regional hospital associations provided evidence intended to demonstrate that their hospitals have been experiencing positive margins because they are in a low-spending phase of their capital cycles. For example, one association representing a major metropolitan area submitted an extensive analysis, including data on margins and changes in unit cost and price, suggesting that its member hospitals are in a lower-spending phase of their capital cycle than other hospitals may be. Other commenters contended that, in order to account adequately for the capital spending cycle, it would be necessary to conduct an analysis over a much longer period, such as 20 years.

Some commenters contended that the capital IPPS is not a separate payment system but should be considered only part of a broader IPPS embracing both capital and operating payments. These commenters further maintained that the proposed reductions in capital IPPS payments are unwarranted in the light of the negative operating IPPS margins for hospitals in recent years. Several commenters pointed out that the combined operating and capital margin for IPPS hospitals was zero in FY 2004. Other commenters similarly noted that MedPAC estimates an overall hospital Medicare margin in 2007 of negative 5.4 percent. Other commenters pointed out that, even considering capital IPPS margins alone, the trend in recent years has been for the margins to decrease. Many commenters suggested that the proposed reductions could cause serious financial hardships for many hospitals and produce a very negative impact upon the addition and

dissemination of newer technologies, health information systems, electronic health

records and scanning devices that are a critical part of healthcare delivery systems and

improvements to enhance patient safety and quality of care. A number of commenters

objected that the cuts would make it much more difficult for hospitals to undertake the

capital improvements required by various state mandates, as well as the adoption of the

information technologies encouraged by various Federal initiatives.

At the same time, many commenters from the hospital industry objected to

employing margin analysis at all as the basis for the proposals, or for the possible

revisions that we discussed to the other capital IPPS payment adjustments. These

commenters contended that revisions to the payment adjustments should not be

considered without updating the regression analyses that were employed originally to

establish these adjustments. Furthermore, most of these commenters maintained that it

would only be appropriate to employ total costs regressions, as opposed to capital

cost-only regressions, in these analyses. Commenters advocated using total cost

regressions on the grounds that doing so would follow precedent (the analysis that

supported the original establishment of the adjustments employed total cost regressions),

and would be consistent with treating the capital IPPS as intrinsically part of a broader

IPPS embracing both capital and operating payments.

Other commenters raised technical issues suggesting that the positive margins in

our analysis were not representative of actual capital costs. Several commenters

contended that the margins may be overstated because many cost reports, especially for

the years 2003 and 2004, have not yet been audited and/or settled. One commenter

suggested that the margins could be overstated because of a large backlog of appeals at the PRRB. According to the commenter, the comparison of the hospitals' capital costs from the cost report could be grossly understated, yielding an inflated margin. Another commenter contended that the elimination of the loss on recapture amount by the BBA of 1997 is skewing the calculation of the capital margins, which therefore should not be the basis for our proposals.

MedPAC supported the proposal to eliminate the large urban add-on adjustment starting in FY 2008. MedPAC noted that Congress equalized the base rates of urban and rural hospitals under the operating IPPS in the MMA, and that eliminating the 3 percent add-on for large urban hospitals under the capital IPPS will similarly contribute to equalizing the capital base rates. MedPAC cited the fact that urban and rural hospitals' overall Medicare margins, reflecting both operating and capital inpatient payments along with payments for outpatient and hospital-based post-acute services, are roughly equal. However, MedPAC opposed the proposal for different updates for urban and rural hospitals on the grounds that such a differential update is inconsistent with the direction of policy for the acute care IPPS that we proposed to follow in eliminating the large urban add-on. MedPAC noted that, while eliminating the large urban adjustment would contribute to equalizing the base rates for urban and rural hospitals, differential updates would then reintroduce separate base rates. MedPAC recommended that we should use the update framework to determine the appropriate update for capital payments and then apply that update to all capital IPPS hospitals. MedPAC also recommended that we should seriously reexamine the appropriateness of the current capital IME adjustment. In

its March 2007 Report to the Congress, MedPAC recommended (based on an analysis of

operating and capital costs combined) that the operating IME adjustment be reduced from

5.5 percent to 4.5 percent per 10 percent increment of teaching intensity. MedPAC

therefore indicated that some reduction in the capital IME adjustment would be consistent

with its finding that the IME adjustment is set too high.

Response: We do not agree with those commenters who argued that we lack the

authority to adopt measures such as those we proposed without specific authorization

from Congress. While the statute governs the operating IPPS in highly prescriptive detail

(section 1886(d) of the Act), the statutory provision governing the capital IPPS (section

1886(g) of the Act) prescribes only several broad governing principles and otherwise

provides the Secretary with broad discretion to design and modify the system within

those principles. The statute does not limit the Secretary's authority to update rates and

gives the Secretary broad discretion to provide for exceptions. It is true that Congress

has, on two occasions, adjusted the rate as originally established and updated by the

Secretary. However, we do not believe that such action precludes the Secretary from

exercising the discretionary authority otherwise conferred by the statute to make similar

revisions to the rates and the adjustments that have been established to account for

appropriate variations in costs among classes of hospitals.

We do not agree with many of the criticisms of our analysis and the conclusions

that we drew from that analysis. We agree that a basic principle of prospective payment

systems is that efficient providers should be able to realize positive margins from the

payment structure. However, prospective payment systems are generally designed to pay

at rates reflecting the costs of hospitals at average levels of efficiency. Under such a

system, hospitals of above average efficiency would be expected to realize positive

margins, while hospitals of less than average efficiency would be expected to realize

negative margins. Therefore, the continuation of significant positive margins across a

prospective payment system as a whole (or across classes of hospitals that receive

specific adjustments) is an indication that the payment rates (or the adjustments to the

rates) may be set at a level higher than necessary to cover the costs of efficient operation.

Under such circumstances, we believe that it is appropriate to revise basic payment rates

or payment adjustments, or both, to account for such evidence.

        We also do not agree that, in this context, the capital IPPS should be treated as a

component of a larger payment system, embracing both the capital and operating IPPSs.

As we have just discussed, the statute governs the operating IPPS in highly prescriptive

detail, while the statutory provision governing the capital IPPS provides the Secretary

with very broad discretion (within certain governing principles) to design and modify the

system. Most especially, the statute specifically defines both the types of adjustments

and the formulas for those adjustments under the operating IPPS. However, it gives the

Secretary broad authority in providing for appropriate adjustments and exceptions under

the capital IPPS. Furthermore, while we adopted approaches on several issues in the

development of the capital IPPS that were based on the premise that the capital and

operating IPPSs might eventually be merged into one system, the two systems have now

operated separately for 15 years without any apparent prospect of integration in the near

future. Therefore, we believe that it is appropriate under the current design of the capital

and operating IPPSs to base proposals for payment policies under the capital IPPS on

analysis that is confined to the data regarding the capital IPPS alone, and that total IPPS

margins should not be the controlling factor in the analysis that we are now conducting.

For this same reason, we do not agree with commenters who urged us to employ updated

versions of the total cost regressions that were originally used to establish the payment

adjustments under the capital IPPS. In the long run, we believe that it makes sense to

base capital payment adjustments on total cost variations only if similar adjustments

under the operating IPPS are also based on total cost regression analysis.

We agree with commenters that the capital spending of hospitals tends to occur in

cycles, with periods of higher capital investment followed by periods in which capital

spending tends to be lower. As some of the commenters noted, we devoted considerable

attention to the potential implications of this capital cycle in developing the original

design of the capital IPPS. At that time, we decided not to build any specific feature into

the system to account for capital cycles, on the grounds that hospitals ought to be able to

manage their spending on the basis of the predetermined rates and adjustments under the

capital IPPS, conserving funds during lower spending portions (and often high interest

rate periods) of the cycle in order to prepare for necessary capital expenditures later. We

do not agree with those commenters who suggested that the existence of a capital

spending cycle accounts for the persistently high margins for some classes of hospitals

that we have observed over the period 1996 through 2004 nationally. There is no reason

to suppose that there would be uniformity or regularity among hospitals in the length of

time between major capital expenditures or the overall pattern of capital spending. To

the degree that a capital cycle exists, it reflects the pattern of spending in individual

hospitals or, in some cases, groups of hospitals where the pattern of spending is

determined by factors such as common ownership, local regulation, or other factors.

There is no uniform or regular capital cycle across IPPS hospitals generally or large

classes of hospitals (for example, teaching hospitals) nationally. In any given year, the

margins of hospitals generally, and of large classes of hospitals defined nationally, would

reflect the experience of many hospitals in the lower spending portions of their capital

cycles, and many other hospitals in the higher spending portions of their capital cycles.

Therefore, the existence of the persistent positive margins that we identified cannot be

explained on the basis of a "capital cycle." For the same reasons, we do not believe that

it is necessary to conduct an analysis of a period of 20 or more years, as suggested by

some commenters, in order to account fully for the existence of a capital cycle.

We are also not persuaded by the technical objections that some commenters raise

to the margin analysis. We have examined the settlement and audit status of cost reports

over the period of our analysis and found a normal and expected pattern. Specifically,

the data from more recent years (especially 2004 and 2005) reflect more cost reports that

have been submitted but not yet settled, and fewer cost reports that have been settled with

audit or subjected to reopening and amendment. Conversely, many more cost reports

from the earlier part of the period we examined (especially those from 2002 and earlier)

have been settled, settled with audit, or reopened and amended. While this analysis

suggests that, as is to be expected, the margin data for the last 2 or 3 years of our analysis

may be subject to some change as more cost reports are audited and settled, we do not

believe that this normal pattern of activity has any significant implications for the validity of our analysis. The general pattern is for settlement and audit activity to reduce, not to increase, the levels of capital and other costs claimed by hospitals on their cost reports. Therefore, we believe that the comparatively lower positive margins of more recent years noted by some commenters are likely, if anything, to be understated compared to the margins that the data will indicate once more of those years' cost reports are audited and settled.

We also do not agree with the commenter who suggested that the margins are skewed by the elimination of the provision to recognize losses or gains on sales. Prior to the BBA of 1997, the Medicare program recognized losses or gains on sales of capital assets in relation to the depreciation that the program for which the program paid under the cost-based payment system. Depreciation payments for the years prior to a sale were accordingly adjusted in the cost report submitted for the year of the sale: an additional payment was made for Medicare's portion of the depreciation on the asset if the hospital experienced a loss on the sale (indicating that prior payments for depreciation had been too low). Conversely, a portion of Medicare's payments for the depreciation of the asset was recaptured (by means of reducing payments to the hospital) in case of a gain on the sale (indicating that prior payments for depreciation had been too high). The BBA of 1997 eliminated recognition of such gains and losses on sales under Medicare's cost accounting rules, effective December 1, 1997. In the light of the congressional elimination of this provision, we do not believe that it would be appropriate (even if it were possible) to take any account of the possible effects of this provision on the margin

data that we have analyzed. It is worth noting, however, that elimination of the provision

to account for gains and losses on sales does not necessarily "skew" the margin data in

the manner suggested by the commenter. Because the provision operated both to increase

to account for losses on sales, and to decrease payments to account for gains on sales, the

overall effect of the provision would not necessarily be (as implied by the commenter) to

reduce the positive margins that are evident in the data.

Furthermore, we do not believe that a backlog of cases at the PRRB would have a

material effect on the level of the margins observed in our analysis. Cases such as those

described by the commenter would be taken to the PRRB when reasonable cost

determinations have an effect on actual payment amounts. Reasonable cost payments for

capital have been a declining factor since the beginning of the capital IPPS transition in

FY 1992. Cost payments declined steadily through the transition period, and since the

end of the transition reasonable cost payments have been limited to a restricted number of

exceptions (for example, new hospitals, extraordinary circumstances, and some large

capital projects).

We agree with MedPAC that eliminating the large urban add-on adjustment,

starting in FY 2008, is warranted. We also agree with MedPAC that following the

statutory precedent toward equalizing the base rates of urban and rural hospitals under the

IPPS provides sufficient rationale for eliminating this adjustment. Therefore, we are

finalizing our proposal to eliminate this adjustment in this final rule with comment

period. In light of the strong overall positive margins across the system, we proposed not

to increase the standard capital rate to account for expenditures otherwise payable due to

this adjustment (approximately $147 million). Rather, in light of the excessive capital

IPPS payments over the period of FYs 1996 through 2004, we continue to believe that

such an increase to the standard capital rate is not appropriate.

We also agree with MedPAC that our proposal for a differential update for urban

and rural hospitals during FYs 2008 and 2009 is not entirely consistent with this direction

of policy for the capital and operating IPPSs. As MedPAC noted, eliminating the large

urban add-on would complete the process of equalizing the base rates of urban and rural

hospitals, but our proposal for differential updates would then reintroduce separate base

rates. Therefore, we have decided not to finalize that proposal in this final rule with

comment period.

We also appreciate MedPAC's recommendation that we should seriously

reexamine the appropriateness of the current capital IME adjustment. As we noted in the

proposed rule, the margin analysis suggested that this adjustment may be too high.

MedPAC's previous analysis had also suggested that the adjustment may be too high. In

light of MedPAC's comment, we extended the analysis that we discussed in the proposed

rule, especially to distinguish the experience of teaching hospitals from the experience of

urban and rural hospitals generally. Specifically, in addition to the categories of hospitals

that we examined in the proposed rule, we also examined the margins of urban, large

urban, and rural teaching hospitals, as opposed to urban, large urban, and rural

nonteaching hospitals. In conducting this analysis, we were able to employ updated cost

report information, and this updated information allowed us to incorporate the margins

for an additional year, FY 2005, into the analysis. The results, for the categories of

hospitals that had already been considered in the proposed rule, were very consistent with

the previous data. However, the data on the experience of urban, large urban, and rural

teaching and nonteaching hospitals provided significant new information, especially in

light of MedPAC's recommendation. We reproduce the table showing the new results

below.

HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996-2005	Aggregate 1998-2005 (excluding 1996 and 1997)
U.S.	17.6	13.4	7.0	6.8	7.3	8.1	8.7	7.6	5.3	3.7	8.5	6.8
URBAN	17.7	13.8	7.8	7.5	8.4	9.2	10.3	9.0	6.4	4.8	9.4	7.9
RURAL	16.8	11.0	2.1	2.4	1.0	1.5	-1.7	-1.4	-2.3	-4.2	2.6	-0.4
No DSH Payments	16.2	11.7	4.2	4.3	5.6	5.5	4.7	4.4	-1.3	-4.7	5.9	3.2
Has DSH Payments	18.5	14.4	8.6	8.1	8.2	9.0	10.0	8.5	7.0	5.9	9.5	8.1
$1-$249,999	14.5	12.9	-0.4	3.1	1.6	4.1	3.2	1.4	-1.7	-4.8	3.2	1.9
$250,000-$999,999	15.5	9.0	2.3	1.6	2.8	2.7	-2.4	-1.5	-4.3	-7.3	1.5	-0.9
$1,000,000-$2,999,999	16.8	13.0	8.7	9.0	8.7	7.0	10.1	5.2	3.2	2.0	8.2	6.6
$3,000,000 or more	20.3	16.6	10.4	9.3	9.7	12.1	13.2	12.5	10.6	9.5	12.2	11.0
TEACHING	19.5	15.7	9.8	9.7	11.2	12.1	13.8	13.2	11.7	10.6	12.7	11.6
Urban	19.7	15.9	10.2	10.0	11.4	12.5	14.0	13.6	11.9	10.9	13.0	11.9
Large Urban	20.5	16.8	11.0	10.1	12.5	13.9	15.2	14.7	12.0	11.9	13.9	12.8
Rural	13.9	8.5	1.0	2.9	5.8	3.2	8.2	4.7	5.7	4.0	5.7	4.5
NON-TEACHING	15.3	10.5	3.4	2.8	2.2	2.6	1.7	0.0	-3.2	-5.1	2.8	0.3
Urban	14.4	10.1	3.8	3.0	3.0	3.1	3.6	0.9	-2.9	-4.9	3.1	0.9
Large Urban	15.5	11.3	6.2	6.1	5.7	5.2	5.3	1.7	-0.9	-3.2	5.1	2.9
Rural	17.3	11.4	2.3	2.4	0.2	1.2	-3.7	-2.6	-3.9	-6.0	2.0	-1.3
Census Division												
New England (1)	27.9	25.9	17.1	15.1	18.2	20.7	21.3	21.1	20.5	20.3	21.0	19.5
Middle Atlantic (2)	19.1	15.5	11.1	11.6	14.1	16.5	18.7	18.0	14.7	16.0	15.6	15.2

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996-2005	Aggregate 1998-2005 (excluding 1996 and 1997)
South Atlantic (3)	18.1	13.9	5.9	4.0	6.0	5.0	6.6	6.9	5.8	2.8	7.4	5.4
East North Central (4)	18.2	12.7	6.4	7.1	8.8	8.5	6.1	7.1	6.6	3.2	8.4	6.7
East South Central (5)	14.9	11.1	3.3	4.1	3.8	3.8	3.8	-0.9	-3.4	-5.8	3.2	0.9
West North Central (6)	14.3	7.0	0.1	-0.3	-1.5	2.0	1.9	3.4	1.6	-0.4	2.8	0.9
West South Central (7)	13.2	8.3	3.3	2.6	-0.7	0.0	1.2	-2.0	-4.0	-6.5	1.2	-1.0
Mountain (8)	17.2	14.7	8.5	7.7	7.2	6.4	2.9	3.3	0.8	-4.7	5.8	3.6
Pacific (9)	20.4	16.1	12.3	11.3	11.9	13.3	14.7	12.1	9.8	8.8	13.0	11.7
Code 99	23.7	24.1	14.5	16.8	19.8	20.7	20.5	25.1	21.6	24.8	21.4	20.8
Bed Size												
< 100 beds	17.7	13.0	4.6	3.5	2.7	2.5	-1.8	-1.2	-6.1	-9.6	2.0	-0.9
100-249 beds	15.1	10.5	3.7	4.5	4.3	6.1	6.0	4.2	1.5	0.8	5.6	3.8
250-499 beds	18.9	14.1	8.9	8.3	10.6	10.7	12.1	11.6	10.3	7.7	11.4	10.1
500-999 beds	19.9	17.1	10.7	10.4	11.3	10.8	12.6	10.1	7.3	7.8	11.6	10.1
>= 1000 beds	8.2	14.0	2.2	-1.3	-6.6	-3.6	6.5	8.1	6.5	2.1	3.5	2.3

Notes:
Based on Medicare Cost Report hospital data updated as of the 1st quarter of 2007.
Medicare payments are from Worksheet E, Part A, Lines 9 and 10.
Expenses are from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8.
We apply the outlier trimming methodology developed with MedPAC.
Code 99 applies when census division information was not specified in the Medicare Cost Report hospital data.

As the table indicates, teaching hospitals in each class have been performing significantly better than comparable nonteaching hospitals. For the period FYs 1998 through 2005, urban teaching hospitals have realized an aggregate positive margin of 11.6 percent, compared to a positive margin of 0.9 percent for urban nonteaching hospitals. Similarly, large urban teaching hospitals have realized an aggregate positive margin of 12.8 percent during that period, while large urban nonteaching hospitals have an aggregate positive margin of only 2.9 percent. There is a similar pattern among rural teaching and nonteaching hospitals, although at lower margin levels. Rural teaching hospitals have experienced an aggregate positive margin over the period FYs 1998 through 2005 of 4.5 percent, while rural nonteaching hospitals have an aggregate negative margin of -1.3 percent. Significantly, the positive margins for teaching hospitals do not exhibit decline to the same degree that many commenters observed in the margins for all hospitals, as well the classes of urban hospitals and rural hospitals, under the capital IPPS. The positive margin among all IPPS hospitals declined from 8.7 percent in FY 2002 to 5.3 percent in FY 2004 and 3.7 percent in FY 2005. Similarly, the aggregate margin for urban hospitals declined from 10.3 percent in FY 2002 to 6.4 percent in FY 2004 and 4.8 percent in FY 2005. The aggregate margin for rural hospitals declined from a positive margin of 1.5 percent in FY 2001 to a negative margin, -4.2 percent, in FY 2005. However, the aggregate margin for teaching hospitals was 12.1 percent in FY 2001 and 10.6 percent in FY 2005. Urban teaching hospitals experienced margins of 12.5 percent in FY 2001, 14.0 percent in FY 2002, 13.6 percent in FY 2003, 11.9 percent in FY 2004, and 10.9 percent in FY 2005. The margins for rural teaching hospitals have

shown greater variation, but still do not exhibit a pattern of significant decline. Rural

teaching hospitals had positive margins of 3.2 percent in FY 2001, 8.2 percent in

FY 2002, 4.7 percent in FY 2003, 5.7 percent in FY 2004, and 4.0 percent in FY 2005.

As we stated in the proposed rule, the statutory history of the capital IPPS

suggests that the system in the aggregate should not provide for continuous, large positive

margins. As we also indicated, a possible reason for the relatively high margins of many

capital IPPS hospitals may be that the payment adjustments provided under the system

are too high, or perhaps even unnecessary. As we stated above, we agree with

MedPAC's recommendation that the appropriateness of the teaching adjustment should

be seriously reexamined. We believe that the record of relatively high and persistent

positive margins for teaching hospitals under the capital IPPS indicates that the current

teaching adjustment is unnecessary, and that it is therefore appropriate to exercise our

discretion under the capital IPPS to eliminate this adjustment. At the same time, we

believe we should mitigate abrupt changes in payment policy and to provide time for

hospitals to adjust to changes in the payments that they can expect under the program.

Therefore, we are adopting the following policy in this final rule with comment period.

We will phase out the adjustment over a 3-year period beginning in FY 2008.

Specifically, we will maintain the current adjustment for FY 2008, in order to give

teaching hospitals an opportunity to plan and make adjustments to the change. During

the second year of the transition, FY 2009, the formula for determining the amount of the

teaching adjustment will be revised so that adjustment amounts will be half of the

amounts provided under the current formula. For FY 2010 and after, hospitals will no

longer receive an adjustment for teaching activity under the capital IPPS. As discussed

previously, in implementing the capital IPPS Congress has in fact mandated that

payments in the aggregate not exceed 90 percent of Medicare inpatient capital costs. For

this reason, and in light of the generally positive margins experienced by virtually all

categories of hospitals under the capital IPPS, we believe that it is not necessary to

increase the standard Federal capital rate to account for this change in payment policy.

While we are formally adopting this final policy in this final rule with comment

period, we believe that this change to the structure of payments under the capital IPPS is

significant enough that it could be valuable to provide the public with an opportunity for

further comment. Therefore, we will accept comments on the policy that we are

adopting, to phase out the capital IPPS teaching adjustment over a 3-year period, with a

50-percent reduction beginning in FY 2009. We will accept public comments on this

final policy for 90 days after the date of publication of this final rule with comment

period. In addition, we will provide additional opportunity for public comment during

the FY 2009 proposed rulemaking cycle for the IPPS. We intend to respond to all

comments that we receive on this final policy during this period in the FY 2009 final rule

for the IPPS. We believe that this will provide a more than adequate opportunity for

hospitals, associations, and other interested parties to raise issues and concerns related to

this final policy.

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

A. 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.) In the FY 2008 IPPS proposed rule, we proposed that the

percentage increase in the rate of increase limits for cancer and children's hospitals and

RNHCIs would be the percentage increase in the FY 2008 IPPS operating market basket,

then estimated to be 3.3 percent. Consistent with our historical approach, if more recent

data are available for the final rule, we use it to calculate the IPPS operating market

basket. For this final rule with comment period, we have calculated the IPPS operating

market basket for FY 2008 using the most recent data available. For cancer and

children's hospitals and RNHCIs, the FY 2008 rate-of-increase percentage that is applied

to FY 2007 target amounts in order to calculate FY 2008 target amounts 3.3 percent,

based on Global Insight, Inc.'s 2007 second quarter forecast of the IPPS operating market

basket increase, in accordance with the applicable regulations in 42 CFR 413.40.

IRFs, IPFs, and LTCHs were paid previously under the reasonable cost

methodology. However, the statute was amended to provide for the implementation of

prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective

payment systems for IRFs, IPFs, and LTCHs provide transition periods of varying

lengths during which time a portion of the prospective payment is based on cost-based

reimbursement rules under Part 413 (certain providers do not receive a transition period

or may elect to bypass the transition period as applicable under 42 CFR Part 412,

Subparts N, O, and P). We note that the various transition periods provided for under the

IRF PPS, IPF PPS, and LTCH PPS have ended or will soon end.

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid

100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting

periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is

subject to 42 CFR Part 413. Similarly, for cost reporting periods beginning on or after

October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal Rate under the

LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006,

no portion of the LTCH PPS payment is subject to 42 CFR Part 413. (We note that, to

the extent a portion of a LTCH's PPS payment was subject to reasonable cost principles,

the Secretary utilized his broad authority under section 123 of the BBRA, as amended by

section 307 of the BIPA, to make such portion subject to 42 CFR Part 413 and various

provisions in section 1886(b) of the Act.) However, except as provided in §412.426(c),

IPFs remain under a blended methodology for cost reporting periods beginning on or

after January 1, 2005, and before January 1, 2008.

Under the broad authority conferred upon the Secretary in section 124(a)(1) of the

BBRA, the Secretary provided that, for IPFs paid under the blended methodology, the

portion of the IPF PPS payment that is based on reasonable cost principles is subject to

the provisions of 42 CFR Part 413 and various provisions in section 1886(b) of the Act.

In order to calculate the portion of the PPS payment that is based on reasonable cost

principles, it is necessary to determine whether the IPF would be considered "existing"

for purposes of section 1886(b)(3)(H) of the Act or "new" for purposes of

section 1886(b)(7) of the Act. We note that readers should not confuse an IPF that is

considered "new" for purposes of section 1886(b)(7) of the Act and §413.40(f)(2)(ii) of

the regulations with an IPF that is considered "new" under §412.426(c) of the

regulations. Any IPF that, under present or previous ownership or both, has its first cost

reporting period as an IPF beginning on or after January 1, 2005, is considered "new" for

purposes of §412.426(c). An IPF that is considered "new" under §412.426(c) is paid

based on 100 percent of the Federal per diem payment amount. Consequently, only those

IPFs considered "new" under section 1886(b)(7) of the Act, but not "new" under

§412.426(c) of the regulations will be paid under a PPS blended payment methodology.

An IPF considered "new" for purposes of §413.40(f)(2)(ii) would have its "reasonable-cost based" portion of its prospective payment subject to the provisions of §§413.40(f)(2)(ii) and 413.40(c)(4)(v), as applicable. An IPF considered "new" for purposes of section 1886(b)(7) of the Act has the target amount for its third cost reporting period determined in accordance with sections 1886(b)(7)(A)(ii) and 1886(b)(3)(A)(ii) of the Act. For the fourth and subsequent cost reporting periods, the target amount is calculated in accordance with section 1886(b)(3)(A)(ii) of the Act. An IPF that would be considered "existing" for purposes of section 1886(b)(3)(H) of the Act has the target amount for the "reasonable-cost based" portion of its prospective payment determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at §413.40(c)(4)(ii).

In the FY 2008 IPPS proposed rule (72 FR 24823), the applicable percentage increase to update the target amount for the reasonable cost-based portion of the PPS payment of an IPF that is considered "existing" under section 1886(b)(3)(H) of the Act or "new" under section 1886(b)(7) of the Act, but not "new" under §412.426(c), was 3.4 percent. However, we noted that if more current data became available prior to publication of the final rule, we would use those data for updating the market basket. Based on more current data, the applicable percentage increase to update the target amount for the reasonable cost-based portion of the PPS payment of an IPF that is considered "existing" under section 1886(b)(3)(H) of the Act or "new" under section 1886(b)(7) of the Act, but not "new" under §412.426(c), is 3.3 percent, based on Global

Insight, Inc.'s 2007 second quarter forecast of the excluded hospital market basket

increase, in accordance with the applicable regulations at 42 CFR 413.40.

We did not receive any public comments on this section of the proposed rule.

B. 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 blended methodology, to elect to be paid

the full Federal prospective payment rather than the transitional period payments

specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316)

establishing the PPS for IRFs, effective for cost reporting periods beginning on or after

January 1, 2002. There was a transition period for cost reporting periods beginning on or

after January 1, 2002, and ending before October 1, 2002. For cost reporting periods

beginning on or after October 1, 2002, payments are based entirely on the adjusted

Federal prospective payment rate determined under the IRF PPS.

C. Separate PPS for LTCHs

On August 30, 2002, we issued a final rule in the **Federal Register**

(67 FR 55954) establishing the PPS for LTCHs, effective for cost reporting periods

beginning on or after October 1, 2002. Except for a LTCH that made an election under

§412.533(c) or a LTCH that is defined as new under §412.23(e)(4), there was a transition

period for cost reporting periods beginning on or after October 1, 2002, and ending

before October 1, 2007. For cost reporting periods beginning on or after

October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

D. Separate PPS for IPFs

In accordance with section 124 of Pub. L. 106-113 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 requirements of 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 a PPS payment, a portion of

which is based on reasonable cost principles and a portion of the Federal per diem

payment amount. 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.

E. Determining LTCH Cost-to-Charge Ratios (CCRs) under the LTCH PPS

        In determining both high-cost outlier and short-stay outlier payments under the

LTCH PPS (at §§412.525(a) and 412.529, respectively), we calculate the estimated cost

of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges

for the case. (In general, we use the LTCH's overall CCR. In some instances we use an

alternative CCR, such as the statewide average CCR in accordance with the regulations at

§412.525(a)(4)(iv)(C) and §412.529(c)(3)(iv)(C), or a CCR that is specified by CMS or

that is requested by the hospital under the provisions of the regulations at

§412.525(a)(4)(iv)(A) and §412.529(c)(3)(iv)(A).) Under the LTCH PPS, a single

prospective payment per discharge is made for both inpatient operating and

capital-related costs. Therefore, we compute a single "overall" or "total" LTCH-specific

CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3,

section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100-4)) as

compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a

LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient

routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating

and capital inpatient routine and ancillary charges) (72 FR 48117).

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 outlier 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.

In the FY 2007 IPPS final rule (71 FR 48115 through 48122), we amended our

regulations and, for discharges occurring on or after October 1, 2006, refined the

methodology for determining the annual CCR ceiling and statewide average CCRs for

LTCHs. We also codified, with modifications and editorial clarifications, our policy for

the reconciliation of high-cost outlier and short stay outlier payments under the LTCH

PPS. We indicated that because, historically, updates to the LTCH PPS CCR ceiling and

statewide average CCRs have been effective on October 1, we would make these updates

(and include relevant impact data) as a part of the IPPS rulemaking cycle.

Specifically, in the FY 2007 IPPS final rule (71 FR 48117 through 48121), under

the broad authority of section 123 of Pub. L. 106-113 and section 307(b)(1) of

Pub. L. 106-554, we established under the LTCH PPS high-cost outlier policy at

§412.525(a)(4)(iv)(C) and the LTCH PPS short-stay outlier policy at

§412.529(c)(3)(iv)(C), for discharges occurring on or after October 1, 2006, that the

fiscal intermediary (or, if applicable, the MAC) may use a statewide average CCR, which

is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH

in one of the following three circumstances: (1) 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); (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 (or,

if applicable, the MAC) may use to determine a LTCH's CCR instead of the statewide

average include data from a different cost reporting period for the LTCH, data from the

cost reporting period preceding the period in which the hospital began to be paid as a

LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care

hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in

the same region.)

As noted above, generally, a LTCH is assigned the applicable statewide average

CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable

maximum CCR threshold (that is, the LTCH CCR ceiling). As we explained in the

FY 2007 IPPS final rule (71 FR 48117), CCRs above this threshold are most likely due to

faulty data reporting or entry, and, therefore, these CCRs should not be used to identify

and make payments for outlier cases. Such data are clearly errors and should not be

relied upon. Thus, under our established policy, generally, if a LTCH's calculated CCR

is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is

assigned to the LTCH instead of the CCR computed from its most recent (settled or

tentatively settled) cost report data.

Under the broad authority of section 123 of Pub. L. 106-113 and section 307(b)(1)

of Pub. L. 106-554, we revised our methodology for determining the annual CCR ceiling

and statewide average CCRs under the LTCH PPS effective October 1, 2006, as we

explained in the FY 2007 IPPS final rule (71 FR 48117 through 48121), because we

believed that those changes were consistent with the LTCH PPS single payment rate for

inpatient operating and capital costs.

For discharges occurring on or after October 1, 2006, we established that the

LTCH CCR ceiling specified under §412.525(a)(4)(iv)(C)(2) for high-cost outliers and

under §412.529(c)(3)(iv)(C)(2) for short-stay outliers is calculated as 3 standard

deviations above the corresponding national geometric mean total CCR (established and

published annually by CMS). (The fiscal intermediary (or, if applicable, the MAC) may

use a statewide average CCR if, among other things, a LTCH's CCR is in excess of the

LTCH CCR ceiling.) The LTCH total CCR ceiling is 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 IPPS hospitals. (Our

rationale for using IPPS hospital data is discussed in the FY 2007 IPPS final rule

(71 FR 48117).) The LTCH CCR ceiling is then established at 3 standard deviations

from the corresponding national geometric mean total CCR. (For further detail on our

methodology for annually determining the LTCH CCR ceiling, we refer readers to the

FY 2007 IPPS final rule (71 FR 48117 through 48119).)

We also established that the LTCH "total" CCR ceiling used under the LTCH

PPS would continue to be published annually in the IPPS proposed and final rules, and

the public should continue to consult the annual IPPS proposed and final rules for

changes to the LTCH total CCR ceiling that would be effective for discharges occurring

on or after October 1 of each year. Accordingly, in the FY 2007 IPPS final rule

(71 FR 48119), we established a FY 2007 LTCH PPS total CCR ceiling of 1.321,

effective for discharges occurring on or after October 1, 2006, and before

October 1, 2007.

In the FY 2008 IPPS proposed rule, in accordance with §412.525(a)(4)(iv)(C)(2)

for high-cost outliers and §412.529(c)(3)(iv)(C)(2) for short-stay outliers, using our

established methodology for determining the LTCH total CCR ceiling (described above),

based on IPPS total CCR data from the December 2006 update to the Provider-Specific

File, we proposed a total CCR ceiling of 1.273 under the LTCH PPS that would be

effective October 1, 2007. Furthermore, in the FY 2008 IPPS proposed rule, we stated

that, if more recent data became available, we would use such data to determine the final

total CCR ceiling under the LTCH PPS for FY 2008 using our established methodology

described above. Based on the latest available data (data from the March 2007 update to

the Provider-Specific File), for this final rule with comment period the total CCR ceiling

of 1.284 under the LTCH PPS will be effective for discharges occurring on or after

October 1, 2007, and before October 1, 2008.

In addition, under the broad authority of section 123 of Pub. L. 106-113 and

section 307(b)(1) of Pub. L. 106-554, in the FY 2007 IPPS final rule (71 FR 48120), we

revised our methodology to determine the statewide average CCRs under

§412.525(a)(4)(iv)(C) for high-cost outliers and under §412.529(c)(3)(iv)(C) for short-

stay outliers for use under the LTCH PPS in a manner similar to the way we computed

the "total" CCR ceiling using IPPS CCR data. Specifically, we first calculated the total

(that is, operating and capital) CCR for each IPPS hospital. We then calculated the

weighted average "total" CCR for all IPPS hospitals in the rural areas of the State, and

the weighted average "total" CCR for all IPPS hospitals in the urban areas of the State.

(For further detail on our methodology for annually determining the LTCH urban and

rural statewide average CCRs, we refer readers to the FY 2007 IPPS final rule

(71 FR 48119 through 48121).) We also established that the applicable statewide average

"total" (operating and capital) CCRs used under the LTCH PPS would continue to be

published annually in the IPPS proposed and final rules, and the public should 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 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48122), the

FY 2007 LTCH PPS statewide average total CCRs for urban and rural hospitals, effective

for discharges occurring on or after October 1, 2006, and before October 1, 2007, were

presented in Table 8C of the Addendum of that final rule (71 FR 48303).

In the FY 2008 IPPS proposed rule, in accordance with §412.525(a)(4)(iv)(C) for

high-cost outliers and §412.529(c)(3)(iv)(C) for short-stay outliers, using our established

methodology for determining the LTCH statewide average CCRs (described above),

based on the most recent complete IPPS total CCR data from the December 2006 update

of the Provider-Specific File, we proposed LTCH PPS statewide average total CCRs for

urban and rural hospitals that would be effective for discharges occurring on or after

October 1, 2007, and before October 1, 2008, presented in Table 8C of the Addendum to

the proposed rule. Furthermore, in the FY 2008 IPPS proposed rule, we stated that, if

more recent data became available, we would use such data to determine the final

statewide average total CCRs for urban and rural hospitals under the LTCH PPS for

FY 2008 using our established methodology described above.

We did not receive any specific public comments on our proposal.

Based on the latest available data (data from the March 2007 update to the

Provider-Specific File), for this final rule with comment period, the LTCH PPS statewide

average total CCRs for urban and rural hospitals that will be effective for discharges

occurring on or after October 1, 2007, and before October 1, 2008, are presented in

Table 8C of the Addendum to this final rule with comment period. We note that, for this

final rule with comment period, consistent with the proposed rule, as we established

when we revised our methodology for determining the applicable LTCH statewide

average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121), and as is the

case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and

Rhode Island are classified as urban, and, therefore, there are no rural statewide average

total CCRs listed for those jurisdictions in Table 8C of the Addendum to this final rule

with comment period. In addition, as we established when we revised our methodology

for determining the applicable LTCH statewide average CCRs in that same final rule, and

as is the case under the IPPS, although Massachusetts has areas that are designated as

rural, there were no short-term acute care IPPS hospitals or LTCHs located in those areas

as of December 2006. Therefore, consistent with the proposed rule, for this final rule

with comment period there is no rural statewide average total CCR listed for rural

Massachusetts in Table 8C of the Addendum of this final rule with comment period. As

we also established when we revised our methodology for determining the applicable

LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through

48121), in determining the urban and rural statewide average total CCRs for Maryland

LTCHs paid under the LTCH PPS, we use, as a proxy, the national average total CCR for

urban IPPS hospitals and the national average total CCR for rural IPPS hospitals,

respectively. We use this proxy because we believe that the CCR data on the Provider-

Specific File for Maryland hospitals may not be accurate (as discussed in greater detail in

that same final rule (71 FR 48120)).

F. 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, generally, 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). If the hospital's operating costs are in excess

of the ceiling, the hospital may file a request for an adjustment payment. The hospital's

request must be received by the hospital's fiscal intermediary no later than 180 days after

the date on the intermediary's initial NPR for the cost reporting period for which the

hospital requests an adjustment. The fiscal intermediary (or, if applicable, the MAC), or

CMS, depending on the type of adjustment requested, then reviews the request and

determines if an adjustment payment is warranted. This determination is sometimes not

made until more than 6 months after the date the request is filed because there are times

when the applications are incomplete and additional information must be requested in

order to have a completed application. However, in an attempt to provide interested

parties with data on the most recent adjustments for which we do have data, we are

publishing data on adjustment payments that were processed by the fiscal intermediary or

CMS during FY 2006.

　　　The table below includes the most recent data available from the fiscal

intermediaries and CMS on adjustment payments that were adjudicated during FY 2006.

As indicated above, the adjustments made during FY 2006 only pertain to cost reporting

periods ending in years prior to FY 2005. Total adjustment payments given to excluded

hospitals and units during FY 2006 are $19,451,125. 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	4	$2,525,385	$1,352,437
Psychiatric	27	$22,016,987	$12,648,694
Long-Term Care	--	--	--
Children's	2	$787,708	$726,217
Cancer	3	$13,813,000	$4,261,560
Religious Nonmedical Health			

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Care Institution	7	$2,484,149	$462,217

VII. Services Furnished to Beneficiaries in Custody of Penal Authorities

Section 1862(a)(2) of the Act prohibits payment under Medicare Part A or Part B

for any items or services for which the beneficiary has no legal obligation to pay, and

which no other person or organization (such as a prepayment plan of which the

beneficiary is a member) has a legal obligation to provide or pay for the service. Our

current regulations at §411.4(b) specify the special conditions when Medicare payment

may be made for services furnished to individuals in custody of penal authorities. These

regulatory conditions include: (1) State or local law requires those individuals or groups

of individuals to repay the cost of medical services they receive while in custody; and

(2) the State or local government entity enforces the requirement to pay by billing all

such individuals, whether or not covered by Medicare or any other health insurance, and

by pursuing collection of the amounts they owe in the same way and with the same vigor

that it pursues the collection of other debts.

However, §411.4(b) does not define "custody" and does not clearly state that

CMS will not defer to a particular State or local government's definition (or

interpretation) of what constitutes "custody." In the FY 2008 IPPS proposed rule

(72 FR 24825), we proposed to specify that, for purposes of Medicare payment,

individuals who are in "custody" include, but are not limited to, individuals who are

under arrest, incarcerated, imprisoned, escaped from confinement, under supervised

release, required to reside in mental health facilities, required to reside in halfway houses,

required to live under home detention, or confined completely or partially in any way

under a penal statute or rule. We believe that this definition of "custody" is in

accordance with how custody has been defined by Federal courts for purposes of the

habeas corpus protections of the Constitution. For example, the term "custody" is

not limited solely to physical confinement. (Sanders v. Freeman, 221 F.3d

846, 850-51 (6th Cir. 2000).) Individuals on parole, probation, bail, or

supervised release may be "in custody."

Comment: One commenter stated that the expansion of the definition of

"custody" to include individuals who have escaped from confinement, on parole, on

probation, or released on bail places an unreasonable burden on hospitals. The

commenter stated that there is no incentive for patients with any of these status

designations to come forward and honestly disclose their status. Moreover, the

commenter pointed out, law enforcement is not in the collection business or overly

concerned with billing for medical services. As a result, the commenter believed that the

burden of seeking compensation for medical care furnished to patients under penal

authority ultimately falls back on the healthcare provider regardless of the Medicare

provisions under sections 1862(a)(2) and (a)(3) of the Act. Therefore, the commenter

recommended that CMS not expand the definition of "custody" unless there is a means to

verify the official status of the patient under penal authority.

Response: We are not expanding the definition of "custody." As we indicated in

the FY 2008 IPPS proposed rule, we are specifying that, for Medicare payment purposes,

"custody" is defined consistent with how the Federal courts have defined custody and

that we will not defer to a particular State or local government's definition (or

interpretation) of what constitutes "custody." (We note that the commenter has not

explained why it believes we are expanding the definition of "custody.") Therefore, if a

State or local government believes that an individual is not under "custody" for Medicare

payment purposes, the State or local government should be prepared to prove to CMS

that the Federal courts have ruled (or would rule) that the class or type of individual at

issue is not considered (or would not be considered) under "custody."

Moreover, CMS contractors typically receive information from the Social

Security Administration's (SSA) Prisoner Update Processing System (PUPS) in order to

stop payment for services furnished to individuals in custody of penal authorities. The

SSA is required by law to suspend payment of social security benefits when an individual

is incarcerated and CMS contractors use that information in order to identify when they

should stop Medicare payment. If Medicare denies payment for services on the basis that

the individual is in "custody" of penal authorities, the health care provider or supplier

will be directed to seek payment from the State or local government (which is similar to

other general payment exclusion situations such as when Medicare directs a civilian

provider or supplier to bill the Department of Veterans Affairs instead of Medicare for a

service). Therefore, there is already a means in place to verify the status of these

individuals and health care providers and suppliers will not be financially burdened by

our clarification of the definition of "custody" because, in the event that Medicare denies

payment, providers and suppliers will be directed to the State or local government for

payment.

Comment: Two commenters were concerned that if the proposed definition of

"custody" is adopted, it would present practical problems for hospitals. One of the

commenters stated that "custody" should not include individuals who are not under

physical confinement, as otherwise it would be extremely difficult to identify individuals

in "custody, " and therefore hospitals would be required to seek criminal history

information and do background checks on all patients being registered. The commenter

also expects that State regulations and law enforcement agencies may have conflicts with

the definition as well. The second commenter asserted that, under the proposed

definition, unless an individual is brought in by governmental authorities, the treating

hospital will not be able to identify many persons in custody (for example, those under

supervised release, or required to live under home detention). The commenter pointed

out that such individuals are unlikely to identify themselves, and many prison records are

protected under Federal, State or local privacy laws. Moreover, the commenter added,

even if the treating hospital can identify an individual as being in "custody" under CMS'

new definition, it will have no way of knowing whether the authority that has placed the

person in custody has a legal obligation to pay for his or her care. The commenter urged

CMS to include a safeguard to protect hospitals that act in good faith but mistakenly bill

Medicare for services furnished to individuals in custody for whom payment is not

reimbursable.

Response: As we stated in response to the previous comment, we are not

expanding the definition of "custody." Nor are we requiring that hospitals seek criminal

histories and do background checks on all patients being registered. If Medicare denies

payment for services on the basis that the individual is in "custody" of penal authorities,

the provider or supplier will be directed to seek payment from the State or local

government (which is similar to other general payment exclusion situations such as when

Medicare directs a civilian provider or supplier to bill the Department of Veterans Affairs

instead of Medicare for a service). If a State or local government believes that an

individual is not under "custody" for Medicare payment purposes, it should be prepared

to prove to Medicare that the Federal courts have ruled (or would rule) that the class or

type of individual at issue is not considered (or would not be considered) under

"custody." Likewise, if a State or local government believes that it has no legal

obligation to pay for the care provided to the individual (see 42 CFR 411.4(b)(1) and

(b)(2)), it should be prepared to prove that to Medicare.

We are finalizing our proposed changes to §411.4(b), with one modification. In

the FY 2008 IPPS proposed rule, we specified that individuals who are "under supervised

release" are in "custody"; however, we did not specify that individuals who are on

"medical furlough" are also in "custody" for Medicare payment purposes. Some State or

local governments use the term "medical furlough" in order to describe individuals who

are "under supervised release." Therefore, we are adding "medical furlough" to the

examples of types of "custody" in order to further clarify that an individual is in custody,

for Medicare payment purposes, if he or she is released by the State or local government

for the purpose of receiving medical services (or accompanied by a police officer, other

penal authority, or other government representative to the location where the medical

services are furnished) and required to return to the State or local government facility

after the medical services are furnished.

VIII. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's

recommendations regarding hospital inpatient payments in our annual proposed and final

IPPS rules. We have reviewed MedPAC's March 2007 "Report to the Congress:

Medicare Payment Policy" and have given it careful consideration in conjunction with

the policies set forth in this document. MedPAC's Recommendation 2A-1 states that,

"The Congress should increase payment rates for the acute inpatient and outpatient

prospective payment systems in 2008 by the projected rate of increase in the hospital

market basket index, concurrent with implementation of a quality incentive payment

program." This recommendation is discussed in Appendix B to this final rule with

comment period.

Recommendation 2A-2: MedPAC recommended that, "Concurrent with

implementation of severity adjustment to Medicare's diagnosis related group payments,

the Congress should reduce the indirect medical education adjustment in fiscal year 2008

by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio.

The funds obtained from reducing the indirect medical education adjustment should be

used to fund a quality incentive payment system." MedPAC further states that the IME

adjustment is "set above the empirical level which contributes to the large differences

between teaching and nonteaching hospitals in financial performance under Medicare."

MedPAC asserts that since there is no accountability for how IME funds are used, and

teaching hospitals will benefit from implementation of the severity adjusted DRGs, the

IME adjustment should be reduced in FY 2008.

Response: We note that MedPAC stated in its March 2007 Report that Congress

made a conscious decision to fund the IME adjustment above the empirical level due to

the concern for how teaching hospitals would fare under the PPS. Because the IME

adjustment is set by Congress, as cited in section 1886(d)(5)(B) of the Act, any change to

the IME adjustment, whether it is a 1 percentage point reduction or reduction of the IME

adjustment to its empirical level, would require a statutory change. Therefore, absent a

change to the IME provision in the Medicare statute for FY 2008, the IME adjustment

will remain at the current level required by the statute, as specified in section IV.D. of

this preamble.

We did not receive any public comments regarding Recommendation 2A-2.

Recommendation 2A-3: MedPAC recommended that, "The Secretary should

improve the form and accompanying instructions for collecting data on uncompensated

care in the Medicare cost report and require hospitals to report using the revised form as

soon as possible." MedPAC indicated that "accurate data on hospitals' charity care and

bad debts are crucial to any effort to help develop a federal payment mechanism to help

hospitals with their uncompensated care."

Response: MedPAC convened an "Expert Panel on Measuring Uncompensated

Care" on May 5, 2005, to address concerns raised by stakeholders on the usefulness of

the S-10 Worksheet data. CMS' representatives participated in the discussions on this

expert panel, and listened carefully to the concerns of MedPAC and the stakeholders

about the S-10 Worksheet. MedPAC is recommending that we adopt the list of

recommended changes to the S-10 Worksheet that resulted from the panel's discussion.

CMS is currently undertaking a major update of the hospital cost report and will be

making changes to the S-10 Worksheet form and accompanying instructions based on the

panel's discussions with MedPAC.

Comment: One commenter supported CMS' proposal to revise the S-10

Worksheet in response to MedPAC's expert panel recommendations. The commenter

stated that its members provide 25 percent of the uncompensated care provided in

hospitals nationwide and that it supported CMS' efforts to expand its collection of

uncompensated care data.

Response: We appreciate the commenter's support of our efforts to improve the

S-10 Worksheet and accompanying instructions for collecting data on uncompensated

care in the Medicare cost report.

In sections II.C. through E. of the preamble of this final rule with comment

period, we further address the recommendations included in Recommendation 1 and

Recommendation 3 in the March 2005 Report to Congress on Physician-Owned Specialty

Hospitals. Recommendation 1 relates 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.

Recommendation 3 recommended that the Secretary implement MedPAC's

recommended policies over a transition period.

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: http://www.medpac.gov.

IX. 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, in the proposed rule, we presented our established process under which commenters could gain access to raw data on an expedited basis. Generally, the data were made available in computer tape or cartridge format or on diskette through the Internet at: http://www.cms.hhs.gov/providers/hipps. We listed the data files and the cost for each file, if applicable, in the proposed rule.

Commenters interested in discussing any data used in constructing the proposed rule or this final rule should contact Nisha Bhat at (410) 786-5320.

B. Collection of Information Requirements

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.

In the FY 2008 IPPS proposed rule, we solicited public comment on each of these

issues for the following sections of this document that contain information collection

requirements. These provisions are discussed in various sections of this final rule with

comment period.

Special treatment: Hospitals located in urban areas and that apply for

reclassifications as rural. (§412.103)

Section 412.103(g) states that (1) for hospitals other than rural referral centers

(RRCs) described in paragraph (g)(2) of this section, the hospital may cancel its rural

reclassification by submitting a written request to the CMS Regional Office not less than

120 days prior to the end of its current cost reporting period, and (2) for hospitals

classified as RRCs under §412.96 based on rural reclassification under this section, the

hospital may cancel its rural reclassification by submitting a written request to the CMS

Regional Office not less than 120 days prior to the end of a Federal fiscal year and after

being paid as rural for at least one 12-month cost reporting period.

The burden associated with these requirements is the time and effort required for

a hospital to develop, draft, and submit its written request for the cancellation of its rural

reclassification. While these requirements are subject to the PRA, we believe the burden

is exempt under 5 CFR 1320.3(c)(4). We believe that the information collection

requirements in §412.103(g)(1) and §412.103(g)(2), respectively, will impact less than

10 entities. The notices will be submitted by individual hospitals and will be reviewed on

a case-by-case basis.

Basic commitments. (§489.20)

Section 489.20(u)(1) requires physician-owned hospitals, as defined in §489.3, to

furnish notice to all patients that the hospital is a physician-owned hospital. The notice

must be furnished at the beginning of their hospital stay or outpatient visit. The burden

associated with the aforementioned requirements is the time and effort associated with a

physician-owned hospital developing a generic notice and providing notice to the

patients. Approximately 175 physician-owned hospitals must comply with this

requirement. We estimate that it will require a hospital's general counsel 4 hours to

develop a standard notice to be furnished to all patients upon admission as an inpatient or

an outpatient. The total annual burden for this requirement is 700 hours.

In addition, we estimate that it will take 30 seconds to provide the notice to a

patient and it will take another 30 seconds to maintain a copy of the disclosure in the

patient's medical record. On average, each hospital will be required to make 1,092

disclosures per year. The total burden associated with the inpatient reporting and

recordkeeping requirements in §489.20(u)(1) is 3,185 annual burden hours.

Based on public comments received during the 60-day comment period for the

Federal Register notice (72 FR 21024) for this information collection request, we

revised our burden estimates to include the burden associated with the

physician-ownership disclosure and recordkeeping requirement for outpatient visits. We

estimate that each hospital will conduct 17,472 disclosures per year. As with the

inpatient disclosure requirement, we estimate that the burden associated with complying

with the outpatient disclosure requirement to be 30 seconds to disclose the information

and 30 seconds to maintain a copy of the disclosure in the patient's medical record. We

estimate the annual burden for the reporting and recordkeeping requirements for

outpatient visits to be 25,480 hours, respectively, for a total of 50,960 hours.

Section 489.20(v) requires all hospitals, as defined in §489.24(b), to furnish all

patients notice, in accordance with §482.13(b)(2), at the beginning of their hospital stay

or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the

hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital

will meet the medical needs of any inpatient who develops an emergency medical

condition, as defined in §489.24(b), at a time when there is no physician present in the

hospital. The burden associated with this requirement is the time and effort necessary for

each hospital to develop a standard notice to furnish to its patients. We believe 2,504

hospitals will be required to comply with this requirement. Complying with the

requirement will require a hospital's general counsel 4 hours to develop a standard notice.

The total annual burden associated with the legal review and development of the standard

notice is 10,016 hours.

We estimate that it will take 30 seconds to provide the notice to a patient, and it

will take another 30 seconds to maintain a copy of the disclosure in the patient's medical

record. On average, each hospital will be required to make 1,092 disclosures per year.

The burden associated with the recordkeeping and reporting requirements for inpatient

admissions as stated in §489.20(v) is 45,573 annual burden hours.

Based on public comments received during the 60-day comment period for the

Federal Register notice (72 FR 21024) for this information collection request, we

revised our burden estimates for §489.20(v) to include the burden associated with

outpatient visits as well. We estimate that each hospital will conduct 17,472 disclosures

per year. As with the inpatient disclosure requirement, we estimate that the burden

associated with complying with the outpatient disclosure requirement to be 30 seconds to

disclose the information and 30 seconds to maintain a copy of the disclosure in the

patient's medical record. We estimate the annual burden for the reporting and

recordkeeping requirements for outpatient visits to be 364,583 hours, respectively, for a

total of 729,165 hours.

Estimated Annual Reporting and Recordkeeping Burden

Regulation Section	OMB Control Number	Respondents	Responses	Burden Per Response (hours)	Inpatient Admission Burden (hours)	Outpatient Visit Burden (hours)	Total Annual Burden (hours)
§489.20(u)	0938-New	175	175	4	-	-	700
			3,248,875	.016667	3,185	50,960	54,145
§489.20(v)	0938-New	2,504	2,504	4	-	-	10,016
			49,735,635	.016667	45,573	729,165	774,738
					Total Annual Burden (Inpatient +Outpatient)		**839,599**

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 already received the Office of Management and Budget's (OMB) approval.

Add-on Payments for New Services and Technologies

Section II.J.1. of the preamble of this final rule with comment period discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2009 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold.

We also detailed the burden associated with this requirement in a final rule published in the **Federal Register** on September 7, 2001 (66 FR 46902). As stated in that final rule, we believe the associated burden is exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Collection of the information for this requirement will be conducted on an individual case-by-case basis.

Occupational Mix Adjustment to the FY 2008 Index (Hospital Wage Index Occupational Mix Survey)

Section III. of the preamble of this final rule with comment period details the

changes to the hospital wage index for FY 2008. Specifically, section III.C. addresses the

occupational mix adjustment to the FY 2008 index. While the preamble does not contain

any new information collection requirements, it is important to note that there is an OMB

approved collection associated with the hospital wage index.

As stated in section III.C. of the preamble of this final rule with comment period,

section 304(c) of Pub. L. 106-554 amended section 1886(d) (3) (E) of the Act to require

CMS to collect data at least once every 3 years on the occupational mix of employees for

each short-term, acute care hospital participating in the Medicare program, in order to

construct an occupational mix adjustment to the wage index. We collect the data via the

occupational mix survey.

The burden associated with this information collection 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.I of the preamble of this final rule with comment period,

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, the burden is approved under OMB control

number 0938–0573, with an expiration date of November 30, 2008.

Reporting of Hospital Quality Data for Annual Hospital Payment Update

As noted in section IV.A.1 of the preamble of this final rule with comment period,

section 5001(a) of the DRA sets out new requirements for the RHQDAPU program. The

RHQDAPU program was established to implement section 501(b) of Pub. L. 108-173,

thereby expanding our Hospital Quality Initiative. The RHQDAPU program originally

consisted of a "starter set" of 10 quality measures. Hospitals participating in the hospital

quality initiative submit their quality data on the 10 measures to receive an increase in

their Medicare Annual Payment Update. The Office of Management and Budget

approved the collection of data associated with the original starter set of quality measures

under OMB control number 0938-0918, with an expiration date of January 31, 2010.

However, we recently submitted a new information collection request containing

additional quality measures to OMB for approval. The new measures collect data for the

Surgical Care Improvement Project (SCIP) and mortality measures. We announced and

sought public comment on the information collection request in both 60-day and 30-day

Federal Register notices published on October 13, 2006 (71 FR 60532), and

December 22, 2006 (71 FR 77026), respectively. The revised information collection

request is currently under review at OMB.

Section IV.A.1 of the preamble of this final rule with comment period also

discusses the use of the HCAHPS survey to capture quality data. The survey is designed

to produce comparable data on the patient's perspective on care that allows objective and

meaningful comparisons between hospitals on domains that are important to consumers.

The HCAHPS survey is currently approved under OMB control number 0938-0981, with

an expiration date of December 31, 2007.

Section IV.A.2.h of the preamble of this final rule with comment period addresses

the reconsideration and appeal procedures for a hospital that we believe did not meet the

RHQDAPU program requirements. If a hospital disagrees with our determination, it may

submit a written request to us requesting that we reconsider our decision. The hospital's

letter must explain the reasons it believes it did meet the RHQDAPU program

requirements. While this is a reporting requirement, the burden associated with it is not

subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information

collection requirements imposed subsequent to an administrative action is not subject to

the PRA.

If you comment on these information collection and recordkeeping requirements,

please mail copies directly to the following:

Centers for Medicare & Medicaid Services,

Office of Strategic Operations and Regulatory Affairs,

Regulations Development Group,

Attn: William N. Parham, III, CMS-1533-F

Room C4-26-05, 7500 Security Boulevard,

Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs,

Office of Management and Budget,

Room 10235, New Executive Office Building,

Washington, DC 20503,

Attn: Carolyn Lovett, CMS Desk Officer, CMS-1533-F**,**

carolyn_lovett@omb.eop.gov. Fax (202) 395-6974.

C. Waiver of Notice of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to

provide a period for public comment before the provisions of a notice such as this take

effect. However, we can waive this procedure 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 notice issued.

We find it unnecessary to undertake notice and comment rulemaking for the

additional change to 42 CFR 412.106(b)(2)(iii) discussed in section IV.E. of the preamble

of this final rule with comment period, because this notice merely provides technical

corrections to the regulations and does not make any substantive changes to the

regulations or our existing policy. Therefore, under 5 U.S.C. 553(b)(B), for good cause,

we are waiving notice and comment procedures.

In addition, as we discussed in section II.I. of the preamble of this final rule with comment period, we proposed in the FY 2008 IPPS proposed rule ((72 FR 24755 through 24771) to adopt the MS-LTC-DRGs as the patient classification system for the LTCH PPS beginning with discharges on or after October 1, 2007. However, in the proposed rule, we omitted proposed changes to the regulation text reflecting the proposed change from LTC-DRGs to MS-LTC-DRGs. Although we did not propose regulation text, as referenced above, our comprehensive descriptions of our proposed adoption of the MS-LTC-DRGs in the preamble of the proposed rule provided the public with detailed specifics of our proposed policy which was subject to notice and comment procedures. We are finalizing the proposed adoption of the MS-LTC-DRGs for use in the LTCH PPS beginning with discharges on or after October 1, 2007, and we are amending the definitions in the regulations at §412.503. By adding this omitted regulation text, we are ensuring that the CFR accurately reflects the policies adopted in the FY 2008 IPPS final rule. We find that undertaking further notice and comment procedures for the purposes of adding conforming definitions in the LTCH PPS regulations on this policy is unnecessary as the regulation text merely implements and reflects our proposed policy and final policy which was subject previously to notice and comment procedures.. Therefore, under 5 U.S.C. 553(b)(B), for good cause, we are waiving notice and comment procedures.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping

requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico,

Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and

recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this final rule, the Centers for Medicare

& Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 411--EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON

MEDICARE PAYMENT

1. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D-4(e)(6), 1871, and 1877(b)(4) and (5) of the

Social Security Act (42 U.S.C. 1302, 1395w-10(e)(6), 1395hh, and 1395nn(b)(4) and

(5)).

2. Section 411.4 is amended by revising the introductory text of paragraph (b) to

read as follows:

§411.4 Services for which neither the beneficiary nor any other person is legally obligated to pay.

*   *   *   *   *

(b) <u>Special conditions for services furnished to individuals in custody of penal authorities</u>. Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. Payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

*   *   *   *   *

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

3. 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).

4. Section 412.2 is amended by adding a new paragraph (g) to read as follows:

§412.2 Basis for payment.

*   *   *   *   *

(g) <u>Payment adjustment for certain replaced devices</u>. CMS makes a payment

adjustment for certain replaced devices, as provided under §412.89.

5. Section 412.4 is amended by--

a. Revising paragraphs (d)(3)(ii)(B) and (d)(3)(ii)(C).

b. Adding a new paragraph (d)(3)(ii)(D).

c. Revising paragraph (f)(3).

d. Revising the introductory text of paragraph (f)(5).

e. Revising paragraph (f)(5)(i).

f. Revising paragraph (f)(5)(iv).

g. Adding a new paragraph (f)(6).

The revisions and additions read as follows:

§412.4 Discharges and transfers.

*   *   *   *   *

(d)   *   *   *

(3)   *   *   *

*   *   *   *   *

(ii)   *   *   *

(B) The proportion of short-stay discharges to postacute care to total discharges

in the DRG exceeds the 55th percentile for all DRGs;

(C) The DRG is paired with a DRG based on the presence or absence of a

comorbidity or a complication or major cardiovascular condition that meets the criteria

specified under paragraphs (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section; and

(D) In the case of MS-DRGs that share the same base MS-DRG, if one MS-DRG meets the criteria specified under paragraph (d)(3)(ii)(B) of this section, every MS-DRG that shares the same base MS-DRG is a qualifying DRG.

*   *   *   *   *

(f)   *   *   *

(3) Transfer assigned to DRG for newborns that die or are transferred to another hospital. If a transfer is classified into CMS DRG 385 (Neonates, Died or Transferred) prior to October 1, 2007, or into MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) on or after October 1, 2007, the transferring hospital is paid in accordance with §412.2(b).

*   *   *   *   *

(5) Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2005, and prior to October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section.

*   *   *   *   *

(iv) If a DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the

criteria specified in paragraphs (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

(6) Special rule for DRGs meeting specific criteria. For discharges occurring on or after October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days.

(iv) If a DRG is part of an MS-DRG group that meets the criteria specified in paragraphs (f)(6)(i) through (f)(6)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

6. Section 412.64 is amended by--

a. Revising paragraph (b)(1)(ii)(B).

b. In paragraph (b)(3), designating the existing text as (b)(3)(i) and adding a new paragraph (b)(3)(ii).

c. Adding a new paragraph (e)(3).

d. Revising paragraph (i)(2).

e. In the introductory text of paragraph (h)(4), removing the date

"September 30, 2007" and adding in its place "September 30, 2008".

The revisions read as follows:

§412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and

subsequent fiscal years.

*   *   *   *   *

(b)   *   *   *

(1)   *   *   *

(ii)   *   *   *

(B) For discharges occurring on or after October 1, 1983, and before

October 1, 2007, the following New England counties are deemed to be parts of urban

areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98-

21, 42 U.S.C. 1395ww (note); Litchfield County, Connecticut; York County, Maine;

Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County,

Rhode Island.

*   *   *   *   *

(3) (i) *   *   *

(ii)   For discharges occurring on or after October 1, 2007, hospitals in the

following New England counties, if not already located in an urban area, are deemed to

be located in urban areas under section 601(g) of the Social Security Amendments of

1983 (Public Law 98-21, 42 U.S.C. 1395ww (note): Litchfield County, Connecticut;

York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire;

and Newport County, Rhode Island.

*   *   *   *   *

(e)   *   *   *

(3) To the extent CMS determines that changes to the DRG classification and

recalibrations of the DRG relative weights for a previous year (or estimates that such

adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate

payments under this subsection during the fiscal year that are a result of changes in

coding or classification of discharges that do not reflect real changes in case mix, CMS

may adjust the standardized amount for subsequent fiscal years so as to eliminate the

effect of such coding and classification changes.

*   *   *   *   *

(i)   *   *   *

(2) Amount of adjustment. A hospital located in a county that meets the criteria

under paragraphs (i)(1)(i) through (i)(1)(iii) of this section will receive an increase in its

wage index that is equal to a weighted average of the difference between the

postreclassified wage index of the MSA (or MSAs) with the higher wage index (or wage

indices) and the postreclassified wage index of the MSA or rural statewide area in which

the qualifying county is located, weighted by the overall percentage of the hospital

employees residing in the qualifying county who are employed in any MSA with a higher

wage index.

*   *   *   *   *

7. The heading of Subpart F is revised to read as follows:

Subpart F--Payments for Outlier Cases, Special Treatment Payment for New Technology,

and Payment Adjustment for Certain Replaced Devices

8. Section 412.88 is amended by revising the introductory text of paragraph

(a)(2) to read as follows:

§412.88 Additional payment for new medical service or technology.

(a)   *   *   *

(2) If the costs of the discharge (determined by applying the operating

cost-to-charge ratios as described in §412.84(h)) exceed the full DRG payment, an

additional amount equal to the lesser of--

*   *   *   *   *

9. A new undesignated center heading and a new §412.89 are added under

Subpart F following §412.88 to read as follows:

Payment Adjustment for Certain Replaced Devices

§412.89 Payment adjustment for certain replaced devices.

(a) <u>General rule</u>. For discharges occurring on or after October 1, 2007, the

amount of payment for a discharge described in paragraph (b) of this section is reduced

when--

(1) A device is replaced without cost to the hospital;

(2) The provider received full credit for the cost of a device; or

(3) The provider receives a credit equal to 50 percent or more of the cost of the

device.

(b) <u>Discharges subject to payment adjustment</u>. (1) Payment is reduced in accordance with paragraph (a) of this section only if the implantation of the device determines the DRG assignment.

(2) CMS lists the DRGs that qualify under paragraph (b)(1) of this section in the annual final rule for the hospital inpatient prospective payment system.

(c) <u>Amount of reduction</u>. (1) For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment.

(2) For a device for which the hospital received a full or partial credit, the amount credited is subtracted from the DRG payment.

10. Section 412.96 is amended by adding a new paragraph (g)(4), to read as follows:

§412.96 Special treatment: Referral centers.

*   *   *   *   *

(g)   *   *   *

(4) A hospital that submits a written request on or after October 1, 2007, to cancel its reclassification under §412.103(g) is deemed to have cancelled its status as a rural referral center effective on the same date the cancellation under §412.103(g) takes effect. The provision of this paragraph (g)(4) applies to hospitals that qualify as rural referral centers under §412.96 based on rural status acquired under §412.103.

*   *   *   *   *

11. Section 412.103 is amended by revising paragraph (g) to read as follows:

§412.103 Special treatment: Hospitals located in urban areas and that apply for reclassifications as rural.

*   *   *   *   *

(g) <u>Cancellation of classification</u>.

(1) <u>Hospitals other than rural referral centers</u>. Except as provided in paragraph (g)(2) of this section--

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period.

(ii) The hospital's cancellation of the classification is effective beginning with the next full cost reporting period.

(2) <u>Hospitals classified as rural referral centers</u>. For a hospital that was classified as a rural referral center under §412.96 based on rural reclassification under this section--

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

(ii) The hospital's cancellation of the classification is not effective until it has been paid as rural for at least one 12-month cost reporting period, and not until the beginning of the Federal fiscal year following such 12-month cost reporting period.

(iii) The provisions of paragraphs (g)(2)(i) and (g)(2)(ii) of this section are effective for all written requests submitted by hospitals on or after October 1, 2007, to cancel rural reclassifications.

12. Section 412.106 is amended by--

a. Revising paragraph (b)(2)(i).

b. Revising paragraph (b)(2)(iii).

The revisions read as follows:

§412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

*   *   *   *   *

(b) *   *   *

(2)   *   *   *

(i) Determines the number of patient days that--

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

*   *   *   *   *

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that--

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (or Medicare Advantage (Part C)).

*   *   *   *   *

13. Section 412.230 is amended by adding a new paragraph (d)(2)(v) to read as follows:

§412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

*   *   *   *   *

(d) * * *

(1) * * *

(2)   * * *

(v) For applications submitted for reclassification effective in FY 2009 and thereafter, a campus of a multicampus hospital that is located in a geographic area different from the area associated with the provider number of the entire multicampus hospital may seek reclassification to another CBSA using the composite wage data of the entire multicampus hospital as its hospital-specific data.

*   *   *   *   *

14. Section 412.232 is amended by adding a new paragraph (d)(2)(iii), to read as follows:

§412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

*   *   *   *   *

(d) * * *

(1)   * * *

(2)   * * *

(iii) For redesignations effective beginning FY 2009, the wage data of an individual campus of a multicampus hospital will be determined by allocating, on the basis of full-time equivalent staff or discharges, the wage data of the entire multicampus hospital between or among the individual campuses of the multicampus hospital. The provision of this paragraph (d)(2)(iii) applies only in the case where an individual campus is located in a geographic area different from the area associated with the provider number of the entire multicampus hospital.

15. Section 412.234 is amended by revising paragraph (c) to read as follows:

§412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

*   *   *   *   *

(c) <u>Appropriate wage data</u>. (1) The hospitals must submit appropriate wage data as provided for in §412.230(d)(2).

(2) For redesignations effective beginning FY 2009, the appropriate wage data of an individual campus located in a geographic area different from the area associated with the provider number of the entire multicampus hospital are the wage data described in §412.232(d)(2)(iii).

16. Section 412.316 is amended by--

a. Revising the introductory text of paragraph (b).

b. Revising paragraph (b)(2).

c. Revising paragraph (b)(3).

The revisions read as follows:

§412.316 Geographic adjustment factor.

*   *   *   *   *

(b) <u>Large urban location</u>. For discharges occurring on or before

September 30, 2007, CMS provides an additional payment to a hospital located in a large

urban area equal to 3.0 percent of what would otherwise be payable to the hospital based

on the Federal rate.

*   *   *   *   *

(2) For discharges occurring on or after October 1, 2004, and before

October 1, 2007, the definition of large urban areas under §412.63(c)(6) continues 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,

and before October 1, 2007, for an urban hospital that is reclassified as rural as set forth

in §412.103, the geographic classification is rural.

*   *   *   *   *

17. Section 412.322 is amended by adding new paragraphs (c) and (d) to read as

follows:

§412.322 Indirect medical education adjustment factor.

*   *   *   *   *

(c) Payment adjustment factor for FY 2009. For discharges occurring on or after

October 1, 2008, and before October 1, 2009, the indirect teaching adjustment factor

equals one-half the amount computed under paragraph (b) of this section.

(d) Payment adjustment factor for FY 2010 and subsequent fiscal years. For

discharges occurring on or after October 1, 2009, CMS makes no separate payment for

indirect teaching medical education under the prospective payment system for inpatient

capital costs.

18. Section 412.503 is amended by revising the definition of "LTC-DRG" and

adding a definition of "MS-LTC-DRG" in alphabetical order, to read as follows:

§412.503 Definitions.

*   *   *   *   *

LTC-DRG stands for the diagnosis-related group used to classify patient

discharges from a long-term care hospital based on clinical characteristics and average

resource use, for prospective payment purposes. Effective October 1, 2007, long-term

care hospital patient discharges occurring on or after October 1, 2007, are classified by a

severity-adjusted patient classification system, the MS-LTC-DRGs. Any reference to the

term "LTC-DRG" shall be considered a reference to the term "MS-LTC-DRG" when

applying the provisions of this subpart for policy descriptions and payment calculations

for discharges from a long-term care hospital occurring on or after October 1, 2007.

MS-LTC-DRG stands for the severity-adjusted diagnosis-related group used to

classify patient discharges from a long-term care hospital based on clinical characteristics

and average resource use, for prospective payment purposes for discharges from a

long-term care hospital occurring on or after October 1, 2007.

*   *   *   *   *

PART 413--PRINCIPLES OF REASONABLE COST REIMBURSEMENT;

PAYMENT FOR END-STAGE RENAL DISEASE SERVICES;

PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED

NURSING FACILITIES

19. 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).

20. Section 413.75(b) is amended by--

a. Adding in alphabetical order a definition of "orientation activities".

b. Revising the definition of "patient care activities".

The addition and revision read as follows:

§413.75 Direct GME payments: General requirements.

*   *   *   *   *

(b) * * *

Orientation activities means activities that are principally designed to prepare an

individual for employment as a resident in a particular setting, or for participation in a

particular specialty program and patient care activities associated with that particular

specialty program.

Patient care activities means the care and treatment of particular patients,

including services for which a physician or other practitioner may bill, and orientation

activities as defined in this section.

*   *   *   *   *

PART 489--PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

21. The authority citation for Part 489 is amended to read as follows:

Authority: Secs. 1102, 1819, 1820(e),1861, 1864(m), 1866, 1869, and 1871 of

the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, 1395ff, and

1395hh).

22. Section 489.3 is amended by adding a definition of "physician-owned

hospital" in alphabetical order to read as follows:

§489.3 Definitions.

*   *   *   *   *

Physician-owned hospital means any participating hospital (as defined in

§489.24) in which a physician or physicians have an ownership or investment interest.

The ownership or investment interest may be through equity, debt, or other means, and

includes an interest in an entity that holds an ownership or investment interest in the

hospital. This definition does not include a hospital with physician ownership or

investment interests that satisfies the requirements at §411.356(a) or (b) of this chapter.

23. Section 489.12 is amended by--

a. Revising paragraph (a)(2).

b. Redesignating paragraph (a)(3) as paragraph (a)(4).

c. Adding a new paragraph (a)(3).

The revision and addition read as follows:

§489.12 Decision to deny an agreement.

(a) * * *

(2) The prospective provider has failed to disclose ownership and control

interests in accordance with §420.206 of this chapter;

(3) The prospective provider is a physician-owned hospital as defined in §489.3

and does not have procedures in place for making physician ownership disclosures to

patients in accordance with §489.20(u); or

*   *   *   *   *

24. Section 489.20 is amended by adding new paragraphs (u) and (v) to read as

follows:

§489.20 Basic commitments.

*   *   *   *   *

(u) In the case of a physician-owned hospital as defined in §489.3 to furnish

written notice to all patients at the beginning of their hospital stay or outpatient visit that

the hospital is a physician-owned hospital in order to assist the patients in making

informed decisions regarding their care, in accordance with §482.13(b)(2) of this

subchapter. The notice should disclose, in a manner reasonably designed to be

understood by all patients, the fact that the hospital meets the Federal definition of a

physician-owned hospital specified in §489.3 and that the list of the hospital's physician owners or investors is available upon request. For the purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(v) In the case of a hospital as defined in §489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with §482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in §489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

25. Section 489.24 is amended by revising paragraph (a)(2) to read as follows:

§489.24 **Special responsibilities of Medicare hospitals in emergency cases.**

(a) *   *   *

(2) Nonapplicability of provisions of this section. Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area,

as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a

72-hour period beginning upon the implementation of a hospital disaster protocol, except

that, if a public health emergency involves a pandemic infectious disease (such as

pandemic influenza), the waiver will continue in effect until the termination of the

applicable declaration of a public health emergency, as provided for by section

1135(e)(1)(B) of the Act..

*   *   *   *   *

26. Section 489.53 is amended by--

a. Redesignating paragraph (c) and (d) as paragraphs (d) and (e), respectively.

b. Adding a new paragraph (c).

c. In newly redesignated paragraph (d)(1), removing the cross-reference

"paragraph (c)(2) of this section" and adding the reference "paragraph (d)(2) of this

section" in its place.

The revisions and additions read as follows:

§489.53 Termination by CMS.

*   *   *   *   *

(c) <u>Termination of agreements with physician-owned hospitals</u>. In the case of a

physician-owned hospital, as defined at §489.3, CMS may terminate the provider

agreement if the hospital failed to comply with the requirements of §489.20(u).

*   *   *   *   *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital

Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance

Program)

Dated:_____

_____

 Herb B. Kuhn,

Acting Deputy 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 Standardized Amounts, Update Factors, and

Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On

or After October 1, 2007

I. Summary and Background

In this Addendum, we are setting forth the methods and data we used to determine

the prospective payment rates for Medicare hospital inpatient operating costs and

Medicare hospital inpatient capital-related costs. We are also setting forth the

rate-of-increase percentages for updating the target amounts for certain hospitals and

hospital units excluded from the IPPS. In general, except for SCHs, MDHs, and hospitals

located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on

100 percent of the Federal national rate, also known as the national adjusted standardized

amount. This amount reflects the national average hospital cost per case from a base

year, updated for inflation.

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 was higher. (MDHs did not have

the option to use their FY 1996 hospital-specific rate.) However, 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 include 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 an MDH's target amount, an MDH must rebase its

hospital-specific rates to its FY 2002 cost report. Section 5003(c) of Pub. L. 109-171

further required that MDHs would 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 on the provisions of

section 5003(d) of Pub. L. 109-171, MDHs are no longer subject to the 12-percent cap on

their DSH payment adjustment factor.

     For hospitals located in Puerto Rico, the payment per discharge is based on the

sum of 25 percent of a Puerto Rico rate that reflects the 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 of this final rule with comment period for a complete description.)

     As discussed below in section II. of the Addendum to this final rule with

comment period, we are finalizing our decision to make changes in the determination of

the prospective payment rates for Medicare inpatient operating costs for FY 2008. In

section III. of the Addendum to this final rule with comment period, we discuss our

policy changes for determining the prospective payment rates for Medicare inpatient

capital-related costs for FY 2008. Section IV. of the Addendum to this final rule with

comment period sets forth our changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2008. The tables to which we refer in the preamble of this final rule with comment period are presented in section V. of the Addendum of this final rule with comment period.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2008

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 standardized amounts set forth in Tables 1A, 1B, and 1C, of section VI. of the Addendum to this final rule with comment period 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 standardized amounts and 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.

● Updates of 3.3 percent for all areas (that is, the estimated full market basket

percentage increase of 3.3 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 the standardized amount to ensure budget neutrality for DRG

recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the

Act.

● An adjustment to ensure the wage index update and changes are budget neutral,

as provided for under section 1886(d)(3)(E) of the Act.

● An adjustment to ensure the effects of geographic reclassification are budget

neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2007

budget neutrality factor and applying a revised factor.

● An adjustment to ensure that the imputed rural floor adopted under section

1886(d)(3)(E) of the Act is budget neutral.

● An adjustment to remove the FY 2007 outlier offset and apply an offset for

FY 2008.

● 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.

● An adjustment to eliminate the effect of coding or classification changes that do not reflect real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act (as discussed in section II.D.6. of the preamble to this final rule with comment period).

We note that two budget neutrality provisions will no longer be applied to the standardized amounts beginning with FY 2008. First, in the FY 2005 IPPS final rule (69 FR 49032 through 49034), we allowed urban hospitals that became rural under the new labor market area definitions to maintain their assignment to the MSA where they were previously located for a 3-year period extending from FY 2005 through FY 2007. In these years, we provided for a budget neutrality adjustment to the standardized amount to ensure that this policy did not increase Medicare expenditures for hospital inpatient services. For FY 2008, this budget neutrality adjustment to the IPPS standardized amounts will no longer be necessary because the provision has expired. Second, in this final rule with comment period, we are making a prospective change to how budget neutrality is applied to implement the rural floor for FY 2008 and subsequent years. As discussed in section III.G.4. of the preamble of this final rule with comment period, we are applying the budget neutrality adjustment to hospital wage indices rather than the standardized amount. However, we are continuing to apply budget neutrality for the imputed rural floor adopted under section 1886(d)(3)(E) of the Act to the standardized amounts.

A. Calculation of the 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 to be the labor-related amount

is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent

of the standardized amount be adjusted by the wage index, unless doing so would result

in lower payments to a hospital than would otherwise be made. (Section

1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for

hospitals located in Puerto Rico.)

For FY 2008, we are not changing the national and Puerto Rico-specific

labor-related and nonlabor-related shares from the percentages established for FY 2007.

Therefore, the labor-related share continues to be 69.7 percent for the national

standardized amounts and 58.7 percent for the Puerto Rico specific standardized amount.

Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a

labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes

are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices

are greater than 1.0000, we are applying the wage index to a labor-related share of 69.7

percent of the national standardized amount. For hospitals located in Puerto Rico, we are

applying a labor-related share of 58.7 percent if its Puerto Rico-specific wage index is

less than or equal to 1.0000. For hospitals located in Puerto Rico whose Puerto-Rico

specific wage index values are greater than 1.0000, we are applying a labor share of

62 percent.

The standardized amounts for operating costs appear in Table 1A, 1B, and 1C of

the Addendum to this final rule with comment period.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv) of the Act requires that, beginning with FY 2004 and

thereafter, an equal standardized amount be computed for all hospitals at the level

computed for large urban hospitals during FY 2003, updated by the applicable percentage

update. Section 1886(d)(9)(A) of the Act equalizes the Puerto Rico-specific urban and

rural area rates. Accordingly, we calculated FY 2008 national and Puerto Rico

standardized amounts irrespective of whether a hospital is located in an urban or rural

location.

3. Updating the Average Standardized Amount

        In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are updating the

equalized standardized amount for FY 2008 by the full estimated market basket

percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX)

of the Act, as amended by section 5001(a)(1) of 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 2008 is 3.3 percent. Thus, for FY 2008, the update to the

average standardized amount is 3.3 percent for hospitals in all areas. The estimated

market basket increase of 3.3 percent is based on the 2007 second quarter forecast of the

hospital market basket increase (as discussed in Appendix B of this final rule with

comment period).

        Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the

standardized amount for payment for inpatient hospital operating costs. Section

1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109-171,

provides for a reduction of 2.0 percentage points from the update percentage increase

(also known as the market basket update) for FY 2007 and each subsequent fiscal year

for any "subsection (d) hospital" that does not submit quality data as discussed in section

IV.A. of the preamble of this final rule with comment period. The standardized amounts

in Tables 1A through 1C of section V. of the Addendum to this final rule with comment

period reflect these differential amounts.

Although the update factors for FY 2008 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 2008 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 with comment period.

4. Other Adjustments to the Average Standardized Amount

As in the past, we adjusted the FY 2008 standardized amount to remove the

effects of the FY 2007 geographic reclassifications and outlier payments before applying

the FY 2008 updates. We then applied budget neutrality offsets for outliers and

geographic reclassifications to the standardized amount based on FY 2008 payment

policies.

We did not remove the prior year's budget neutrality adjustments for

reclassification and recalibration of the DRG weights and for updated wage data because,

in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated

aggregate payments after updates in the DRG relative weights and wage index should

equal estimated aggregate payments prior to the changes. If we removed the prior year's

adjustment, we would not have satisfied these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before

and after making changes that are required to be budget neutral (for example, changes to

DRG classifications, recalibration of the DRG relative weights, updates to the wage

index, and different geographic reclassifications). We included outlier payments in the

simulations because they may be affected by changes in these parameters.

We also adjusted the standardized amount this year by an estimated amount to

ensure that aggregate IPPS payments did not exceed the amount of payments that would

have been made in the absence of the rural community hospital demonstration program,

as required under section 410A of Pub. L. 108-173. This demonstration is required to be

budget neutral under section 410A(c)(2) of Pub. L. 108-173. For FY 2008, we are also

applying budget neutrality to the standardized amount for the imputed rural floor adopted

under section 1886(d)(3)(E) of the Act. For FY 2008 and FY 2009, we also made an

adjustment to eliminate the effect of coding or classification changes that did not reflect

real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi)

of the Act.

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 with comment period, we normalized the

recalibrated DRG weights by an adjustment factor so that the average case weight after

recalibration is equal to the average case weight prior to recalibration. However,

equating the average case weight after recalibration to the average case weight before

recalibration does not necessarily achieve budget neutrality with respect to aggregate

payments to hospitals because payments to hospitals are affected by factors other than

average case weight. Therefore, as we have done in past years, we made a budget

neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the

Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on

an annual basis beginning October 1, 1993. This provision also requires us to make any

updates or adjustments to the wage index in a manner that ensures that aggregate

payments to hospitals are not affected by the change in the wage index. Consistent with

current policy, for FY 2008, we adjusted 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 with comment period.

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 2006

discharge data to simulate payments and compared aggregate payments using the

FY 2007 relative weights and wage indexes to aggregate payments using the proposed

FY 2008 relative weights and wage indexes. The same methodology was used for the

FY 2007 budget neutrality adjustment. Based on this comparison, we computed a budget

neutrality adjustment factor equal to 0.996563 to be applied to the national standardized

amount. We also adjusted the Puerto Rico-specific standardized amount for the effect of

DRG reclassification and recalibration. We computed a budget neutrality adjustment factor of 0.995913 to be applied to the Puerto Rico-specific standardized amount. These budget neutrality adjustment factors are applied to the standardized amounts for FY 2007 without removing the prior year's budget neutrality adjustments. In addition, as discussed in section IV. of the Addendum to this final rule with comment period, we applied the same DRG reclassification and recalibration budget neutrality factor of 0.995913 to the hospital-specific rates that is effective for cost reporting periods beginning on or after October 1, 2007.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account "in applying any budget neutrality adjustment with respect to such index"

under section 1886(d)(8)(D) of the Act. To calculate the budget neutrality factor, we

used FY 2006 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 an adjustment factor of 0.991695 to ensure that the effects of these provisions

are budget neutral, consistent with the statute.

        The adjustment factor was applied to the standardized amount after removing the

effects of the FY 2007 budget neutrality adjustment factor. We note that the FY 2008

adjustment reflects FY 2008 wage index reclassifications approved by the MGCRB or the

Administrator. (Section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications

effective for 3 years. Therefore, the FY 2008 geographic reclassification could either be

the continuation of a 3-year reclassification that began in FY 2006 or FY 2007, or a new

one beginning in FY 2008.)

c. Imputed Rural Floor—Budget Neutrality Adjustment

        For FY 2005 through FY 2008, we have adopted an imputed rural floor under the

authority of section 1886(d)(3)(E) of the Act. 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. To calculate the

budget neutrality factor, we used FY 2006 discharge data to simulate payments. We

compared total IPPS payments before and after the application of the imputed rural floor.

Based on these simulations, we calculated an adjustment factor of 0.999318 to ensure that

the effect of the imputed rural floor is budget neutral.

d. Case-Mix Budget Neutrality Adjustment

The MS-DRGs will increase the total number of DRGs from 538 to 745. We believe that such a significant expansion in the number of DRGs will lead hospitals to improve coding and documentation in order to have a case assigned to a DRG with a higher payment. As explained above, we made an adjustment to ensure that the DRG relative weights remain budget neutral assuming constant utilization. However, without an adjustment to the IPPS rates to account for expected case-mix growth due to improved coding rather than to underlying changes in patient severity, the change to MS-DRGs would not be budget neutral. Section 1886(d)(3)(A)(vi) of the Act provides the Secretary with explicit authority to adjust the standardized amounts to account for case mix growth due to improved documentation and coding. Further, the Secretary may subsequently revisit this adjustment if actual data is different than the projection.

Based on the Office of Actuary's analysis (as discussed in more detail in section II.D.6. of the preamble of this final rule with comment period), using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix, we reduced the IPPS standardized amounts by -1.2 percent for FY 2008. Section 1886(d)(3)(A)(vi) further gives the Secretary authority to revisit adjustments to the standardized amounts for changes in coding or classification of discharges that were based on estimates in a future year. Consistent with the statute, we will compare the actual increase in case-mix due to documentation and coding to our projection once we have actual data for FY 2008. At that time, if necessary, we may

make a further adjustment to the standardized amounts to account for the difference

between our projection and actual data.

e. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic

prospective payments for "outlier" cases involving extraordinarily high costs. To qualify

for outlier payments, a case must have costs greater than the sum of the prospective

payment rate for the DRG, any IME and DSH payments, any new technology add-on

payments, and the "outlier threshold" or "fixed loss" amount (a dollar amount by which

the costs of a case must exceed payments in order to qualify for an outlier payment). We

refer to the sum of the prospective payment rate for the DRG, any IME and DSH

payments, any new technology add-on payments, and the outlier threshold as the outlier

"fixed-loss cost threshold." To determine whether the costs of a case exceed the

fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the

case to convert the charges to estimated costs. Payments for eligible cases are then made

based on a marginal cost factor, which is a percentage of the estimated costs above the

fixed-loss cost threshold. The marginal cost factor for FY 2008 is 80 percent, the same

marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any

year are projected to be not less than 5 percent nor more than 6 percent of total operating

DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the

Secretary to reduce the average standardized amount by a factor to account for the

estimated proportion of total DRG payments made to outlier cases. Similarly, section

1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized

amount applicable to hospitals located in Puerto Rico to account for the estimated

proportion of total DRG payments made to outlier cases. More information on outlier

payments may be found on the CMS Web site at

http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage .

(1) FY 2008 outlier fixed-loss cost threshold

        For FY 2008, we proposed to use the same methodology used for FY 2007

(71 FR 48148 through 484151) to calculate the outlier threshold. Similar to the

methodology used in the FY 2007 final rule, for FY 2008, we applied an adjustment

factor to the CCRs to account for cost and charge inflation (as explained below). As we

have done in the past, to calculate the proposed FY 2008 outlier threshold, we simulated

payments by applying FY 2008 rates and policies using cases from the FY 2006

MedPAR files. Therefore, in order to determine the FY 2008 outlier threshold, we

inflated the charges on the MedPAR claims by 2 years, from FY 2006 to FY 2008.

        We proposed to continue to use the refined methodology that takes into account

the lower inflation in hospital charges that are occurring as a result of the outlier final rule

(68 FR 34494), which changed our methodology for determining outlier payments by

implementing the use of more current CCRs. Our refined methodology uses more recent

data that reflect the rate-of-change in hospital charges under the new outlier policy.

        Using the most recent data available, we calculated the 1-year average annualized

rate-of-change in charges-per-case from the last quarter of FY 2005 in combination with

the first quarter of FY 2006 (July 1, 2005 through December 31, 2005) to the last quarter

of FY 2006 in combination with the first quarter of FY 2007 (July 1, 2006 through

December 31, 2006). This rate of change was 7.26 percent (1.0726) or 15.04 percent

(1.1504) over 2 years.

As we have done in the past, we established the proposed FY 2008 outlier

threshold using hospital CCRs from the December 2006 update to the Provider-Specific

File (PSF)--the most recent available data at the time of the proposed rule. This file

includes CCRs that reflected implementation of the changes to the policy for determining

the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 final rule (71 FR 48150), we worked with the Office

of Actuary to derive the methodology described below to develop the CCR adjustment

factor. For FY 2008, we proposed to use the same methodology to calculate the CCR

adjustment by using the FY 2006 operating cost per discharge increase in combination

with the actual FY 2006 market basket increase determined by Global Insight, Inc. (we

note that the FY 2006 actual (otherwise referred to as "final") market basket increase

reflects historical data whereas the published FY 2006 market basket update factor was

based on Global Insight, Inc.'s 2005 second quarter forecast with historical data through

the first quarter of 2005), 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 2008, we determined the adjustment by

taking the percentage increase in the operating costs per discharge from FY 2004 to FY

2005 (1.0529) from the cost report and dividing it by the final market basket increase

from FY 2005 (1.043) 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 2002 to FY

2003 percentage increase of operating costs per discharge of 1.0721 divided by FY 2003

final market basket increase of 1.041, FY 2003 to FY 2004 percentage increase of

operating costs per discharge of 1.0624 divided by FY 2004 final market basket increase

of 1.04). For FY 2008, we averaged the differentials calculated for FY 2003, FY 2004,

and FY 2005 which resulted in a mean ratio of 1.0203. We multiplied the 3-year average

of 1.0203 by the 2006 market basket percentage increase of 1.0420, which resulted in an

operating cost inflation factor of 6.32 percent or 1.0632. We then divided the operating

cost inflation factor by the 1-year average change in charges (1.0726) and applied an

adjustment factor of 0.9912 to the operating CCRs from the PSF.

As stated in the FY 2007 final rule, we continue to believe it is appropriate to

apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9

months for fiscal intermediaries (or, if applicable, the MAC) to tentatively settle a cost

report from the fiscal year end of a hospital's cost reporting period. The average "age" of

hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the

PSF until the beginning of FY 2007 is approximately 1 year. Therefore, as stated above,

we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and applied an adjustment

factor of 0.964 (cost inflation factor of 1.0340 divided by a charge inflation factor of

1.0726) 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. Therefore, we believe it is appropriate to apply the charge factor

to both the operating and capital CCRs.

Using this methodology, we calculated a proposed outlier fixed-loss cost

threshold for FY 2008 equal to the prospective payment rate for the DRG, plus any IME

and DSH payments, and any add-on payments for new technology, plus $23,015.

Comment: One commenter believed that the estimate of FY 2007 outlier

payments was overstated. The commenter performed its own analysis and determined

that outlier payments were 4.63 percent of overall payments for FY 2007. The

commenter noted that CMS did not use the most recent CCR data to determine the

FY 2007 outlier payment estimate. Specifically, the commenter stated, CMS used CCR

data from October 1, 2006, while the commenter used CCRs from January 1, 2007.

Based on its analysis, the commenter noted that the outlier projection methodology can

be improved because a 0.5 percent shortfall in outlier payments for FY 2007 represents

$420 million lost by hospitals.

As a result, the commenter suggested the following improvements to the outlier

projection methodology. First, the commenter suggested that the methodology to

develop the adjustment factor to the CCRs is unnecessarily complicated and does not lead

to a more accurate result. The commenter urged CMS to adopt a methodology that uses

recent historical industry wide average rate of change, similar to the methodology used to

develop the charge inflation factor. Another commenter stated that it is not clear if the

historical record supports the assumption that costs and the market basket maintain a

relatively constant relationship over time. Second, the commenter suggested that the

CCRs should be projected over different periods of time, some less or more than one

year, based on variations in hospital fiscal year ends. The commenter believed this

methodology would more accurately project the decline in CCRs. The commenter also

noted that, if CMS does not adopt the MS-DRGs for FY 2008, the threshold will need to

be recalculated using the CMS-DRGs. Third, the commenter noted that CMS used the

December 2006 CCR update for the proposed rule and has historically used the March

update for the final rule. The commenter urged CMS to use the June 2007 update instead

of the March 2007 update for the final rule. Other commenters recommended that CMS

lower the outlier threshold in addition to what CMS proposed because cases that were

outliers under the CMS DRGs will now end up as cases without outlier payments under

the MS-DRGs.

     Response: We used the October 2006 PSF to compute the FY 2007 outlier

estimate, as these are the CCRs on file at the beginning of the fiscal year. As we have

stated in the past, CCRs in the PSF are updated throughout the year and once a CCR is

inputed into the PSF, the CCR may be used for payment for a year or more until the next

tentative or final cost report is settled (whichever is from the most recent period).

Therefore, we do not agree that the January 2007 PSF will necessarily provide more

accurate CCRs to compute FY 2007 outlier payments than the October 2006 PSF update.

     In response to the comment that CCRs should be projected over different periods

of time, as we have mentioned in the past, it is possible that some of the CCRs in the

March PSF will be used in FY 2008 for actual outlier payments, while other CCRs may

be 1 year old. Therefore, we apply a 1-year adjustment to the CCRs. However, we will

study and consider this proposal for the future.

        With respect to the comment on our methodology used to adjust the CCRs, as we

stated in the FY 2007 IPPS final rule (71 FR 48151), we believe this calculation of an

adjustment to the CCRs is more accurate and stable than the commenter's methodology

because it takes into account the costs per discharge and the market basket percentage

increase when determining a cost adjustment factor. There are times where the market

basket and the cost per discharge will be constant, while other times these values will

differ from each other, depending on the fiscal year. Therefore as mentioned above,

using the market basket in conjunction with the cost per discharge uses two sources that

measure potential cost inflation and ensures a more accurate and stable cost adjustment

factor. Additionally, we are continuing to use the March update of the PSF for the final

rule as the June PSF update will not be ready for use until the end of July, which is

beyond the timetable necessary for us to compute the outlier threshold and publish this

final rule with comment period by August 1st. Finally, as noted in sections II.E. and H.

in the preamble of this final rule with comment period, we adopted and implemented a

blend of CMS and MS-DRG weights for FY 2008. Therefore, the current threshold is

based on cases that are grouped and paid using blended MS-DRG weights. Additionally,

we address the impact of the MS-DRGs on the outlier threshold below.

        Because we are not making any changes to our methodology for this final rule

with comment period, for FY 2008, we are using the same methodology we proposed to

calculate the outlier threshold. Using the most recent data available, we calculated the

1-year average annualized rate-of-change in charges per case from the first quarter of

FY 2006 in combination with the second quarter of FY 2006 (October 1, 2005 through

March 31, 2006) to the first quarter of FY 2007 in combination with the second quarter of

FY 2007 (October 1, 2006 through March 31, 2007). This rate of change was 6.2 percent

(1.062) or 12.78 percent (1.1278) over 2 years.

As we have done in the past, we established the FY 2008 outlier threshold using

hospital CCRs from the March 2007 update to the PSF--the most recent available data at

the time of this final rule with comment period. This file includes CCRs that reflected

implementation of the changes to the policy for determining the applicable CCRs that

became effective August 8, 2003 (68 FR 34494).

For FY 2008, we calculated the CCR adjustment by using the operating cost per

discharge increase in combination with the final market basket increase determined by

Global Insight, Inc., as well as the charge inflation factor described above to estimate the

adjustment to the CCRs. We determined the operating CCR adjustment by taking the

percentage increase in the operating costs per discharge from FY 2004 to FY 2005

(1.0564) from the cost report and dividing it by the final market basket increase from FY

2005 (1.043) 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 2002 to FY 2003 percentage

increase of operating costs per discharge of 1.0715 divided by FY 2003 final market

basket increase of 1.041, FY 2003 to FY 2004 percentage increase of operating costs per

discharge of 1.0617 divided by FY 2004 final market basket increase of 1.04). For FY

2008, we averaged the differentials calculated for FY 2003, FY 2004, and FY 2005

which resulted in a mean ratio of 1.0210. We multiplied the 3-year average of 1.0210 by

the 2006 market basket percentage increase of 1.0430, which resulted in an operating cost

inflation factor of 6.49 percent or 1.0649. We then divided the operating cost inflation

factor by the 1-year average change in charges (1.062) and applied an adjustment factor

of 1.0027 to the operating CCRs from the PSF.

We used the same methodology for the capital CCRs and applied an adjustment

factor of 0.9744 (cost inflation factor of 1.0348 divided by a charge inflation factor of

1.062) 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. Therefore, we believe it is appropriate to apply the charge factor

to both the operating and capital CCRs.

Using this methodology, we calculated an outlier fixed-loss cost threshold for

FY 2008 equal to the prospective payment rate for the DRG, plus any IME and DSH

payments, and any add-on payments for new technology, plus $22,635. With this

threshold, we project that outlier payments will equal 5.1 percent of total IPPS payments.

As we did in establishing the FY 2007 outlier threshold (71 FR 48149), in our

projection of FY 2008 outlier payments, we are not making any adjustments for the

possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report

settlement. We continue to believe that, due to the policy implemented in the outlier final

rule (68 FR 34494, June 9, 2003), CCRs will no longer fluctuate significantly and,

therefore, few hospitals will actually have these ratios reconciled upon cost report

settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs

and outlier payments reconciled in any given year. We also noted that reconciliation

occurs because hospitals' actual CCRs for the cost reporting period are different than the

interim CCRs used to calculate outlier payments when a bill is processed. Our

simulations assume that CCRs accurately measure hospital costs based on information

available to us at the time we set the outlier threshold. For these reasons, we are not

making any assumptions about the effects of reconciliation on the outlier threshold

calculation.

       We note that there are some factors that contributed to a lower fixed loss outlier

threshold for FY 2008 compared to FY 2007. First, the case-weighted national average

operating CCR declined by approximately an additional 1.5 percentage points from the

March 2006 update (used to calculate the FY 2007 outlier threshold) to the March 2007

update of the PSF. Additionally, as discussed in section II.D. of the preamble of this final

rule with comment period, we are adopting the use of MS-DRGs under the IPPS for

FY 2008. The MS-DRG system will increase the number of DRGs from 538 to 745, and

better recognize severity of illness than the CMS DRGs. Better recognition of severity of

illness with the MS-DRGs means that nonoutlier payments will compensate hospitals for

the higher costs of some cases that previously received outlier payments. As cases are

paid more accurately, in order to meet the 5.1 percent target, we need to decrease the

fixed-loss outlier threshold so that more cases qualify for outlier payments. Therefore, we

believe that the above factors cumulatively contributed to a lower fixed-loss outlier

threshold in FY 2008 compared to FY 2007.

Comment: Similar to its statement in the March 2005 Report to Congress,

MedPAC commented there is a need to reform the financing of outlier payments.

MedPAC explained that variation in the prevalence of outlier cases contributes to

disparities in relative probability across and within DRGs. MedPAC explained that these

disparities can penalize hospitals that treat patients in DRGs with a low prevalence of

outliers. Therefore, MedPAC recommended that Congress give the Secretary authority to

adjust the DRG relative weights to account for differences by DRG in the prevalence of

outlier cases.

Response: As noted in the FY 2007 final rule (71 FR 47921), we do not have the

statutory authority to implement MedPAC's recommendation. Therefore, we placed

most of our attention and resources on the recommendations related to refinement of the

current DRGs. However, we intend to examine MedPAC's recommendation regarding

outliers in more detail in the future.

Comment: One commenter recommended that CMS make a midyear change to

the outlier threshold if it appears that the 5.1 percent target will not be met. The

commenter suggested that CMS use more recent CCR data for a midyear correction to the

outlier threshold and use thresholds such as if outlier payments less than 95 percent or

greater than 105 percent of the 5.1 percent target to trigger a midyear adjustment. Other

commenters recommended that CMS further lower the threshold because CMS did not

spend the total allocated pool of cost outlier funds allocated for outlier payments in

FYs 2005, 2006, and 2007.

Response: With respect to the comments above, we have responded to similar comments in the FY 2006 IPPS final rule (70 FR 47495). We refer readers to that final rule.

Comment: One commenter recommended that CMS keep the proposed threshold for FY 2008 or use the FY 2007 outlier threshold for FY 2008 because CMS has underpaid the outlier pool for a number of years and has underestimated the outlier threshold as well.

Response: With respect to the comment above, we have responded to a similar comment in the FY 2007 IPPS final rule (71 FR 48151). We refer readers to that final rule. We further note that the threshold we are finalizing for FY 2008 is lower than the FY 2007 outlier threshold and the FY 2008 proposed outlier threshold. If outlier payments are lower than the 5.1 percent removed from IPPS rates, one would expect that the commenter would be suggesting reducing the outlier threshold so a higher percentage of total payments are made as outliers.

(2) Other changes concerning outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), 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 2008 will result in outlier payments that will equal to

5.1 percent of operating DRG payments and 4.83 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 2008

standardized amount by the same percentage to account for the projected proportion of

payments paid as outliers.

The outlier adjustment factors that are applied to the standardized amount for the

FY 2008 outlier threshold are as follows:

	Operating Standardized Amounts	Capital Federal Rate
National	0.948980	0. 951665
Puerto Rico	0. 964470	0. 956231

Consistent with current policy, we applied the outlier adjustment factors to

FY 2008 rates after removing the effects of the FY 2007 outlier adjustment factors on the

standardized amount.

To determine whether a case qualifies for outlier payments, we apply

hospital-specific CCRs to the total covered charges for the case. Estimated operating and

capital costs for the case are calculated separately by applying separate operating and

capital CCRs. These costs are then combined and compared with the outlier fixed-loss

cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide

average CCRs for hospitals with CCRs that fell below 3 standard deviations from the

national mean CCR. However, for those hospitals for which the fiscal intermediary or

MAC computes operating CCRs greater than 1.238 or capital CCRs greater than 0.152, or

hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as

described at §412.84(i)(3) of our regulations), we still use statewide average CCRs to

determine whether a hospital qualifies for outlier payments.[29] Table 8A in section V. of

the Addendum of this final rule with comment period contains the statewide average

operating CCRs for urban hospitals and for rural hospitals for which the fiscal

intermediary or MAC is unable to compute a hospital-specific CCR within the above

range. Effective for discharges occurring on or after October 1, 2007, these statewide

average ratios replace the ratios published in the IPPS final rule for FY 2007

(71 FR 48303). Table 8B in section V. of the Addendum to this final rule with comment

period contains the comparable statewide average capital CCRs. Again, the CCRs in

Tables 8A and 8B will be used during FY 2008 when hospital-specific CCRs based on

the latest settled cost report are either not available or are outside the range noted above.

For an explanation of Table 8C, please see section V. of the Addendum to this final rule

with comment period.

        We finally note that we published a manual update (Change Request 3966) to

our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the

Medicare Claims Processing Manual. The manual update covered an array of topics,

including CCRs, reconciliation, and the time value of money. We encourage hospitals

that are assigned the statewide average operating and/or capital CCRs to work with their

fiscal intermediaries (or MAC if applicable) on a possible alternative operating and/or

capital CCR as explained in Change Request 3966. Use of an alternative CCR developed

by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible

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[29] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

overpayments or underpayments at cost report settlement thus ensuring better accuracy

when making outlier payments and negating the need for outlier reconciliation. We also

note that a hospital may request an alternative operating or capital CCR ratio at any time

as long as the guidelines of Change Request 3966 are followed. To download and view

the manual instructions on outlier and cost-to-charge ratios, please visit the Web site:

http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf.

(3) FY 2006 and FY 2007 outlier payments

      In the FY 2007 IPPS final rule (70 FR 47496), we stated that, based on available

data, we estimated that actual FY 2006 outlier payments would be approximately

4.62 percent of actual total DRG payments. This estimate was computed based on

simulations using the FY 2005 MedPAR file (discharge data for FY 2005 bills). That is,

the estimate of actual outlier payments did not reflect actual FY 2006 bills, but instead

reflected the application of FY 2006 rates and policies to available FY 2005 bills.

      Our current estimate, using available FY 2006 bills, is that actual outlier payments

for FY 2006 were approximately 4.65 percent of actual total DRG payments. Thus, the

data indicate that, for FY 2006, the percentage of actual outlier payments relative to

actual total payments is lower than we projected before FY 2006. 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 2006 are equal to 5.1 percent of total DRG payments.

      We currently estimate that actual outlier payments for FY 2007 will be

approximately 4.6 percent of actual total DRG payments, 0.5 percentage points lower

than the 5.1 percent we projected in setting the outlier policies for FY 2007. This

estimate is based on simulations using the FY 2006 MedPAR file (discharge data for

FY 2006 bills). We used these data to calculate an estimate of the actual outlier

percentage for FY 2007 by applying FY 2007 rates and policies, including an outlier

threshold of $24,485 to available FY 2006 bills. We note that our estimate of FY 2007

outlier payments is 0.3 percentage points less than our estimate from the proposed rule.

We believe the 1.06 percentage point change in the charge inflation factor from the

proposed rule to this final rule with comment period contributed to a lower FY 2007

outlier payment estimate in this final rule with comment period. Additionally, we used a

more recent update of the FY 2006 MedPAR claims database and the PSF for this final

rule with comment period, which also affects the FY 2007 outlier payment estimate, and

could contribute to a lower FY 2007 outlier payment estimate for this final rule with

comment period.

f. 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.H. of the preamble to this final rule with comment period, we

have satisfied this requirement by adjusting national IPPS rates by a factor that is

sufficient to account for the added costs of this demonstration. We estimate that the

average additional annual payment that will be made to each participating hospital under

the demonstration will be approximately $1,075,765. We based this estimate on the

recent historical experience of the difference between inpatient cost and payment for

hospitals that are participating in the demonstration program. For 9 participating

hospitals, the total annual impact of the demonstration program for FY 2008 is

$9,681,893. The required adjustment to the Federal rate used in calculating Medicare

inpatient prospective payments as a result of the demonstration is 0.999903.

In order to achieve budget neutrality, we adjust the national IPPS rates by an

amount sufficient to account for the added costs of this demonstration. In other words,

we apply budget neutrality across the payment system as a whole rather than merely

across the participants of this demonstration, consistent with past practice. We believe

that the language of the statutory budget neutrality requirement permits the agency to

implement the budget neutrality provision in this manner. The statutory language

requires that "aggregate payments made by the Secretary do not exceed the amount which

the Secretary would have paid if the demonstration…was not implemented," but does not

identify the range across which aggregate payments must be held equal.

5. FY 2008 Standardized Amount

The adjusted standardized amount is divided into labor-related and

nonlabor-related portions. Tables 1A and 1B in section V. of the Addendum to this final

rule with comment period contain the national standardized amounts that we apply to all

hospitals, except hospitals located in Puerto Rico, for FY 2008. The Puerto Rico-specific

amounts are shown in Table 1C. The amounts shown in Tables 1A and 1B differ only in

that the labor-related share applied to the standardized amounts in Table 1A is 69.7

percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and

1886(d)(9)(C)(iv) of the Act, we apply a labor-related share of 62 percent, unless

application of that percentage would result in lower payments to a hospital than would

otherwise be made. In effect, the statutory provision means that we apply a labor-related

share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indexes

are less than or equal to 1.0000.

In addition, Tables 1A and 1B include standardized amounts reflecting the full 3.3

percent update for FY 2008, and standardized amounts reflecting the 2.0 percentage point

reduction to the update (a 1.3 percent update) applicable for hospitals that fail to submit

quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico

payment rate is based on the discharge-weighted average of the national large urban

standardized amount (this amount is set forth in Table 1A). The labor-related and

nonlabor-related portions of the national average standardized amounts for Puerto Rico

hospitals for FY 2008 are set forth in Table 1C of section V. of the Addendum to this

final rule with comment period. This table also includes the Puerto Rico standardized

amounts. The labor-related share applied to the Puerto Rico specific standardized

amount is 58.7 percent, or 62 percent, depending on which provides higher payments to

the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of

Pub. L. 108-173, provides that the labor-related share for hospitals located in Puerto Rico

be 62 percent, unless the application of that percentage would result in lower payments to

the hospital.) The following table illustrates the changes from the FY 2007 national

average standardized amount. The second and third columns show the changes from the

FY 2007 standardized amounts for hospitals that satisfy the quality data submission

requirement for receiving the full update (3.3 percent) with the different labor-related

shares that apply to hospitals. The fourth and fifth columns show the changes for

hospitals receiving the reduced update (1.3 percent) with the different labor-related shares

that apply to hospitals. The first row of the table shows the updated (through FY 2007)

average standardized amount after restoring the FY 2007 offsets for outlier payments,

demonstration budget neutrality, the wage index transition budget neutrality, and the

geographic reclassification budget neutrality. The DRG reclassification and recalibration

and wage index budget neutrality factor is cumulative. Therefore, the FY 2007 factor is

not removed from this table. We have added two additional rows: one for the

documentation and coding adjustment and the other for the rural floor adjustment. The

rural floor adjustment removes the effect of the budget neutrality adjustment applied in

FY 2007 to the standardized amount for application of the rural floor. It is meant to

address a single year transition from a cumulative budget neutrality adjustment applied to

the standardized amount to a noncumulative adjustment applied to the wage index. (For

a complete discussion on the documentation and coding adjustment and the rural floor

adjustment, we refer readers to section III.G.4. of the preamble to this final rule with

comment period and section II.D. of the Addendum to this final rule with comment

period.)

**Comparison of FY 2007 Standardized Amounts to the FY 2008 Single Standardized
Amount with Full Update and Reduced Update**

	Full Update (3.3 percent); Wage index is greater than 1.0000	Full Update (3.3 percent); Wage index is less than 1.0000	Reduced Update (1.3 percent); Wage index is greater than 1.0000	Reduced Update (1.3 percent); Wage index is less than 1.0000
FY 2007 Base Rate, after removing reclassification budget neutrality, demonstration budget neutrality, wage index transition budget neutrality factors and outlier offset (based on the labor and market share percentage for FY 2008)	Labor: $3,609.23 Nonlabor: $1,569.01	Labor: $3, 609.23 Nonlabor: $1, 569.01	Labor: $3,609.23 Nonlabor: $1,569.01	Labor: $3,609.23 Nonlabor: $1,569.01
FY 2008 Update Factor	1.033	1.033	1.013	1.013
FY 2008 DRG Recalibrations and Wage Index Budget Neutrality Factor	0.996563	0. 996563	0.996563	0. 996563
FY 2008 Reclassification Budget Neutrality Factor	0. 991695	0. 991695	0. 991695	0. 991695
Adjusted for Blend of FY 2007 DRG Recalibration and Wage Index Budget Neutrality Factors	Labor: $3,684.66 Nonlabor: $1,601.80	Labor: $3,277.61 Nonlabor: $1,570.99	Labor: $3,613.33 Nonlabor: $1,570.79	Labor: $3,214.15 Nonlabor: $1,969.96
Imputed Rural Floor Budget Neutrality Factor	0.999318	0.999318	0.999318	0.999318
FY 2008 Outlier Factor	0.948980	0.948980	0.948980	0.948980
Rural Demonstration Budget Neutrality Factor	0. 999903	0. 999903	0. 999903	0. 999903
FY 2008 Documentation and Coding Adjustment	0.988	0.988	0.988	0.988
Rural Floor Adjustment	1.002214	1.002214	1.002214	1.002214
Rate for FY 2008	Labor: $3,459.66 Nonlabor: $1,503.98	Labor: $3,077.46 Nonlabor: $1,886.18	Labor: $3,392.68 Nonlabor: $1,474.86	Labor: $3,017.87 Nonlabor: $1,849.67

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 (as set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for hospitals located in Puerto Rico are set forth in Table 1C of section V. of the Addendum of this final rule with comment period. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico standardized amount is 58.7 percent, or 62 percent, depending on which results in higher payments 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 located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

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

Tables 1A through 1C, as set forth in section V. of the Addendum to this final rule with comment period, contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2008. This section addresses two types of adjustments to the standardized amounts that were made in determining the prospective payment rates as described in this Addendum.

1. 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 with comment period, we discuss the data

and methodology for the FY 2008 wage index.

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

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment

to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher

labor-related costs for these two States are taken into account in the adjustment for area

wages described above. For FY 2008, we adjusted the payments for hospitals in Alaska

and Hawaii by multiplying the nonlabor-related portion of the standardized amount by

the applicable adjustment factor contained in the table below.

Table of Cost-of-Living Adjustment Factors:
Alaska and Hawaii Hospitals

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

(The above factors are based on data obtained from the U.S. Office of Personnel
Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble of this final rule with comment period,

we are adopting a revised classification system for all hospital discharges, assigning them

into MS-DRGs, and have developed relative weights for each MS-DRG that reflect the

resource utilization of cases in each MS-DRG relative to Medicare cases in other

MS-DRGs. Table 5 of section V. of the Addendum to this final rule with comment

period contains the relative weights that we will apply to discharges occurring in

FY 2008. These factors have been recalibrated as explained in section II. of the preamble

of this final rule with comment period.

D. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2008   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 2008 equals the Federal

rate.

The prospective payment rate for SCHs for FY 2008 equals the higher of the

applicable Federal rate, or the hospital-specific rate as described below. The prospective

payment rate for MDHs for FY 2008 equals the higher of the Federal rate, or the Federal

rate plus 75 percent of the difference between the Federal rate and the hospital-specific

rate as described below. The prospective payment rate for hospitals located in

Puerto Rico for FY 2008 equals 25 percent of the Puerto Rico rate plus 75 percent of the

applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1--Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2--Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3--For hospitals in Alaska and Hawaii, multiply the non-labor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4--Add the amount from Step 2 and the non-labor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5--Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS-DRG (see Table 5 of section V. of the Addendum to this final rule with comment period).

The Federal rate as determined in Step 5 is then further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act, the payment in Step 5 is increased by 25 percent.

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

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that 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 are no longer subject to the 12-percent cap on their DSH

payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on

the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the

FY 1996 costs per discharge and for MDHs, the FY 2002 cost per discharge. For a more

detailed discussion of the calculation of the hospital-specific rates, we refer the reader to

the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with

comment (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001

IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the

hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed

in section IV.C. of the preamble to this final rule with comment period. The resulting

rate is used in determining the payment rate an SCH or MDH will receive for its

discharges beginning on or after October 1, 2007.

Comment: One commenter stated that CMS did not formally state a budget neutrality factor for the hospital-specific rate in the proposed rule and omitted it from the final notice of IPPS rates for FY 2007 published in **Federal Register** on October 11, 2006. The commenter asked that the CMS formally state the budget neutrality factor that will apply to the hospital-specific rates for SCHs and MDHs. Further, the commenter requested that the documentation and coding adjustment not apply to the hospital-specific rate for MDHs and SCHs.

Response: We regret not publishing the DRG recalibration budget neutrality factor that is applicable to the hospital-specific rate for MDHs and SCHs in the final notice of IPPS rates for FY 2007 published in the **Federal Register** on October 11, 2007. We will make the annual DRG recalibration budget neutrality factor available in this section of each year's IPPS proposed and final rules. The FY 2008 DRG recalibration factor that will apply to the hospital-specific rate of MDHs and SCHs is 0.983962. This factor includes the -1.2 percent documentation and coding adjustment.

Hospitals that are paid under section 1886(d) of the Act based on a hospital-specific rate are subject to the DRG reclassification and recalibration factor component of the budget neutrality adjustment because, as IPPS, hospitals, they are paid based on DRGs. Changes in DRG relative weights from one year to the next affect aggregate SCH and MDH payments, which, in turn, affect total payments to hospitals under section 1886(d) of the Act. Because SCHs and MDHs are paid under section 1886(d) of the Act, we believe their DRG payments should be factored into the DRG reclassification and recalibration factor component of the budget neutrality adjustment to

ensure that recalibration does not affect total payments to hospitals under section 1886(d) of the Act. Similarly, we believe the hospital-specific rates for MDHs and SCHs should be subject to the documentation and coding adjustment we are applying under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality for the adoption of the MS-DRGs. That is, as these hospitals use the same DRG system as all other hospitals, we believe they should be equally subject to the budget neutrality adjustment that we are applying for adoption of the MS-DRGs to all other hospitals.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2008

We are increasing the hospital-specific rates by 3.3 percent (the estimated hospital market basket percentage increase) for SCHs and MDHs for FY 2008. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2008, is the market basket rate-of-increase. 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 2008, is the market basket rate-of-increase. For those SCHs and MDHs that fail to submit quality data, the update to the hospital-specific rates is 1.3 percent.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2007, and Before October 1, 2008

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1- Select the applicable average standardized amount considering the applicable wage index (see Table 1C).

Step 2 - Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3 - Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4 - Multiply the amount from Step 3 by the applicable MS-DRG relative weight (see Table 5 of section V. of the Addendum to this final rule with comment period).

Step 5 - Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1 - Select the applicable average standardized amount.

Step 2--Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3 - Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4 - Multiply the amount from Step 3 by the applicable MS-DRG relative weight (see Table 5 of section V. of the Addendum to this final rule with comment period).

Step 5 - Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate is then further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2008

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology based fully on the Federal rate.

The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2008, which is effective for discharges occurring on or after October 1, 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

be adjusted annually by a factor equal to the estimated proportion of outlier payments

under the capital Federal rate to total capital payments under the capital Federal rate. In

addition, §412.308(c)(3) requires that the capital Federal rate be reduced by an

adjustment factor equal to the estimated proportion of payments for (regular and special)

exceptions under §412.348. Section 412.308(c)(4)(ii) requires that the capital standard

Federal rate be adjusted so that the effects of the annual DRG reclassification and the

recalibration of DRG weights and changes in the geographic adjustment factor 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 for 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,

the budget neutrality adjustment factor in effect as of September 30, 1995, be applied to

the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate.

That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the

unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was

effective from October 1, 1997 through September 30, 2002, making the total reduction

17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and

implemented in §412.308(b)(6) of the regulations, the 2.1 percent 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 made under the regular exception policy effective with cost reporting periods

beginning in FY 2002, we discontinued use of the capital cost model. The capital cost

model and its application during the transition period are described in Appendix B of the

FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for the use of a blended payment system for payments

to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient

capital-related costs. Accordingly, under the capital PPS, we compute a separate

payment rate specific to hospitals located in Puerto Rico using the same methodology

used to compute the national Federal rate for capital-related costs. In accordance with

section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs,

hospitals located in Puerto Rico are paid for operating costs under a special payment

formula. Prior to FY 1998, hospitals located in Puerto Rico were paid a blended

operating rate that consisted of 75 percent of the applicable standardized amount specific

to Puerto Rico hospitals and 25 percent of the applicable national average standardized

amount. Similarly, prior to FY 1998, hospitals located in Puerto Rico were paid a

blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-

specific rate and 25 percent of the applicable capital Federal rate. However, effective

October 1, 1997, in accordance with section 4406 of Pub. L. 105-33, the methodology for

operating payments made to hospitals located in Puerto Rico under the IPPS was revised

to make payments based on a blend of 50 percent of the applicable standardized amount

specific to Puerto Rico hospitals and 50 percent of the applicable national average

standardized amount. In conjunction with this change to the operating blend percentage,

effective with discharges occurring on or after October 1, 1997, we also revised the

methodology for computing capital payments to hospitals located in Puerto Rico to be

based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the

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

hospitals located in Puerto Rico from 50 percent to 62.5 percent and decreased the Puerto

Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for

discharges occurring on or after April 1, 2004 through September 30, 2004 (see the

March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section

504 of Pub. L. 108-173 provided that the national portion of operating IPPS payments for

hospitals located in Puerto Rico be equal to 75 percent and the Puerto Rico portion of

operating IPPS payments be equal to 25 percent for discharges occurring on or after

October 1, 2004. Consistent with that change in operating IPPS payments to hospitals

located in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we

revised the methodology for computing capital payments to hospitals located in Puerto

Rico to be based on a blend of 25 percent of the Puerto Rico 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 2007 IPPS final rule (71 FR 48161), we established a tentative capital Federal rate of

$427.38 for FY 2007. In the **Federal Register** notice establishing the occupational mix

adjusted payment rates for FY 2007 (71 FR 59891), we established the final FY 2007

Federal rate of $427.03 for FY 2007. In the discussion that follows, we explain the

factors that we used to determine the FY 2008 capital Federal rate. In particular, we

explain why the FY 2008 capital Federal rate will decrease approximately 0.86 percent,

compared to the FY 2007 capital Federal rate. (As discussed in section V. of the

preamble of this final rule with comment period, we did not finalize the proposed zero

percent update for urban hospitals, which would have resulted in separate capital Federal

rates for FY 2008 for rural hospitals and for urban hospitals. Thus, a single capital

Federal rate for FY 2008 was determined for all hospitals.) However, taking into account

an estimated increase in Medicare fee-for-service discharges in FY 2008 as compared to

FY 2007, we estimated aggregate capital payments will increase by approximately 2.9

percent during this 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 a 0.1 percent change in actual payments to

hospitals. As noted above, aggregate payments under the capital IPPS are projected to

increase in FY 2008 compared to FY 2007.

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 2008 under that framework is 0.9 percent based on the best data available at this time.

The update factor under that framework is based on a projected 1.3 percent increase in

the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix,

a -0.4 percent adjustment for the FY 2006 DRG reclassification and recalibration, and a

forecast error correction of 0.0 percent. As discussed below in section III.C. of the

Addendum to this final rule with comment period, we continue to believe that the CIPI is

the most appropriate input price index for capital costs to measure capital price changes

in a given year. We also explain the basis for the FY 2008 CIPI projection in that same

section of this Addendum. As noted above, and as discussed in greater detail in section

V. of the preamble of this final rule with comment period, we are not finalizing the

proposed zero percent update for urban hospitals, which would have resulted in separate

capital Federal rates for FY 2008 for rural hospitals and for urban hospitals. Therefore,

we applied the 0.9 percent FY 2008 update factor to all hospitals. In addition, as also

noted below, the capital rates have been further adjusted to account for documentation

and coding improvements under the MS-DRGs discussed in section II.D. of the preamble

of this final rule with comment period. Below we describe the policy adjustments that

have been applied in the update framework for FY 2008.

The case-mix index is the measure of the average DRG weight for cases paid

under the IPPS. Because the DRG weight determines the prospective payment for each

case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

● The average resource use of Medicare patients changes ("real" case-mix change);

● Changes in hospital coding of patient records result in higher weight DRG assignments ("coding effects"); and

● The annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect").

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent the change to the MS-DRGs, for FY 2008, we project a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will also equal 1.0 percent for FY 2008. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase

in case-mix. Therefore, the net adjustment for case-mix change in FY 2008 is 0.0

percentage points.

The capital update framework also contains an adjustment for the effects of DRG

reclassification and recalibration. This adjustment is intended to remove the effect on

total payments of prior year's changes to the DRG classifications and relative weights, in

order to retain budget neutrality for all case-mix index-related changes other than those

due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag

in data used to determine the adjustment for the effects of DRG reclassification and

recalibration. For example, we adjusted for the effects of the FY 2006 DRG

reclassification and recalibration as part of our update for FY 2008. We estimate that

FY 2006 DRG reclassification and recalibration resulted in a 0.4 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 -0.4 percent adjustment for DRG reclassification in the update for FY 2008 to

maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The

input price index forecast is based on historical trends and relationships ascertainable at

the time the update factor is established for the upcoming year. In any given year, there

may be unanticipated price fluctuations that may result in differences between the actual

increase in prices and the forecast used in calculating the update factors. In setting a

prospective payment rate under the framework, we make an adjustment for forecast error

only if our estimate of the change in the capital input price index for any year is off by

0.25 percentage points or more. There is a 2-year lag between the forecast and the

availability of data to develop a measurement of the forecast error. A forecast error of

0.10 percentage point was calculated for the FY 2006 update. That is, current historical

data indicate that the forecasted FY 2006 CIPI (0.80 percent) used in calculating the

FY 2006 update factor slightly understated the actual realized price increases

(0.90 percent) by 0.10 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 2008.

Under the capital IPPS update framework, we also make an adjustment for

changes in intensity. We calculate this adjustment using the same methodology and data

that were used in the past under the framework for operating IPPS. The intensity factor

for the operating update framework reflects how hospital services are utilized to produce

the final product, that is, the discharge. This component accounts for changes in the use

of quality-enhancing services, for changes within DRG severity, and for expected

modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per

admission, adjusted for price level changes (the CPI for hospital and related services) and

changes in real case-mix. The use of total charges in the calculation of the intensity

factor makes it a total intensity factor; that is, charges for capital services are already built

into the calculation of the factor. Therefore, we have incorporated the intensity

adjustment from the operating update framework into the capital update framework.

Without reliable estimates of the proportions of the overall annual intensity increases that

are due, respectively, to ineffective practice patterns and the combination of

quality-enhancing new technologies and complexity within the DRG system, we assume

that one-half of the annual increase is due to each of these factors. The capital update

framework thus provides an add-on to the input price index rate of increase of one-half of

the estimated annual increase in intensity, to allow for increases within DRG severity and

the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year

average. Past studies of case-mix change by the RAND Corporation (Has DRG Creep

Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988 by G. M.

Carter, J. P. Newhouse, and D. A. Relles, R-4098-HCFA/ProPAC (1991)) suggest that

real case-mix change was not dependent on total change, but was usually a fairly steady

increase of 1.0 to 1.5 percent per year. However, we used 1.4 percent as the upper bound

because the RAND study did not take into account that hospitals may have induced

doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per

admission, adjusted for price level changes (the CPI for hospital and related services),

and changes in real case-mix. As we noted above, in accordance with §412.308(c)(1)(ii),

we began updating the capital standard Federal rate in FY 1996 using an update

framework that takes into account, among other things, allowable changes in the intensity

of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below), and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, the intensity adjustment for FY 2008 is based on data from the 5-year period beginning with FY 2002 and extending through FY 2006. 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), the FY 2006 IPPS final rule (70 FR 47500), and the FY 2007 IPPS final rule (72 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) and the FY 2007

IPPS final rule (71 FR 48157), 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 and FY 2007, respectively.

On June 9, 2003, we published in the **Federal Register** revisions to our outlier

policy for determining the additional payment for extraordinarily high-cost cases

(68 FR 34494 through 34515). These revised policies were effective on August 8, 2003,

and October 1, 2003. While it does appear that a response to these policy changes is

beginning to occur, that is, the change in charges for FYs 2004 and 2005 are somewhat

less than the previous 4 years, and the change in charges for FY 2006 is slightly less than

FY 2005, 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, FY 2005, and FY 2006 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 the effects of hospitals attempting to

maximize outlier payments, while lessening costs, continue to skew the charge data.

Therefore, we are making a 0.0 percent adjustment for intensity for FY 2008. 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 2008 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 0.9 percent

capital update factor under the capital update framework for FY 2008 as shown in the

table below. (As noted above and as discussed in section V. of the preamble of this final

rule with comment period, we are not finalizing the proposed zero percent update for

urban hospitals. Thus, the 0.9 percent capital update factor discussed above was applied

in determining the capital Federal rate for FY 2008 for all hospitals.)

CMS FY 2008 Update Factor to the Capital Federal Rate
for All Hospitals

Capital Input Price Index	1.3
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	-0.4
Forecast Error Correction	0.0
Total Update for Hospitals	0.9

b. MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a

Report to Congress. In its March 2007 Report to Congress, MedPAC did not make an

update recommendation for capital IPPS payments for FY 2008. However, in that same

report, MedPAC made an update recommendation for hospital inpatient and outpatient

services (page 67). MedPAC reviews inpatient and outpatient services together because

they are so closely interrelated. For FY 2008, MedPAC recommended an increase in the

payment rate for the operating IPPS by the projected increase in the hospital market

basket index concurrent with implementation of a quality incentive payment policy.

(MedPAC's Report to the Congress: Medicare Payment Policy, March 2007,

Section 2A.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for

inpatient operating and inpatient capital-related costs. A single set of thresholds is used

to identify outlier cases for both inpatient operating and inpatient capital-related

payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient

capital-related costs be reduced by an adjustment factor equal to the estimated proportion

of capital-related outlier payments to total inpatient capital-related PPS payments. The

outlier thresholds are set so that operating outlier payments are projected to be

5.1 percent of total operating DRG payments.

Comment: One commenter expressed concern regarding the "significant change"

to the proposed outlier adjustment factor that has been applied in determining the

proposed FY 2008 capital Federal Rate, which would have the effect of decreasing the

FY 2008 capital Federal Rate by 0.88 percent (72 FR 24847). The commenter stated that

there seems to be a "large change" in the capital outlier adjustment factor, given the fact

that both the FY 2008 IPPS proposed rule (72 FR 24837) and the FY 2007 IPPS final rule

(71 FR 48151) indicate that estimated capital outlier payments would equal 4.87 percent

of capital IPPS payments. The commenter pointed out that, in both the FY 2008 IPPS

proposed rule and the FY 2007 IPPS final rule, there appears to be inconsistencies

regarding the estimated percentage of capital outlier payments. Specifically, in the

FY 2007 IPPS final rule (71 FR 48151), in section II.A.4.c.ii. of the Addendum, it states

that capital outlier payments are estimated to be 4.87 percent in FY 2007, while in section

III.A.2. of the Addendum of that same final rule (71 FR 48158), it states that we estimate

that capital outlier payments would equal 4.32 percent in FY 2007. Similarly, in the

FY 2008 IPPS proposed rule (72 FR 24837), in section II.A.4.d.(2). of the Addendum, it

states that capital outlier payments are estimated to be 4.87 percent in FY 2008, while in

section III.A.1.b. of the Addendum of that same proposed rule (72 FR 24843), it states

that we estimate that proposed capital outlier payments would equal 5.16 percent in

FY 2008. The commenter requested that CMS explain the inconsistencies in estimated

capital outlier payments noted above and that CMS review the calculations to ensure that

the correct outlier adjustment is applied in determining the capital Federal rate for

FY 2008.

    Response: We appreciate the commenter bringing the inconsistencies in

estimated capital outlier payments in the FY 2007 IPPS final rule and the FY 2008 IPPS

proposed rule to our attention. After careful review of the calculation of the outlier

adjustment factors used in determining the FY 2007 and proposed FY 2008 capital

Federal rates, respectively, we have determined that the estimated 4.87 percent of capital

outlier payments for both FY 2007 and FY 2008 as stated in section II.A.4.c.ii. of the

Addendum of the FY 2007 IPPS final rule (71 FR 48151) and in section II.A.4.d.(2). of

the Addendum of the FY 2008 IPPS proposed rule (72 FR 24837), respectively, were

typographical errors. The correct estimate of capital outlier payment for FY 2007 was

4.32 percent, and therefore, we applied an outlier adjustment of 0.9568 (1 - 0.0432 =

0.9568) in determining the FY 2007 capital Federal rate, as discussed in section III.A.2.

of the Addendum of the FY 2007 IPPS final rule (71 FR 48158). The correct estimate of

proposed capital outlier payment for FY 2008 is 5.16 percent, and therefore, we proposed

to apply an outlier offset of 0.9484 (1 - 0.0516 = 0.9484) in determining the proposed

FY 2008 capital Federal rate, as stated in section III.A.1.b. of the Addendum of the

FY 2008 IPPS proposed rule (72 FR 24843). We also note that we estimate that the

percentage of capital outlier payments to total capital standard payments for FY 2008 will

be slightly higher than the percentages for FY 2007, and that the outlier reduction factors

are not applied cumulatively in determining the capital Federal rate. Therefore, the net

change in the proposed outlier adjustment to the proposed capital Federal rate for

FY 2008 is 0.9912 (0.9484/0.9568) or -0.88 percent. Thus, the proposed outlier

adjustment decreases the proposed FY 2008 capital Federal rate by -0.88 percent

compared with the FY 2007 outlier adjustment (72 FR 24843).

While it may appear that there is a "large change" in the estimate of capital outlier

payments (and capital outlier offset) from FY 2007 to FY 2008, we wish to point out that

the estimated 5.16 percent proposed for FY 2008 does not appear to be considerably

different from our estimate of capital outlier payments for the past several years of 4.87

percent proposed for FY 2007 (71 FR 24196), 4.85 percent established for FY 2006

(70 FR 47501), 5.03 percent proposed for FY 2006 (70 FR 23477) and for FY 2005

(69 FR 28383), 4.94 percent established for FY 2005 (69 FR 49286), 4.77 percent

established for the first half of FY 2004 (68 FR 57734), 4.92 percent established for the

second half of FY 2004 (Change Request 3158; March 26, 2004), 5.45 percent proposed

for FY 2004 (68 FR 27240), 5.31 percent established for FY 2003 (67 FR 50129), and

5.40 percent proposed for FY 2003 (67 FR 31514). We also note, as discussed in the

FY 2008 IPPS proposed rule (72 FR 24837), we proposed a lower fixed-loss outlier

threshold in FY 2008 compared to FY 2007. We explained that as we are better able to

estimate the costs using CCRs and charges, and cases are paid more accurately with

better recognition of severity of illness using the proposed MS-DRGS, in order to meet

the 5.1 percent target for operating IPPS outlier payments, we proposed to decrease the

fixed-loss outlier threshold so that more cases qualify for outlier payments. As explained

below, §412.312(c) provides for a single set of thresholds to identify outlier cases for

both operating and inpatient capital IPPS payments. Therefore, we believe it is

appropriate that the estimate of capital outlier payments would increase for FY 2008 as

compared to FY 2007. As requested by the commenter and as stated above, we have

carefully reviewed the calculations to ensure that the correct outlier adjustment, as

discussed in greater detail below, is applied in determining the capital Federal rate for

FY 2008. (We note that there is usually a change in the outlier adjustment between the

proposed and final rules for a given year due to the use of more updated data and any

changes between proposed and finalized policies that affect payments. For example, in

the FY 2007 proposed rule (71 FR 24196), the proposed FY 2007 outlier offset was

0.9513, while we established an outlier offset for FY 2007 of 0.9568, as discussed

below.)

In the **Federal Register** notice establishing the final occupational mix adjusted

payment rates for FY 2007 (71 FR 59890), we estimated that outlier payments for capital

would equal 4.32 percent of inpatient capital-related payments based on the capital

Federal rate in FY 2007. Based on the thresholds as set forth in section II.A. of the

Addendum to this final rule with comment period, we estimate that outlier payments for

capital-related costs will equal 4.83 percent for inpatient capital-related payments based

on the Federal rate in FY 2008. Therefore, we are applying an outlier adjustment factor

of 0.9517 to the capital Federal rate. Thus, we estimate that the percentage of capital

outlier payments to total capital standard payments for FY 2008 will be slightly higher than the percentages for FY 2007.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2008 outlier adjustment of 0.9517 is a -0.53 percent change from the FY 2007 outlier adjustment of 0.9568. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2008 is 0.9947 (0.9517/0.9568). Thus, the outlier adjustment decreases the FY 2008 capital Federal rate by 0.53 percent compared with the FY 2007 outlier adjustment.

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

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of the Addendum to this final rule with comment period, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we will no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the factors for FY 2008, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2007 DRG relative weights and the FY 2007 GAF to estimated aggregate capital Federal rate payments based on the FY 2008 relative weights and the FY 2008 GAF. As we established in the final FY 2007 occupational mix adjusted payment rates' notice (71 FR 59890), the budget neutrality factors were 0.9906 for the national capital rate and 0.9968 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 applied an incremental budget neutrality adjustment of 1.0018 for FY 2008 to the previous

cumulative FY 2007 adjustments of 0.9906, yielding an adjustment of 0.9924, through

FY 2008. For the Puerto Rico GAF, we applied an incremental budget neutrality

adjustment of 1.0008 for FY 2008 to the previous cumulative FY 2007 adjustment of

0.9968, yielding a cumulative adjustment of 0.9976 through FY 2008.

We then compared estimated aggregate capital Federal rate payments based on

the FY 2007 DRG relative weights and the FY 2007 GAF to estimated aggregate capital

Federal rate payments based on the FY 2008 DRG relative weights and the FY 2008

GAF. The incremental adjustment for DRG classifications and changes in relative

weights is 0.9979 both nationally and for Puerto Rico. The cumulative adjustments for

DRG classifications and changes in relative weights and for changes in the GAF through

FY 2008 are 0.9903 nationally and 0.9955 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 | | | | Incremental Adjustment | | | |
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	Cumulative
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	——
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00178	0.99792	0.99970	0.99027	1.00079[15]	0.99792	0.99870	0.99554

[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.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to the methodology 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 **Federal Register** notice establishing the final FY 2007 occupational mix adjusted payment rates (71 FR 59890), we calculated a GAF/DRG budget neutrality factor of 0.9986 for FY 2007. For FY 2008, we are establishing a GAF/DRG budget neutrality factor of 0.9997. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 2007 to FY 2008 is 0.9997. The cumulative change in the capital Federal rate due to the adjustment is 0.9903 (the product of the incremental

factors for FYs 1994 though 2007 and the incremental factor of 0.9997 for FY 2008).

(We note that averages of the incremental factors that were in effect during FYs 2004 and

2005, respectively, were used in the calculation of the cumulative adjustment of 0.9903

for FY 2008.)

The factor accounts for DRG reclassifications and recalibration and for changes in

the GAF. It also incorporates the effects on the GAF of FY 2008 geographic

reclassification decisions made by the MGCRB compared to FY 2007 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 2008 capital Federal rate because, in accordance with §412.348(b),

regular exception payments were only made for cost reporting periods beginning on or

after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the

FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no

payments are made under the regular exceptions provision. However, in accordance with

§412.308(c), we still need to compute a budget neutrality adjustment for special

exception payments under §412.348(g). We describe our methodology for determining

the exceptions adjustment used in calculating the FY 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 the following criteria: (1) a project need requirement as described at

§412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity

test as described at §412.348(g)(4); (2) an age of assets test as described at

§412.348(g)(3); and (3) a project size requirement as described at §412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have

qualified for special exceptions payments under §412.348(g). Because we have cost

reports ending in FY 2006 for all of these hospitals, we calculated the adjustment based

on actual cost experience. Using data from cost reports ending in FY 2006 from the

December 2006 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 2006, this ratio is rounded to 0.0003.

Because we have not received all cost reports ending in FY 2006, 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 2005. This ratio also rounded to 0.0003.

Because special exceptions are budget neutral, we are offsetting the capital Federal rate

by 0.03 percent for special exceptions payments for FY 2008. Therefore, the exceptions

adjustment factor is equal to 0.9997 (1 – 0.0003) to account for special exceptions

payments in FY 2008.

In the FY 2007 IPPS final rule (71 FR 48161), we estimated that total (special)

exceptions payments for FY 2007 would equal 0.03 percent of aggregate payments based

on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of

0.9997 (1 - 0.0003) to determine the FY 2007 capital Federal rate. As we stated above,

we estimate that exceptions payments in FY 2008 will equal 0.03 percent of aggregate

payments based on the FY 2008 capital Federal rate. Therefore, we are applying an

exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2008.

The exceptions adjustment factor for FY 2008 is the same as the factor used in

determining the FY 2007 capital Federal rate in the FY 2007 IPPS final rule

(71 FR 48161), and is the same factor used for the occupational mix adjusted payment

rates since the adjustments made to the wage index had no effect on capital exceptions

payments (71 FR 59890). The exceptions reduction factors are not built permanently into

the capital rates; that is, the factors are not applied cumulatively in determining the

capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in

determining the FY 2008 capital Federal rate is 1.0000 (0.9997/0.9997).

5. Capital Standard Federal Rate for FY 2008

In the **Federal Register** notice that established the occupational mix adjusted

payment rates for FY 2007 (71 FR 59891), we established a capital Federal rate of

$427.03 for FY 2007. As discussed above and in section V. of the preamble of this final

rule with comment period, we are not finalizing the proposed zero percent update for

urban hospitals, which would have resulted in separate capital Federal rates for FY 2008

rural and urban hospitals. Therefore, we are establishing an update of 0.9 percent in

determining the FY 2008 capital Federal rate for all hospitals. However, under the

statutory authority at section 1886(d)(3)(A)(vi) of the Act, we are applying an additional

1.2 percent reduction to the standardized amounts for both capital and operating Federal

payment rates in FY 2008. The 1.2 percent reduction is based on our Actuary's analysis

of the effect of changes in coding or classification of discharges that do not reflect real

changes in case-mix in light of the adoption of the MS-DRGs. Although the 1.2 percent

reduction is outside the established process for developing the capital Federal payment

rate, it nevertheless is a factor in the final prospective payment rate to hospitals for

capital-related costs. For that reason, the capital Federal payment rates established in this

final rule with comment period were determined by applying the 1.2 percent reduction.

As a result of the 0.9 percent update, the 1.2 percent reduction to account for

improvements in documentation and coding, and the other factors as discussed above, we

are establishing a capital Federal rate of $423.34 for all hospitals for FY 2008. The

capital Federal rate for FY 2008 was calculated as follows:

● The FY 2008 update factor is 1.0090, that is, the update is 0.9 percent.

● The FY 2008 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 (for all hospitals) is 0.9997.

● The FY 2008 outlier adjustment factor is 0.9517.

● The FY 2008 (special) exceptions payment adjustment factor is 0.9997.

● The FY 2008 reduction for improvements in documentation and coding under the MS-DRGs is 1.2 percent.

Because the capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing the following charts that show how each of the factors and adjustments for FY 2008 affected the computation of the FY 2008 capital Federal rate in comparison to the FY 2007 capital Federal rate. The FY 2008 update factor has the effect of increasing the capital Federal rate by 0.90 percent compared to the FY 2007 capital Federal rate. The GAF/DRG budget neutrality factor has the effect of decreasing the capital Federal rate by 0.03 percent. The FY 2008 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.53 percent compared to the FY 2007 capital Federal rate. The FY 2008 exceptions payment adjustment factor remains unchanged from the FY 2007 exceptions payment adjustment factor, and therefore, has a 0.0 percent net effect on the FY 2008 capital Federal rate. In addition to the factors

historically used to determine the capital Federal rate, for FY 2008, we are establishing

an adjustment factor to account for improvements in documentation and coding expected

to result from the MS-DRGs we are adopting, as discussed above in section III. of the

Addendum to this final rule with comment period, in determining the capital Federal rate

for FY 2008. The combined effect of all the changes decreases the capital Federal rate by

0.86 percent compared to the FY 2007 capital Federal rate.

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Comparison of Factors and Adjustments:
FY 2007 Capital Federal Rate and
FY 2008 Capital Federal Rate

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	FY 2007	**FY 2008[4]**	**Change**	**Percent Change[5]**
Update Factor[1]	1.0110	1.0090	1.0090	0.00
GAF/DRG Adjustment Factor[1]	0.9986	0.9997	0.9997	-0.03
Outlier Adjustment Factor[2]	0.9568	0.9517	0.9947	-0.53
Exceptions Adjustment Factor[2]	0.9997	0.9997	1.0000	0.00
MS-DRG Upcoding Adjustment Factor[3]	--------	0.9880	0.9880	-1.20
Capital Federal Rate	$427.03	$423.34	0.9914	-0.86

[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 2007 to FY 2008 resulting from the application of the 0.9997 GAF/DRG budget neutrality factor for FY 2008 is 0.9997.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2008 outlier adjustment factor is 0.9517/0.9568, or 0.9947.

[3] Adjustment to FY 2008 IPPS rates to account for upcoding expected to result from the adoption of the MS-DRGs, as discussed above in section III. of the Addendum to this final rule with comment period.

[4] Factors for FY 2008, as discussed above in section III. of the Addendum to this final rule with comment period.

[5] Percent change of individual factors may not sum due to rounding.

We are also providing the following chart that shows how the final FY 2008

capital Federal rate (for all hospitals) differs from the proposed FY 2008 capital Federal

rates for rural hospitals and for urban hospitals as presented in the FY 2008 IPPS

proposed rule (72 FR 24847). As noted above, we are not finalizing the proposal that

would have resulted in a separate capital Federal rates for FY 2008 for rural hospitals and

for urban hospitals. Therefore, we applied the 0.9 percent FY 2008 update factor to all

hospitals.

Comparison of Factors and Adjustments:
Proposed FY 2008 Capital Federal Rate and
Final FY 2008 Capital Federal Rate

	Proposed FY 2008 for Rural Hospitals	Proposed FY 2008 for Urban Hospitals	Final FY 2008 for All Hospitals[*]	Percent Change for Rural Hospitals[**]	Percent Change for Urban Hospitals[**]
Update Factor	1.0080	1.0000	1.0090	0.01	0.90
GAF/DRG Adjustment Factor	1.0018	1.0018	0.9997	-0.21	-0.21
Outlier Adjustment Factor	0.9484	0.9484	0.9517	0.35	0.35
Exceptions Adjustment Factor	0.9997	0.9997	0.9997	0.00	0.00
MS-DRG Upcoding Adjustment Factor	0.9760	0.9760	0.9880	1.23	1.23
Capital Federal Rate	$417.26	$413.87	$423.34	1.46	2.29

[*] As discussed in section V. of the preamble of this final rule with comment period, we did not finalize the proposed zero percent update for urban hospitals, which would have resulted in a different capital Federal rates for FY 2008 for rural hospitals and for urban hospitals. Consequently, in this final rule with comment period, the same update was applied for all hospitals (both urban and rural), and one capital Federal rate was established for FY 2008 for both urban and rural hospitals.

[5*] Percent change of individual factors may not sum due to rounding.

6. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments

to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient

capital-related costs. Accordingly, under the capital PPS, we computed a separate

payment rate specific to hospitals located in Puerto Rico using the same methodology

used to compute the national Federal rate for capital-related costs. Under the broad

authority of section 1886(g) of the Act, as discussed in section V. of the preamble of this

final rule with comment period, beginning with discharges occurring on or after

October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a

blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal

rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only,

while the capital Federal rate is derived from the costs of all acute care hospitals

participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we

applied 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 used 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

applied separate budget neutrality adjustments for the national GAF and for the Puerto

Rico GAF. However, we applied 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 the Addendum to this final rule with comment period, for Puerto Rico,

the GAF budget neutrality factor is 1.0008, while the DRG adjustment is 0.9979, for a

combined cumulative adjustment of 0.9987.

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 2007, before application of the GAF, the special capital rate for hospitals

located in Puerto Rico was $203.06 for discharges occurring on or after October 1, 2006,

through September 30, 2007. With the changes we are making to the factors used to

determine the capital rate, the FY 2008 special capital rate for hospitals in Puerto Rico is

$199.80.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2008

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals

(except "new" hospitals under §412.324(b) and under §412.304(c)(2)) are paid based on

100 percent of the capital Federal rate in FY 2007. The applicable capital Federal rate

was determined by making the following adjustments:

● For outliers, by dividing the capital standard Federal rate by the outlier

reduction factor for that fiscal year; and

● For the payment adjustments applicable to the hospital, by multiplying the

hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor,

when appropriate.

For purposes of calculating payments for each discharge during FY 2008, the

capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG

weight) x (GAF) 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. (As discussed above and in section V. of the preamble of this final rule with comment period, we are eliminating the large urban add-on adjustment in existing regulations at §412.316, beginning in FY 2008.)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2008 are in section II.A..of the Addendum to this final rule with comment period. For FY 2008, 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 fixed-loss amount of $22,635.

An eligible hospital may also qualify for a special exceptions payment under §412.348(g) up through the 10th year beyond the end of the capital transition period if it meets the following criteria: (1) a project need requirement described at §412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at §412.348(g)(4); and (2) a project size requirement as described at §412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under §412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under §412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) any amount by which a hospital's cumulative capital payments exceed its

cumulative minimum payment levels applicable under the regular exceptions process for

cost reporting periods beginning during which the hospital has been subject to the capital

PPS; and (2) any amount by which a hospital's current year operating and capital

payments (excluding 75 percent of operating DSH payments) exceed its operating and

capital costs. Under §412.348(g)(6), the minimum payment level is 70 percent for all

eligible hospitals.

During the transition period, new hospitals (as defined under §412.300) were

exempt from the capital IPPS for their first 2 years of operation and were paid 85 percent

of their reasonable costs during that period. Effective with the third year of operation

through the remainder of the transition period, under §412.324(b) we paid the hospitals

under the appropriate transition methodology (if the hold-harmless methodology were

applicable, the hold-harmless payment for assets in use during the base period would

extend for 8 years, even if the hold-harmless payments extend beyond the normal

transition period).

Under §412.304(c)(2), for cost reporting periods beginning on or after

October 1, 2002, we pay a new hospital 85 percent of its reasonable costs during the first

2 years of operation unless it elects to receive payment based on 100 percent of the

capital Federal rate. Effective with the third year of operation, we pay the hospital based

on 100 percent of the capital Federal rate (that is, the same methodology used to pay all

other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a

fixed-weight price index that measures the price changes associated with capital costs

during a given year. The CIPI differs from the operating input price index in one

important aspect--the CIPI reflects the vintage nature of capital, which is the acquisition

and use of capital over time. Capital expenses in any given year are determined by the

stock of capital in that year (that is, capital that remains on hand from all current and

prior capital acquisitions). An index measuring capital price changes needs to reflect this

vintage nature of capital. Therefore, the CIPI was developed to capture the vintage

nature of capital by using a weighted-average of past capital purchase prices up to and

including the current year.

We periodically update the base year for the operating and capital input 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 2008

Based on the latest forecast by Global Insight, Inc. (second quarter of 2007), we

forecast that the CIPI will increase to 1.3 percent in FY 2008. This reflects a projected

1.9 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 2008, partially offset by a 2.6 percent decline in vintage-weighted interest

expenses in FY 2008. The weighted average of these three factors produces the 1.3

percent increase for the CIPI as a whole in FY 2008.

IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units:

Rate-of-Increase Percentages

Historically, hospitals and hospital units excluded from the prospective payment

system received payment for inpatient hospital services they furnished on the basis of

reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the

target amount as defined in §413.40(a)) was set for each hospital or hospital unit based on

the hospital's own cost experience in its base year. The target amount was multiplied by

the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in

§413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior

to October 1, 1997, these payment provisions applied consistently to all categories of

excluded providers (rehabilitation hospitals and units (now referred to as IRFs),

psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals,

and cancer hospitals).

Payment for services furnished in children's hospitals and cancer hospitals that

are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based

on the hospital's own historical cost experience. (We note that, in accordance with

§403.752(a), RNHCIs are also subject to the rate-of-increase limits established under

§413.40 of the regulations.)   We had previously proposed that the FY 2008

rate-of-increase percentage for cancer and children's hospitals and RNHCIs would be the

percentage increase in the FY 2008 IPPS operating market basket, estimated to be

3.3 percent. Consistent with our historical approach, if more recent data are available for

the final rule, we use it to calculate the IPPS operating market basket. For this final rule

with comment period, we have calculated the IPPS operating market basket for FY 2008

using the most recent data available. For cancer and children's hospitals and RNHCIs,

the FY 2008 rate-of-increase percentage which is applied to FY 2007 target amounts in

order to calculate FY 2008 target amounts is 3.3 percent, based on Global Insight, Inc.'s

2007 second quarter forecast of the IPPS operating market basket increase, in accordance

with the applicable regulations at 42 CFR 413.40.

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost

methodology. However, the statute was amended to provide for the implementation of

prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective

payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying

lengths of time during which a portion of the prospective payment is based on cost-based

reimbursement rules under Part 413 (certain providers do not receive a transitioning

period or may elect to bypass the transition as applicable under 42 CFR Part 412,

Subparts N, O, and P.) We note that the various transitioning periods provided for under

the IRF PPS, IPF PPS, and the LTCH PPS have ended or will soon end.

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid

100 percent of the adjusted Federal rate under the IRF PPS.   Therefore, for cost reporting

periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is

subject to Part 413. Similarly, for cost reporting periods beginning on or after

October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal rate under the

LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006,

no portion of the LTCH PPS payment is subject to 42 CFR Part 413. (We note that to the

extent a portion of a LTCH's PPS payment was subject to reasonable cost principles, the

Secretary utilized his broad authority under section123 of the BBRA, amended by section

307 of BIPA, to make such portion subject to 42 CFR Part 413 and various provisions in

1886(b) of the Act.)

Except as provided in §412.426(c), IPFs remain under a blend methodology for

cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008.

Under the broad authority conferred upon the Secretary in section 124(a)(1) of the BBRA

of 1999, the Secretary provided that, for IPFs paid under the blend methodology, the

portion of the IPF PPS payment that is based on reasonable cost principles is subject to

the rules of 42 CFR Part 413 and various provisions in section 1886(b) of the Act. In

order to calculate the portion of the PPS payment that is based on reasonable cost

principles, it is necessary to determine whether the IPF would be considered "existing"

for purposes of section 1886(b)(3)(H) of the Act or "new" for purposes of

section 1886(b)(7) of the Act. We note that readers should not confuse an IPF that is

considered "new" for purposes of section 1886(b)(7) of the Act and §413.40(f)(2)(ii) of

the regulations with an IPF that is considered "new" under §412.426(c) of the

regulations. Any IPF that, under present or previous ownership or both, has its first cost

reporting period as an IPF beginning on or after January 1, 2005, is considered "new" for

purposes of §412.426(c). An IPF that is considered "new" under §412.426(c) is paid

based on 100 percent of the Federal per diem payment amount. Consequently, only those

IPFs considered "new" under section 1886(b)(7) of the Act, but not "new" under

§412.426(c) will be paid under a PPS blended payment methodology. An IPF considered

"new" for purposes of §413.40(f)(2)(ii) would have its "reasonable-cost based" portion of

its prospective payment subject to the provisions of §413.40(f)(2)(ii) and

§413.40(c)(4)(v), as applicable. An IPF considered "new" for purposes of

section 1886(b)(7) of the Act has the target amount for its third cost reporting period

determined in accordance with sections 1886(b)(7)(A)(ii) and 1886(b)(3)(A)(ii) of the

Act. For the fourth and subsequent cost reporting periods, the target amount is calculated

in accordance with section 1886(b)(3)(A)(ii) of the Act. An IPF that would be

considered "existing" for purposes of section 1886(b)(3)(H) of the Act would have its the

target amount for the "reasonable-cost based" portion of its prospective payment

determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the provisions of

§413.40(c)(4)(ii) of the regulations.

        In the FY 2008 IPPS proposed rule (72 FR 24823), the applicable percentage

increase to update the target amount for the reasonable cost-based portion of the PPS

payment of an IPF that is considered "existing" under section 1886(b)(3)(H) of the Act or

"new" under section 1886(b)(7) of the Act, but not "new" under the provisions of

§412.426(c), was 3.4 percent. However, we noted that if more current data became

available prior to publication of the final rule, we would use those data for updating the

market basket. Based on more recent data, the applicable percentage increase to update

the target amount for the reasonable cost-based portion of the PPS payment of an IPF that

is considered "existing" under section 1886(b)(3)(H) of the Act or "new" under section

1886(b)(7) of the Act, but not "new" under §412.426(c), is 3.3 percent, based on Global

Insight, Inc.'s 2007 second quarter forecast of the excluded hospital market basket

increase, in accordance with the applicable regulations at 42 CFR 413.40.

We did not receive any public comments on this section of the proposed rule.

V. Tables

This section contains the tables referred to throughout the preamble to this final

rule with comment period and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A,

4B, 4C, 4D, 4F, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6J, 6K, 7A, 7B, 8A, 8B, 8C, 9A,

9C, 10, and 11 are presented below. As explained in sections II.D.2. and II.G.8. of the

preamble of this final rule with comment period, Table 6I--Complete List of

Complication and Comorbidity (CC) Exclusions, is available only through the Internet on

the CMS Web site at: http://www.cms.hhs.gov/AcuteInpatientPPS/. The tables

presented below are as follows:

Table 1A--National Adjusted Operating Standardized Amounts, Labor/Nonlabor

(69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Is Greater Than 1)

Table 1B--National Adjusted Operating Standardized Amounts, Labor/Nonlabor

(62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal

To 1)

Table 1C--Adjusted Operating Standardized Amounts for Puerto Rico,

Labor/Nonlabor

Table 1D--Capital Standard Federal Payment Rate

Table 2--Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal

Year 2006; Hospital Wage Indexes for Federal Fiscal Year 2008; Hospital Average

Hourly Wages for Federal Fiscal Years 2006 (2002 Wage Data), 2007 (2003 Wage Data),

and 2008 (2004 Wage Data); and 3-Year Average of Hospital Average Hourly Wages

Table 3A--FY 2008 and 3-Year Average Hourly Wage for Urban Areas by CBSA

Table 3B--FY 2008 and 3-Year Average Hourly Wage for Rural Areas by CBSA

Table 4A--Wage Index and Capital Geographic Adjustment Factor (GAF) for

Urban Areas by CBSA--FY 2008

Table 4B--Wage Index and Capital Geographic Adjustment Factor (GAF) for

Rural Areas by CBSA--FY 2008

Table 4C--Wage Index and Capital Geographic Adjustment Factor (GAF) for

Hospitals That Are Reclassified by CBSA--FY 2008

Table 4F--Puerto Rico Wage Index and Capital Geographic Adjustment Factor

(GAF) by CBSA--FY 2008

Table 4J--Out-Migration Adjustment--FY 2008

Table 5--List of Medicare Severity Diagnosis-Related Groups (MS-DRGs),

Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay

Table 6A--New Diagnosis Codes

Table 6B--New Procedure Codes

Table 6C--Invalid Diagnosis Codes

Table 6D--Invalid Procedure Codes

Table 6E--Revised Diagnosis Code Titles

Table 6F--Revised Procedure Code Titles

Table 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 2006 MedPAR Update--March 2007 GROUPER V24.0 CMS DRGs

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of

Stay: FY 2006 MedPAR Update--March 2007 GROUPER V25.0 MS-DRGs

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--July 2007

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--July 2007

Table 8C--Statewide Average Total Cost-to-Charge Ratios for LTCHs--July 2007

Table 9A--Hospital Reclassifications and Redesignations--FY 2008

Table 9C--Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the

Act--FY 2008

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 Medicare

Severity Diagnosis-Related Group (MS-DRG)--July 2007

Table 11--FY 2008 MS-LTC-DRGs, Relative Weights, Geometric Average

Length of Stay, Short-Stay Outlier Threshold, and IPPS Comparable Threshold

**TABLE 1A.--NATIONAL ADJUSTED OPERATING STANDARDIZED
AMOUNTS; LABOR/NONLABOR (69.7 PERCENT LABOR SHARE/30.3
PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)**

Full Update (3.3 Percent)		Reduced Update (1.3 Percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,459.66	$1,503.98	$3,392.68	$1,474.86

TABLE 1B.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Full Update (3.3 Percent)		Reduced Update (1.3 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,077.46	$1,886.18	$3,017.87	$1,849.67

Table 1C.--ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,459.66	$1,503.98	$3,077.46	$1,886.18
Puerto Rico	$1,454.91	$891.72	$1,377.47	$969.16

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$423.34
Puerto Rico	$199.80

TABLE 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURING IN FEDERAL FISCAL YEAR 2006; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2008; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2006 (2002 WAGE DATA), 2007 (2003 WAGE DATA), AND 2008 (2004 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
010001	1.5191	0.7567	21.6546	22.1989	23.2195	22.3615
010005	1.1378	0.8629	22.4906	23.6022	23.0203	23.0415
010006	1.5126	0.7692	23.4823	23.4975	23.7502	23.5724
010007	1.0207	0.7567	18.2429	19.9329	21.3492	19.8699
010008	1.0417	0.7741	20.4591	17.9533	22.0793	19.9268
010009	0.9702	0.8629	23.2228	23.5626	25.9011	24.2272
010010	1.1043	0.8724	21.4974	27.0385	22.8602	23.5943
010011	1.6748	0.8855	27.4850	27.6658	27.4668	27.5393
010012	1.2356	0.9388	22.7020	24.4059	25.5767	24.1956
010015	1.0427	0.7613	21.5111	22.3383	27.0806	23.3440
010016	1.5770	0.8855	25.1502	24.6488	26.8611	25.5444
010018	1.7123	0.8855	22.2990	23.7048	24.8974	23.6077
010019	1.2722	0.7692	22.0906	22.8766	23.3460	22.7785
010021	1.1851	0.7567	18.6785	19.7367	21.0624	19.7975
010022	0.9498	0.9812	24.5671	25.8404	27.4318	25.9300
010023	1.8506	0.8111	27.6174	25.4272	26.1739	26.4108
010024	1.6018	0.8111	20.7265	22.0819	25.0715	22.5306
010025	1.3028	0.8587	21.2674	22.7635	23.6186	22.5541
010027	0.7634	0.7567	15.3705	16.4682	17.0513	16.2718
010029	1.5710	0.8587	22.6976	23.9007	25.0468	23.9133
010032	0.9313	0.7892	19.1555	19.3311	18.5545	19.0122
010033	2.0854	0.8855	26.3784	27.4181	29.1471	27.6506
010034	1.0453	0.8111	16.9686	17.7457	19.1549	17.9513
010035	1.3134	0.8724	22.2870	24.2425	24.2746	23.6062
010036	1.1619	0.7567	22.9747	21.5796	24.2887	22.9479
010038	1.2689	0.8022	21.4509	23.7039	27.0752	24.1209
010039	1.6606	0.9017	25.8820	26.9919	28.6462	27.1994
010040	1.6563	0.8144	22.8851	24.3207	24.7657	23.9967
010043	1.0807	0.8855	22.5944	21.9774	23.9121	22.8205
010044	1.0847	0.8724	21.4036	22.5009	24.4276	22.7205
010045	1.2233	0.8724	19.8803	20.4927	23.1695	21.0755
010046	1.5335	0.8144	21.6965	23.4219	25.9105	23.5410
010047	0.8960	0.7694	21.0605	26.4851	19.7542	21.9502

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
010049	1.1433	0.7567	20.2413	21.7888	22.4248	21.5072
010050	1.0408	0.8855	22.1584	22.9620	24.4060	23.1658
010051	0.8299	0.8530	15.2207	18.7701	18.0305	17.3881
010052	0.8767	0.7670	16.4958	25.9233	36.3638	26.9159
010053	***	*	19.0108	*	*	19.0108
010054	1.0736	0.8629	22.5554	23.3624	24.4810	23.4780
010055	1.6124	0.7567	22.3800	22.5396	22.4145	22.4451
010056	1.6378	0.8855	23.7144	23.7398	24.5754	24.0311
010058	1.0119	0.8855	18.5538	19.5092	17.0150	18.2415
010059	1.0245	0.8629	21.3237	23.0012	24.8199	23.0577
010061	0.9828	0.8108	21.9370	24.1185	25.2454	23.7791
010062	1.0225	0.7567	18.3435	21.4805	21.7112	20.4976
010064	1.6963	0.8855	26.1110	24.8155	27.6149	26.1441
010065	1.5265	0.8724	21.3785	23.0477	24.3346	22.9447
010066	0.8369	0.7567	17.6152	19.8692	25.4612	20.9377
010068	***	*	19.0789	22.7156	24.4145	22.0070
010069	1.0252	0.7567	21.3609	23.1243	23.6272	22.6667
010072	***	*	21.8169	24.4989	*	23.1419
010073	0.9793	0.7567	16.4168	18.3963	19.0046	17.9415
010078	1.6180	0.8022	21.6857	23.5279	24.3828	23.2230
010079	1.2228	0.9017	21.8199	22.7337	22.3034	22.2840
010083	1.1887	0.8123	22.3040	22.4279	24.0036	22.9553
010084	1.3254	0.8855	24.7127	26.3238	26.5079	25.8383
010085	1.3335	0.8629	24.4710	24.2609	23.6280	24.1072
010086	1.0994	0.7567	18.6081	22.2096	21.5584	20.7409
010087	1.9947	0.7947	22.5225	22.4318	24.8320	23.2268
010089	1.2932	0.8855	22.8448	25.0811	26.2628	24.6788
010090	1.7444	0.8539	23.6948	26.0494	26.3957	25.3396
010091	0.9568	0.7613	18.6912	23.1310	22.5272	21.3026
010092	1.5529	0.8530	24.4592	26.6796	26.9959	26.0279
010095	0.8468	0.8530	13.9326	16.5250	17.0024	15.8689
010097	0.7113	0.8111	16.7549	19.4511	19.2481	18.5000
010098	0.9805	*	14.3076	*	*	14.3076
010099	0.9660	0.7567	18.7910	20.8383	20.6736	20.0891
010100	1.6851	0.8123	21.2915	23.8919	25.1460	23.5431
010101	1.1060	0.8724	21.6593	24.2575	25.0974	23.6323
010102	0.9334	0.7567	21.0902	25.6158	26.9859	24.5977
010103	1.8910	0.8855	26.1163	27.8272	28.9636	27.5991
010104	1.8838	0.8855	24.7394	27.6471	28.3126	26.8465

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
010108	1.0938	0.8111	28.4624	24.6740	25.4325	26.1487
010109	0.9828	0.8018	21.6194	17.6733	21.0449	20.0231
010110	0.7586	0.7781	17.5957	26.0038	19.8738	20.8832
010112	0.9652	0.7567	16.8902	17.1833	20.4027	18.1182
010113	1.6646	0.7947	21.4121	22.3282	24.7170	22.7864
010114	1.3662	0.8855	22.3752	25.6152	25.7090	24.6272
010115	0.6881	*	21.7477	*	*	21.7477
010118	1.2151	0.8162	19.7673	21.4630	22.7191	21.2742
010120	0.9625	0.7567	20.9450	20.9019	22.1868	21.3553
010121	***	*	24.0867	*	*	24.0867
010125	1.0635	0.8043	18.4113	21.5123	22.8911	20.8639
010126	1.1765	0.8111	23.1381	23.9327	24.4957	23.8552
010128	0.8778	0.7613	21.4200	23.6647	24.9881	23.3836
010129	1.0394	0.7701	21.3555	22.1574	21.8502	21.7888
010130	1.0252	0.8855	23.2488	23.7528	24.5644	23.8767
010131	1.3963	0.9017	25.7837	26.4297	27.2707	26.5327
010137	1.2204	0.8855	24.7366	27.5782	28.5843	26.9190
010138	0.6023	0.7633	13.8476	16.7602	14.5551	15.1032
010139	1.5875	0.8855	25.3014	26.8726	28.1473	26.8270
010143	1.2118	0.8724	22.0215	26.2762	24.0674	24.0861
010144	1.6376	0.7947	20.8209	22.5133	22.3916	21.9338
010145	1.4727	0.8530	24.9531	24.5092	25.8293	25.1083
010146	1.0794	0.8022	20.8917	22.6586	22.6879	22.1063
010148	0.8692	0.7567	20.5589	23.9246	23.5714	22.6800
010149	1.2877	0.8111	26.5854	24.4805	25.4354	25.4861
010150	1.0284	0.8111	21.6377	23.6080	24.4098	23.2040
010152	1.2978	0.7947	22.6202	22.4075	23.7803	22.9411
010157	1.1357	0.7692	24.3559	23.3828	24.2206	23.9837
010158	1.1916	0.7832	24.3531	23.5533	25.5905	24.4669
010162	***	*	*	33.8777	*	33.8777
010163	***	*	*	*	34.0325	34.0325
010164	1.1737	0.7975	*	*	23.2447	23.2447
010165	***	*	*	*	28.8040	28.8040
010166	***	*	*	*	29.7256	29.7256
010167	1.4919	0.8855	*	*	*	*
010168	1.1249	0.9019	*	*	*	*
020001	1.7991	1.2083	32.8120	35.4232	36.5298	34.9510
020004	1.1287	*	32.0966	31.8004	*	31.9467
020006	1.3160	1.2083	36.0540	34.3752	37.0211	35.7758

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
020008	1.2411	1.2083	35.9236	36.1250	39.3432	37.1503
020012	1.3780	1.2083	31.8995	32.5975	33.9375	32.8391
020014	1.1294	1.2083	32.0894	29.4472	30.9722	30.8221
020017	1.9188	1.2083	33.5852	35.4119	35.8804	34.9149
020018	0.9273	1.9278	*	*	*	*
020019	0.8687	1.9278	*	*	*	*
020024	1.1780	1.2083	33.0644	29.5195	38.6934	33.4500
020026	1.4935	1.9278	*	*	*	*
020027	0.9341	1.9278	*	*	*	*
030001	1.5488	1.0110	29.9840	32.4791	33.4178	31.9042
030002	2.0931	1.0110	29.0519	30.2200	31.0818	30.0874
030006	1.6975	0.9416	25.8872	27.0599	27.7421	26.9373
030007	1.4495	1.1187	29.6174	31.1928	33.7213	31.5818
030009	***	*	22.3993	26.5408	*	23.8204
030010	1.4087	0.9416	24.8275	28.5684	30.6261	28.0431
030011	1.4962	0.9416	25.1361	28.1423	28.8203	27.4688
030012	1.3876	0.9961	26.3859	27.3895	29.1042	27.6846
030013	1.4744	1.0085	25.7050	27.0111	31.2815	28.0280
030014	1.5918	1.0110	25.6259	29.6582	29.8296	28.4308
030016	1.2374	1.0110	26.7003	29.1980	30.7896	28.9890
030017	2.0652	1.0110	26.2452	30.6007	34.4852	30.7776
030018	1.3205	1.0110	28.9476	29.4566	31.8056	30.0512
030019	1.3316	1.0110	27.3156	29.5921	30.1934	29.0814
030022	1.5703	1.0110	26.4404	30.5710	30.3746	29.2068
030023	1.7873	1.1551	33.8333	34.2142	35.8287	34.6826
030024	2.0639	1.0110	31.6658	31.9247	33.1797	32.2883
030027	0.9709	*	20.4032	*	*	20.4032
030030	1.5768	1.0110	30.2712	32.0994	34.4166	32.2546
030033	1.2960	1.1187	26.6531	28.7508	29.9383	28.4685
030036	1.4588	1.0110	30.3521	30.9834	33.0523	31.6117
030037	2.1478	1.0110	28.6453	31.2877	34.1079	31.4098
030038	1.6801	1.0110	29.5509	29.9314	31.7238	30.2225
030040	0.9098	*	24.8145	27.5322	*	26.1823
030043	1.2683	0.8854	24.7932	26.5834	27.3856	26.2806
030055	1.4591	0.9576	24.5202	27.1473	27.1621	26.3554
030060	1.0894	*	24.3523	24.8373	*	24.5964
030061	1.6799	1.0110	25.5529	28.0696	28.1337	27.3140
030062	1.2025	0.8854	23.8068	26.6880	28.9587	26.5838
030064	1.9657	0.9416	25.4922	28.3853	29.8226	28.0126

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
030065	1.5912	1.0110	27.1646	29.5883	31.0817	29.3880
030067	1.0582	0.9152	20.4376	20.7591	27.4497	22.9601
030068	1.1135	0.8854	20.8846	23.1394	23.8792	22.6625
030069	1.4256	0.9333	26.3518	30.2224	29.7802	28.7293
030071	0.8920	1.4400	*	*	*	*
030073	1.0393	1.4400	*	*	*	*
030074	0.8727	1.4400	*	*	*	*
030077	0.7686	1.4400	*	*	*	*
030078	0.9911	1.4400	*	*	*	*
030080	1.5497	0.9416	25.2077	27.1360	28.6568	27.0149
030083	1.4230	1.0110	27.5353	27.4983	33.5302	29.3979
030084	0.9008	1.4400	*	*	*	*
030085	1.5896	0.9416	24.5792	26.8364	28.1388	26.6166
030087	1.6937	1.0110	26.6594	29.5962	31.2331	29.4038
030088	1.3707	1.0110	26.6796	27.8604	29.9758	28.2309
030089	1.6397	1.0110	27.1835	28.9068	30.1591	28.8100
030092	1.4993	1.0110	27.3203	31.7512	30.6343	30.0167
030093	1.2962	1.0110	25.8955	26.4430	27.8821	26.8453
030094	1.4039	1.0110	29.5948	31.5422	33.4050	31.6120
030099	0.8736	0.8854	26.3236	27.1402	26.9227	26.8026
030100	2.0564	0.9416	29.0691	31.5628	34.7532	31.7816
030101	1.4424	1.1222	26.1927	27.8302	30.6764	28.3394
030102	2.3653	1.0110	29.0942	31.6285	33.6247	31.5058
030103	1.7635	1.0110	30.1994	31.7322	32.2833	31.3997
030105	2.2401	1.0110	31.3094	31.2970	32.7449	31.8780
030106	1.7527	1.0110	34.7221	32.9840	36.4667	34.9449
030107	1.9168	1.0110	*	35.6197	35.5386	35.5721
030108	2.0446	1.0110	*	*	29.9395	29.9395
030109	***	*	*	16.5906	*	16.5906
030110	1.6188	1.0110	*	31.4852	29.7949	30.5015
030111	1.0309	0.9416	*	*	33.3711	33.3711
030112	1.9762	1.0110	*	*	36.6601	36.6601
030113	0.8959	1.4400	*	*	*	*
030114	1.3883	0.9416	*	*	*	*
030115	1.3514	1.0110	*	*	*	*
030117	1.1079	0.9333	*	*	*	*
030118	1.0969	0.9961	*	*	*	*
030119	1.1665	1.0110	*	*	*	*
040001	1.0776	0.8871	23.7718	22.9327	22.9948	23.2132

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
040002	1.2042	0.7516	20.1384	21.2020	25.0000	22.0327
040004	1.7265	0.8871	25.0286	27.1741	28.1117	26.7791
040007	1.7562	0.8960	25.7142	40.1291	29.1941	31.6856
040010	1.4682	0.8871	23.0274	24.2315	26.5287	24.6226
040011	1.0455	0.7516	20.3970	21.0967	22.2431	21.2830
040014	1.3571	0.8725	25.3451	26.4777	28.9855	26.8514
040015	0.9961	0.7516	19.2831	20.4279	20.1061	19.9379
040016	1.7616	0.8960	22.1228	25.8056	26.5911	24.8386
040017	1.0969	0.8714	21.9875	21.9147	23.8768	22.5741
040018	1.0812	0.8052	23.6044	24.0026	25.6751	24.3852
040019	1.1088	0.8963	23.7328	23.8706	24.9113	24.1695
040020	1.5861	0.8963	21.6603	22.6497	23.9470	22.7542
040021	1.5370	0.8960	25.6917	25.4046	26.1853	25.7538
040022	1.5695	0.8871	25.4052	29.5000	27.9902	27.5948
040026	1.5090	0.9105	25.4072	27.7931	29.5299	27.6091
040027	1.4827	0.8619	21.1412	21.4252	23.8220	22.1274
040029	1.4947	0.8960	24.0704	24.8409	25.1479	24.6992
040036	1.6105	0.8960	26.3226	27.6234	29.7150	27.9675
040039	1.2755	0.8153	19.5998	21.2712	21.4819	20.7976
040041	1.1732	0.8725	22.1531	23.7787	26.4964	24.1438
040042	1.3805	0.9313	19.9627	21.1716	19.8709	20.3344
040045	1.0416	*	17.2281	*	*	17.2281
040047	1.1288	0.7633	21.9163	22.4249	23.0358	22.4531
040050	1.2290	0.7516	16.3930	17.6906	18.5119	17.5660
040051	0.9632	0.7516	19.1400	21.3342	22.0394	20.8386
040053	***	*	20.7823	*	*	20.7823
040054	***	*	18.2685	18.0509	19.5353	18.6008
040055	1.5244	0.8052	23.3156	23.0448	24.9164	23.7097
040062	1.6625	0.8052	23.3082	23.8994	25.2303	24.1355
040067	1.1373	0.7523	16.8800	19.0471	18.9872	18.2681
040069	1.0183	0.8963	24.4662	24.8060	24.9996	24.7603
040071	1.4578	0.8725	24.3824	25.4680	25.2840	25.0575
040072	1.1153	0.7516	19.9009	22.4741	22.1058	21.4220
040074	1.1975	0.8960	25.2423	25.2699	26.2661	25.5884
040075	***	*	18.3253	*	*	18.3253
040076	1.0000	0.8725	20.6272	23.5742	23.0954	22.4197
040077	0.9991	*	18.2082	*	*	18.2082
040078	1.5994	0.9105	24.5377	23.5915	26.1937	24.6735
040080	1.0440	0.8503	22.3392	24.1921	24.8760	23.8555

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
040081	0.8581	0.7873	15.1081	16.8437	17.2536	16.4124
040084	1.1949	0.8960	24.7225	27.7626	26.6449	26.4201
040085	0.9758	0.8963	29.8444	22.9916	25.7215	25.8637
040088	1.4610	0.7764	22.6183	22.4860	23.6276	22.9191
040091	1.1764	0.7781	23.1320	24.2398	23.1913	23.5100
040100	1.3403	0.8725	20.0460	21.3051	22.6131	21.3769
040105	1.0556	*	18.2182	*	*	18.2182
040109	1.1066	*	22.8801	*	*	22.8801
040114	1.8129	0.8960	24.8992	26.7581	27.7928	26.5383
040118	1.4728	0.8503	24.7363	26.0388	26.8908	25.8812
040119	1.4205	0.8725	21.0103	24.3680	24.2419	23.2187
040126	***	*	14.0700	15.6985	17.3715	15.6137
040132	***	*	28.1393	*	22.0054	24.3534
040134	2.3671	0.8960	27.3412	31.9325	32.2832	30.5661
040137	1.3102	0.8960	25.2907	25.9979	27.7360	26.2750
040138	1.4215	0.8871	25.7513	27.8584	28.3342	27.5137
040141	0.8436	0.8871	24.0901	26.1041	30.3475	26.8847
040142	1.4672	0.9105	27.9696	21.4222	23.8620	24.1239
040143	***	*	*	37.1976	*	37.1976
040144	***	*	*	21.4008	*	21.4008
040145	1.7860	0.8503	*	*	24.4367	24.4367
040146	***	*	*	*	33.7876	33.7876
040147	1.7139	0.8960	*	*	*	*
050002	1.3854	1.5353	34.1948	35.5184	41.7336	37.3207
050006	1.6408	1.2651	30.5373	33.5751	37.1639	33.5391
050007	1.4971	1.4946	38.7033	43.4440	45.8773	42.7095
050008	1.2726	1.4826	39.1539	49.3167	46.8706	45.1816
050009	1.8133	1.4267	39.6393	43.0584	46.2186	43.0443
050013	1.9732	1.4267	31.9837	35.7591	43.5623	36.9784
050014	1.2471	1.2918	33.0373	36.0305	37.4135	35.5238
050015	1.3247	*	30.7940	32.2188	*	31.5274
050016	1.3297	1.2054	26.2161	24.5768	31.0653	27.2795
050017	1.9740	1.3067	36.6593	39.6653	42.2200	39.5192
050018	1.1994	1.1735	22.3472	23.3204	31.8310	25.3549
050022	1.5661	1.1735	29.8632	31.6467	33.0592	31.4883
050024	1.1366	1.1735	27.5587	29.4062	33.4334	30.2003
050025	1.8859	1.1735	36.1622	33.5466	32.7476	34.1071
050026	1.5103	1.1735	28.3027	31.5250	33.1277	31.0373
050028	1.2341	1.1735	26.6160	27.3826	28.5736	27.5339

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050030	1.2224	1.1735	24.9707	27.2945	30.9014	27.6434
050036	1.5133	1.1735	32.7929	33.8000	36.0905	34.2482
050038	1.6423	1.5439	38.7527	44.2265	48.7483	44.0206
050039	1.6082	1.1735	31.6734	35.2630	36.6943	34.5173
050040	1.2674	1.1735	34.3279	35.8322	35.7054	35.3257
050042	1.5020	1.2651	33.9415	37.3760	40.3326	37.2065
050043	1.6341	1.5353	43.1589	45.4887	48.2283	45.6945
050045	1.3077	1.1735	23.8408	25.0150	27.0676	25.4080
050046	1.1412	1.1735	25.6875	26.1926	29.1125	26.9715
050047	1.7685	1.4826	40.9874	55.9367	45.1675	47.4627
050054	1.1914	1.1735	24.1262	21.3650	24.0338	23.1316
050055	1.3290	1.4826	37.5879	42.9516	44.2926	41.4282
050056	1.3794	1.1735	27.9330	30.6126	32.7693	30.4552
050057	1.6643	1.1735	29.4351	30.0236	31.7467	30.4506
050058	1.6021	1.1735	33.8215	33.1409	37.2538	34.6985
050060	1.4479	1.1735	27.3282	29.9762	32.0196	29.7255
050061	***	*	32.2172	*	*	32.2172
050063	1.3845	1.1735	33.3039	34.0906	36.3085	34.5048
050065	***	*	34.0280	34.9110	38.2421	35.7006
050067	1.1973	1.2019	31.9597	38.8070	40.1393	37.4080
050069	1.7482	1.1735	31.2172	34.6353	35.3850	33.8185
050070	1.2780	1.4946	45.3382	47.4099	46.4009	46.4522
050071	1.2898	1.5343	44.9464	50.7602	49.6495	48.7326
050072	1.3417	1.5343	44.2651	49.4344	50.0343	48.1855
050073	1.3036	1.5343	45.9765	49.9730	49.0069	48.5026
050075	1.3055	1.5353	47.2356	54.4089	49.8290	50.5649
050076	1.8910	1.5343	46.4991	52.3788	50.2039	49.9372
050077	1.6158	1.1735	32.0245	34.8660	36.5384	34.5331
050078	1.2608	1.1735	31.1425	32.0133	30.4274	31.1478
050079	1.5056	1.5343	47.8597	47.3449	48.8994	47.9784
050082	1.6846	1.1735	37.7783	38.2878	37.8905	37.9882
050084	1.5633	1.1941	33.0179	35.5196	39.5748	36.0222
050088	***	*	25.7385	*	*	25.7385
050089	1.3519	1.1735	33.5324	33.9593	36.4018	34.5988
050090	1.2783	1.4800	32.9584	33.8953	37.7421	34.8400
050091	1.0225	1.1735	30.8560	32.1301	37.1223	33.3203
050093	1.5015	1.1735	33.4118	36.9481	36.8486	35.7397
050096	1.2246	1.1735	24.6679	34.9237	33.1322	30.9608
050099	1.4850	1.1735	31.0437	33.4174	32.0650	32.2103

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050100	1.8315	1.1735	29.6949	31.4404	33.3959	31.5609
050101	1.2932	1.5343	40.3195	42.4589	47.9327	43.6371
050102	1.2847	1.1735	29.1364	32.0617	32.8434	31.6405
050103	1.5381	1.1735	34.2529	34.0935	35.6773	34.7050
050104	1.4331	1.1735	29.7326	32.3043	33.6204	31.9100
050107	1.5168	1.1735	33.1358	32.5846	33.5687	33.0959
050108	1.9263	1.3067	35.5711	38.8672	42.0131	38.9520
050110	1.2783	1.1735	26.1453	26.8408	28.0670	27.0290
050111	1.2625	1.1735	28.1588	28.7875	31.8766	29.6686
050112	1.5360	1.1735	36.8026	37.7281	38.9483	37.8620
050113	1.2266	1.4946	33.8064	39.4882	42.8884	38.6364
050114	1.4296	1.1735	31.1295	34.0309	35.7274	33.6746
050115	1.4671	1.1735	30.9288	28.8051	32.5257	30.7642
050116	1.7151	1.1735	34.5109	36.8825	37.6018	36.4210
050117	***	*	32.4413	34.2020	35.0531	33.2964
050118	1.2250	1.2019	35.4044	39.9683	41.6701	39.0065
050121	1.2978	1.1735	27.9537	30.6105	34.6244	31.1240
050122	1.5193	1.1941	34.2416	33.9812	34.0259	34.0785
050124	1.2869	1.1735	28.0288	30.2522	29.9944	29.4697
050125	1.5000	1.5439	41.7020	44.9523	47.7578	44.7946
050126	1.4916	1.1735	29.3360	31.7619	32.6686	31.2868
050127	1.3314	1.3067	26.1222	32.0355	40.7610	31.7807
050128	1.4725	1.1735	31.0662	31.1308	33.4233	31.8929
050129	1.8417	1.1735	32.2680	34.7359	36.9887	34.5850
050131	1.3370	1.4800	40.5321	45.3152	47.5257	44.5040
050132	1.4264	1.1735	35.1544	35.9199	39.6807	36.9017
050133	1.5413	1.2918	31.3530	31.9527	33.1814	32.2802
050135	1.0333	1.1735	24.3927	25.1813	25.3209	25.0624
050136	1.3553	1.4800	37.4560	43.3747	46.6619	42.5341
050137	1.4485	1.1735	38.4827	39.1496	40.2457	39.4250
050138	1.7510	1.1735	46.9557	45.3727	40.6343	43.8129
050139	1.3026	1.1735	37.6217	37.8986	38.7385	38.1892
050140	1.3857	1.1735	39.6269	40.9725	39.4954	39.9747
050144	***	*	33.5109	33.6662	38.2424	35.1804
050145	1.4357	1.4593	42.3134	42.2921	48.0796	44.3363
050146	1.7450	*	*	*	*	*
050148	1.0844	*	27.3005	28.2305	*	27.7734
050149	1.4992	1.1735	33.2270	35.8821	37.3616	35.7587
050150	1.2109	1.2918	31.7560	33.6583	37.9946	34.4499

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050152	1.4661	1.4826	43.6487	46.1553	51.6567	47.1769
050153	1.4470	1.5439	43.3190	42.8955	47.6374	44.7563
050155	***	*	21.8550	16.9516	16.7756	18.0652
050158	1.3557	1.1735	35.1326	35.7805	39.9160	36.9712
050159	1.4329	1.1735	31.3199	32.5704	34.6915	32.9769
050167	1.3248	1.1941	28.5179	31.4798	34.0418	31.2303
050168	1.6239	1.1735	33.2506	37.9784	40.5973	37.3823
050169	1.4402	1.1735	27.4644	29.4693	31.4115	29.5647
050172	***	*	28.5604	*	*	28.5604
050173	1.3511	1.1735	30.3582	29.0576	31.6717	30.3454
050174	1.5310	1.4800	40.1747	44.4199	48.1740	44.3520
050175	***	*	30.5733	33.3061	35.0152	32.9392
050177	***	*	25.1442	24.0717	*	24.6196
050179	1.2416	1.2019	27.1155	30.4973	31.6651	30.0130
050180	1.5481	1.5343	40.2504	42.0358	45.7099	42.7961
050188	1.4245	1.5439	39.5110	41.0943	43.7381	41.3973
050189	1.0027	1.4593	29.1279	30.1155	28.7580	29.3259
050191	1.5039	1.1735	34.2091	37.7805	37.8756	36.5700
050192	0.9795	1.1735	27.0424	27.1400	27.8386	27.3401
050193	1.2009	1.1735	29.6421	33.9520	29.0623	30.7523
050194	1.3918	1.5719	40.9096	44.7107	49.0030	44.8987
050195	1.5358	1.5353	48.4358	48.8595	53.5583	50.3395
050196	1.0252	1.1735	32.1933	34.0956	32.8293	33.0383
050197	2.1090	1.5343	48.9053	50.0728	52.9998	50.6892
050204	1.4292	1.1735	28.6423	32.0121	35.3954	32.0139
050205	1.4338	1.1735	27.8611	29.3334	30.6322	29.3026
050207	***	*	29.5214	30.0062	31.3431	30.2629
050211	1.2807	1.5353	41.2166	35.0515	35.0289	36.9047
050214	***	*	23.9972	25.4647	*	24.7211
050215	***	*	43.7985	48.8112	50.7578	47.7260
050219	1.2434	1.1735	22.4065	26.4143	25.8378	24.8927
050222	1.7011	1.1735	29.1094	32.3882	33.7510	31.8388
050224	1.7135	1.1735	29.3143	32.5010	35.7280	32.5355
050225	1.4565	1.1735	29.9656	34.0836	35.1227	33.2224
050226	1.6587	1.1735	30.5867	32.4411	35.4597	32.8050
050228	1.2780	1.4826	42.4226	43.7939	47.1430	44.4650
050230	1.5630	1.1735	32.9555	34.0600	35.8490	34.3219
050231	1.6220	1.1735	30.9607	32.1813	33.7139	32.3034
050232	1.7586	1.2054	27.4099	26.3004	34.3242	29.3642

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050234	1.1638	1.1735	29.6561	32.3726	34.8308	32.2031
050235	1.5172	1.1735	29.2979	30.5405	37.0858	32.3689
050236	1.4069	1.1735	32.1647	33.0686	32.6462	32.6402
050238	1.5198	1.1735	31.1764	33.3346	34.0823	32.9745
050239	1.6081	1.1735	31.0963	33.1148	35.9041	33.4240
050240	***	*	35.5735	36.1154	40.7427	37.4962
050242	1.3910	1.5719	44.3130	46.4844	50.9882	47.3502
050243	1.6367	1.1735	31.4883	32.9385	36.1209	33.6114
050245	1.3986	1.1735	28.6527	27.3866	33.2556	29.8371
050248	1.0733	1.4593	35.3864	*	40.4941	37.6896
050251	***	*	27.2675	27.8452	*	27.5819
050253	***	*	24.0044	23.5381	*	23.7879
050254	1.2483	1.3067	27.0041	31.2386	33.0865	30.5679
050256	***	*	29.8194	29.6793	32.7159	30.6561
050257	0.9657	1.1735	21.3216	20.1829	24.0737	21.8495
050261	1.3143	1.1735	27.3234	29.2150	30.8704	29.2688
050262	2.1509	1.1735	44.0256	39.9946	41.4835	41.8533
050264	1.3224	1.5353	41.1211	47.7024	43.4181	44.0806
050270	***	*	32.4812	33.6855	36.0111	34.0811
050272	1.3840	1.1735	27.1989	29.4671	30.9290	29.2682
050276	1.1508	1.5343	39.3778	41.1406	43.7943	41.5076
050277	1.0162	1.1735	32.5213	35.4443	35.0079	34.2968
050278	1.5556	1.1735	29.9244	31.8712	34.3798	32.1741
050279	1.1670	1.1735	27.6573	29.7118	31.6738	29.7052
050280	1.6965	1.2809	35.2030	38.8341	41.3912	38.4324
050281	1.3944	1.1735	27.3824	29.4882	31.6639	29.5782
050283	1.4818	1.5353	43.0638	44.3122	43.6855	43.6928
050289	1.6753	1.4946	41.1774	44.2814	50.1762	45.4611
050290	1.7010	1.1735	34.5482	37.3563	40.6192	37.4597
050291	1.9433	1.4800	35.3653	38.4365	41.2100	38.2986
050292	1.0703	1.1735	26.8879	26.9786	27.3365	27.0752
050295	1.4721	1.1735	36.1950	34.7382	38.4256	36.5470
050296	1.1731	1.5439	39.0060	39.9842	42.5405	40.5415
050298	1.1699	1.1735	27.7416	30.2022	33.7864	30.5471
050299	***	*	31.5435	35.1249	32.3707	32.9747
050300	1.4383	1.1735	30.7148	30.2874	33.6821	31.6610
050301	1.2929	1.4146	31.9995	35.9491	37.1103	35.1041
050305	1.4781	1.5353	44.8630	44.9681	48.5339	46.1773
050308	1.5103	1.5439	43.0691	43.7413	46.4180	44.3895

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050309	1.4582	1.3067	34.4145	38.2659	40.1499	37.7086
050312	***	*	33.9022	36.8498	*	35.1423
050313	1.2035	1.1941	31.8003	35.0478	37.5024	34.9828
050315	1.2649	1.1735	28.5933	33.2038	32.5538	31.5496
050320	1.3051	1.5353	40.2352	45.7686	46.2071	44.0268
050324	1.7775	1.1735	32.9792	34.5503	36.3474	34.6949
050325	1.2706	1.1768	30.6116	31.3730	37.0441	33.1665
050327	1.7326	1.1735	33.0087	33.9507	35.9349	34.3185
050329	1.2912	1.1735	26.2121	23.2927	33.0390	27.5539
050331	1.1678	*	20.2692	*	*	20.2692
050333	1.0046	1.1735	23.4009	19.6352	18.6534	20.3803
050334	1.6297	1.4593	40.7467	43.9656	47.2968	44.0650
050335	1.3979	1.1768	28.9403	30.9928	34.7192	31.6181
050336	1.2364	1.1941	28.5659	30.4664	31.5480	30.2596
050342	1.2383	1.1735	26.8507	29.2244	30.4226	28.9062
050348	1.7681	1.1735	37.7898	31.5156	32.7107	33.8510
050349	0.9573	1.1735	17.4791	24.4863	25.4266	22.6536
050350	1.3644	1.1735	31.1833	31.0136	31.7908	31.3398
050351	1.5102	1.1735	30.8661	30.6599	33.3064	31.6205
050352	1.3903	1.3067	33.9362	36.7673	37.0807	35.9210
050353	1.4804	1.1735	31.8291	29.4215	30.4206	30.5535
050357	1.4436	1.1735	32.3095	32.6763	36.2089	33.9116
050359	1.1695	1.1735	25.7739	29.8345	31.3391	29.0490
050360	1.4971	1.4800	37.0769	47.4497	52.3811	45.4210
050366	1.1802	1.1750	31.1854	33.6714	37.1527	33.8230
050367	1.4016	1.5343	38.7727	38.6330	40.1904	39.2572
050369	1.4153	1.1735	29.5697	30.6439	32.2467	30.8346
050373	1.5107	1.1735	31.9271	35.1380	34.3737	33.8407
050376	1.5472	1.1735	32.9393	34.3539	35.2837	34.2241
050378	0.9463	1.1735	34.2417	37.9904	40.1923	37.5531
050379	***	*	32.9576	*	*	32.9576
050380	1.6789	1.5439	42.0781	46.0276	49.4258	45.7911
050382	1.3885	1.1735	29.4323	30.4014	32.6683	30.8167
050385	1.3083	1.4800	34.5183	36.8107	36.4188	35.9492
050390	1.1270	1.1735	26.0066	27.3183	27.9359	27.0767
050391	***	*	18.1005	17.2141	*	17.6460
050393	1.4101	1.1735	30.0661	34.1743	35.6356	33.2874
050394	1.6049	1.1735	27.5061	27.4861	32.1894	29.1045
050396	1.6109	1.1735	33.5699	32.4918	37.3972	34.4575

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050397	0.7608	1.1735	28.1639	28.3671	29.6825	28.7688
050407	1.1110	1.4826	37.9066	42.2748	44.6839	41.6954
050410	***	*	21.3814	*	*	21.3814
050411	1.3617	1.1735	37.8064	38.8294	38.6328	38.4664
050414	1.3219	1.3067	34.6672	38.7585	41.8688	38.5190
050417	1.2763	1.1735	29.5031	32.9341	36.1222	32.8901
050419	0.8450	*	33.3124	*	*	33.3124
050420	***	*	24.9401	35.2869	39.9237	32.7481
050423	1.0733	1.1735	30.6416	28.3768	31.9751	30.4055
050424	1.9946	1.1735	31.0730	34.5680	36.6091	34.1652
050425	1.3231	1.3067	42.4177	49.2245	46.6628	46.3213
050426	1.4953	1.1735	30.6899	33.2031	34.9855	32.9985
050430	0.9678	1.1735	25.0604	23.9045	24.5327	24.4191
050432	***	*	30.8030	33.1876	35.2416	33.0686
050433	1.6238	1.1735	23.0807	21.3573	21.1287	21.8785
050434	1.0477	1.1735	26.1622	32.6255	33.7794	31.2611
050435	1.2745	1.1735	28.0305	30.6530	33.0372	30.6068
050438	1.5345	1.1735	27.2662	36.3026	36.2044	33.3758
050441	1.9501	1.5439	42.9765	44.5694	46.6160	44.7589
050444	1.3280	1.2213	30.5504	34.6313	37.6821	34.7268
050447	0.9382	1.1735	25.2573	26.7960	29.0780	27.0889
050448	1.3449	1.1735	27.9759	30.6201	32.7748	30.3937
050454	1.9048	1.4826	43.5311	38.5833	40.2811	40.7579
050455	1.6157	1.1735	22.7235	30.4606	34.5445	29.0773
050456	1.2382	1.1735	22.5630	21.6261	27.7659	24.0209
050457	1.6411	1.4826	45.5828	47.8947	50.0282	47.8438
050464	1.6927	1.2019	37.3692	38.3058	41.6235	39.0262
050468	1.5316	1.1735	29.5448	31.1111	35.7409	32.2602
050469	1.0345	*	28.9080	30.6502	*	29.7684
050470	1.1011	1.1735	24.6755	27.8678	31.0466	28.1052
050471	1.7531	1.1735	34.5211	35.4768	36.8680	35.6234
050476	1.4502	1.4146	34.6585	38.7856	41.1042	38.1894
050477	***	*	34.6995	37.7668	40.1566	37.8028
050478	0.9888	1.1735	33.3999	40.2558	41.1668	38.4344
050481	1.4426	1.1735	33.7445	36.1394	38.8650	36.2140
050485	1.6524	1.1735	31.4233	36.1488	34.6219	34.0204
050488	1.3381	1.5353	42.9904	42.6854	45.0630	43.6228
050491	***	*	32.1379	34.3598	*	33.1420
050492	1.2500	1.1735	27.1540	28.0826	30.7718	28.6561

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050494	1.3595	1.2918	35.9910	38.1177	40.6384	38.1894
050496	1.7137	1.5343	42.2672	48.2468	51.6363	47.5810
050498	1.3353	1.3067	33.0298	37.1667	41.0350	37.0348
050502	1.7120	1.1735	29.5616	28.7046	31.8872	30.0325
050503	1.5059	1.1735	31.6418	34.0994	37.3605	34.4052
050506	1.6121	1.2054	36.0164	37.7420	39.8586	37.9166
050510	1.1736	1.5343	47.5510	52.5376	49.4533	49.9483
050512	1.4090	1.5353	46.9233	50.9264	48.8057	49.0411
050515	1.4085	1.1735	38.9978	38.9542	40.2957	39.4965
050516	1.4990	1.3067	36.2772	39.8161	43.0249	39.7478
050517	1.2487	1.1735	23.9007	20.0213	22.4096	21.9265
050523	1.2609	1.5343	35.5452	40.6535	43.4579	39.9385
050526	1.3236	1.1735	31.3744	28.1997	33.3964	30.8791
050528	1.1384	1.1735	29.6838	31.4941	36.2908	32.6332
050531	1.0427	1.1735	26.9420	27.1974	28.3348	27.4859
050534	1.4830	1.1735	29.8603	33.1666	36.6447	33.1978
050535	***	*	32.3723	34.6143	37.8174	35.0680
050537	1.4153	1.3067	31.3844	34.9931	38.2145	35.0179
050539	***	*	29.8242	*	*	29.8242
050541	1.5793	1.5343	46.1121	52.5908	48.0867	48.9365
050543	0.7499	1.1735	26.1103	29.4443	24.4913	26.5587
050545	0.8097	1.1735	30.5554	31.3080	35.3209	32.3832
050546	0.6608	1.1735	30.2329	33.2245	36.5099	33.2376
050547	0.9370	1.4800	33.2204	34.8401	33.8036	33.9243
050548	0.8110	1.1735	30.3775	39.2234	41.1075	36.6565
050549	1.5409	1.1735	34.9818	35.2792	38.3927	36.2153
050550	***	*	30.2301	30.9612	34.9476	31.9494
050551	1.3354	1.1735	31.6165	34.0467	37.2506	34.3701
050552	1.0600	1.1735	27.1744	33.0711	33.9810	31.2584
050557	1.6021	1.2019	31.8048	33.3654	35.7023	33.6767
050561	1.5394	1.1735	38.8652	38.0196	38.2543	38.3445
050567	1.6001	1.1735	32.9829	35.7063	37.6384	35.4790
050568	1.1557	1.1735	24.4061	25.2337	26.0908	25.2915
050569	1.3188	*	33.0259	31.6785	*	32.3431
050570	1.5431	1.1735	34.0171	34.5161	38.4373	35.7023
050571	***	*	33.6156	34.7627	39.0649	35.8458
050573	1.6281	1.1735	34.1991	34.7279	35.2842	34.7594
050575	1.2413	1.1735	25.2513	25.1457	23.7990	24.6725
050577	***	*	30.8841	32.3744	*	31.6437

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050578	1.5073	1.1735	33.8825	35.2390	31.3639	33.5051
050579	***	*	39.4976	42.5081	*	40.8657
050580	1.2333	1.1735	31.6256	31.5806	34.1531	32.4721
050581	1.4916	1.1735	32.1801	34.0136	37.7567	34.6700
050583	1.6463	1.1735	33.3697	34.5747	37.4450	35.0070
050584	1.3197	1.1735	24.8180	30.3434	30.7839	28.6031
050585	***	*	22.7121	22.2521	*	22.4798
050586	1.2833	1.1735	27.4173	26.4782	31.3513	28.3870
050588	1.3520	1.1735	32.8212	32.7556	37.7387	34.4140
050589	1.1529	1.1735	30.9546	34.5100	37.6886	34.3942
050590	1.2947	1.3067	32.2142	38.4971	41.7519	37.3616
050591	***	*	28.8549	30.6106	34.7133	31.3307
050592	***	*	24.4542	27.3606	31.8053	27.4568
050594	***	*	34.7946	36.5256	42.0788	37.6355
050597	1.2585	1.1735	27.5691	28.8294	31.5625	29.3959
050599	1.8926	1.3067	38.1975	32.7835	34.7187	35.1751
050601	1.5530	1.1735	34.7409	36.0572	39.7717	36.8588
050603	1.4447	1.1735	30.2464	34.0275	35.0279	33.2305
050604	1.3981	1.5439	49.9428	55.0821	49.4446	51.2951
050608	1.2664	1.1735	23.3630	30.4169	31.2909	28.2962
050609	1.2820	1.1735	41.1797	41.7208	39.7397	40.7273
050613	***	*	*	42.8108	42.9930	42.8892
050615	***	*	33.2909	35.9547	39.1299	36.0890
050616	1.5105	1.1735	36.9017	37.7284	37.1200	37.2515
050618	0.9805	1.1735	27.4539	31.3182	33.1472	30.7682
050623	***	*	32.0627	*	*	32.0627
050624	1.2787	1.1735	32.2907	33.9594	35.9346	34.1566
050625	1.7417	1.1735	36.3631	38.6591	41.0439	38.7106
050630	***	*	30.9410	*	*	30.9410
050633	1.2282	1.2054	35.3734	36.8302	38.4916	36.8992
050636	1.2917	1.1735	30.5156	32.5576	33.0718	32.0958
050641	1.2925	1.1735	21.4612	39.6921	32.3586	29.3383
050644	0.9879	1.1735	27.6547	28.8237	30.7981	29.0878
050660	1.7387	*	*	*	*	*
050662	0.8701	1.5439	32.6362	33.2446	38.3017	34.3633
050663	1.2787	1.1735	25.7747	27.7334	17.7035	22.5204
050667	0.8474	1.4267	26.3937	24.2771	25.9161	25.5327
050668	1.2080	1.4826	31.8065	56.6555	51.6049	44.4447
050674	1.1462	1.3067	42.6866	48.0893	47.0720	46.1691

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050677	1.4838	1.1735	38.7984	38.5770	39.2161	38.8994
050678	1.3184	1.1735	30.7219	32.4473	33.7633	32.3842
050680	1.2329	1.5343	38.3946	38.2871	37.9856	38.2008
050682	0.8469	1.1735	21.7792	17.9077	22.2193	20.5433
050684	1.1133	1.1735	26.4234	27.5256	28.8378	27.6192
050686	1.2184	1.1735	40.9486	41.0188	39.7757	40.4752
050688	1.2024	1.5439	41.9325	44.1510	49.4062	45.3230
050689	1.5246	1.5343	42.2018	45.0951	48.8533	45.3625
050690	1.1505	1.4800	47.2769	50.9094	49.0226	49.1863
050693	1.3838	1.1735	35.0621	34.5797	39.6838	36.3980
050694	1.0491	1.1735	28.9544	30.7858	32.1065	30.6719
050695	***	*	35.6548	39.6004	49.0340	41.9291
050696	2.2803	1.1735	35.9220	37.3837	39.8963	37.7297
050697	1.1042	1.2809	25.1984	16.6605	22.1441	20.8111
050699	***	*	26.8211	28.9083	21.5725	25.9115
050701	1.3268	1.1735	29.6253	31.9529	34.9876	32.5132
050704	1.0048	1.1735	25.3488	29.7740	31.6097	29.0145
050707	1.2478	1.4946	34.0550	35.7311	43.5555	37.4838
050708	1.5880	1.1735	22.5034	30.5860	31.8442	27.9326
050709	1.4145	1.1735	25.6119	26.8549	24.5621	25.5804
050710	1.4535	1.1735	39.9858	45.8022	44.2482	43.5809
050713	***	*	20.2803	21.1273	21.4825	20.8079
050714	1.3819	1.5719	33.6676	31.9527	34.1542	33.3149
050717	1.4472	1.1735	38.0796	39.3227	38.8773	38.7316
050718	***	*	21.4996	25.5140	31.9622	26.0529
050720	0.9087	1.1735	30.0811	29.4726	30.3595	29.9462
050722	0.9937	1.1735	*	31.4867	33.7991	32.6970
050723	1.3661	1.1735	35.0119	38.5446	38.7140	37.6299
050724	1.9875	1.1735	34.4267	31.6910	35.2344	33.8380
050725	0.8900	1.1735	21.7816	24.3100	30.0580	25.0169
050726	1.4849	1.2019	27.8433	30.6479	28.6361	29.1183
050727	1.2033	1.1735	24.3026	33.9118	32.7783	30.6217
050728	***	*	36.0820	39.3581	41.8263	38.7034
050729	***	*	34.2580	36.5432	38.1882	36.3976
050730	***	*	51.5425	37.0629	39.2046	42.2691
050732	2.3947	1.1735	*	*	33.6831	33.6831
050733	1.6531	1.2809	*	*	40.1517	40.1517
050734	***	*	*	*	31.2883	31.2883
050735	1.3414	1.1735	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
050736	1.2215	1.1735	*	*	*	*
050737	1.4935	1.1735	*	*	*	*
050738	1.3812	1.1735	*	*	*	*
050739	1.6758	1.1735	*	*	*	*
050740	1.3840	1.1735	*	*	*	*
050741	1.4977	1.1735	*	*	*	*
050742	1.3973	1.1735	*	*	*	*
050744	1.9639	1.1735	*	*	*	*
050745	1.3614	1.1735	*	*	*	*
050746	1.7868	1.1735	*	*	*	*
050747	1.4029	1.1735	*	*	*	*
050748	1.0605	1.1941	*	*	*	*
050749	1.2549	1.1735	*	*	*	*
050750	1.4161	1.2019	*	*	*	*
050751	3.3418	1.1735	*	*	*	*
050752	1.4159	1.1735	*	*	*	*
050753	1.7076	1.1735	*	*	*	*
050754	1.2457	1.4946	*	*	*	*
050755	1.4141	1.1735	*	*	*	*
050756	1.9522	1.1735	*	*	*	*
050758	3.6091	1.1735	*	*	*	*
060001	1.5654	1.0454	26.8470	29.6191	31.0018	29.1634
060003	1.3970	1.0454	24.2224	29.4809	31.3616	28.3333
060004	1.2505	1.0454	29.9649	32.4609	32.0095	31.4837
060006	1.3300	0.9447	24.5704	25.2139	27.2057	25.6628
060008	1.2032	0.9447	23.3859	23.0947	26.5175	24.3270
060009	1.4945	1.0454	28.7645	31.5210	32.4208	30.9678
060010	1.6912	0.9732	28.9850	27.1916	29.5304	28.5344
060011	1.6330	1.0454	27.2833	35.1573	32.1001	31.3632
060012	1.4825	0.9466	26.2469	27.3885	28.7724	27.4500
060013	1.5046	0.9447	24.5994	26.8675	27.9145	26.4238
060014	1.8610	1.0454	31.2588	31.0542	31.9389	31.4097
060015	1.7851	1.0454	30.4533	32.5285	32.2927	31.6808
060016	1.2417	0.9447	25.6527	26.5427	27.1430	26.4586
060018	1.2836	0.9447	25.7628	24.1086	25.3897	25.0879
060020	1.6165	0.9447	22.6748	24.5992	25.9147	24.3734
060022	1.6516	0.9466	26.5238	28.2944	29.3379	28.0339
060023	1.6699	1.0454	27.7644	29.5760	31.1556	29.4769
060024	1.8432	1.0454	29.0130	30.0279	31.5411	30.2384

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
060027	1.6691	1.0454	28.0909	29.6121	30.9212	29.6273
060028	1.5125	1.0454	30.0448	31.6900	32.1656	31.3047
060030	1.4488	0.9732	26.6251	27.8642	29.9513	28.1546
060031	1.5591	0.9466	26.3650	27.8345	29.3907	27.8462
060032	1.4850	1.0454	30.4247	31.0686	32.7383	31.4187
060034	1.6640	1.0454	29.8445	30.9359	32.1252	30.9377
060036	1.1018	0.9447	20.7131	20.3226	22.8256	21.2502
060041	0.8785	0.9447	23.4978	24.6142	25.9710	24.7303
060043	1.1879	0.9447	18.7897	18.2143	21.9955	19.6596
060044	1.2127	0.9447	25.0360	26.5611	24.8352	25.4581
060049	1.2787	0.9579	29.0598	29.3724	30.2192	29.5665
060054	1.4508	1.0135	22.3490	24.3389	25.0980	23.9188
060064	1.7308	1.0454	31.3105	32.3681	33.2428	32.1357
060065	1.3983	1.0454	31.1987	32.4735	33.8538	32.5473
060071	1.1697	0.9447	25.7248	27.6657	28.1762	27.2779
060075	1.3389	1.0135	32.7563	32.2545	37.6023	34.1968
060076	1.2662	0.9447	26.8236	26.5631	30.7808	28.0383
060096	1.5564	1.0454	30.0602	32.1310	37.8243	33.2697
060100	1.6916	1.0454	32.1537	32.6104	33.2145	32.6673
060103	1.3607	1.0454	30.3003	31.6314	32.9690	31.6638
060104	1.3818	1.0454	32.0889	32.4232	35.4409	33.2464
060107	1.4409	1.0454	26.1883	26.8388	28.0660	27.0405
060112	1.6549	1.0454	*	34.9272	34.7116	34.8116
060113	1.4257	1.0454	*	*	32.6073	32.6073
060114	1.3815	1.0454	*	*	34.8536	34.8536
060115	0.8094	0.9447	*	*	*	*
060116	1.4020	1.0454	*	*	*	*
060117	1.5297	0.9447	*	*	*	*
060118	1.2063	0.9447	*	*	*	*
070001	1.6191	1.2625	34.0302	35.8958	37.0403	35.6798
070002	1.7625	1.2432	31.1530	33.4398	34.7636	33.1056
070003	1.1124	1.2432	32.4197	34.1352	35.6320	34.0741
070004	1.1690	1.2432	29.2544	29.4448	29.9557	29.5654
070005	1.3939	1.2625	32.1668	33.7813	34.9404	33.6347
070006	1.3734	1.3001	36.8469	37.9148	39.3935	38.0396
070007	1.3262	1.2432	31.7125	35.9617	36.2914	34.6709
070008	1.1977	1.2432	26.4806	28.5506	30.7305	28.5900
070009	1.1826	1.2432	30.2706	32.9299	35.5670	32.9116
070010	1.7655	1.3001	32.5798	35.3730	36.7227	34.9766

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
070011	1.4443	1.2432	29.9105	31.8987	31.6843	31.1785
070012	1.2719	1.2432	44.1424	29.4216	31.9345	33.9309
070015	1.3965	1.3001	33.4595	35.3385	37.3454	35.4457
070016	1.5006	1.2625	31.0904	31.4930	33.2391	31.9056
070017	1.3588	1.2625	31.7223	34.0490	35.6456	33.8516
070018	1.4240	1.3001	37.6081	39.7515	41.8460	39.8228
070019	1.3281	1.2625	31.8148	34.5125	33.7246	33.3670
070020	1.3289	1.2432	31.0935	33.6453	32.9714	32.5833
070021	1.1631	1.2432	33.2357	36.9241	38.5623	36.2063
070022	1.6736	1.2625	35.4120	39.0462	40.2283	38.2889
070024	1.3628	1.2432	32.0430	35.2323	34.7419	34.0490
070025	1.8086	1.2432	30.9938	32.4085	34.5887	32.6669
070027	1.4467	1.2432	31.8018	29.8513	30.4433	30.7112
070028	1.5979	1.3001	31.5035	35.1966	38.0855	34.9184
070029	1.3082	1.2432	27.7213	30.9299	31.0662	29.9131
070031	1.2692	1.2625	28.9189	30.1915	30.4054	29.8553
070033	1.4708	1.3001	37.1929	40.1594	41.7955	39.7822
070034	1.3978	1.3001	36.3899	38.3965	40.1685	38.3201
070035	1.2876	1.2432	27.5585	30.7440	32.2766	30.1626
070036	1.6060	1.2432	36.1610	38.3413	42.3391	39.0110
070038	1.3936	1.2625	25.7516	25.7914	35.8053	27.8684
070039	0.9371	1.2625	31.2269	36.1369	34.7219	33.8193
070040	0.9999	1.2432	*	*	*	*
080001	1.6247	1.0765	30.0242	32.0105	33.5310	31.8696
080002	***	*	27.7932	29.6800	31.3391	29.5960
080003	1.5716	1.0765	29.2266	30.7697	34.3048	31.5058
080004	1.5142	1.0666	27.4921	30.1094	32.2443	30.0060
080006	1.3077	1.0104	25.6160	27.4749	28.8862	27.4041
080007	1.3915	1.0498	27.0074	30.1100	31.1645	29.4885
090001	1.7715	1.0675	35.0413	36.6577	38.3043	36.6494
090003	1.2497	1.0675	29.2660	31.0419	32.1960	30.9276
090004	1.9608	1.0675	32.2021	35.6964	37.3798	35.0400
090005	1.3882	1.0675	30.7728	33.0178	33.7448	32.5073
090006	1.4079	1.0675	29.5590	29.4912	31.3562	30.1264
090008	1.3376	1.0675	29.1059	32.0745	33.7471	31.3884
090011	2.0575	1.1016	34.0693	36.7579	38.0654	36.2932
100001	1.5331	0.9089	24.4060	26.4631	27.2809	26.0728
100002	1.4368	1.0247	25.3389	27.2350	28.7068	27.1087
100004	0.9210	*	16.5974	*	*	16.5974

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
100006	1.6452	0.9284	26.3789	29.1505	28.3673	27.9603
100007	1.6373	0.9284	26.5378	28.5702	29.0472	28.0969
100008	1.7213	1.0008	27.4314	29.1705	30.3392	29.0493
100009	1.4490	1.0008	25.9381	27.4424	27.8618	27.0421
100012	1.6154	0.9485	26.3788	28.4600	29.8353	28.2813
100014	1.4083	0.9170	24.5862	25.1524	27.4019	25.7601
100015	1.3028	0.9170	24.6038	26.0916	27.2483	25.9359
100017	1.6275	0.9170	26.1580	27.9654	28.2402	27.5020
100018	1.6508	0.9618	28.1481	30.2423	30.6545	29.7108
100019	1.6608	0.9380	27.6179	28.6630	30.3008	28.8670
100020	***	*	23.9414	27.1257	*	25.5458
100022	1.7420	1.0247	29.9345	32.8088	36.7912	33.2233
100023	1.5160	0.9170	23.0074	25.2652	25.4270	24.5739
100024	1.1780	1.0008	30.2395	29.1894	29.5423	29.6470
100025	1.6816	0.8733	22.1580	23.3843	26.7013	24.0625
100026	1.5788	0.8733	21.4703	23.4730	26.0147	23.7184
100027	***	*	16.1223	18.9432	*	17.4007
100028	1.3580	0.9380	26.8661	27.7497	27.5664	27.4076
100029	1.2822	1.0008	27.5844	28.8842	30.5382	29.0530
100030	1.2839	0.9284	24.0943	24.6314	25.3513	24.7170
100032	1.8022	0.9170	25.2450	26.8162	26.9275	26.3598
100034	1.8268	1.0008	25.9415	28.1280	27.2915	27.0674
100035	1.5677	0.9770	26.9407	29.4803	30.2382	28.8750
100038	1.8213	1.0247	29.8583	31.3403	31.6657	30.9770
100039	1.5152	1.0247	28.4627	28.2531	29.3699	28.6922
100040	1.7005	0.9089	23.6443	26.2429	27.2835	25.7456
100043	1.3766	0.9170	25.2273	26.4221	27.0054	26.2287
100044	1.4158	1.0035	28.3596	30.3659	33.1141	30.6154
100045	1.3353	0.9170	26.9641	29.7375	26.5413	27.7587
100046	1.3025	0.9170	26.3673	26.9469	26.7702	26.6963
100047	1.8643	0.9770	25.0404	26.7674	29.9729	27.2658
100048	0.9265	0.8733	18.8770	19.3226	20.2657	19.5008
100049	1.1601	0.8834	22.9809	24.0385	24.5571	23.8789
100050	1.1287	1.0008	19.8713	21.5101	25.3354	22.2763
100051	1.3531	0.9284	23.1940	28.0946	28.6225	26.7140
100052	1.4482	0.8834	22.3920	23.6796	23.4036	23.1677
100053	1.2917	1.0008	27.3224	28.5118	31.7415	29.1121
100054	1.3029	0.8733	28.0512	28.7646	30.5515	29.0987
100055	1.4149	0.9170	23.5332	25.6243	27.3826	25.3801

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
100057	1.4545	0.9284	25.3897	24.8010	26.3134	25.5307
100061	1.5462	1.0008	29.2565	31.4413	30.4528	30.3973
100062	1.6808	0.8733	25.2340	25.1280	25.9597	25.4599
100063	1.3031	0.9170	24.7026	25.5097	26.4139	25.5745
100067	1.4065	0.9170	26.1213	26.8628	27.4762	26.8565
100068	1.6610	0.9170	25.9202	26.1341	27.6576	26.5514
100069	1.4494	0.9170	24.7442	25.7450	27.2108	25.8887
100070	1.7132	0.9770	24.8883	26.8461	29.2005	26.9667
100071	1.2744	0.9170	24.9682	26.3768	25.3667	25.5850
100072	1.3878	0.9170	26.0459	25.7962	27.1889	26.3540
100073	1.7724	1.0247	30.3358	30.5845	29.4165	30.1139
100075	1.4514	0.9170	25.1691	25.7612	27.6534	26.2376
100076	1.1671	1.0008	21.9483	23.4551	24.0412	23.1092
100077	1.3562	0.9770	26.0347	30.6925	30.7564	29.1495
100079	1.5014	*	*	*	*	*
100080	1.7114	1.0247	27.0126	28.2188	29.5346	28.2767
100081	0.9416	0.8733	15.6661	16.9756	19.5711	17.4305
100084	1.7873	0.9284	26.3393	27.4947	32.7503	28.7737
100086	1.2965	1.0247	28.2641	28.5971	29.9072	28.9234
100087	1.8981	0.9770	27.1531	29.5823	30.5938	29.1299
100088	1.5782	0.9089	25.9182	26.7574	28.2825	27.0232
100090	1.4904	0.9089	24.2422	26.5703	27.6175	26.1889
100092	1.5158	0.9380	28.4789	27.8341	26.6315	27.6313
100093	1.7127	0.8733	21.3524	21.6438	22.5555	21.8792
100099	1.0873	0.8834	21.3035	25.8454	26.2395	24.4525
100102	1.0996	0.8858	23.8596	26.1015	27.8551	25.9619
100105	1.4480	0.9851	26.8091	29.9745	30.9915	29.2009
100106	1.0560	0.8733	24.0389	24.7650	24.8098	24.5435
100107	1.2347	0.9485	26.1337	27.4760	30.5764	28.1079
100108	0.8046	0.8733	22.0750	21.3540	22.6270	21.9880
100109	1.2508	0.9170	24.9951	25.5669	26.2446	25.6303
100110	1.6550	0.9284	29.1494	29.4788	29.5985	29.4188
100113	2.0264	0.9301	26.3806	28.0440	29.2429	27.9271
100114	1.3817	1.0008	29.2195	29.2862	30.2544	29.5959
100117	1.2145	0.9089	26.4536	27.7198	28.4928	27.6036
100118	1.3596	0.9089	28.0569	27.6438	27.0981	27.5188
100121	1.1043	0.8834	24.8579	26.2990	27.9353	26.4264
100122	1.2268	0.8733	23.4751	24.6285	26.7175	24.9538
100124	1.1542	0.8733	22.7023	24.0333	24.8880	23.9087

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
100125	1.1875	1.0008	26.7452	29.7750	31.7749	29.5544
100126	1.3314	0.9170	24.4515	29.6247	28.3213	27.4142
100127	1.5666	0.9170	24.4485	26.0923	27.4632	26.0315
100128	2.2084	0.9170	29.4979	29.2566	30.0324	29.6033
100130	1.1786	1.0247	24.2046	26.0268	28.3651	26.1504
100131	1.4165	1.0008	29.2462	27.8164	29.7647	28.9653
100132	1.2457	0.9170	24.3293	26.0526	27.8180	26.1461
100134	0.8565	0.8733	20.9243	20.7367	21.6544	21.1186
100135	1.6113	0.9027	24.0024	26.7030	29.1856	26.5350
100137	1.2884	0.8834	25.1974	24.8519	26.8391	25.6704
100139	0.8316	0.9301	17.5489	18.2197	21.1310	18.9563
100140	1.0862	0.9089	26.4720	26.1352	27.8352	26.8143
100142	1.2095	0.8733	22.9577	24.8853	25.6999	24.5446
100150	1.2689	1.0008	26.1990	26.8492	27.7740	26.9185
100151	1.7476	0.9089	28.1322	30.6447	29.7267	29.4931
100154	1.5849	1.0008	27.6127	28.2506	29.7332	28.5816
100156	1.1335	0.9301	26.7092	27.5706	28.3927	27.6111
100157	1.5749	0.9170	27.3851	29.7455	30.3086	29.2306
100160	1.1427	0.8733	26.9851	30.7454	30.6902	29.5445
100161	1.5163	0.9284	28.8077	28.0545	29.5673	28.8155
100166	1.4671	0.9770	27.9618	28.8685	30.1811	28.9924
100167	1.3044	1.0247	30.3694	30.2166	31.7813	30.8188
100168	1.4077	1.0247	27.1292	27.6739	27.0938	27.2997
100172	1.2812	1.0008	18.2735	20.7857	22.2183	20.2634
100173	1.6816	0.9170	24.8721	26.5436	28.6402	26.6632
100175	0.9376	0.8733	23.5455	23.9665	25.0913	24.2153
100176	1.9322	1.0247	31.2694	30.7087	33.3181	31.7301
100177	1.3034	0.9380	26.6781	28.0089	29.6284	28.1072
100179	1.8025	0.9089	29.5619	29.1111	29.2795	29.3153
100180	1.3656	0.9170	27.1804	29.9238	31.0099	29.4514
100181	1.0916	1.0008	21.8540	24.3708	23.9656	23.5712
100183	1.2331	1.0008	27.4951	29.0270	30.5042	28.9860
100187	1.2405	1.0008	27.3653	27.8144	30.7705	28.5922
100189	1.3212	1.0247	28.4136	28.8320	29.9376	29.0848
100191	1.3251	0.9170	26.6341	28.3710	29.4533	28.2035
100200	1.3568	1.0247	29.8963	28.7694	29.6400	29.4296
100204	1.5564	0.9301	25.7537	27.4763	27.2819	26.8493
100206	1.3044	0.9170	25.2196	27.0295	27.7551	26.6843
100209	1.4511	1.0008	26.6245	26.8473	28.5336	27.3567

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
100210	1.6418	1.0247	28.9486	29.8515	32.0830	30.2959
100211	1.1980	0.9170	24.7095	24.7533	26.2859	25.2466
100212	1.5281	0.8733	24.7566	26.1846	27.7960	26.2590
100213	1.5667	0.9770	27.1936	27.9283	29.5218	28.1998
100217	1.2128	0.9851	25.2907	27.3989	27.7683	26.8879
100220	1.7272	0.9485	26.0905	28.3868	29.3601	28.0186
100223	1.5830	0.8733	24.7015	25.0332	26.1115	25.3049
100224	1.2841	1.0247	24.8077	26.6446	28.0455	26.4947
100225	1.2966	1.0247	28.4316	28.5259	30.8782	29.2134
100226	1.2741	0.9089	29.3317	28.8165	28.8791	28.9967
100228	1.3720	1.0247	29.8952	28.1396	30.1635	29.3741
100230	1.3872	1.0247	28.1703	29.8493	31.9448	29.9638
100231	1.7057	0.8733	25.5175	25.7037	26.6773	25.9676
100232	1.2525	0.9301	24.9322	28.5537	28.3892	27.3025
100234	1.2967	1.0247	26.3601	27.4456	28.8835	27.5798
100236	1.4833	0.9770	26.6585	28.9955	28.3017	27.9879
100237	1.9061	1.0247	31.3543	31.7848	33.1536	32.0709
100238	1.6524	0.9170	28.4302	30.1094	31.4198	30.0500
100239	1.2450	0.9770	27.7592	28.6893	29.0650	28.5164
100240	1.0067	1.0008	25.3265	27.3523	29.7000	27.5097
100242	1.4462	0.8733	24.0990	25.6083	26.1988	25.3024
100243	1.5930	0.9170	26.1131	27.4534	28.3894	27.3449
100244	1.4214	0.9485	25.2584	26.6876	28.2881	26.8124
100246	1.5767	1.0035	28.9894	29.3310	30.1061	29.4946
100248	1.5245	0.9170	27.7798	28.8082	30.2133	28.9513
100249	1.2736	0.9170	23.2084	24.9876	26.4676	24.9134
100252	1.1775	0.9851	25.8540	27.8256	27.1639	26.9484
100253	1.3700	1.0247	25.7121	27.4927	28.7770	27.3747
100254	1.5053	0.9027	25.7338	26.1406	27.4900	26.4898
100255	1.2926	0.9170	24.4808	26.5571	27.3866	26.1585
100256	1.8509	0.9170	28.8856	30.3081	30.2093	29.8134
100258	1.5137	1.0247	31.2482	31.2203	33.8630	32.1172
100259	1.2826	0.9170	26.0175	27.4809	29.0612	27.5355
100260	1.3247	1.0035	27.5188	26.7129	28.2301	27.4901
100264	1.3409	0.9170	25.5489	26.8216	28.0370	26.7874
100265	1.2691	0.9170	24.1454	25.7432	26.3326	25.4676
100266	1.4175	0.8733	23.2340	23.0208	24.2517	23.5318
100267	1.3146	0.9770	27.3769	28.7259	28.9674	28.3539
100268	1.1557	1.0247	29.2898	29.0668	30.5750	29.6378

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
100269	1.3557	1.0247	26.7450	26.6047	27.8407	27.0869
100271	2.3567	*	*	*	*	*
100275	1.2876	1.0247	26.0361	26.8943	28.7797	27.3049
100276	1.2417	1.0247	30.0576	29.7606	30.5720	30.1327
100277	1.4051	1.0008	16.5427	20.4791	24.1122	20.4492
100279	1.3366	0.9485	26.8606	28.6383	29.2257	28.2861
100281	1.3703	1.0247	28.6660	29.6698	30.9131	29.8017
100284	1.0113	1.0008	23.8170	22.3134	25.2637	23.6827
100285	1.2689	1.0247	*	*	41.9481	41.9481
100286	1.6191	0.9618	29.4284	28.3645	25.8085	27.6610
100287	1.3868	1.0247	28.3427	28.1051	29.7536	28.7018
100288	1.5156	1.0247	33.8141	28.7902	31.0506	31.0802
100289	1.6865	1.0247	29.2915	29.6376	31.9011	30.3063
100290	1.1899	0.9315	23.5080	27.1011	28.7111	26.4179
100291	1.2458	0.9380	*	28.4722	28.1515	28.2974
100292	1.3544	0.8733	*	26.7063	27.7644	27.2418
100293	***	*	*	32.7963	*	32.7963
100294	***	*	*	30.7557	*	30.7557
100295	***	*	*	26.1983	*	26.1983
100296	1.3408	1.0008	*	*	29.3870	29.3870
100297	***	*	*	*	32.1536	32.1536
100298	0.8217	0.9027	*	*	19.0297	19.0297
100299	1.2623	0.9770	*	*	34.3697	34.3697
100300	1.5491	0.9770	*	*	*	*
100301	2.4311	0.8733	*	*	*	*
100302	1.1232	0.9284	*	*	*	*
110001	1.3413	0.8582	25.3102	26.4338	26.5640	26.1063
110002	1.3627	0.9812	25.3897	26.4715	26.2228	26.0377
110003	1.2925	0.7861	21.4002	22.7066	24.2097	22.7660
110004	1.3576	0.8962	23.9911	24.9978	25.1846	24.7384
110005	1.2344	0.9812	22.8999	28.1209	27.2826	26.2185
110006	1.5283	0.9996	28.6090	28.3839	*	28.4953
110007	1.5851	0.8666	23.8729	26.6396	26.3133	25.6316
110008	1.3081	0.9812	27.1711	29.2947	30.9757	29.1807
110010	2.2316	0.9812	29.7142	31.7185	33.2396	31.5599
110011	1.2246	0.9812	26.0899	28.0598	28.5892	27.5869
110015	1.0599	0.9812	26.6610	28.1274	28.8796	27.9810
110016	1.2630	0.8587	21.7610	22.7263	24.3563	22.9378
110018	1.1608	0.9812	28.2431	26.8016	30.1849	28.3512

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
110020	1.3212	0.9812	26.8501	28.3822	27.5559	27.6146
110023	1.2983	0.9812	27.3029	29.8061	29.3282	28.8606
110024	1.4918	0.8890	25.7205	27.0225	27.3357	26.6955
110025	1.4750	0.9764	26.1311	31.0703	30.2845	29.1378
110026	1.1088	0.7861	21.2827	21.8018	22.8820	21.9825
110027	1.0967	0.7861	20.2175	22.6058	25.5291	22.6326
110028	1.7895	0.9598	28.1619	30.4641	31.4568	30.0489
110029	1.8257	0.9812	24.8893	27.3618	29.2134	27.2823
110030	1.3179	0.9812	26.4770	29.6841	29.9531	28.7936
110031	1.2864	0.9812	24.7874	27.1989	29.5533	27.2214
110032	1.1823	0.7861	21.9407	23.2586	25.1896	23.4280
110033	1.4755	0.9812	28.3210	30.3415	32.4178	30.4701
110034	1.7240	0.9598	26.9986	27.2338	28.7915	27.6795
110035	1.7468	0.9812	27.4583	28.9408	30.1852	28.9129
110036	1.8443	0.8890	26.8789	26.6664	27.2280	26.9397
110038	1.5056	0.8454	21.2138	22.2720	22.9685	22.1533
110039	1.3676	0.9598	24.7248	26.3503	26.2485	25.8081
110040	1.0900	0.9812	19.7509	20.9487	23.9526	21.5987
110041	1.2685	0.9812	23.4073	24.8864	26.1948	24.8276
110042	1.0546	0.9812	28.6873	34.9954	33.4391	32.3610
110043	1.7588	0.8890	26.6323	27.8477	28.8551	27.7751
110044	1.1550	0.7861	20.9654	23.3039	24.3772	22.8675
110045	1.0604	0.9812	24.9821	24.4275	27.7619	25.7235
110046	1.1564	0.9812	23.8292	26.7464	*	25.2689
110050	1.0878	0.8582	26.1319	27.5985	27.0651	26.9506
110051	1.1325	0.7861	19.4276	20.1756	21.4898	20.4314
110054	1.3879	0.9812	25.7085	28.9254	29.4691	28.1296
110059	1.1614	0.7861	20.5565	23.2137	24.7838	22.7781
110064	1.5600	0.9019	24.2739	24.1219	26.9363	25.1484
110069	1.3210	0.9567	24.1669	26.2085	29.9098	26.8651
110071	1.1303	0.7861	18.0224	21.3963	21.2041	20.2222
110073	1.0732	0.7861	18.6336	18.5753	23.3571	20.1191
110074	1.5633	0.9996	27.1207	27.9190	31.0062	28.6224
110075	1.2368	0.8890	22.0935	23.7585	24.8244	23.5723
110076	1.4789	0.9812	26.3506	28.7871	29.4344	28.2028
110078	2.0203	0.9812	29.5779	29.9625	30.5196	30.0318
110079	1.4371	0.9812	23.1024	26.8412	27.3274	25.6718
110080	***	*	22.3213	18.4714	*	20.3904
110082	1.9484	0.9812	29.8366	30.8320	30.1072	30.2642

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
110083	1.9004	0.9812	27.8245	30.4287	34.0610	30.7539
110086	1.2918	0.7861	21.1508	21.6898	22.9959	21.9535
110087	1.4785	0.9812	28.0471	28.1633	31.0403	29.1240
110089	1.1256	0.7861	21.9509	23.9026	24.3327	23.4318
110091	1.2985	0.9812	26.5523	29.5337	27.0994	27.7306
110092	1.0708	0.7861	18.5527	20.8911	21.4168	20.2706
110095	1.4671	0.8666	23.4846	26.3075	28.0526	25.9759
110100	0.9760	0.8651	16.5600	16.2575	20.8201	17.8670
110101	1.0211	0.7928	16.4269	19.4257	21.0983	18.9322
110104	1.0922	0.7861	18.7951	20.3777	21.8966	20.4323
110105	1.3384	0.7861	21.1077	23.1405	23.4010	22.5530
110107	1.9638	0.9748	26.2526	28.9352	30.1027	28.5426
110109	1.0216	0.7861	21.4279	23.0376	21.6023	22.0301
110111	1.1565	0.9598	29.2189	25.1270	25.7084	26.4563
110112	0.9102	0.7861	24.2464	22.7672	26.4089	24.5417
110113	0.9646	0.9598	19.1752	21.3417	22.0793	20.8903
110115	1.6861	0.9812	32.0198	31.5074	32.7927	32.1145
110121	1.0425	0.8454	21.6637	26.2336	23.4571	23.8303
110122	1.5379	0.8454	23.7589	25.1934	25.4439	24.7899
110124	1.0500	0.7861	22.7058	22.9212	22.9571	22.8637
110125	1.2981	0.9567	22.4238	23.7834	24.7347	23.6390
110128	1.2619	0.8890	24.4596	25.7839	25.4190	25.2198
110129	1.5740	0.9019	23.3631	25.9625	30.0444	26.3986
110130	0.9401	0.7861	18.7549	19.1284	20.4349	19.4669
110132	0.9900	0.7861	19.2307	20.2502	21.2642	20.2556
110135	1.2746	0.7861	20.4412	22.5346	24.0945	22.4857
110136	***	*	15.8573	18.8212	*	17.2827
110142	0.9496	0.8046	18.1980	21.3935	21.6286	20.4908
110143	1.4032	0.9812	27.7055	28.6583	29.9139	28.7963
110146	1.0451	0.9089	23.9067	27.0987	29.0193	26.6351
110149	***	*	27.1477	28.4040	*	27.8380
110150	1.3058	0.9812	22.6624	25.3742	26.9884	24.9555
110153	1.1347	0.9567	24.5368	25.7467	29.3305	26.5481
110161	1.5077	0.9812	29.3201	30.4885	31.5001	30.4389
110163	1.4442	0.8666	26.0764	28.2169	27.7679	27.3543
110164	1.6466	0.9748	27.0600	28.8946	30.0145	28.6658
110165	1.3804	0.9812	26.8378	27.0977	28.7902	27.5702
110166	***	*	26.8070	*	*	26.8070
110168	1.8202	0.9812	27.0022	28.5700	29.7774	28.4702

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
110172	1.3257	0.9812	29.1703	31.1234	31.3999	30.6003
110177	1.7868	0.9598	26.7504	28.8356	29.7079	28.4491
110179	***	*	26.0759	*	*	26.0759
110183	1.2715	0.9812	29.6132	28.6208	28.3505	28.8254
110184	1.2398	0.9812	26.5240	28.3545	29.4071	28.1771
110186	1.3729	0.9019	25.0298	27.4925	28.2880	26.9617
110187	1.2163	0.9812	24.2933	25.2139	26.9638	25.5788
110189	1.1273	0.9812	26.7654	26.1418	26.2799	26.3816
110190	1.0370	0.8102	14.2518	23.3204	24.5224	20.0525
110191	1.3276	0.9812	26.8277	27.7760	30.9481	28.4955
110192	1.3990	0.9812	26.7852	28.8267	30.0843	28.6181
110193	***	*	27.3341	27.9161	*	27.6234
110194	0.9359	0.7861	18.4776	19.1920	21.0826	19.6210
110198	1.3957	0.9812	31.7748	31.0557	32.8171	31.8629
110200	1.9226	0.9019	22.3249	24.9236	27.2974	24.7904
110201	1.4598	0.9748	28.2232	31.0841	32.0967	30.4769
110203	0.9675	0.9812	26.8768	29.7888	32.3441	29.6046
110205	1.1514	0.8368	19.7408	22.0207	23.9738	21.9564
110209	0.5324	0.7861	19.0450	21.1534	21.2428	20.5456
110212	1.2000	0.8204	40.5120	*	*	40.5120
110214	***	*	*	37.1450	*	37.1450
110215	1.2911	0.9812	25.7886	27.5566	29.5238	27.7250
110219	1.4241	0.9812	27.0362	28.8814	32.2603	29.4317
110220	***	*	*	37.5741	*	37.5741
110221	***	*	*	28.0500	*	28.0500
110222	***	*	*	35.6189	*	35.6189
110223	***	*	*	*	25.3071	25.3071
110224	***	*	*	*	33.6464	33.6464
110225	1.1627	0.9812	*	*	29.5373	29.5373
110226	1.1705	0.9812	*	*	*	*
110228	0.6858	0.9812	*	*	*	*
120001	1.7954	1.1305	34.7715	34.1385	39.6348	36.0753
120002	1.2128	1.0740	29.9913	32.3784	34.1709	32.1936
120004	1.3302	1.1305	28.6527	30.0668	31.3555	30.0081
120005	1.3171	1.0740	29.3405	31.1985	33.6942	31.4363
120006	1.2693	1.1305	31.2285	31.6785	34.2231	32.3972
120007	1.7199	1.1305	30.4247	30.2473	30.8773	30.5122
120010	1.8852	1.1305	30.1659	29.5714	30.8526	30.1903
120011	1.5612	1.1305	34.1643	37.1792	39.1941	36.8951

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
120014	1.2810	1.0740	28.6416	30.3463	30.9839	30.0257
120016	***	*	19.6039	*	*	19.6039
120019	1.1328	1.0740	30.3809	30.4257	33.0114	31.2831
120022	1.9275	1.1305	26.6100	29.9527	32.5326	29.5914
120025	***	*	30.2367	*	*	30.2367
120026	1.4060	1.1305	30.3293	32.4566	34.2244	32.4725
120027	1.3547	1.1305	28.6717	28.7905	29.5825	29.0488
120028	1.3018	1.1305	30.3794	32.4847	34.0451	32.3420
120029	***	*	*	*	44.6382	44.6382
130002	1.4431	0.8706	23.6078	24.7871	24.7266	24.4032
130003	1.3970	0.9614	27.6345	28.6158	28.6136	28.2894
130005	***	*	25.7523	*	*	25.7523
130006	1.7752	0.9496	25.3221	27.2158	28.0048	26.8675
130007	1.8212	0.9496	24.9562	28.7246	30.4958	27.9567
130013	1.3847	0.9496	27.9209	30.9609	36.1570	31.7470
130014	1.2226	0.9496	24.3885	27.2543	27.5936	26.3567
130018	1.7059	0.9272	26.4125	27.3439	28.4041	27.3783
130021	***	*	16.1658	*	*	16.1658
130024	1.1822	0.8493	23.3347	23.6212	24.8035	23.9293
130025	1.2426	0.7818	20.1452	21.1998	22.7962	21.4285
130028	1.4835	0.9186	26.3443	27.2195	28.4934	27.4962
130049	1.6067	1.0226	26.9749	27.3597	29.0185	27.8229
130062	***	*	20.6642	25.6467	29.1925	24.9270
130063	1.3933	0.9496	22.5904	26.0955	27.7607	25.3662
130065	1.9742	0.9272	*	21.9792	30.4547	26.6750
130066	2.0724	0.9674	*	*	28.9883	28.9883
130067	0.5728	0.9272	*	*	21.3867	21.3867
130068	2.6786	0.9674	*	*	*	*
140001	1.1034	0.8714	22.3170	22.3001	22.2003	22.2726
140002	1.3394	0.8982	24.6954	27.0165	27.4779	26.4101
140007	1.3523	1.0588	28.3482	30.7378	31.4024	30.1866
140008	1.4485	1.0588	28.5297	29.1767	31.8008	29.7872
140010	1.5341	1.0588	35.1024	31.8806	40.1360	35.1264
140B10[3]		1.0471	35.1024	31.8806	40.1360	35.1264
140011	1.1265	0.8345	22.4091	23.8575	25.8864	24.1284
140012	1.1597	1.0471	28.6564	29.0336	31.8213	29.7772
140013	1.4752	0.9385	23.3065	23.9269	25.0951	24.0826
140015	1.4276	0.8982	23.0600	24.4687	24.6409	24.0661
140016	1.0141	*	18.1242	*	*	18.1242

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
140018	1.4713	1.0588	27.7548	26.3533	30.7398	28.2267
140019	0.9076	0.8345	18.9228	21.3438	22.3179	20.8686
140024	***	*	17.5249	*	*	17.5249
140026	1.1369	0.8660	23.0470	25.9669	26.0493	25.0156
140029	1.5629	1.0588	28.6565	30.2688	36.7722	31.7994
140030	1.5605	1.0588	29.7771	30.2776	31.6822	30.5819
140032	1.2251	0.8982	24.0573	26.7310	27.5367	26.1095
140033	0.7592	1.0471	25.6068	27.9993	29.5256	27.5611
140034	1.1489	0.8982	23.0033	24.0470	24.4653	23.8461
140040	1.2143	0.9225	22.2969	23.2293	24.5589	23.3454
140043	1.2831	0.8893	26.7996	27.3469	29.8633	28.0422
140045	***	*	20.6548	*	*	20.6548
140046	1.5047	0.8982	23.2127	24.7334	25.6230	24.5835
140048	1.2906	1.0588	28.2222	29.3877	30.6686	29.4175
140049	1.4765	1.0588	27.4009	29.0976	30.8617	29.2268
140051	1.5046	1.0588	27.7901	30.9696	32.1730	30.2784
140052	1.2926	0.8982	23.5662	25.9617	26.9907	25.5002
140053	1.8975	0.8942	24.8455	27.4518	28.4513	26.9029
140054	1.4482	1.0588	31.8564	33.1406	34.2378	33.0651
140058	1.2520	0.8982	22.8423	24.6058	25.2568	24.2526
140059	1.0745	0.8982	22.4652	22.6743	21.6230	22.2390
140061	***	*	20.8063	*	*	20.8063
140062	1.3499	1.0588	34.7704	34.1230	36.8271	35.2283
140063	1.4161	1.0588	27.8306	28.6559	30.5465	28.9957
140064	1.1956	0.9225	22.0407	23.8639	25.7551	23.9579
140065	1.4090	1.0588	29.4678	30.1856	31.5510	30.3798
140066	1.0931	0.8982	21.9771	22.1524	22.0225	22.0498
140067	1.8440	0.9385	25.3986	28.3506	29.8982	27.9265
140068	1.2030	1.0588	27.3956	28.3938	26.7166	27.5195
140075	1.3290	1.0588	27.9325	26.2626	35.9507	29.4588
140077	1.0118	0.8982	19.1363	20.3999	21.6468	20.4044
140080	1.4044	1.0588	23.2575	28.8791	29.9067	27.0464
140082	1.5865	1.0588	25.6645	28.3429	31.0516	28.3204
140083	0.9167	1.0588	26.2972	26.8919	27.2189	26.8114
140084	1.3044	1.0471	29.2515	30.5036	30.7251	30.1522
140088	1.9227	1.0588	32.4978	30.5450	32.6866	31.9069
140089	1.2571	0.8345	23.3401	24.1066	24.9120	24.1080
140091	1.7600	0.9315	26.8518	27.8536	28.2095	27.6630
140093	1.2233	0.9244	25.3127	28.3298	28.6709	27.3188

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
140094	1.0741	1.0588	27.9273	27.3841	28.7647	28.0321
140095	1.1840	1.0588	27.6799	28.7617	29.7385	28.6923
140100	1.4114	1.0471	37.0820	41.3374	37.2961	38.7112
140101	1.2087	1.0588	28.5365	29.4081	28.9723	28.9915
140103	1.1471	1.0588	23.3258	23.6406	24.0926	23.6947
140105	2.4503	1.0588	27.4531	29.5274	29.6590	28.8385
140109	1.2813	*	19.5675	*	*	19.5675
140110	1.1010	1.0471	27.9844	28.6364	30.3432	29.0082
140113	1.6263	0.9315	26.7969	29.5452	30.2542	28.8718
140114	1.4998	1.0588	28.3014	28.2151	29.8316	28.7971
140115	1.1211	1.0588	25.1498	26.0383	25.4576	25.5430
140116	1.2804	1.0588	31.9902	34.5537	34.3876	33.6671
140117	1.5489	1.0588	26.8802	27.7201	30.9679	28.4756
140118	1.5337	1.0588	29.7570	32.5518	33.1987	31.8004
140119	1.8437	1.0588	36.1419	34.2118	32.2185	34.0199
140120	1.2654	0.9385	22.7375	23.9724	25.9275	24.2583
140122	1.4644	1.0588	28.4188	30.5653	30.2888	29.7419
140124	1.2540	1.0588	36.1327	35.7563	38.2191	36.7032
140125	1.1728	0.8982	20.4014	22.7571	26.5801	23.2037
140127	1.5916	0.9483	24.1658	25.6668	27.8363	25.8841
140130	1.2387	1.0471	29.5247	32.6209	32.5425	31.6158
140133	1.2958	1.0588	28.0339	31.0269	30.3259	29.7606
140135	1.4316	0.8345	22.3264	23.3196	24.6645	23.4680
140137	1.0331	0.8982	21.4699	23.4174	31.4349	24.5880
140141	***	*	21.7872	*	*	21.7872
140143	1.1598	1.0471	26.2954	27.4499	26.1126	26.6046
140145	1.0894	0.8982	23.4608	26.0875	25.2040	24.9380
140147	1.1114	0.8345	19.8541	21.0686	21.1817	20.6906
140148	1.7334	0.8942	24.7031	25.5677	27.0038	25.7606
140150	1.7108	1.0588	35.2711	52.0970	35.5951	40.9580
140151	0.8038	1.0588	23.4879	27.0312	26.0825	25.5372
140152	1.1775	1.0588	27.6086	30.2209	29.8647	29.2051
140155	1.3616	1.0471	28.9724	29.5734	32.7960	30.4671
140158	1.3843	1.0588	27.0986	27.3721	30.4445	28.3050
140160	1.2234	0.9703	24.5373	25.8684	27.6905	26.0399
140161	1.0989	1.0471	23.1647	25.2898	28.8266	25.7893
140162	1.5902	0.9483	27.4471	29.4121	32.1810	29.6162
140164	1.8223	0.8982	23.7457	24.6009	25.9726	24.8076
140165	***	*	16.6304	*	*	16.6304

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
140166	1.1619	0.8345	23.1005	26.4800	26.2875	25.2809
140167	1.1608	0.8345	22.8911	22.8703	24.9904	23.5836
140172	1.3652	1.0588	29.8568	32.1220	33.0926	31.7168
140174	1.5704	1.0588	27.8131	30.5905	31.2231	29.9167
140176	1.2291	1.0588	31.3490	32.9794	32.6145	32.3408
140177	0.9037	1.0588	22.5610	26.4340	25.5725	24.9321
140179	1.2694	1.0588	27.6376	29.3657	30.2944	29.1090
140180	1.1722	1.0588	28.3629	27.8887	29.1352	28.4623
140181	1.1314	1.0588	25.0101	25.0226	27.6835	25.9072
140182	1.5031	1.0588	28.2211	30.1755	32.8972	30.2922
140184	1.2951	0.8345	21.1802	25.2327	26.6104	24.4280
140185	1.4648	0.8982	23.8531	25.2423	26.5398	25.2116
140186	1.5398	1.0471	30.6951	29.8022	30.7212	30.4067
140187	1.5456	0.8982	23.2892	24.8332	25.5873	24.5668
140189	1.1669	0.8345	23.7198	22.5965	24.7013	23.6837
140190	***	*	19.8296	*	*	19.8296
140191	1.3318	1.0588	25.8678	28.5836	31.9943	28.7069
140197	1.2406	1.0588	23.0684	24.0463	24.9103	23.9565
140199	1.0545	*	22.0315	*	*	22.0315
140200	1.4401	1.0588	26.3379	28.8435	30.6641	28.5880
140202	1.5516	1.0471	29.7870	32.7915	32.9433	31.9581
140206	1.2638	1.0588	30.6561	29.7953	29.6275	30.0202
140207	1.2121	1.0588	24.1048	26.0535	28.2262	26.0084
140208	1.6599	1.0588	29.4708	29.5380	31.4035	30.1416
140209	1.5570	0.9385	24.5376	26.3230	29.7965	26.7808
140210	1.0667	0.8345	19.2640	20.6954	19.2053	19.6895
140211	1.3090	1.0588	29.7054	30.3286	31.4539	30.5683
140213	1.2470	1.0588	30.2945	31.6926	32.1031	31.3688
140217	1.5498	1.0588	31.5324	32.1277	32.9404	32.2271
140223	1.4787	1.0588	30.4923	31.7267	33.5083	31.9322
140224	1.3760	1.0588	28.2177	29.6181	31.2237	29.6765
140228	1.5681	0.9804	25.6419	27.9456	28.2855	27.2863
140231	1.4308	1.0588	30.6410	30.0236	34.8291	31.8587
140233	1.6653	1.0471	28.6305	29.7093	31.5168	29.9830
140234	1.0454	0.8660	23.6928	24.5476	25.7353	24.6552
140239	1.5950	0.9804	29.0092	31.1879	31.0918	30.4218
140240	1.4146	1.0588	28.7310	31.5637	32.7986	30.9712
140242	1.5032	1.0588	32.0522	34.6120	35.2351	33.9225
140250	1.2378	1.0588	28.5971	29.6305	31.2533	29.8441

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
140251	1.3940	1.0588	27.1687	28.0622	28.3598	27.8740
140252	1.4020	1.0588	33.3351	34.4268	35.8762	34.5480
140258	1.5174	1.0588	30.2639	34.2333	33.0093	32.5353
140275	1.3123	0.8893	26.1473	27.8186	28.5064	27.4339
140276	1.8647	1.0588	29.8325	31.6359	32.1048	31.2217
140280	1.4651	0.8893	23.4447	24.9401	26.6536	24.9140
140281	1.7584	1.0588	30.4838	33.3903	35.6589	33.1771
140285	***	*	20.7576	*	*	20.7576
140286	1.1539	1.0588	29.1543	30.3237	32.0048	30.4851
140288	1.5228	1.0588	29.3988	31.5197	31.5944	30.8910
140289	1.3067	0.8982	22.6211	23.8452	25.6847	24.0649
140290	1.3576	1.0588	31.7341	31.8135	32.5247	32.0531
140291	1.6115	1.0471	29.8958	31.9052	33.8706	31.9796
140292	1.1022	1.0588	27.6285	28.5094	30.6917	28.8381
140294	1.1266	0.8345	23.4503	24.0750	26.1595	24.6196
140300	1.1884	1.0588	34.8568	35.1494	42.5240	37.4107
140301	1.1568	1.0588	31.7073	49.9507	39.4295	38.1755
140303	2.2073	1.0588	*	29.6470	*	29.6470
150001	1.1331	0.9717	29.6844	28.9075	31.8089	30.1191
150002	1.4417	1.0471	25.0063	26.6222	27.6481	26.6696
150003	1.7490	0.8676	25.3458	26.7585	26.9771	26.3734
150004	1.4753	1.0471	26.8458	28.7336	30.9626	28.8237
150005	1.2795	0.9717	27.2369	29.5371	30.5367	29.1856
150006	1.3979	0.9503	26.4062	25.6265	27.1364	26.4180
150007	1.3720	0.9463	26.6073	29.4971	30.0500	28.8176
150008	1.3865	1.0471	26.6928	27.5703	27.0525	27.1187
150009	1.4332	0.9029	22.2147	25.4496	25.7616	24.5212
150010	1.4963	0.9463	26.8523	27.2272	28.4118	27.4601
150011	1.2451	0.9589	24.3490	25.3178	26.7686	25.4614
150012	1.5620	0.9643	27.3029	30.0348	31.2282	29.5432
150013	***	*	21.8465	*	*	21.8465
150015	1.3250	0.8899	26.2434	28.0931	27.3811	27.2243
150017	1.8561	0.9041	25.2342	26.3973	26.3379	26.0051
150018	1.7221	0.9540	26.3289	27.3689	29.1137	27.6515
150021	1.8096	0.9041	29.6967	28.9196	30.0030	29.5366
150022	1.0788	0.8726	22.6773	23.1041	23.8971	23.1999
150023	1.5637	0.9589	23.7159	26.9095	27.7520	25.8891
150024	1.4818	0.9717	27.1589	28.1655	28.4170	27.8897
150026	1.3161	0.9540	28.1127	28.6517	30.4967	29.1723

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
150027	1.0482	*	17.4862	*	*	17.4862
150029	1.4657	0.9643	26.9680	28.7187	29.9307	28.4271
150030	1.1967	0.9589	26.9534	29.1493	29.3588	28.5143
150033	1.5576	0.9717	27.9995	28.6838	29.7744	28.8059
150034	1.4561	1.0471	26.0465	28.6429	28.0434	27.6127
150035	1.5977	0.9241	26.6620	26.9700	27.8904	27.1979
150037	1.3217	0.9717	28.5451	31.0935	29.0161	29.5237
150038	1.1328	0.9717	28.8054	29.3156	33.0112	30.3936
150042	1.3921	0.8823	23.0102	22.8786	25.1403	23.6714
150044	1.3927	0.9029	23.7066	25.2137	25.2685	24.7693
150045	1.0745	0.9041	25.2225	26.9818	27.5340	26.5867
150046	1.4882	0.8823	21.9369	24.5593	26.5876	24.4158
150047	1.7159	0.9041	25.8348	25.5194	25.8497	25.7351
150048	1.3899	0.9661	27.1817	27.1233	28.1525	27.5023
150049	1.3604	*	22.3370	*	*	22.3370
150051	1.6346	0.9589	23.7061	26.5655	28.9157	26.4848
150052	1.0751	*	20.6339	*	*	20.6339
150056	1.9446	0.9717	28.2842	28.8727	29.3500	28.8453
150057	2.0988	0.9717	24.8605	28.9529	30.3287	27.8807
150058	1.5711	0.9643	27.5341	29.1444	29.1255	28.6425
150059	1.5551	0.9717	28.5715	31.4987	31.3362	30.4971
150060	***	*	24.8544	*	*	24.8544
150061	1.1275	0.8568	22.2822	21.3711	22.6746	22.1018
150062	1.1339	*	24.6088	*	*	24.6088
150064	1.2000	0.8568	23.7707	25.4987	28.7978	26.0980
150065	1.2625	0.9589	25.9461	27.9283	30.2053	27.9985
150069	1.1757	0.9661	25.2656	26.2028	26.0909	25.8564
150072	1.1657	0.8673	20.5111	21.2120	21.7644	21.1633
150074	1.4427	0.9717	25.2586	25.9321	28.5655	26.5901
150075	1.0975	0.9041	24.0745	25.1568	25.7245	24.9787
150076	1.2881	0.9503	28.1874	29.3249	30.1120	29.2167
150079	1.1099	*	21.4067	*	*	21.4067
150082	1.6825	0.8568	25.5860	28.3494	26.4544	26.8048
150084	1.8395	0.9717	29.3905	31.1720	33.1784	31.1870
150086	1.1722	0.9661	23.9404	25.1992	26.6745	25.3042
150088	1.2748	0.9589	23.6253	27.2103	29.1509	26.6306
150089	1.6023	0.8568	25.0449	24.7233	24.8045	24.8596
150090	1.6407	1.0471	26.2899	30.4835	30.6412	29.1401
150091	1.1638	0.9041	30.6209	30.4234	32.1627	31.1005

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
150097	1.1290	0.9717	25.0367	27.7468	29.1359	27.3220
150100	1.6877	0.8568	24.3530	25.7997	26.9724	25.6239
150101	1.0665	0.9041	29.1657	29.0301	30.5475	29.5654
150102	1.0330	0.9241	24.5923	25.7424	25.8742	25.4603
150104	1.0856	0.9717	25.5872	28.2552	28.7788	27.5177
150106	1.0158	*	20.9387	*	*	20.9387
150109	1.4641	0.8676	23.5865	25.3367	26.8464	25.2376
150112	1.4978	0.9589	26.5643	28.0068	29.8540	28.1787
150113	1.2888	0.9589	24.8760	24.7960	25.9814	25.2159
150115	1.4230	0.8568	19.3411	22.0747	22.5793	21.2670
150122	1.3185	*	26.0173	*	*	26.0173
150124	***	*	21.3933	*	*	21.3933
150125	1.5103	1.0471	26.7666	27.6535	29.3596	27.9342
150126	1.4164	1.0471	26.9887	28.9454	29.4300	28.4467
150128	1.4409	0.9717	26.4976	28.7810	29.5008	28.2807
150129	1.1548	0.9717	29.9099	29.7398	31.4317	30.3985
150130	1.6136	*	21.7400	*	*	21.7400
150132	***	*	25.6257	27.6560	*	26.6249
150133	1.2457	0.9041	22.7292	25.1322	24.2538	24.0313
150134	1.0198	0.9029	23.8525	26.3249	21.6740	23.7590
150136	***	*	26.2704	*	*	26.2704
150146	1.1370	0.9041	29.3383	29.5256	30.3343	29.7676
150147	1.5120	1.0471	22.8456	27.2339	26.1646	25.6998
150149	1.0014	0.8568	23.6360	23.7026	24.9629	24.1402
150150	1.3167	0.9041	25.5331	27.0542	26.7700	26.4920
150151	***	*	38.1445	*	*	38.1445
150152	***	*	44.7145	*	*	44.7145
150153	2.4172	0.9717	*	32.1022	35.0617	33.7428
150154	2.5712	0.9717	*	29.8514	29.8894	29.8711
150155	***	*	*	45.0121	*	45.0121
150156	***	*	*	25.9681	*	25.9681
150157	1.6761	0.9717	*	*	32.3106	32.3106
150158	1.2402	0.9717	*	*	*	*
150160	2.0073	0.9717	*	*	*	*
150161	1.4755	0.9717	*	*	*	*
150162	1.7836	0.9717	*	*	*	*
150163	1.1054	0.9029	*	*	*	*
160001	1.2039	0.9222	25.1220	24.5108	25.7255	25.1337
160005	1.2097	0.8476	21.8949	23.1034	24.7755	23.2878

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
160008	1.0516	0.8476	20.7200	22.1402	22.4758	21.7846
160013	1.2974	0.8655	23.7163	24.0956	24.4099	24.0734
160014	***	*	20.5882	*	*	20.5882
160016	1.5636	0.9222	23.3619	24.5338	27.1460	24.9575
160020	1.1531	*	19.5554	*	*	19.5554
160024	1.5654	0.9157	26.2392	27.4158	29.3756	27.6168
160026	***	*	24.7424	*	*	24.7424
160028	1.3092	0.9473	26.2948	27.8535	30.0576	28.1943
160029	1.6382	0.9423	27.9277	28.7324	30.6687	29.0931
160030	1.3868	1.0016	26.7068	28.7786	30.9415	28.8521
160031	0.7988	*	19.7368	*	*	19.7368
160032	1.0669	0.8711	23.4727	25.4662	26.2935	25.1093
160033	1.7485	0.8893	24.6768	26.5315	27.2060	26.1337
160034	1.0217	*	19.3503	*	*	19.3503
160039	0.9129	*	22.1180	*	*	22.1180
160040	1.2906	0.8719	23.9053	25.9032	26.8110	25.5671
160045	1.6881	0.8684	25.4153	26.6463	27.5289	26.5339
160047	1.3936	0.9473	25.2072	26.0227	28.1280	26.4469
160048	***	*	19.5831	*	*	19.5831
160050	1.0566	*	24.5402	*	*	24.5402
160057	1.2590	0.9137	23.0937	25.1272	25.6274	24.6663
160058	1.9710	0.9423	27.1646	28.4167	28.9924	28.2025
160064	1.6011	0.9113	28.6139	28.7668	28.4209	28.5968
160066	0.9354	*	22.7709	*	*	22.7709
160067	1.3637	0.8719	23.4060	24.8137	26.0243	24.7721
160069	1.5286	0.8875	25.3402	27.4473	27.6157	26.8150
160079	1.4774	0.8684	23.7234	24.7372	26.1618	24.8787
160080	1.2832	0.8893	23.1837	25.8252	27.2370	25.4033
160081	***	*	23.1930	*	*	23.1930
160082	1.7698	0.9157	26.4398	27.4718	28.7831	27.5581
160083	1.6593	0.9157	28.2193	27.3004	28.3921	27.9725
160089	1.2887	0.9137	22.6551	23.2149	23.2888	23.0562
160091	***	*	17.9862	*	*	17.9862
160101	1.0750	0.9157	25.1000	25.0503	25.4740	25.2122
160104	1.6546	0.8893	24.9134	28.1891	29.8126	27.8799
160110	1.5341	0.8719	24.9434	26.6633	28.8134	26.8749
160112	1.2895	0.8476	23.0672	24.7957	25.2886	24.4326
160117	1.3823	0.8875	25.0278	25.4659	27.3927	25.9740
160118	***	*	19.7764	*	*	19.7764

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
160122	1.0947	0.8476	22.5872	23.9177	24.4996	23.6844
160124	1.1525	0.8476	23.1690	22.5482	24.3063	23.3383
160126	1.0265	*	19.8323	*	*	19.8323
160146	1.3905	0.9083	22.9897	22.6949	24.8485	23.4694
160147	1.2941	0.9222	26.6438	28.6303	29.8992	28.4676
160153	1.7364	0.9083	28.9881	29.9378	30.6173	29.8520
160154	1.1302	*	*	*	*	*
160155	1.7147	0.8893	*	*	*	*
170001	1.1457	0.7979	21.9131	23.1260	23.8863	22.9705
170006	1.3231	0.8966	21.9019	24.2068	27.1033	24.4549
170009	1.0518	0.9318	29.2588	30.9025	29.6386	29.9250
170010	1.2444	0.7979	24.0008	23.9707	25.5573	24.5518
170012	1.6127	0.8717	24.7392	26.1367	27.1195	25.9606
170013	1.6234	0.8717	25.0419	25.2476	26.7124	25.6577
170014	1.0200	0.9318	23.5960	23.8135	24.2322	23.8856
170015	***	*	20.2368	*	*	20.2368
170016	1.6402	0.8556	25.9482	25.8061	26.7536	26.1671
170017	1.0743	0.8938	24.7771	26.9657	27.2925	26.3737
170019	1.1990	*	22.0251	*	*	22.0251
170020	1.5974	0.8717	23.1800	23.2757	24.1149	23.5243
170022	1.1485	*	22.2878	*	*	22.2878
170023	1.4198	0.8717	23.9808	24.0561	23.9812	24.0054
170027	1.3961	0.7979	22.5103	23.1766	23.4037	23.0169
170033	1.3489	0.8717	20.7864	21.9709	24.1882	22.2852
170039	0.9451	0.8938	21.5203	26.9852	26.0952	24.6299
170040	1.9800	0.9318	28.2856	28.4458	30.2468	29.0256
170049	1.5227	0.9318	24.7895	25.2070	26.4086	25.4876
170052	***	*	18.5291	*	*	18.5291
170058	1.0973	0.9318	23.3398	22.9210	26.5949	24.2599
170068	1.2243	0.9151	22.6087	23.0635	23.8812	23.1883
170070	***	*	16.0162	*	*	16.0162
170074	1.2229	0.7979	21.0565	23.7829	23.0567	22.6765
170075	0.8299	0.7979	16.5444	19.7760	19.9351	18.7474
170085	0.6104	*	*	*	*	*
170086	1.5806	0.8556	24.0812	26.1362	26.3615	25.5525
170093	***	*	16.5553	*	*	16.5553
170094	0.9369	0.7979	21.3887	21.5295	16.5136	19.6903
170098	***	*	20.1242	*	*	20.1242
170103	1.2869	0.8938	22.8707	23.8042	24.2003	23.6452

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
170104	1.4622	0.9318	26.9671	26.2990	27.6211	26.9584
170105	1.0944	0.7979	21.4422	21.9606	22.7412	22.0343
170109	1.0365	0.9318	23.2626	23.1088	23.8515	23.4041
170110	0.8838	0.7979	22.9195	23.3260	23.9572	23.4236
170114	0.9064	*	18.9158	*	*	18.9158
170120	1.3860	0.8966	21.0499	22.0253	22.2805	21.7560
170122	1.6825	0.8938	25.3982	26.6605	28.7175	26.8262
170123	1.6951	0.8938	27.2239	27.6653	27.0843	27.3131
170133	1.0455	0.9318	22.9309	23.1226	25.2301	23.8079
170137	1.2778	0.7979	23.8862	24.7096	25.3395	24.6697
170142	1.4000	0.8452	22.5778	23.9527	24.6019	23.7457
170143	***	*	20.4459	*	*	20.4459
170144	***	*	24.6259	*	*	24.6259
170145	1.0844	0.7979	21.5756	23.2162	23.3967	22.7065
170146	1.5046	0.9318	29.1358	29.8858	29.0720	29.3567
170147	***	*	21.4753	22.4973	24.3268	22.5630
170150	1.1567	0.8145	18.5744	20.9448	19.6160	19.7250
170166	0.9972	0.7979	19.2842	21.0762	22.6968	21.0440
170175	1.4183	0.8717	23.9304	25.6281	26.7229	25.4235
170176	1.5941	0.9318	26.2366	27.2332	29.0735	27.5811
170180	***	*	25.1368	32.5010	*	27.5335
170182	1.4404	0.9318	25.7443	27.3503	28.9710	27.3812
170183	1.9426	0.8938	24.5539	25.8340	26.1890	25.5209
170185	1.2377	0.9318	26.7797	27.8139	28.1780	27.6778
170186	2.6627	0.8938	31.7896	32.8392	30.2613	31.6196
170187	1.4872	0.7979	23.3702	22.8493	24.1461	23.4565
170188	1.9667	0.9318	29.9751	30.6844	32.2573	31.0137
170190	1.0160	0.8452	22.8729	22.9540	26.2625	24.0473
170191	1.7207	0.7979	21.3069	22.1197	24.3813	22.6600
170192	1.9119	0.8938	27.9704	26.2724	27.7421	27.3099
170193	1.4210	0.8717	24.7429	20.6821	24.8531	23.2189
170194	1.0835	0.9318	27.9903	29.9014	27.6989	28.5239
170195	2.2763	0.9318	*	30.1001	29.5947	29.8108
170196	2.3666	0.8938	*	*	32.1832	32.1832
180001	1.2557	0.9661	25.4217	27.6917	29.7423	27.6443
180002	1.0602	0.8073	22.9727	25.7862	26.5488	25.1142
180004	1.0972	0.7810	19.5437	22.0797	20.8805	20.8284
180005	1.1194	0.8724	24.5561	24.9779	25.6159	25.0807
180006	***	*	14.8011	*	*	14.8011

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
180007	1.5249	0.9002	22.7606	25.7042	27.1924	25.2359
180009	1.7050	0.8878	25.3837	26.4101	27.3228	26.4316
180010	1.8883	0.9002	24.7256	25.6153	27.7600	26.0458
180011	1.5427	0.8797	22.7364	25.5463	24.9909	24.4168
180012	1.4909	0.9029	24.6642	25.6000	26.7279	25.6690
180013	1.5074	0.9364	22.9512	23.7075	24.8125	23.8157
180016	1.3302	0.9029	23.1832	24.8408	24.7091	24.2487
180017	1.3231	0.7978	20.8630	21.8885	21.9715	21.5934
180018	1.3148	0.7810	19.0992	20.9857	23.3035	21.1384
180019	1.0932	0.9661	24.1342	24.0283	24.6279	24.2639
180020	1.0481	0.7810	21.9494	24.6953	25.9975	24.2711
180021	0.9698	0.7810	18.5966	20.7950	22.0740	20.5368
180024	1.1161	0.9029	32.1824	31.1159	26.3532	29.7120
180025	1.1421	0.9029	19.1543	22.6897	28.5935	23.5037
180026	1.0693	*	18.2120	*	*	18.2120
180027	1.2468	0.8095	23.8763	20.8303	21.7639	22.0496
180028	0.9153	*	24.7967	*	*	24.7967
180029	1.3898	0.8797	23.0536	25.6479	26.1528	24.9999
180035	1.6203	0.9661	29.8438	31.0794	32.8461	31.2815
180036	1.2418	0.8878	25.1154	25.2972	25.6959	25.3664
180037	1.3241	0.9029	25.7361	26.3132	27.8506	26.6118
180038	1.5448	0.8697	24.6348	26.0440	26.9752	25.9113
180040	1.9692	0.9029	26.2125	27.9979	28.5162	27.6103
180043	1.1554	0.7810	19.0617	20.9326	20.6439	20.2180
180044	1.7146	0.8724	23.0971	24.4569	25.8060	24.4869
180045	1.3291	0.9661	25.8349	27.4732	29.4127	27.6339
180046	0.9468	0.9002	27.2244	27.1034	27.0962	27.1405
180047	***	*	21.8036	*	*	21.8036
180048	1.2971	0.9029	21.6571	23.9230	24.3696	23.3120
180049	1.4467	0.8797	23.3407	22.4769	24.3699	23.3961
180050	1.1550	0.7810	22.6473	26.3604	25.9557	24.9976
180051	1.2878	0.8218	21.3312	23.5299	24.3916	23.1293
180053	0.9914	0.7810	19.1578	21.3044	22.1921	20.9808
180055	1.1922	*	20.7237	*	*	20.7237
180056	1.1773	0.8465	22.8910	24.3074	24.5326	23.9077
180063	1.1034	*	17.9741	*	*	17.9741
180064	1.1693	0.8124	16.2638	17.1009	20.1799	17.8239
180066	1.0839	0.9364	24.9543	22.2713	23.7860	23.6485
180067	2.0260	0.9002	25.4080	26.0238	27.9852	26.5262

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
180069	1.0876	0.8724	22.3673	26.3701	26.6714	25.1966
180070	1.1689	0.8049	20.1308	20.6741	20.2189	20.3433
180078	1.1526	0.8724	26.2636	27.6806	28.2762	27.4283
180079	1.1914	0.8069	19.7791	20.2100	23.6005	21.2540
180080	1.2789	0.8012	21.7380	21.5818	23.7788	22.3758
180087	1.2564	0.7810	18.4331	20.8841	22.0302	20.4642
180088	1.6692	0.9029	27.5767	28.0916	28.6107	28.1051
180092	1.1840	0.9002	22.5679	23.7909	23.7866	23.3989
180093	1.6493	0.8123	20.5422	20.5807	21.4392	20.8528
180095	1.0472	0.7810	17.9677	17.9146	21.5639	18.9610
180101	1.1640	0.9002	25.4796	27.4506	28.1621	27.0742
180102	1.5933	0.8095	18.4388	21.0896	25.2343	21.3176
180103	2.1748	0.9002	26.9407	28.4583	28.1734	27.8598
180104	1.5693	0.8095	24.9441	25.6157	25.9689	25.5126
180105	0.8863	0.7810	19.7615	21.6002	23.1917	21.5276
180106	0.8981	0.7810	17.8020	20.2884	20.7220	19.6713
180115	0.9198	0.7810	20.9831	20.5539	20.3089	20.6170
180116	1.2129	0.8345	22.7353	23.5354	25.8927	24.0625
180117	0.9573	0.7810	21.1854	22.8469	24.7378	22.8812
180124	1.3102	0.9364	23.1917	24.8292	25.4664	24.5483
180127	1.3502	0.9029	23.4765	24.6774	26.3947	24.8368
180128	0.9285	0.7810	20.8406	22.6056	23.8144	22.4361
180130	1.6785	0.9029	26.0278	27.8900	29.1712	27.7427
180132	1.4705	0.8797	23.7652	24.5105	25.3789	24.5776
180134	0.9988	*	18.6779	*	*	18.6779
180138	1.2338	0.9029	27.3400	28.1901	28.6871	28.0932
180139	0.9711	0.7810	23.5363	23.3569	24.7575	23.8896
180141	1.8039	0.9029	25.3042	25.3357	27.5912	26.1155
180143	1.6427	0.9002	25.1613	28.1924	30.8734	28.2381
180144	***	*	*	29.5052	*	29.5052
180147	***	*	*	*	31.1615	31.1615
180148	***	*	*	*	30.1250	30.1250
180149	0.9785	0.7810	*	*	*	*
190001	1.1366	0.7586	19.7516	22.1394	22.1569	21.3062
190002	1.6414	0.8322	22.0056	23.3368	24.6984	23.3292
190003	1.4785	0.8322	23.4977	25.8294	26.7844	25.3504
190004	1.5564	0.7975	23.3290	25.3473	25.0803	24.6173
190005	4.8105	0.8711	22.3208	22.6029	24.2899	23.0169
190006	1.4684	0.8322	22.2467	22.7979	24.8836	23.2631

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
190007	1.1753	0.7586	19.7528	21.8205	23.1426	21.5670
190008	1.7624	0.7975	24.0111	24.6074	26.3638	24.9678
190009	1.2890	0.7977	19.8404	21.1005	24.0696	21.5285
190010	***	*	21.6889	*	*	21.6889
190011	0.9912	0.7869	19.7319	21.4052	21.6991	20.9430
190013	1.4546	0.7783	20.8626	21.4573	23.7333	22.0204
190014	1.1832	0.7586	22.4596	22.7151	22.6405	22.6128
190015	1.3272	0.8711	22.8875	23.7789	25.1767	23.9766
190017	1.3890	0.7773	21.5033	24.5390	24.7537	23.6080
190019	1.7987	0.7977	23.7168	24.0468	25.4624	24.4141
190020	1.2331	0.8009	21.6136	22.1967	23.4602	22.4018
190025	1.3046	0.7586	20.8950	23.5007	24.5024	22.9204
190026	1.6225	0.7977	22.5087	23.7702	24.1556	23.4858
190027	1.6702	0.7783	21.2526	24.3006	26.7132	24.0310
190034	1.2388	0.7775	19.6943	20.7334	21.2130	20.5411
190036	1.6983	0.8711	24.8152	25.4164	25.6551	25.3044
190037	0.6483	0.7783	18.6393	19.4071	20.7271	19.5622
190039	1.6426	0.8711	25.6665	24.4386	25.4003	25.1722
190040	1.3451	0.8711	26.7428	28.6297	28.0169	27.7947
190041	1.4801	0.8551	24.6734	28.5376	28.0050	27.0392
190043	***	*	17.3477	*	*	17.3477
190044	1.3206	0.7846	19.5567	20.9993	21.2604	20.6016
190045	1.6104	0.8711	25.3854	25.8238	27.1996	26.1757
190046	1.4983	0.8711	24.2128	23.8552	24.7370	24.2698
190048	1.0173	*	19.6288	*	*	19.6288
190050	1.0996	0.7630	19.1076	21.0259	20.9142	20.3649
190053	1.1445	0.7686	16.4968	17.9788	18.5819	17.7257
190054	1.3646	0.7671	20.1108	23.1471	22.7011	22.0095
190060	1.4954	0.7783	23.6278	23.7393	22.6291	23.3259
190064	1.6406	0.8009	23.3617	23.1358	23.7298	23.4086
190065	1.6036	0.8009	23.7450	22.1880	23.1202	23.0047
190077	0.9332	*	18.8409	*	*	18.8409
190078	1.0556	0.7773	21.3786	22.2431	22.2346	21.9592
190079	1.2228	0.8711	21.2546	24.0985	23.8192	23.0910
190081	0.8766	0.7586	15.6146	20.0121	21.4510	18.9734
190086	1.2998	0.7764	19.8823	22.0610	22.2895	21.4355
190088	1.0983	0.8551	22.3480	23.8562	23.1638	23.1096
190090	1.0644	0.7586	20.2045	23.1241	24.3303	22.5642
190095	***	*	18.0174	*	*	18.0174

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
190098	1.7671	0.8551	24.6353	25.6854	25.7449	25.3598
190099	1.0514	0.8009	20.4597	22.0610	23.2343	21.9199
190102	1.5319	0.8322	25.2267	27.3126	26.9700	26.4749
190106	1.1179	0.7977	21.7228	23.5376	26.6227	23.8316
190109	1.2697	*	18.6524	*	*	18.6524
190111	1.6595	0.8551	24.4998	25.5729	26.5722	25.5481
190114	1.0528	0.7586	15.8031	17.2678	19.1586	17.4128
190115	1.2579	0.8551	26.6295	28.2066	26.0797	26.9667
190116	1.1795	0.7671	20.3845	22.3710	23.4013	22.0638
190118	0.9119	0.8551	19.7024	22.8809	21.2580	21.3081
190122	1.3165	0.8009	23.7082	22.0072	22.2371	22.6302
190124	***	*	24.6675	26.0032	27.9484	26.2122
190125	1.5999	0.7869	23.9649	25.5463	24.8256	24.7616
190128	1.1274	0.8009	27.9136	28.3257	29.6682	28.6616
190131	1.2853	0.8009	25.1917	27.8465	28.6795	27.2765
190133	0.8990	0.7687	13.6266	18.2045	22.4311	19.4522
190135	***	*	26.8238	27.7540	30.5646	28.1639
190140	0.9706	0.7621	17.6936	18.9652	23.0485	19.9125
190144	1.1642	0.8551	21.7547	22.9181	23.7875	22.8280
190145	0.9239	0.7676	18.9678	19.9265	20.8579	19.9365
190146	1.5689	0.8711	26.1792	27.4824	28.7200	27.4158
190149	1.0427	*	18.8819	*	*	18.8819
190151	0.9473	0.7586	18.6293	18.7467	18.8391	18.7428
190152	1.5619	0.8711	27.6099	28.1334	30.8512	28.8848
190158	***	*	26.3042	26.4787	30.6450	27.6757
190160	1.6083	0.7869	21.6740	22.9325	24.7822	22.9872
190161	1.2550	0.7783	19.1022	22.6187	22.9035	21.4144
190162	***	*	25.0328	25.2953	*	25.1543
190164	1.1717	0.8198	22.8599	25.2560	26.6207	24.9939
190167	1.2689	0.8322	24.3185	26.4669	25.3283	25.3447
190175	1.3803	0.8711	27.1531	26.0547	27.4256	26.8730
190176	1.7567	0.8711	25.6997	25.8826	26.2596	25.9476
190177	1.7190	0.8711	27.4621	27.7792	28.2751	27.8348
190182	***	*	28.4799	27.1682	29.8656	28.5188
190183	1.1703	0.7975	19.8084	22.6928	22.0119	21.4403
190184	1.0091	0.7764	23.9608	24.9476	24.1626	24.3753
190185	***	*	24.7912	25.6394	28.9759	26.4364
190190	0.9347	0.7747	16.1195	24.3327	26.7043	22.8841
190191	1.3288	0.8322	23.5734	24.1923	26.1628	24.6319

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
190196	0.9294	0.8322	24.7135	24.0385	25.8472	24.8787
190197	1.3883	0.7869	24.3735	25.8071	26.4825	25.5498
190199	1.0219	0.8009	14.1409	27.3304	32.0194	23.0028
190200	***	*	27.5681	28.8173	27.4781	27.9971
190201	1.2441	0.7783	24.5877	25.1010	24.4563	24.7120
190202	1.3990	0.8009	24.7944	27.6084	29.6612	27.4877
190203	***	*	26.8795	28.1832	29.9753	28.2129
190204	1.5165	0.8711	28.3684	28.1033	30.5140	28.9472
190205	1.6775	0.8322	24.4540	26.6832	28.2484	26.4802
190206	1.5731	0.8711	26.0139	26.7401	29.2371	27.2862
190208	0.8612	0.7586	24.2588	28.7308	27.9908	27.1395
190218	1.1033	0.8551	25.0356	26.7262	28.1039	26.6017
190236	1.4943	0.8551	23.6824	24.7142	26.4614	24.9863
190241	1.2264	0.7975	23.9700	25.2123	25.7906	25.0883
190242	1.1676	0.8009	23.0072	24.8461	25.0035	24.3294
190245	1.7027	0.7869	27.1786	25.5751	26.7642	26.5210
190246	1.6612	0.7747	*	*	22.7833	22.7833
190247	***	*	*	32.7499	*	32.7499
190248	***	*	*	23.2220	*	23.2220
190249	1.8972	0.8009	*	20.0468	25.2523	22.1292
190250	2.1185	0.8711	*	31.5101	33.3302	32.3430
190251	1.2888	0.8009	*	21.4464	23.8389	22.5823
190252	***	*	*	23.6924	*	23.6924
190253	***	*	*	22.8060	23.8037	23.3049
190254	***	*	*	32.9290	*	32.9290
190255	0.7428	0.8322	*	22.2412	16.1593	18.2998
190256	0.8040	0.8711	*	*	25.9577	25.9577
190257	1.6107	0.7647	*	*	26.5505	26.5505
190258	1.0203	0.8551	*	31.3715	26.1141	28.3735
190259	1.8072	0.8322	*	*	26.5084	26.5084
190260	***	*	*	*	29.3947	29.3947
190261	1.6813	0.7869	*	*	27.0441	27.0441
190262	***	*	*	*	30.3719	30.3719
190263	2.4748	0.8322	*	*	26.4202	26.4202
190264	***	*	*	*	26.5842	26.5842
190265	0.7095	0.7869	*	*	22.6231	22.6231
190266	1.9424	0.8009	*	*	*	*
190267	1.2028	0.8711	*	*	*	*
190268	1.3593	0.8322	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
190270	1.7939	0.8711	*	*	*	*
190272	1.5530	0.8322	*	*	*	*
190273	1.6476	0.8009	*	*	*	*
200001	1.3864	0.9881	25.1144	25.2542	26.3045	25.5700
200002	1.0776	0.8408	25.7478	25.7212	27.1151	26.1903
200008	1.3373	0.9991	27.4412	27.7137	29.1836	28.1476
200009	1.9781	0.9991	31.1056	30.7510	32.5812	31.4774
200012	1.3475	*	25.7623	*	*	25.7623
200013	***	*	24.4131	*	*	24.4131
200018	1.2583	0.8408	23.6337	23.5632	22.5027	23.1555
200019	1.2478	0.9991	25.1367	25.6649	27.7896	26.2304
200020	1.2349	1.0173	31.7083	32.6436	34.0916	32.8279
200021	1.2526	0.9991	24.5519	27.1381	29.2054	27.0896
200024	1.5917	0.9589	26.0080	27.5410	29.7817	27.8465
200025	1.1475	0.9991	26.0573	26.3124	28.5750	27.0015
200027	***	*	26.3118	*	*	26.3118
200028	***	*	24.3271	*	*	24.3271
200031	1.2583	0.8408	21.9489	21.2370	22.2151	21.8012
200032	1.1121	0.8874	25.5227	26.3322	26.8993	26.2493
200033	1.8746	0.9881	28.6479	29.3108	31.7007	29.9421
200034	1.3358	0.9589	26.2926	27.0582	27.0103	26.8004
200037	1.2367	0.8408	23.2333	24.1732	24.9418	24.1299
200039	1.3017	0.9589	25.1196	25.1179	26.6409	25.6399
200040	1.2319	0.9991	25.5405	25.9893	27.8053	26.5224
200041	1.1511	0.8408	24.5532	24.9670	26.6777	25.4297
200050	1.2555	0.9881	26.4992	27.6825	29.5033	27.9408
200052	1.0971	0.8408	21.8726	22.5159	24.4204	22.9910
200063	1.1426	0.9589	25.0167	25.8623	27.9748	26.3221
210001	1.3534	0.9442	27.7561	28.2858	29.3471	28.4871
210002	1.9675	1.0030	26.4992	32.3005	33.7388	30.7141
210003	1.6589	1.0675	29.8684	34.1109	30.7334	31.5417
210004	1.4229	1.1016	34.2392	33.6056	31.7132	33.1035
210005	1.2759	1.1016	28.7557	28.9554	29.5835	29.1066
210006	1.0873	1.0030	25.4081	25.9005	27.3620	26.2242
210007	1.8886	1.0030	30.2548	31.8767	30.7124	30.9328
210008	1.3842	1.0030	25.2833	24.3341	28.8850	26.1403
210009	1.6931	1.0030	26.2360	27.7900	30.2661	28.0855
210010	***	*	25.7775	*	*	25.7775
210011	1.3772	1.0030	27.5031	30.8575	31.0966	29.8770

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
210012	1.6040	1.0030	27.4103	30.3078	31.1778	29.7278
210013	1.2771	1.0030	25.1348	28.5328	28.9917	27.5062
210015	1.2770	1.0030	28.2029	29.9261	32.2774	30.1836
210016	1.7522	1.1016	32.2081	32.3506	33.5493	32.6964
210017	1.1905	0.8911	23.2167	25.1890	26.8592	25.1002
210018	1.1898	1.1016	29.1870	29.5533	29.6521	29.4662
210019	1.7927	0.8911	26.1824	27.3731	28.7844	27.4744
210022	1.3934	1.1016	33.8015	35.4727	37.3092	35.4772
210023	1.4341	1.0109	30.4656	32.1812	33.0212	31.9645
210024	1.7296	1.0030	29.5579	30.6359	32.9434	31.0668
210025	1.2742	0.8911	26.0771	23.8552	24.8570	24.7700
210027	1.5326	0.8911	26.0111	24.6343	24.4821	25.0058
210028	1.0538	0.9423	25.9221	26.3469	26.7462	26.3461
210029	1.2601	1.0030	27.9741	31.0266	31.8539	30.2810
210030	1.2157	0.8911	29.5635	26.9763	32.2033	29.6024
210032	1.1523	1.0666	26.1829	27.0727	27.9359	27.1028
210033	1.1658	1.0030	29.0420	28.5534	29.2504	28.9511
210034	1.2970	1.0030	28.4308	30.2908	32.3827	30.4309
210035	1.2764	1.0675	26.1083	28.6484	27.3901	27.4000
210037	1.1898	0.8911	27.0973	27.3287	27.8394	27.4525
210038	1.2307	1.0030	29.5980	29.8121	32.3206	30.5517
210039	1.1414	1.0675	27.6940	30.4991	32.4139	30.2667
210040	1.2133	1.0030	29.3514	28.3559	29.2390	28.9752
210043	1.2979	1.0109	27.5657	26.6524	32.6961	28.8477
210044	1.3213	1.0030	28.8700	29.7339	30.3349	29.6367
210045	0.9662	0.8911	15.6380	14.2223	16.3724	15.4690
210048	1.2751	1.0030	28.4638	27.5043	26.0650	27.2655
210049	1.2023	1.0030	26.9656	26.0900	27.0161	26.6997
210051	1.3644	1.0675	29.2998	29.8892	29.5219	29.5723
210054	1.2933	1.0675	26.2295	27.4328	27.7607	27.1406
210055	1.1642	1.0675	29.9708	30.6941	31.4905	30.7118
210056	1.2997	1.0030	28.6091	30.0810	32.3518	30.4754
210057	1.3572	1.1016	32.2883	31.6787	32.8299	32.2617
210058	1.0863	1.0030	29.7841	31.0873	31.1988	30.7830
210060	1.1804	1.0675	28.5087	27.1764	29.9626	28.5557
210061	1.2433	0.8911	23.6662	23.1645	25.0253	23.9970
220001	1.1993	1.1354	29.0014	30.6070	31.2316	30.2898
220002	1.3836	1.1487	30.3598	32.4356	33.6649	32.2137
220003	1.1827	*	22.0549	*	*	22.0549

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
220006	***	*	30.8599	30.7673	33.6438	31.7232
220008	1.2814	1.1303	30.1043	31.3385	34.7924	32.1143
220010	1.2471	1.1303	29.7998	30.7804	32.0925	30.8934
220011	1.1289	1.1487	34.4064	34.7655	36.5640	35.2410
220012	1.5403	1.2611	35.7872	37.8763	39.7564	37.8806
220015	1.1909	1.0450	28.3397	29.6315	32.4903	30.2089
220016	1.1221	1.0450	28.0608	30.4813	32.5863	30.3587
220017	1.2751	1.1843	29.7108	31.6170	33.3020	31.5466
220019	1.0840	1.1354	23.2544	24.4009	25.7855	24.4947
220020	1.2035	1.1303	26.5305	28.5288	30.8458	28.6772
220024	1.2983	1.0450	27.3488	28.7342	31.9491	29.2912
220025	1.0403	1.1354	23.0637	25.6478	30.4369	26.1069
220028	***	*	32.0980	31.7122	39.3089	34.1922
220029	1.1319	1.1303	28.6970	30.6935	31.6363	30.3492
220030	1.1315	1.0450	24.4289	26.8849	28.1347	26.5400
220031	1.6670	1.1843	34.8183	36.8477	38.9433	36.9174
220033	1.2129	1.1303	28.2539	31.8249	32.3495	30.8022
220035	1.4179	1.1303	28.6238	31.4470	34.8739	32.8577
220036	1.5119	1.1843	31.5184	33.1436	35.9124	33.5798
220046	1.4766	1.0052	28.1396	30.4460	31.4510	30.0573
220049	1.2148	1.1487	27.7518	30.4740	32.4652	30.2584
220050	1.0817	1.0450	26.3768	28.3434	29.5194	28.1065
220051	1.3058	0.9705	29.8380	30.2552	30.1022	30.0683
220052	1.1342	1.1843	29.8577	32.4130	32.3532	31.5202
220058	0.9584	1.1354	24.9642	25.7247	27.8893	26.1881
220060	1.1735	1.1843	32.3362	32.5477	34.7336	33.2260
220062	0.5718	1.1354	24.2779	25.0766	25.4224	24.9426
220063	1.2551	1.1487	27.3968	30.2866	32.9283	30.2274
220065	1.2422	1.0450	26.5513	27.6009	30.1103	28.0583
220066	1.3440	1.0450	27.1317	27.8073	29.9736	28.3106
220067	1.1846	1.1843	29.8911	30.2222	32.4019	30.8648
220070	1.1331	1.1487	31.9283	33.1299	34.2598	33.1439
220071	1.8639	1.1843	32.2936	36.5065	37.4087	35.4748
220073	1.1778	1.1303	31.3566	34.2989	36.0289	33.8953
220074	1.3058	1.1303	28.4930	30.5607	31.4730	30.1564
220B74[4]		1.1843	28.4930	30.5607	31.4730	30.1564
220075	1.5116	1.1843	29.1588	30.9175	32.2957	30.7771
220076	***	*	29.7507	27.5148	*	28.6235
220077	1.6762	1.1025	30.2684	31.7325	34.0168	32.0323

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
220080	1.2068	1.1303	28.9835	29.9595	31.1268	30.0450
220082	1.2840	1.1487	26.9841	30.0611	30.8230	29.3142
220083	1.0834	1.1843	32.9143	34.5118	34.5969	33.9912
220084	1.2052	1.1487	32.5711	30.9527	31.6955	31.7158
220086	1.8146	1.1843	34.3667	34.2388	35.3451	34.6686
220088	1.8790	1.1843	28.5462	35.8255	34.7637	32.6700
220089	***	*	31.1708	32.6305	34.8205	32.8410
220090	1.1951	1.1354	30.8685	32.9011	34.1963	32.7325
220095	1.1073	1.1354	27.4273	28.0673	30.8626	28.8006
220098	1.1432	1.1487	28.8314	30.5869	31.5403	30.3885
220100	1.3485	1.1843	29.6912	31.9859	34.6599	32.1947
220101	1.2863	1.1487	33.1690	35.3464	37.7809	35.5307
220105	1.2082	1.1487	31.9421	33.2625	34.4029	33.2435
220108	1.1284	1.1843	30.6252	32.6131	33.8854	32.3646
220110	2.0146	1.1843	36.6084	39.2167	40.7382	38.9261
220111	1.2052	1.1843	31.1850	33.6167	34.2498	33.0681
220116	1.9487	1.1843	32.9988	36.4149	38.8799	36.0050
220119	1.0940	1.1843	30.1056	30.9965	32.0863	31.1230
220126	1.1444	1.1843	28.7805	31.4882	32.6938	30.9694
220133	***	*	33.6003	29.4855	34.9182	32.6345
220135	1.3229	1.2611	33.9866	36.0203	37.5189	35.8946
220153	***	*	*	*	19.8085	19.8085
220154	0.9781	1.1843	28.6461	*	28.7898	28.7112
220162	1.6210	*	*	*	*	*
220163	1.5708	1.1354	33.6484	34.4874	37.4968	35.2942
220171	1.7187	1.1487	30.4036	32.7414	35.9948	33.0860
220174	1.2041	1.1303	31.7572	30.0406	30.9503	30.8602
220175	1.2664	*	*	*	*	*
220176	1.6820	1.1354	*	*	*	*
230002	1.2938	1.0143	29.1410	32.9010	32.7578	31.6084
230003	1.2256	0.9474	26.1278	27.5824	28.4716	27.4080
230004	1.7418	0.9968	26.7206	29.3934	31.5136	29.3059
230005	1.2619	0.9381	24.1902	25.8768	27.7463	25.8963
230006	1.0740	*	23.8835	*	*	23.8835
230013	1.3243	1.0243	23.7822	24.6511	27.2075	25.1219
230015	1.1456	0.9203	24.6571	26.2782	27.2541	26.0748
230017	1.6997	1.0500	29.5178	31.8821	32.5396	31.3897
230019	1.6525	1.0243	28.4575	32.3401	34.3213	31.6365
230020	1.7510	1.0143	29.2869	28.5646	29.5324	29.1347

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
230021	1.5938	1.0146	24.9551	26.5659	28.6169	26.7256
230022	1.3116	0.9906	23.3000	25.6683	30.1195	26.2393
230024	1.6711	1.0143	30.0813	32.1483	32.5892	31.6103
230027	1.0649	*	23.5511	*	*	23.5511
230029	1.6033	1.0243	29.0935	32.3538	32.3845	31.2338
230030	1.2720	0.8974	22.3174	23.8082	25.1100	23.7840
230031	1.3712	1.0033	25.4679	29.7232	30.0120	28.2715
230034	1.3767	0.8908	26.7967	24.4845	24.4141	25.2370
230035	1.2614	0.9374	21.2317	24.8822	25.6715	24.0699
230036	1.4568	0.9394	28.3622	29.3754	29.9642	29.2271
230037	1.3478	1.0143	26.2000	28.9244	28.5311	27.9038
230038	1.7887	0.9474	26.3480	28.2012	29.1263	27.9600
230040	1.2065	0.9374	24.2349	25.5154	26.3190	25.3856
230041	1.6028	0.9394	26.1760	27.8853	27.9569	27.3833
230042	***	*	26.2037	*	*	26.2037
230046	1.9067	1.0498	30.3591	31.6235	32.2924	31.4692
230047	1.4044	1.0095	28.1351	31.1771	31.7075	30.3611
230053	1.6335	1.0143	29.8703	32.5711	32.1566	31.5479
230054	1.8867	0.9357	24.9905	25.7591	26.3251	25.7015
230055	1.2660	0.8908	25.4143	27.4349	28.4787	27.1074
230058	1.1260	0.8908	24.0657	25.9291	27.3156	25.7990
230059	1.5526	0.9474	25.5350	27.9091	28.5875	27.3993
230060	1.2205	0.8908	25.5015	28.2874	27.0288	26.9333
230065	***	*	28.4631	32.6255	*	29.9929
230066	1.3080	0.9968	27.4928	30.6184	30.2104	29.5137
230069	1.1594	1.0243	29.5556	30.2663	31.3406	30.4158
230070	1.6379	0.9122	24.2342	25.6778	26.8315	25.5687
230071	0.8679	1.0243	26.3907	28.3064	29.6728	28.1431
230072	1.3908	0.9474	24.4933	26.2838	27.4742	26.0946
230075	1.3788	1.0099	27.6193	28.2540	30.9525	28.9620
230077	1.9004	1.0243	27.6157	29.8538	30.5567	29.3470
230078	1.0892	0.8908	23.9902	25.6809	25.7232	25.1289
230080	1.3052	0.9394	21.2314	24.1573	24.5432	23.3438
230081	1.1911	0.8908	23.0788	24.7374	26.4337	24.7718
230082	1.6774	*	22.2165	*	*	22.2165
230085	1.1931	1.0500	22.7313	23.4959	25.4289	23.9146
230087	***	*	16.9168	*	*	16.9168
230089	1.3368	1.0143	28.7015	31.0522	32.8450	30.6488
230092	1.3633	1.0143	26.3584	28.6829	29.3442	28.2036

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
230093	1.2101	0.8966	26.4967	25.5804	27.4463	26.5309
230095	1.3084	0.8908	21.3916	22.8681	25.1854	23.1780
230096	1.1209	1.0146	28.7681	30.6024	31.7399	30.4267
230097	1.7979	0.9374	26.5773	28.2526	29.8962	28.2268
230099	1.2073	1.0143	26.4882	29.0221	29.3720	28.3183
230100	1.1880	0.8908	21.8895	24.1881	25.2118	23.7862
230101	1.2029	0.8908	24.3772	25.4839	28.4372	26.1557
230103	***	*	21.6609	*	*	21.6609
230104	1.5968	1.0143	30.5570	32.4634	32.4125	31.7994
230105	1.8559	0.9394	27.2705	32.4583	30.5515	30.1274
230106	1.1782	0.9474	24.3980	25.3243	27.8584	25.9492
230108	1.1225	0.8908	18.4064	20.2539	24.4337	20.8956
230110	1.2978	0.8908	28.7704	27.0040	25.7196	27.1027
230117	1.8739	1.0500	29.4775	32.7994	33.0602	31.7183
230118	1.0425	0.8908	22.3636	23.6110	24.8890	23.5923
230119	1.3965	1.0143	30.2441	30.7488	31.9696	31.0539
230120	1.1884	*	24.1485	*	*	24.1485
230121	1.2817	0.9906	24.5220	26.4940	26.8361	25.9746
230130	1.7325	1.0243	26.6076	30.1608	31.2744	29.4079
230132	1.4181	1.1012	30.5318	32.3939	35.5304	32.7891
230133	1.3876	0.8908	24.3174	23.9442	25.0647	24.4539
230135	1.4429	1.0143	25.8407	25.9583	23.6005	25.1118
230141	1.6587	1.1012	28.6326	31.6152	33.2553	31.1646
230142	1.2476	1.0143	26.9433	27.8377	29.7417	28.1870
230143	***	*	21.4083	*	*	21.4083
230144	2.3494	1.0498	*	*	*	*
230146	1.3924	1.0143	26.3432	26.8156	27.2621	26.8179
230151	1.3157	1.0243	28.2243	27.4546	29.8366	28.4831
230153	***	*	22.8644	*	*	22.8644
230156	1.6271	1.0498	31.1909	32.3755	33.9034	32.4969
230165	1.6925	1.0143	28.9636	29.6376	31.4242	30.0168
230167	1.6197	1.0047	27.4562	29.8071	31.0657	29.4630
230169	***	*	31.8442	*	*	31.8442
230172	1.1867	*	25.7402	*	*	25.7402
230174	1.2752	0.9474	27.6920	30.0563	29.7488	29.1588
230176	1.2853	1.0143	27.3605	28.1498	28.9798	28.2393
230180	1.1328	0.8908	24.7358	26.0707	24.9696	25.2514
230184	***	*	23.6706	34.6295	*	25.2502
230186	***	*	26.2282	*	*	26.2282

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
230189	***	*	23.0100	*	*	23.0100
230190	0.8738	1.0500	29.9603	30.7875	33.8229	31.5779
230193	1.2839	1.0033	23.3565	25.1626	26.4728	25.0025
230195	1.4446	1.0095	28.2892	29.5656	30.9702	29.6539
230197	1.5799	1.1012	30.0367	32.0063	33.7128	31.9307
230204	1.3299	1.0095	29.1466	31.5615	32.2882	31.0169
230207	1.3461	1.0243	24.5201	25.4268	25.1983	25.0567
230208	1.1990	0.9374	21.9651	23.7523	24.3476	23.3648
230212	0.9926	1.0498	29.7981	31.9818	32.8567	31.5065
230216	1.5505	1.0033	27.5230	29.0147	29.2061	28.5839
230217	1.3820	1.0099	28.6074	30.1136	31.9732	30.2664
230222	1.3803	0.9394	26.9724	29.9341	30.6482	29.2060
230223	1.2980	1.0243	29.2854	28.6745	29.8430	29.2661
230227	1.5005	1.0095	29.5798	30.8218	33.6716	31.2208
230230	1.5223	1.0047	27.9607	29.8763	31.1712	29.6595
230235	1.0691	*	21.8777	*	*	21.8777
230236	1.5042	0.9474	28.4754	31.3110	30.8556	30.2130
230239	1.2714	0.8908	22.1040	21.0814	22.1579	21.7759
230241	1.2149	1.0033	27.4890	27.6106	28.5516	27.9012
230244	1.4375	1.0143	26.4326	29.6283	30.0405	28.6466
230254	1.5090	1.0243	28.1216	29.2653	29.5874	28.9733
230257	0.9484	1.0095	27.8198	29.6712	30.6372	29.3897
230259	1.2662	1.0498	26.8677	27.4217	27.5982	27.2972
230264	1.8524	1.0095	19.2398	22.7768	28.5416	23.0410
230269	1.5020	1.0243	28.8187	31.3226	31.3800	30.6060
230270	1.2636	1.0143	27.8488	28.5372	28.8173	28.4111
230273	1.5130	1.0143	29.9307	31.9862	31.5396	31.1383
230275	0.4718	0.9122	23.1095	23.8104	25.2133	24.0702
230277	1.4057	1.0243	29.1973	29.8372	31.4023	30.1462
230279	0.4951	1.0243	24.7673	27.2816	27.9726	26.6926
230283	***	*	26.2622	33.5531	*	27.8105
230289	***	*	29.7721	*	*	29.7721
230291	***	*	30.9656	*	*	30.9656
230292	***	*	31.8943	*	*	31.8943
230294	***	*	*	31.6195	*	31.6195
230295	***	*	*	27.1298	*	27.1298
230296	***	*	*	*	34.2107	34.2107
230297	1.6768	1.0095	*	*	*	*
230299	0.7569	1.0095	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
230300	2.9905	1.0095	*	*	*	*
240001	1.5368	1.0896	31.5753	33.1499	34.7673	33.1702
240002	1.8838	1.0081	28.9860	31.6000	33.1051	31.2232
240004	1.5928	1.0896	30.8072	32.7010	32.5777	32.0088
240006	1.0956	1.0490	30.1949	31.0777	33.4777	31.6176
240010	2.0512	1.0490	31.3733	33.4668	32.7261	32.5154
240013	***	*	28.3860	*	*	28.3860
240014	1.0234	1.0896	29.8623	29.8905	30.7519	30.1868
240016	1.2729	*	26.7814	*	*	26.7814
240017	1.1862	*	24.4417	24.3596	*	24.4015
240018	1.2793	0.9918	25.6236	28.1432	29.4995	27.7723
240019	1.0504	1.0081	28.6723	33.7546	32.7052	31.5906
240020	1.0690	1.0896	31.2443	31.3874	33.2449	31.9653
240021	1.0320	*	27.1236	*	*	27.1236
240022	1.0313	0.9113	25.2066	26.1920	27.3137	26.2644
240027	0.9334	*	18.2482	*	*	18.2482
240029	0.9036	*	25.3568	*	*	25.3568
240030	1.3356	1.0322	24.7154	26.5508	27.1312	26.1217
240031	***	*	26.7778	*	*	26.7778
240036	1.6944	1.1058	28.0812	32.7028	34.2980	31.6464
240038	1.5433	1.0896	31.0779	31.9891	33.0554	32.0416
240040	1.0727	1.0081	27.4895	27.5074	28.9009	27.9569
240043	1.2167	0.9113	21.8684	23.3489	24.0708	23.1186
240044	1.0578	0.9738	22.0973	25.0988	26.8681	24.6231
240047	1.5014	1.0081	28.8289	28.6406	29.7835	29.0980
240050	1.1121	1.0896	26.4854	27.5553	30.9805	28.4152
240052	1.2203	0.9113	26.4256	28.7206	29.4617	28.2289
240053	1.4790	1.0896	29.5315	31.4324	33.1148	31.4053
240056	1.2476	1.0896	31.6623	33.1728	34.0845	32.9884
240057	1.8390	1.0896	30.6258	30.7703	33.4713	31.6052
240059	1.1410	1.0896	29.7916	31.0911	32.4803	31.1825
240061	1.8232	1.0490	30.6383	33.1799	32.0828	31.9873
240063	1.6425	1.0896	32.3487	33.7895	35.2877	33.8358
240064	1.1840	0.9956	29.9662	34.3757	27.2407	30.4845
240066	1.5079	1.0896	33.4532	35.3441	36.0705	35.0117
240069	1.2056	1.0490	28.9496	29.3718	30.9719	29.7863
240071	1.1303	1.0490	28.0586	28.6950	31.7754	29.4920
240075	1.1560	1.0322	26.1956	27.5039	29.1171	27.5983
240076	1.0339	1.0896	29.8561	30.6936	33.1439	31.3353

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
240078	1.7528	1.0896	32.3235	32.5785	34.6118	33.2014
240080	1.9192	1.0896	31.6828	32.5725	34.8064	32.9942
240083	1.2282	*	26.6582	*	*	26.6582
240084	1.1711	1.0081	26.8141	26.5975	27.0995	26.8366
240088	1.2869	1.0322	28.0825	28.0603	29.1387	28.4292
240093	1.4134	1.0896	25.5805	27.2928	29.1717	27.3783
240100	1.3073	0.9113	27.6299	30.8391	31.5774	30.0103
240101	1.1570	0.9113	25.5355	25.6963	26.8849	26.0843
240103	***	*	22.7077	*	*	22.7077
240104	1.1350	1.0896	31.4306	31.6511	35.0736	32.8285
240106	1.6075	1.0896	29.3455	30.5927	32.8156	30.9392
240109	0.8676	*	16.5051	*	*	16.5051
240115	1.5330	1.0896	31.3869	32.0107	33.5288	32.3224
240117	1.1821	0.9640	23.6230	24.5750	27.6950	25.3203
240123	***	*	21.7500	*	*	21.7500
240128	***	*	21.5791	23.3334	*	22.4504
240132	1.2808	1.0896	31.7139	32.1233	34.6191	32.7811
240141	1.1219	1.0896	26.4016	31.4468	32.8689	30.5116
240143	0.8966	*	21.7416	*	*	21.7416
240152	***	*	29.6196	*	*	29.6196
240162	***	*	22.2722	*	*	22.2722
240166	1.1560	0.9113	25.7509	27.6987	26.5328	26.6686
240187	1.3285	1.0896	27.8811	27.8844	29.1582	28.3455
240196	0.8200	1.0896	30.7720	31.5965	34.3743	32.2603
240206	0.8831	1.4400	*	*	*	*
240207	1.1964	1.0896	31.7665	32.5589	34.6792	33.0557
240210	1.2901	1.0896	32.1564	32.7123	34.4184	33.1005
240211	0.9769	0.9925	18.8503	22.5430	17.4044	19.3517
240213	1.3936	1.0896	32.7532	33.8680	35.7818	34.1758
250001	1.9108	0.7950	22.7827	23.5222	23.7773	23.3786
250002	0.9543	0.7752	23.3844	23.4063	25.4201	24.0840
250004	1.9118	0.8963	24.1065	24.7907	25.8722	24.9584
250006	1.1133	0.8963	24.0191	24.4282	25.9199	24.8140
250007	1.2414	0.8607	25.8710	24.8929	27.7665	26.1862
250009	1.2438	0.8435	22.2323	23.0352	23.4866	22.9223
250010	0.9922	0.7752	19.4402	21.4322	21.8665	20.9164
250012	0.9498	0.9313	20.2922	21.5540	23.4837	21.7607
250015	1.1227	0.7752	20.7555	22.0067	22.2803	21.6585
250017	1.0264	0.7752	21.3950	22.7660	33.6840	25.4569

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
250018	0.8983	0.7752	16.6292	17.1276	17.9025	17.2152
250019	1.5215	0.8607	23.9741	25.7376	26.2199	25.3039
250020	0.9941	0.7752	21.4019	22.1851	23.7245	22.4970
250021	***	*	20.3564	*	*	20.3564
250023	0.8728	0.8216	16.2418	18.0108	18.5067	17.6056
250025	1.0996	0.7752	20.5258	22.5621	23.1738	22.1091
250027	0.9597	0.7752	17.3481	24.4937	26.9922	22.7357
250031	1.3166	0.7950	21.4326	24.8139	25.9189	23.7971
250034	1.5394	0.8963	24.3189	26.1887	26.7996	25.7643
250035	0.8596	0.7752	17.2046	20.1622	19.1038	18.8948
250036	1.0403	0.8539	19.1975	20.3625	19.7951	19.8104
250037	0.9020	*	17.4012	*	*	17.4012
250038	0.9406	0.7950	18.9050	22.2571	26.9621	22.1505
250039	0.9692	*	17.3155	*	*	17.3155
250040	1.4843	0.8216	23.2285	24.5962	27.3366	25.0602
250042	1.2097	0.8963	23.4135	25.6807	26.1190	25.0569
250043	1.0165	0.7752	19.8097	18.8979	20.8841	19.8723
250044	1.0512	0.7752	23.3862	24.0508	24.9199	24.1132
250045	0.8706	*	26.3831	*	*	26.3831
250048	1.6242	0.7950	22.9765	25.2092	24.7659	24.3112
250049	0.8734	0.7752	17.7005	19.1044	20.4775	19.2031
250050	1.1882	0.7752	19.1467	20.8084	21.1657	20.4032
250051	0.8083	0.7752	10.6095	14.3741	13.9532	12.9323
250057	1.1237	0.7752	20.1900	22.7601	24.3654	22.3993
250058	1.2419	0.7752	18.1704	19.2502	18.9970	18.8129
250059	0.9234	0.7752	19.2976	23.8997	26.7491	23.0906
250060	0.8007	0.7752	16.8247	28.1431	25.4779	22.9648
250061	0.9008	0.7752	12.8174	17.8267	18.7413	16.2215
250067	1.0773	0.7752	21.6911	23.1193	25.2189	23.3711
250069	1.4798	0.8162	22.8162	22.6353	22.4194	22.6160
250072	1.6974	0.7950	24.6587	25.8399	25.5337	25.3438
250077	0.9375	0.7752	14.7632	18.3735	19.0416	17.4307
250078	1.6957	0.8216	20.9354	22.1243	22.8430	21.9367
250079	0.8566	0.7950	38.0032	45.5166	43.0845	42.6371
250081	1.3341	0.8162	24.7031	23.9995	25.6808	24.7915
250082	1.4638	0.7955	19.6966	23.0287	23.5399	22.0713
250084	1.2087	0.7752	18.5775	19.6492	19.1604	19.1217
250085	0.9997	0.7752	19.7008	22.5513	24.2915	22.2573
250093	1.1868	0.7752	21.3237	23.0984	23.9128	22.7658

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
250094	1.7390	0.8216	22.7312	24.1422	24.7718	23.8835
250095	1.0356	0.7752	21.3511	21.7488	23.6140	22.2444
250096	1.1760	0.7950	22.6298	24.9187	26.3743	24.6259
250097	1.6155	0.8009	20.1687	21.8139	22.0211	21.3430
250099	1.2795	0.7950	19.5797	21.1269	21.5656	20.7220
250100	1.4728	0.8162	24.2209	25.6846	27.0286	25.6566
250101	***	*	19.3543	*	*	19.3543
250102	1.5957	0.7950	24.2868	24.6652	25.4050	24.7885
250104	1.4888	0.8162	22.6591	23.4303	24.4311	23.5422
250105	0.9250	*	18.1195	*	*	18.1195
250107	0.5882	*	17.8999	*	*	17.8999
250112	0.9893	0.7752	21.2824	24.3069	26.3357	23.9697
250117	1.1062	0.8216	23.3673	22.2450	23.7337	23.1049
250120	***	*	23.4277	24.6370	26.6522	24.9400
250122	1.1115	0.7752	24.5854	27.2795	27.4424	26.3827
250123	1.3323	0.8607	24.5115	26.6221	27.9058	26.3779
250124	0.8198	0.7950	17.2181	20.4394	20.5667	19.3927
250125	1.2242	0.8607	27.7077	27.5158	26.7687	27.3398
250126	0.9523	0.7752	21.7112	24.4126	25.0019	23.6618
250127	0.8846	1.4400	*	*	*	*
250128	0.9268	0.8198	17.6269	17.7624	21.7882	19.2637
250134	0.8858	0.7950	25.8369	22.2167	21.0211	22.9411
250136	1.0311	0.7950	23.0637	22.9468	25.2241	23.7171
250138	1.3296	0.7950	23.8861	24.3018	25.2642	24.4955
250141	1.5435	0.9313	27.6158	28.5922	30.5112	28.9880
250146	0.7934	*	18.6486	*	*	18.6486
250149	0.8337	0.7752	15.0641	16.8796	17.2268	16.4094
250151	0.4710	0.7752	17.2205	18.8846	22.8238	18.4860
250152	0.8555	0.7950	25.7837	26.9334	26.4559	26.3576
250153	***	*	29.0461	*	*	29.0461
250155	***	*	*	22.5728	*	22.5728
250156	***	*	*	*	16.8659	16.8659
250157	***	*	*	*	29.6398	29.6398
250160	2.3735	0.8198	*	*	*	*
250161	2.1565	0.7950	*	*	*	*
260001	1.6505	0.9211	25.9250	27.9230	29.5271	27.7489
260002	***	*	26.4879	*	*	26.4879
260004	0.9691	0.8153	16.9422	20.3217	21.3629	19.5753
260005	1.5536	0.8982	26.5773	27.7855	27.9477	27.4315

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
260006	1.4872	0.8153	26.7587	30.3440	27.3754	28.2413
260008	***	*	18.9522	*	*	18.9522
260009	1.1605	0.9318	22.1816	24.2360	25.7546	24.0697
260011	1.5003	0.8702	22.7062	25.6387	27.5762	25.2813
260012	***	*	20.3061	*	*	20.3061
260013	***	*	20.5007	*	*	20.5007
260015	1.0079	0.8503	22.5409	24.6139	25.0640	24.0564
260017	1.3285	0.8702	22.7022	23.5713	25.0461	23.8093
260018	1.0396	*	17.0434	*	*	17.0434
260020	1.7374	0.8982	26.0407	27.4730	29.3080	27.6649
260021	1.3986	0.8982	27.6329	29.3646	32.6735	29.7171
260022	1.4082	0.8476	22.8085	23.3393	24.8713	23.6527
260023	1.3554	0.8982	21.2077	24.3192	25.4314	23.5901
260024	1.1334	0.8153	18.4829	19.4952	19.2199	19.0583
260025	1.3603	0.8982	22.4645	22.2451	24.0358	22.9418
260027	1.6405	0.9318	25.3348	26.3590	29.3811	27.0039
260032	1.8518	0.8982	23.9478	25.6763	27.4857	25.6996
260034	0.9779	0.9318	24.1143	25.0573	27.1685	25.5196
260035	***	*	17.8741	*	*	17.8741
260036	***	*	22.1913	*	*	22.1913
260040	1.6616	0.8791	23.3566	24.3938	25.9074	24.5552
260047	1.4495	0.8702	24.4185	25.4978	26.6343	25.5319
260048	1.1748	0.9318	24.3906	27.6117	28.1515	26.7038
260050	1.1594	0.8826	23.6849	25.0506	26.2346	25.0319
260052	1.3105	0.8982	24.5165	26.0052	27.6360	26.0330
260053	1.0761	*	21.6607	*	*	21.6607
260057	1.0689	0.9318	19.3335	20.9639	21.5925	20.6154
260059	1.1569	0.8230	19.7243	22.6922	22.3885	21.6448
260061	1.1348	0.8153	21.5264	22.4766	22.8589	22.2793
260062	1.2554	0.9318	26.4539	28.1661	28.4975	27.7053
260064	1.3816	0.8537	19.0543	22.2395	23.3498	21.5194
260065	1.7758	0.8791	23.0015	27.1014	29.3564	26.5324
260067	0.9311	*	17.6256	*	*	17.6256
260068	1.7942	0.8537	24.9504	26.0295	27.3475	26.1217
260070	0.9560	0.8153	18.4779	24.6331	21.9701	21.9657
260073	***	*	21.6214	*	*	21.6214
260074	1.2370	0.8537	24.8655	25.6218	28.0468	26.1521
260077	1.6220	0.8982	25.5782	26.7466	27.6624	26.6607
260078	1.2824	0.8153	19.0802	20.1983	21.1539	20.1477

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
260080	0.9199	0.8153	14.7774	17.9107	18.6070	17.0074
260081	1.5693	0.8982	26.3969	28.1182	29.1890	27.9120
260085	1.5678	0.9318	25.6302	26.6718	28.0306	26.7545
260086	0.9570	*	19.1702	*	*	19.1702
260091	1.5284	0.8982	27.2407	28.0537	28.5473	27.9539
260094	1.7033	0.8619	23.2544	24.1473	23.8654	23.7602
260095	1.3886	0.9318	25.5668	24.2698	27.6196	25.7194
260096	1.5016	0.9318	27.5592	29.7312	30.7267	29.3752
260097	1.2010	0.8453	21.3957	25.0624	25.5634	24.1104
260102	0.9492	0.9318	24.2368	27.2145	26.7624	26.1065
260104	1.5666	0.8982	26.2867	28.6247	28.0235	27.6814
260105	1.8547	0.8982	28.8849	29.8848	29.4766	29.4216
260107	1.2949	0.9318	26.7781	25.8177	27.9710	26.8276
260108	1.8354	0.8982	24.9880	26.6374	27.0758	26.2658
260110	1.6385	0.8982	23.7978	24.7656	26.6030	25.1086
260113	1.1068	0.8345	20.9644	21.2072	21.8884	21.3627
260115	1.1422	0.8982	21.9858	23.1396	24.6389	23.3012
260116	1.0970	0.8240	18.5076	21.3503	20.7479	20.1811
260119	1.3301	0.8503	24.9937	27.9769	31.5490	28.0677
260122	***	*	20.8015	*	*	20.8015
260127	0.9486	*	21.8533	*	*	21.8533
260137	1.7241	0.9211	22.7431	24.3273	27.6592	24.9488
260138	1.9932	0.9318	28.5610	30.4410	30.6284	29.8958
260141	1.8464	0.8537	22.4886	24.1555	25.5663	24.0283
260142	1.0863	0.8153	20.3993	21.5923	21.7609	21.2699
260147	0.9227	0.8153	18.5153	21.4235	22.1928	20.7819
260159	***	*	23.7427	22.6276	23.9515	23.4460
260160	1.0727	0.8153	21.0544	23.8257	25.5096	23.4627
260162	1.3822	0.8982	25.1423	27.0236	28.4660	26.9323
260163	1.1447	0.8240	20.1949	21.6408	21.5566	21.0997
260164	1.3771	*	19.7068	*	*	19.7068
260166	1.2270	0.9318	27.0237	29.1225	28.5858	28.2382
260175	1.0781	0.9318	22.6171	25.1817	24.6064	24.1908
260176	1.7021	0.8982	27.4244	29.3034	31.1056	29.3206
260177	1.2063	0.9318	26.1178	27.0185	28.7942	27.3136
260178	1.8398	0.8537	22.2251	25.4782	27.1201	25.2036
260179	1.5496	0.8982	26.1419	26.6069	28.3234	27.0262
260180	1.5401	0.8982	26.7461	28.2931	29.3820	28.1562
260183	1.6674	0.8982	26.0418	27.5577	29.2684	27.6352

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
260186	1.5439	0.8702	25.3148	26.9797	28.8610	27.0998
260190	1.1950	0.9318	26.4505	27.9137	30.5343	28.3451
260191	1.3649	0.8982	23.3856	24.6973	26.3244	24.8437
260193	1.1902	0.9318	26.2979	26.8922	28.1060	27.0944
260195	1.2138	0.8153	22.3959	22.6870	24.0411	23.0824
260198	0.9613	0.8982	27.5996	28.0021	27.2555	27.6065
260200	1.2664	0.8982	24.8624	28.2453	27.4784	26.8903
260207	1.1544	0.8791	19.7294	22.6109	22.9579	22.0292
260209	1.1052	0.8702	23.2430	25.0098	25.0749	24.4649
260210	1.2687	0.8982	25.3781	26.8745	30.5975	27.6599
260211	1.5777	0.9318	33.9109	40.9821	35.9113	37.0332
260213	***	*	*	*	34.8953	34.8953
260214	1.2383	0.9318	*	*	*	*
260215	0.8925	*	*	*	*	*
260216	1.1892	0.9318	*	*	*	*
260217	1.9096	0.8153	*	*	*	*
270002	1.1596	0.8335	22.7322	24.0534	25.2907	24.0317
270003	1.3075	0.8761	26.4843	28.8700	29.1938	28.2090
270004	1.6785	0.8870	23.5454	26.1319	26.6779	25.4900
270011	1.0334	0.8335	22.1394	22.7061	24.4696	23.0853
270012	1.5540	0.8761	25.2873	25.2914	26.5854	25.7202
270014	1.9641	0.8738	26.2025	25.8231	27.4811	26.5073
270017	1.3197	0.8738	27.5483	26.5404	27.4150	27.1724
270021	***	*	21.7056	*	*	21.7056
270023	1.5487	0.8738	26.7576	25.5682	26.3076	26.1917
270032	1.0283	0.8335	19.6212	20.3469	20.4330	20.1359
270036	***	*	20.4241	*	*	20.4241
270049	1.7517	0.8870	26.3996	27.1634	28.6880	27.4297
270051	1.5580	0.8335	26.6619	26.5621	24.9371	25.9492
270057	1.2534	0.8335	24.2980	25.5811	27.1838	25.7301
270060	***	*	17.7564	*	*	17.7564
270074	0.9156	1.4400	*	*	*	*
270081	0.9750	0.8569	17.4862	19.5612	20.0438	18.9885
270086	1.0637	0.8761	*	21.0808	20.7976	20.9433
270087	1.2167	0.8335	*	25.9772	24.8022	25.3663
280003	1.7479	0.9872	29.3921	30.6124	30.1057	30.0354
280009	1.8630	0.9626	26.7678	27.0705	29.3634	27.7395
280013	1.7335	0.9473	26.1908	27.0250	27.9523	27.0727
280020	1.7374	0.9872	26.5068	27.3284	32.3896	28.7656

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
280021	1.1678	*	22.0489	*	*	22.0489
280023	1.3669	0.9626	22.3230	26.7980	29.5132	26.0305
280030	1.8904	0.9473	30.7481	29.5102	30.6991	30.3314
280032	1.2987	0.9626	23.6462	24.3995	24.7539	24.2697
280040	1.6380	0.9473	26.9827	28.7207	29.5276	28.4319
280054	1.1439	*	23.5665	*	*	23.5665
280057	0.8606	*	20.4830	*	*	20.4830
280060	1.6779	0.9473	26.2139	27.7496	30.3049	28.0748
280061	1.3957	0.9009	24.9482	26.0208	26.4824	25.8457
280065	1.2385	0.9744	26.0135	28.0581	28.0132	27.3416
280077	1.3374	0.8926	25.5624	27.0860	28.2206	26.9878
280081	1.7068	0.9473	26.0541	28.7464	31.1212	28.6426
280105	1.2617	0.9473	26.7555	27.8599	29.8488	28.1889
280108	1.0740	*	23.2503	*	*	23.2503
280111	1.1900	0.8846	23.4770	24.5617	27.4853	25.3180
280117	1.1038	*	24.1521	*	*	24.1521
280119	0.8357	1.4400	*	*	*	*
280123	0.9968	0.8969	*	15.4047	22.2185	17.7515
280125	1.5929	0.8846	21.7657	22.1345	23.2900	22.4202
280127	1.7915	0.9872	*	29.3684	25.6806	27.2615
280128	2.9055	0.9872	*	28.5422	28.8734	28.7213
280129	1.9024	0.9473	*	*	27.8793	27.8793
280130	1.3731	0.9473	*	*	29.8588	29.8588
290001	1.8514	1.1062	31.1981	36.3129	35.5113	34.2992
290002	0.9058	0.9701	18.3469	17.3876	23.9348	19.4284
290003	1.8286	1.1452	28.1625	30.3373	32.8182	30.4051
290005	1.4267	1.1452	27.6697	28.3366	31.7107	29.0818
290006	1.1835	1.0851	27.9501	31.7301	31.9838	30.5940
290007	1.6319	1.1452	37.5559	38.1938	39.7323	38.5049
290008	1.2061	0.9701	27.9714	27.3019	31.1116	28.8004
290009	1.7155	1.1062	29.8019	36.2724	32.3348	32.7010
290010	***	*	23.9655	*	*	23.9655
290012	1.3595	1.1452	31.0843	32.3966	35.7988	33.1284
290016	***	*	26.1925	*	*	26.1925
290019	1.4106	1.0851	28.6158	29.3650	30.5964	29.5670
290020	0.9879	0.9701	21.6993	23.2103	27.6277	23.8492
290021	1.7447	1.1452	33.2116	32.7894	36.7310	34.3050
290022	1.6617	1.1452	29.4422	29.9717	33.5330	30.9653
290027	0.8977	0.9701	15.1448	23.9959	23.9818	21.2171

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
290032	1.4261	1.1062	31.7105	31.6711	34.6589	32.6749
290039	1.5622	1.1452	31.2941	32.1423	34.9622	32.8643
290041	1.3799	1.1452	33.9877	34.2436	37.6077	35.4456
290042	***	*	*	*	22.4859	22.4859
290044	***	*	*	37.1662	*	37.1662
290045	1.5944	1.1452	30.9612	33.1512	34.4584	33.0001
290046	1.3262	1.1452	*	*	38.7966	38.7966
290047	1.4997	1.1452	*	*	33.4695	33.4695
290049	1.3649	0.9701	*	*	26.0725	26.0725
290051	1.6073	0.9701	*	*	*	*
290052	0.9497	0.9701	*	*	*	*
300001	1.5464	1.1259	27.5032	29.2260	29.8145	28.8796
300003	2.1048	1.1259	33.3560	34.7900	37.0886	35.1221
300005	1.4049	1.1259	25.6699	27.8000	27.8431	27.1342
300006	***	*	23.3200	*	*	23.3200
300010	***	*	27.5028	*	*	27.5028
300011	1.2835	1.1328	28.4044	30.9403	31.8928	30.4453
300012	1.3798	1.1328	30.5198	30.4972	31.2655	30.7729
300014	1.1573	1.1259	27.5151	29.7667	29.1847	28.8592
300017	1.3085	1.1259	29.6957	29.9560	31.6699	30.4413
300018	1.4139	1.1259	29.7209	29.4270	31.7891	30.3785
300019	1.2712	1.1259	25.9656	27.5672	28.2287	27.2950
300020	1.1611	1.1328	28.6723	30.8491	30.9783	30.1937
300023	1.3397	1.1259	28.6309	31.0040	31.2726	30.3861
300029	1.7558	1.1259	29.0806	29.8117	31.4429	30.1534
300034	1.9005	1.1328	29.7484	30.7676	31.6880	30.7463
310001	1.7835	1.3229	35.3612	41.7460	39.3391	38.8076
310002	1.8123	1.3001	37.3461	37.9183	37.8652	37.7010
310003	1.1430	1.3229	32.8935	36.2346	39.0785	36.1404
310005	1.3200	1.1673	29.0084	32.1319	33.6311	31.6195
310006	1.2207	1.3229	27.4545	28.4771	28.7321	28.2234
310008	1.3040	1.3229	31.2579	32.6788	33.3172	32.4236
310009	1.3170	1.3001	32.7384	33.6940	33.6165	33.3550
310010	1.2809	1.1616	28.5852	33.9552	33.7009	32.1235
310011	1.2513	1.1616	30.8612	31.2907	34.3497	32.1653
310012	1.6576	1.3229	34.6882	38.3590	39.8568	37.6617
310013	1.3567	1.3001	30.6248	31.0447	35.6260	32.2970
310014	1.9393	1.1616	29.7204	30.0793	32.9016	30.9529
310015	1.9968	1.3001	36.4776	36.8818	39.2928	37.5859

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
310016	1.3504	1.3229	33.9862	35.6155	38.2740	36.0399
310017	1.3322	1.3001	30.9233	32.2434	35.7308	32.9489
310018	1.1974	1.3001	30.3381	30.3234	32.9704	31.1743
310019	1.5532	1.3229	29.6592	30.3518	30.6369	30.2334
310020	1.5417	1.3229	30.6722	33.5516	37.3372	35.3958
310021	1.6673	1.1616	31.3410	32.1929	31.6562	31.7278
310022	1.2929	1.1616	28.2024	30.4043	31.1951	29.9534
310024	1.2735	1.1673	30.9171	33.3415	33.8622	32.7353
310025	1.3583	1.3229	31.1274	34.3687	32.2630	32.6293
310026	1.1811	1.3229	27.5171	29.1588	30.1392	28.9609
310027	1.3916	1.1673	28.8314	29.7793	31.5967	30.0516
310028	1.1683	1.1673	31.3849	32.2977	33.9911	32.5804
310029	1.9359	1.1616	30.7707	32.9246	33.6695	32.4534
310031	3.0047	1.1616	33.9685	37.0668	39.3783	36.7939
310032	1.3402	1.1616	27.5232	30.7865	33.0258	30.4634
310034	1.3881	1.1616	29.9162	31.7012	32.7523	31.4431
310037	1.3845	1.3229	35.0329	38.5415	38.2865	37.2934
310038	1.9967	1.3001	33.4822	35.9190	36.3344	35.3017
310039	1.2652	1.3001	28.8292	31.4278	33.2100	31.1031
310040	1.3306	1.3229	34.1113	33.8535	37.7945	35.2738
310041	1.3033	1.1616	32.8085	32.8390	33.9799	33.1814
310042	***	*	30.7357	34.4986	*	32.5359
310044	1.3437	1.1616	31.3205	31.9678	33.7614	32.3239
310045	1.6620	1.3229	34.1060	36.7862	38.4424	36.4052
310047	1.3103	1.2063	32.7880	34.1520	37.3695	34.8319
310048	1.3604	1.1616	30.2025	32.9681	33.9506	32.4220
310049	***	*	27.8565	*	*	27.8565
310050	1.2632	1.3001	27.3033	29.1732	32.3686	29.5226
310051	1.4210	1.1673	33.7168	35.0121	38.1174	35.6230
310052	1.3148	1.1616	30.8036	32.5778	33.5849	32.3047
310054	1.3491	1.3001	34.1860	34.4431	36.9095	35.1806
310057	1.3580	1.1616	29.5221	31.1268	31.8933	30.8472
310058	1.0998	1.3229	28.0815	27.1555	30.4080	28.5500
310060	1.2257	1.1616	25.1575	27.3415	27.8242	26.8643
310061	1.2040	1.1616	28.2129	31.6648	39.0538	32.6390
310063	1.3566	1.1673	31.4884	31.9247	33.8519	32.4001
310064	1.5564	1.2063	33.4440	35.7607	38.6310	36.0389
310069	1.2283	1.1616	28.1681	31.7642	34.4669	31.6153
310070	1.4393	1.3001	33.2310	34.3225	36.3279	34.6577

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
310073	1.9384	1.1616	32.0328	32.6733	34.2858	33.0132
310074	1.4076	1.3229	29.4834	40.3494	39.6196	36.4297
310075	1.3486	1.1616	31.6869	31.5226	32.5338	31.9060
310076	1.6948	1.3001	36.4280	38.0643	37.5163	37.3327
310077	***	*	32.6644	34.6085	*	33.6290
310078	***	*	29.8014	30.5761	*	30.1919
310081	1.2435	1.1616	26.6136	30.1561	31.0699	29.3013
310083	1.2967	1.3001	28.2392	30.3580	31.9151	30.1908
310084	1.2495	1.1616	32.9001	33.5941	32.6051	33.0233
310086	1.2196	1.1616	29.3058	29.5566	29.8794	29.5860
310088	1.1944	1.2063	26.4966	29.9929	30.3552	28.9197
310090	1.2491	1.1673	30.8941	32.8191	33.4615	32.3298
310091	1.1872	1.1616	27.7204	29.3969	31.9762	29.6739
310092	1.4211	1.1616	29.4998	29.7958	32.7054	30.6412
310093	1.2376	1.3001	28.0401	29.1288	30.2860	29.1452
310096	2.0682	1.3001	34.4275	34.1524	35.0707	34.5571
310105	1.2642	1.3229	31.9769	30.1069	32.5672	31.5194
310108	1.3920	1.3001	30.1002	33.0172	34.5866	32.5569
310110	1.3054	1.1616	31.2164	33.2246	33.4809	32.6996
310111	1.2374	1.1616	30.7475	31.8393	34.8284	32.5303
310112	1.3369	1.1616	30.4192	31.2372	32.2676	31.3091
310113	1.2469	1.1616	29.6079	31.0436	33.6771	31.5140
310115	1.3257	1.1616	29.6020	29.5320	31.9208	30.3993
310116	1.2613	1.3229	25.6976	29.2748	29.8144	28.1684
310118	1.2995	1.3229	28.8797	31.1803	31.2296	30.4800
310119	1.9452	1.3001	37.7876	43.1238	41.5702	40.9091
310120	1.1067	1.1673	31.4111	29.2535	33.3861	31.2922
310122	***	*	*	*	41.9029	41.9029
310123	***	*	*	*	37.1022	37.1022
310124	***	*	*	*	41.8827	41.8827
310125	***	*	*	*	36.2186	36.2186
310126	1.5770	1.1673	*	*	*	*
310127	2.1663	1.1616	*	*	*	*
320001	1.6904	0.9725	26.9434	29.6182	30.0077	28.9126
320002	1.4655	1.0682	30.5158	32.0477	33.1342	31.9538
320003	1.1309	1.0379	28.1402	27.6222	31.4473	29.2088
320004	1.3372	0.8965	24.9481	24.7803	26.2073	25.3027
320005	1.3986	0.9725	23.8264	24.7543	28.7893	25.7109
320006	1.3191	0.9725	24.2812	26.9080	28.0964	26.5135

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
320009	1.5653	0.9725	22.8293	32.0116	27.8084	27.0081
320011	1.1591	0.9407	24.2279	25.6693	27.9522	25.9810
320013	1.1095	1.0379	28.9276	22.8283	30.5865	26.9423
320014	1.0798	0.8965	24.5310	27.2806	28.7089	26.9267
320016	1.1809	0.8965	23.5040	25.0835	27.1492	25.3050
320017	1.1952	0.9725	25.0286	31.6357	33.3496	30.1544
320018	1.4708	0.8989	23.2360	26.5109	25.9248	25.0333
320019	1.5804	0.9725	31.5192	27.8067	35.0217	30.9860
320021	1.6072	0.9725	27.2357	26.9918	28.8504	27.7586
320022	1.1616	0.8965	23.7160	23.9595	25.3707	24.3634
320030	1.0991	0.8965	22.1971	21.0378	24.4497	22.6078
320033	1.1954	1.0379	27.6393	31.7114	30.1471	29.8084
320037	1.2522	0.9725	23.3999	24.9657	25.2876	24.5736
320038	1.2776	0.8965	20.1533	21.7022	32.7192	25.2889
320046	***	*	24.3534	*	*	24.3534
320057	0.8729	1.4400	*	*	*	*
320058	0.7716	1.4400	*	*	*	*
320059	0.8739	1.4400	*	*	*	*
320060	0.9509	1.4400	*	*	*	*
320061	0.8807	1.4400	*	*	*	*
320062	0.8932	1.4400	*	*	*	*
320063	1.3138	0.9522	24.4696	25.0031	26.0104	25.1846
320065	1.3090	0.9522	26.6603	27.3163	25.7945	26.5978
320067	0.8771	0.8965	23.7745	24.9865	24.7025	24.5152
320069	1.1009	0.8965	20.9167	22.4128	23.9863	22.4807
320070	0.9497	1.4400	*	*	*	*
320074	1.1777	0.9725	22.2175	31.1333	28.4396	27.5523
320079	1.0746	0.9725	25.2105	26.1188	27.6877	26.3861
320083	2.5829	0.9725	28.2114	26.6921	29.5483	28.1910
320084	0.9585	0.8965	17.2511	17.5788	22.7706	19.1172
320085	1.6988	0.8989	24.8752	27.9944	27.4100	26.8654
330001	***	*	33.4718	*	*	33.4718
330002	1.4701	1.3229	31.1924	30.9600	32.1956	31.4367
330003	1.3898	0.8667	22.9945	24.4326	25.2223	24.2261
330004	1.2772	1.0762	26.0445	28.0594	30.2236	28.0555
330005	1.5846	0.9588	29.0124	30.3200	31.5030	30.2924
330006	1.2549	1.3229	31.5370	33.6284	34.2001	33.1191
330008	1.1962	0.9588	21.8198	23.4429	25.2005	23.4731
330009	1.2209	1.3229	35.4986	36.2820	38.9166	36.8498

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average Hourly Wage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
330010	0.9609	0.8470	19.6920	20.7476	19.7098	20.0039
330011	1.3861	0.9068	21.8008	25.1308	27.4747	24.7766
330013	1.8871	0.8667	24.5162	26.4578	26.8382	25.9719
330014	1.3021	1.3229	38.8123	42.1759	45.7619	42.1087
330016	***	*	28.4391	22.0493	23.0769	24.0047
330019	1.2350	1.3229	34.8266	38.5368	39.7429	37.6992
330023	1.5532	1.2341	31.6208	35.9428	36.4736	34.8790
330024	1.8568	1.3229	37.8398	42.7691	43.2342	41.1289
330025	1.0759	0.9588	20.2776	21.2565	23.2424	21.5975
330027	1.3410	1.3001	39.0717	42.8000	45.1920	42.3263
330028	1.4248	1.3229	34.2709	36.6498	36.2901	35.6915
330029	0.4658	0.9588	19.1589	23.2039	24.0679	21.4788
330030	1.2420	0.8918	22.9937	24.6175	25.3454	24.2688
330033	1.1925	0.8630	22.5680	24.5510	24.8022	23.9493
330036	1.1741	1.3229	28.9409	29.1884	30.3757	29.5029
330037	1.1940	0.8918	20.6904	22.3689	21.9246	21.6480
330041	1.3233	1.3229	36.0286	37.4883	36.9934	36.8228
330043	1.3835	1.2877	34.7480	39.1643	38.8060	37.6024
330044	1.3073	0.8416	24.1907	26.5669	28.2293	26.3415
330045	1.3333	1.2877	36.1893	38.1269	40.0326	38.1677
330046	1.3813	1.3229	44.8494	50.3152	47.4975	47.5047
330047	1.1878	0.8470	24.0678	24.3932	24.9934	24.5012
330049	1.5198	1.2341	29.2904	29.8350	34.8585	31.4556
330053	1.0489	0.8918	18.5289	20.6272	21.8383	20.3286
330055	1.5717	1.3229	38.4839	41.5934	42.2007	40.8306
330056	1.4406	1.3229	37.8444	36.0136	38.8910	37.5789
330057	1.7329	0.8667	24.4680	26.4989	27.7121	26.2563
330058	1.2624	0.8918	21.3727	22.2524	22.6852	22.1185
330059	1.5241	1.3229	39.7387	41.7343	44.9162	42.1521
330061	1.1882	1.3229	33.2848	36.0587	37.8828	35.7862
330062	2.5188	*	21.0464	*	*	21.0464
330064	1.1797	1.3229	36.4276	38.0437	38.2332	37.5276
330065	1.0343	0.9588	23.9128	25.3043	24.4004	24.5186
330066	1.2786	0.8667	24.7941	29.1780	25.8174	26.6320
330067	1.4312	1.2341	26.4243	27.8900	29.2571	27.8298
330072	1.3677	1.3229	36.4336	37.8505	39.6996	37.9172
330073	1.0856	0.8918	20.1490	22.5592	23.4020	22.0432
330074	1.2120	0.8918	21.4274	22.6629	23.4576	22.5315
330075	1.1282	0.9950	22.4188	23.1592	24.2552	23.2899

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
330078	1.4627	0.9588	23.3981	25.8073	27.2870	25.5271
330079	1.3912	0.9427	22.5237	24.6054	24.9941	24.0665
330080	1.1613	1.3229	39.1724	39.1417	38.9405	39.0850
330084	1.0884	0.8416	21.5455	22.5573	25.6880	23.2872
330085	1.1341	0.9602	23.9568	25.3285	26.6235	25.3048
330086	1.3276	1.3229	29.1784	32.7675	35.5269	32.6267
330088	1.0140	1.2877	31.3973	34.0789	35.3871	33.6067
330090	1.4711	0.8416	23.6174	25.5351	26.8730	25.3567
330091	1.3626	0.9588	23.8063	25.9378	27.0040	25.6221
330094	1.2531	0.9270	23.0001	25.7116	26.9148	25.1933
330095	***	*	31.9873	*	*	31.9873
330096	1.2247	0.8416	22.0337	22.7189	24.2422	22.9958
330097	1.0476	*	20.3189	*	*	20.3189
330100	1.0885	1.3229	34.4621	38.3333	39.6244	37.5351
330101	1.9277	1.3229	38.7503	40.1929	43.7944	40.9964
330102	1.3807	0.9588	24.8184	25.3879	26.6887	25.6620
330103	1.1464	0.8416	21.1452	22.8242	24.5585	22.8019
330104	1.3459	1.3229	32.8818	33.7537	35.1076	33.9518
330106	1.7219	1.3001	41.4561	43.8210	46.3657	43.9257
330107	1.2616	1.2877	31.3888	34.9047	35.7384	34.0853
330108	1.1667	0.8416	22.2607	23.2919	23.9368	23.1807
330111	1.0707	0.9588	20.9387	20.3473	40.4349	24.2740
330115	1.1806	0.9950	23.3043	25.2373	23.8235	24.1488
330119	1.7980	1.3229	39.1114	39.0528	42.2901	40.1403
330125	1.7884	0.8918	26.7119	27.2920	28.0584	27.3748
330126	1.3165	1.3001	31.6370	35.2257	36.5689	35.2864
330127	1.3535	1.3229	44.6103	45.3680	45.2993	45.0871
330128	1.2254	1.3229	37.7166	39.5197	41.7790	39.6524
330132	1.1447	0.8540	17.4946	21.0479	21.7648	20.0521
330133	1.3564	1.3229	36.6962	39.3837	38.5228	38.1376
330135	1.1403	1.1624	29.0837	27.9132	32.0525	29.6962
330136	1.5167	0.9602	24.2010	25.8531	26.6680	25.5995
330140	1.8311	0.9950	25.7573	27.6183	29.3461	27.5931
330141	1.3221	1.2877	34.8902	39.4701	39.3741	38.0047
330144	1.0380	0.8416	20.9935	22.9561	23.3874	22.4515
330151	1.1204	0.8416	19.1841	21.7665	19.7959	20.1957
330152	1.2991	1.3229	36.5136	37.6721	38.2079	37.4707
330153	1.7292	0.8667	24.5219	26.4386	28.4446	26.4931
330154	1.7046	*	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
330157	1.3499	0.9602	25.2312	26.5686	27.1432	26.3138
330158	1.5286	1.3229	32.2990	38.2033	41.7010	37.3746
330159	1.3642	0.9950	28.9094	28.2774	31.7835	29.5880
330160	1.5280	1.3229	34.1960	36.6208	37.1915	36.0563
330162	1.2882	1.3229	32.1783	34.9460	37.6226	34.8806
330163	1.1295	0.9588	24.0200	27.1933	28.3910	26.5660
330164	1.4564	0.8918	28.8481	27.7217	27.8746	28.1414
330166	1.0847	0.8416	19.4360	20.4680	20.7121	20.1917
330167	1.7096	1.3001	34.4748	36.7653	39.1251	36.7245
330169	1.3878	1.3229	39.3361	45.3774	46.4939	43.5632
330171	***	*	30.0122	30.4005	35.1577	31.6504
330175	1.1111	0.8665	22.2067	23.8509	24.1005	23.3987
330177	0.9871	0.8416	19.6100	20.6338	22.9834	21.0962
330180	1.2276	0.8667	22.1920	24.3761	25.4170	23.9998
330181	1.2695	1.3001	38.5351	41.4104	43.0977	41.0544
330182	2.3153	1.3001	39.6038	40.9014	41.3033	40.6150
330184	1.4028	1.3229	34.4044	35.8102	39.0437	36.4620
330185	1.2774	1.2877	32.3466	36.3155	38.4002	35.8311
330188	1.2399	0.9588	23.9210	25.1153	27.5988	25.5243
330189	1.3891	0.8667	21.6229	22.3484	22.4383	22.1391
330191	1.2688	0.8667	24.0232	25.5656	26.4328	25.3769
330193	1.3142	1.3229	37.1807	39.9327	39.8910	39.0190
330194	1.7350	1.3229	43.9910	45.5639	46.8880	45.5320
330195	1.7167	1.3229	40.0206	39.7802	41.7885	40.5432
330196	1.2488	1.3229	33.2171	36.7178	38.2525	36.0781
330197	1.0612	0.8416	23.4290	26.8921	25.9872	25.4383
330198	1.3652	1.3001	30.5485	33.4930	34.8985	33.0524
330199	1.1995	1.3229	35.0059	38.6407	40.3948	37.9488
330201	1.5865	1.3229	39.3682	37.2064	42.6707	39.7180
330202	1.2534	1.3229	38.0129	37.4150	37.4158	37.6076
330203	1.4666	0.9950	26.5882	32.1207	34.0499	30.8856
330204	1.3463	1.3229	37.6849	39.6393	41.9953	39.7978
330205	1.1752	1.1624	32.1618	31.9510	33.9418	32.7294
330208	1.1543	1.3229	29.6282	32.1256	33.5287	31.7776
330209	***	*	29.7988	30.2038	*	30.0002
330211	1.1591	0.8416	22.9966	24.4470	25.8752	24.4788
330212	***	*	27.2232	*	*	27.2232
330213	1.1103	0.8416	22.5191	24.4049	27.4890	24.8466
330214	1.9072	1.3229	37.8500	41.8719	42.1339	40.5132

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
330215	1.3051	0.8774	22.6744	23.7361	23.9583	23.4620
330218	1.0747	0.9950	24.1106	26.9638	26.9982	26.0474
330219	1.7282	0.9588	29.3644	29.8889	32.5658	30.5817
330221	1.3569	1.3229	36.5539	39.2080	40.0514	38.6296
330222	1.2879	0.8667	23.9746	25.8507	27.7198	25.9137
330223	1.0006	0.8416	19.4229	23.3669	26.1264	22.8482
330224	1.3195	1.0762	25.7850	27.9231	29.1738	27.6678
330225	1.2331	1.3001	29.2719	32.3585	35.7651	32.4734
330226	1.3402	0.8918	21.8977	24.5646	24.8471	23.8237
330229	1.1912	0.8416	20.6095	21.9356	23.0577	21.8545
330230	1.0056	1.3229	33.3175	37.1298	38.6569	36.3376
330231	1.0910	1.3229	36.9619	40.6697	44.9422	40.8973
330232	1.1619	0.8667	24.4531	26.3313	27.4639	26.1069
330233	1.4122	1.3229	45.5132	47.3497	52.7070	48.3785
330234	2.3951	1.3229	40.6314	48.2306	49.3219	45.8241
330235	1.1932	0.9602	23.3866	27.7031	29.4346	26.7570
330236	1.5608	1.3229	35.6347	40.2386	42.8981	39.6841
330238	1.2617	0.8918	20.8639	21.7435	21.8386	21.4871
330239	1.2553	0.8416	21.5397	22.3854	23.1885	22.3782
330240	1.2125	1.3229	39.9450	43.5753	40.5001	41.3038
330241	1.8062	0.9950	29.0882	30.2304	32.7683	30.7645
330242	1.3309	1.3229	33.6926	37.4870	36.9015	35.9785
330245	1.8746	0.8774	22.8003	26.1811	27.4326	25.5154
330246	1.3355	1.2877	34.6329	37.1611	35.7416	35.8265
330247	0.8998	1.3229	32.2300	35.4980	39.0219	35.4575
330249	1.3506	0.9950	22.9834	25.3246	24.6091	24.2993
330250	1.3317	0.9584	25.1664	27.1606	29.0080	27.1471
330259	1.4233	1.3001	31.9152	35.1514	36.4788	34.5426
330261	1.2665	1.3229	30.7942	33.7834	40.2579	34.7049
330263	1.0274	0.8416	22.4675	23.8738	24.1333	23.5408
330264	1.2911	1.1624	30.0139	30.4701	31.0557	30.7362
330265	1.1847	0.8918	20.4635	21.6477	23.9081	21.9775
330267	1.3602	1.3229	31.5478	32.8541	34.9885	33.1377
330268	0.9185	0.8416	20.9720	25.3567	23.8793	23.3606
330270	2.0320	1.3229	42.2111	57.3596	55.2136	51.3968
330273	1.4013	1.3229	30.4720	37.0157	35.9298	34.5428
330276	1.1000	0.8445	22.2353	24.3300	26.0935	24.2204
330277	1.1770	0.9709	25.3582	26.4535	30.9053	27.3708
330279	1.5223	0.9588	25.2130	27.4539	29.6385	27.5185

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[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
330285	2.0056	0.8918	27.9018	30.1928	31.1235	29.7578
330286	1.3671	1.2877	33.3552	35.5895	37.6040	35.5541
330290	1.7307	1.3229	36.9981	39.4690	40.6933	39.0180
330304	1.3100	1.3229	34.5761	36.2845	37.3537	36.1514
330306	1.4163	1.3229	35.6640	36.3552	38.7713	36.9913
330307	1.3298	0.9709	27.5699	29.2529	29.5885	28.8558
330314	***	*	25.5597	26.2719	28.1788	26.6141
330316	1.2422	1.3229	34.8623	34.8567	37.1766	35.6163
330331	1.2558	1.3001	36.1630	39.8402	41.2694	39.1625
330332	1.2696	1.3001	33.3050	35.1646	37.0111	35.2121
330333	***	*	26.1917	*	*	26.1917
330338	***	*	31.3761	37.7497	*	34.6182
330339	0.7538	0.8667	22.6569	23.5786	24.3066	23.5064
330340	1.2556	1.2877	33.9358	37.9000	37.4161	36.3862
330350	1.4785	1.3229	36.6250	41.1339	44.4617	40.7608
330353	1.2406	1.3229	37.6549	45.9692	45.0977	43.0087
330354	2.1152	*	*	*	*	*
330357	1.2623	1.3229	35.5975	38.2286	40.3850	37.9060
330372	1.2748	1.3001	32.6721	36.1840	35.1297	34.7443
330385	1.1071	1.3229	46.3221	48.6175	49.0859	47.9732
330386	1.2175	1.1570	27.9943	29.9366	33.3216	30.4750
330389	1.7369	1.3229	34.7669	37.1862	39.6871	37.2049
330390	1.2347	1.3229	36.0573	36.3842	35.5562	35.9780
330393	1.7487	1.2877	34.8095	38.0619	39.2186	37.4063
330394	1.6374	0.9068	25.2229	27.3388	28.4597	27.0157
330395	1.4395	1.3229	37.3096	36.3921	37.5791	37.0864
330396	1.5369	1.3229	35.0297	37.4998	39.4904	37.3259
330397	1.4390	1.3229	38.4741	37.5682	41.4448	39.1440
330399	1.0823	1.3229	32.3688	34.7394	36.7626	34.6081
330401	1.3638	1.2877	40.6249	37.8559	40.4485	39.6496
330403	0.9812	0.8918	23.1886	25.5163	25.2937	24.6332
330404	0.8616	1.3229	*	*	*	*
330405	0.8688	1.3229	*	*	*	*
330406	0.8696	0.8667	*	*	*	*
340001	1.5135	0.9505	25.0041	28.3988	29.5709	27.7170
340002	1.8226	0.9201	27.3349	28.4860	29.6622	28.5097
340003	1.1864	0.8603	23.3066	24.1602	26.0888	24.5124
340004	1.4204	0.9078	25.4474	26.6404	27.5283	26.5365
340005	0.9877	*	22.3814	*	*	22.3814

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
340008	1.1890	0.9342	26.6314	26.7443	27.7206	27.0545
340010	1.3717	0.9474	24.5666	27.2105	28.7544	26.8571
340011	1.1392	0.8603	19.9484	19.7441	22.0047	20.5590
340012	1.2501	0.8603	22.7189	23.2288	24.7576	23.5973
340013	1.2482	0.9342	23.0261	23.9492	26.3607	24.4161
340014	1.5499	0.9078	25.1872	27.4888	27.8384	26.8919
340015	1.3635	0.9342	26.2276	28.0585	28.3928	27.5641
340016	1.2882	0.8603	23.0359	25.6454	27.2365	25.3118
340017	1.3185	0.9201	23.8229	25.7780	27.5672	25.7234
340018	***	*	23.7243	*	*	23.7243
340020	1.2026	0.8759	23.7995	26.4465	27.5473	25.9059
340021	1.3011	0.9342	26.0995	29.4864	29.3835	28.3680
340023	1.3623	0.9403	24.4896	26.4225	26.2716	25.7465
340024	1.1034	0.8780	22.2522	23.6638	26.4001	24.1341
340025	1.3306	0.9201	21.2276	23.5881	24.0101	22.9999
340027	1.1603	0.9267	23.6326	25.5973	26.3840	25.2711
340028	1.5229	0.9917	26.3298	28.0323	30.7591	28.3770
340030	2.0915	0.9738	29.0122	29.6630	30.4591	29.7351
340032	1.4483	0.9505	26.7475	26.5958	28.7636	27.4150
340035	1.0908	0.8603	23.5476	23.9669	24.6262	24.0395
340036	1.3746	0.9663	25.2077	27.2691	27.3860	26.6516
340037	1.1084	0.8765	21.6411	25.6262	29.0618	25.6372
340038	1.2390	0.8856	14.0713	22.4829	24.2111	19.1097
340039	1.2793	0.9342	27.1275	27.4457	27.8228	27.4762
340040	1.9853	0.9267	26.3325	27.6626	28.7434	27.6121
340041	1.1974	0.8972	23.6600	24.3595	26.8314	25.0117
340042	1.2701	0.8603	23.0236	25.0110	25.6349	24.5586
340045	***	*	23.1918	*	*	23.1918
340047	1.8409	0.9078	25.0605	27.4022	28.4968	27.0295
340049	1.8539	0.9738	30.4827	30.6791	29.6826	30.2360
340050	1.1118	0.9593	24.2533	26.0365	27.5274	25.9407
340051	1.2249	0.8814	23.4091	23.9612	24.4561	23.9489
340053	1.4951	0.9505	27.7261	27.8577	28.9355	28.1746
340055	1.2468	0.8972	24.1057	26.0647	26.5752	25.5723
340060	1.1417	0.9106	22.8657	22.9097	25.1791	23.6619
340061	1.8143	0.9738	27.5594	27.0089	29.8574	28.1792
340064	1.0718	0.8603	22.9143	23.4233	23.9701	23.4394
340068	1.2500	0.9156	21.8830	22.6814	23.6757	22.7411
340069	1.8788	0.9738	27.4473	29.3439	31.4951	29.4988

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
340070	1.2881	0.9106	24.9033	25.3226	26.6546	25.6458
340071	1.0900	0.9474	25.4537	26.3921	27.9748	26.6157
340072	1.2076	0.8603	23.1163	25.2493	24.1350	24.1644
340073	1.5996	0.9738	30.2061	30.9849	31.6803	30.9681
340075	1.2344	0.8972	26.0226	25.1551	25.1438	25.4402
340084	1.1981	0.9505	21.2580	21.1363	23.1300	21.8526
340085	1.1465	0.9106	23.9793	26.5164	27.9572	26.0805
340087	1.2855	0.8603	22.0070	22.4287	25.4730	23.2835
340090	1.3673	0.9663	23.4541	26.4031	26.7428	25.6227
340091	1.5783	0.9078	25.8266	27.1285	28.8044	27.3003
340096	1.2025	0.9106	25.2169	24.9036	26.5438	25.5729
340097	1.2782	0.8603	24.2127	26.2228	29.8005	26.6208
340098	1.4555	0.9505	27.3308	28.2493	29.7180	28.4477
340099	1.3045	0.8603	20.3683	21.8564	23.9702	22.0907
340104	0.9032	0.8765	15.7521	16.1204	17.0165	16.3439
340106	1.1098	0.8603	22.4894	26.0892	26.1340	24.8429
340107	1.2251	0.9007	22.9698	24.1762	26.5626	24.5944
340109	1.2621	0.8777	23.4419	25.4464	26.6383	25.1802
340113	1.9376	0.9505	28.2568	28.5587	30.3841	29.0850
340114	1.5717	0.9738	26.6813	28.3222	28.1311	27.7304
340115	1.6237	0.9738	25.0212	26.7592	27.2781	26.3719
340116	1.7673	0.8972	25.3213	27.5881	29.3698	27.4192
340119	1.3174	0.9505	24.2287	25.6226	29.4470	26.4336
340120	1.0111	0.8603	23.0915	25.9134	25.5399	24.8578
340121	1.1158	0.9325	21.7576	23.1343	23.8854	22.9469
340123	1.3425	0.9106	26.1083	26.0637	28.5669	26.9166
340124	1.0382	0.9474	20.8018	22.2988	23.5480	22.2128
340126	1.2869	0.9474	25.0189	26.9866	28.2247	26.7666
340127	1.1535	0.9738	25.7831	26.4746	28.2161	26.8349
340129	1.2620	0.9342	25.4902	25.7976	26.7606	26.0415
340130	1.3501	0.9505	25.2941	26.1717	28.1594	26.5940
340131	1.5008	0.9267	27.9358	27.4750	28.8542	28.1014
340132	1.1997	0.8603	21.3521	23.5856	24.6162	23.2107
340133	1.0172	0.8911	22.5558	23.4678	24.8579	23.5985
340137	***	*	21.0642	22.1741	28.9672	23.0834
340138	0.8513	0.9738	21.3670	*	*	21.3670
340141	1.6608	0.9325	27.3355	29.3878	29.3171	28.6965
340142	1.1641	0.8603	22.9907	26.6886	27.7555	25.9008
340143	1.5125	0.8972	25.3633	28.0082	27.9777	27.1349

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
340144	1.2444	0.9342	27.2686	26.1865	27.0150	26.8087
340145	1.1836	0.9342	23.7131	25.8459	26.7482	25.4578
340147	1.2997	0.9474	25.4534	26.9162	28.2626	26.9073
340148	1.4008	0.9078	23.5880	25.3660	25.8325	24.9278
340151	1.1655	0.8655	22.0052	22.7736	23.2158	22.6707
340153	1.8783	0.9505	26.4896	27.6509	28.5979	27.6012
340155	1.4288	0.9738	30.4940	30.3443	30.9501	30.6075
340156	0.8520	1.4400	*	*	*	*
340158	1.1142	0.9325	26.4849	27.7816	27.6526	27.2851
340159	1.2295	0.9738	23.2991	24.2588	25.3108	24.3176
340160	1.3379	0.8603	20.7525	21.7923	23.4631	22.0123
340166	1.2893	0.9505	26.0558	27.1132	28.5395	27.2674
340168	0.3793	0.9325	17.3249	*	*	17.3249
340171	1.1727	0.9505	28.2734	27.8539	27.4701	27.8495
340173	1.2942	0.9738	27.5072	28.3502	30.2815	28.7937
340177	1.0970	*	24.7471	26.7155	*	25.7127
340178	***	*	28.7218	*	*	28.7218
340179	***	*	*	34.1895	*	34.1895
340182	***	*	*	27.8071	*	27.8071
340183	1.0758	0.9505	*	*	*	*
350002	1.8100	0.7311	22.0283	22.4307	23.5869	22.7218
350003	1.1839	0.7311	21.8061	23.9639	24.9975	23.6038
350006	1.5595	0.7311	19.4985	21.2726	22.4626	21.0496
350009	1.1330	0.7943	23.0873	23.8681	24.5737	23.8529
350010	0.9689	0.7309	19.1964	20.1290	20.4198	19.9342
350011	1.9811	0.7943	23.1947	23.8400	24.1135	23.7260
350014	0.9073	0.7309	17.7565	19.1684	17.5837	18.1607
350015	1.6836	0.7311	20.1161	20.9046	21.3342	20.8695
350017	1.2734	0.7309	21.0243	22.4359	21.6187	21.6699
350019	1.6836	0.8048	22.1960	23.2018	24.9615	23.5379
350030	0.9632	0.7309	18.9978	20.2722	22.5976	20.6218
350061	1.4521	*	22.0515	*	*	22.0515
350063	0.8917	1.4400	*	*	*	*
350070	1.8140	0.7943	25.2836	25.2365	26.2454	25.5903
360001	1.4384	0.9661	23.9101	25.8669	28.8623	26.1633
360002	1.2621	0.8838	24.5789	24.5155	25.4859	24.8654
360003	1.7764	0.9661	27.5029	28.9672	30.7812	29.0939
360006	1.8868	1.0024	28.1698	30.1363	30.9806	29.7940
360008	1.3246	0.8724	24.5714	26.2632	27.5683	26.1309

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
360009	1.6060	0.9307	23.1012	25.0007	27.0618	25.0993
360010	1.2245	0.8806	23.1178	23.7825	24.7352	23.9121
360011	1.2621	0.9820	25.5340	27.6036	31.5587	28.1839
360012	1.3982	1.0024	27.5470	30.1416	31.0526	29.6656
360013	1.0958	0.9307	26.8130	27.0893	29.8412	27.9268
360014	1.1327	0.9820	25.3861	27.1017	27.0743	26.5482
360016	1.4372	0.9661	26.1283	27.8031	29.6298	27.8544
360017	1.7047	1.0024	27.2910	29.8525	31.7081	29.6406
360019	1.3006	0.9215	25.5926	26.9178	27.2997	26.6163
360020	1.6208	0.9215	24.4343	23.6400	25.6328	24.5734
360024	***	*	23.5793	*	*	23.5793
360025	1.4534	0.9268	25.5633	27.4533	27.1546	26.7668
360026	1.3232	0.9278	23.5898	25.5379	25.2945	24.8038
360027	1.6134	0.9215	25.4894	27.4454	28.2923	27.0621
360029	1.0868	0.9268	22.7785	24.3216	26.4208	24.5306
360032	1.2095	0.8696	23.2638	25.0034	25.9916	24.7563
360035	1.7331	1.0024	27.5220	30.0172	31.3181	29.6743
360036	1.2087	0.9215	27.6094	27.8343	29.3514	28.2918
360037	1.4271	0.9345	24.3982	29.0046	30.0446	27.6736
360038	1.5417	0.9661	22.8009	25.4274	31.0611	26.3008
360039	1.4955	0.9820	24.0218	23.9783	24.7873	24.2790
360040	1.1430	0.9083	24.0942	24.8569	25.5337	24.8329
360041	1.4959	0.9345	24.1080	26.1522	26.6755	25.6870
360044	1.1369	0.8823	21.8411	21.5619	24.3840	22.5769
360046	1.2023	0.9661	25.0775	25.4673	26.2417	25.5994
360047	1.0860	*	21.7248	*	*	21.7248
360048	1.7561	0.9268	28.8107	29.3415	29.4378	29.2064
360049	***	*	25.8367	26.2222	*	26.0185
360051	1.7003	0.9278	25.7556	26.8501	28.1167	26.9164
360052	1.6091	0.9278	24.5405	26.2066	26.8806	25.8864
360054	1.3924	0.8724	23.0376	22.9359	24.8248	23.5845
360055	1.4142	0.8991	26.3112	27.3941	30.0143	27.8971
360056	1.6185	0.9661	23.1024	26.5318	30.3677	26.6371
360058	1.0590	0.8696	23.4429	23.8119	24.5003	23.9275
360059	1.5014	0.9345	25.3516	29.3624	30.6173	28.4902
360062	1.4838	1.0024	28.6518	31.7422	32.8893	31.2563
360064	1.5933	0.8991	22.2393	25.2336	27.7795	24.9763
360065	1.2190	0.9268	26.3036	28.0405	29.7155	28.0324
360066	1.5166	0.9307	27.3362	27.1436	29.7605	28.0751

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
360068	1.8866	0.9268	25.8414	26.2065	26.6933	26.2583
360069	1.2464	*	24.2444	*	*	24.2444
360070	1.6587	0.8917	24.8863	27.2389	27.8891	26.6577
360071	1.1157	0.8731	22.0786	23.4619	26.4081	23.9600
360072	1.5232	1.0024	24.4332	25.9589	27.2286	25.9259
360074	1.3002	0.9268	24.9055	25.8959	27.5328	26.1112
360075	1.1472	0.9345	26.8453	26.8925	26.1657	26.5905
360076	1.4890	0.9661	25.9369	28.1013	29.0148	27.7077
360077	1.5236	0.9345	25.6505	28.4449	28.0133	27.3825
360078	1.2784	0.9215	26.1313	25.7885	27.4689	26.4454
360079	1.7865	0.9661	26.0935	27.2437	30.1230	27.8340
360080	1.1302	0.8696	20.8309	21.4526	22.7020	21.7298
360081	1.3518	0.9268	27.5695	29.8366	29.5312	28.9628
360082	1.3503	0.9345	27.1197	29.2561	28.7925	28.4298
360084	1.6077	0.8917	25.8415	27.3917	28.5402	27.2566
360085	2.0267	1.0024	29.0081	31.5800	32.8502	31.2560
360086	1.6601	0.9278	22.1859	25.4218	27.3124	24.9575
360087	1.2859	0.9345	25.4040	29.6579	28.4185	27.8522
360089	1.1454	0.8696	22.7951	25.3465	25.5608	24.5874
360090	1.5834	0.9268	26.7717	29.0199	30.7530	28.8616
360091	1.3288	0.9345	27.5067	25.8657	27.6809	27.0164
360092	1.2652	1.0024	25.6618	25.4954	25.4055	25.5165
360094	***	*	26.6348	*	*	26.6348
360095	1.4011	0.9268	26.1275	26.4635	29.3787	27.2944
360096	1.0887	0.8697	24.6317	25.9275	26.8653	25.8210
360098	1.3625	0.9345	24.8447	25.5973	26.6382	25.7210
360100	1.1996	0.8917	23.0561	25.4523	23.6167	24.0350
360101	1.3614	0.9345	26.6209	27.6030	29.7817	28.0282
360106	***	*	24.1588	*	*	24.1588
360107	1.1208	0.9268	25.9697	24.6095	26.0534	25.5448
360109	1.0704	0.8696	25.4184	26.3131	30.1382	27.2363
360112	1.9950	0.9268	28.6784	30.5715	31.1356	30.1179
360113	1.3132	0.9661	25.6493	26.6556	30.2871	27.4975
360115	1.2830	0.9345	24.0052	25.9841	26.1821	25.4599
360116	1.1956	0.9661	18.0655	25.1717	26.4968	23.3911
360118	1.5295	0.9209	27.7289	27.3884	28.5643	27.8933
360121	1.3608	0.9268	24.5593	27.4442	28.3835	26.7824
360123	1.4120	0.9345	22.6523	27.1920	28.0334	25.8336
360125	1.1989	0.8696	22.1096	24.1388	25.9067	23.9904

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
360128	***	*	21.0067	*	*	21.0067
360130	1.4726	0.9345	22.9762	25.6570	26.3986	25.2275
360131	1.3046	0.8917	24.0496	25.3719	26.6635	25.3529
360132	1.3628	0.9661	25.9453	27.7724	29.4070	27.6756
360133	1.6044	0.9278	24.6208	29.8684	31.7521	28.7271
360134	1.7956	0.9661	29.2974	27.7339	28.5141	28.4865
360137	1.7456	0.9345	26.9522	26.1250	27.6894	26.9256
360141	1.6591	0.8991	27.7085	29.7937	31.1778	29.5401
360142	1.0665	*	22.1610	*	*	22.1610
360143	1.2889	0.9345	24.6306	28.3057	26.9394	26.6732
360144	1.3635	0.9345	25.7079	28.2473	28.9177	27.6781
360145	1.6717	0.9345	25.8268	27.1908	28.1835	27.1041
360147	1.2487	0.8696	24.1953	25.5854	27.5548	25.7876
360148	1.0887	0.8696	26.1947	26.0837	26.3399	26.2104
360150	1.2305	0.9215	24.7667	25.1217	28.2561	26.0004
360151	1.6215	0.8917	24.8629	25.3780	26.5636	25.6137
360152	1.5002	1.0024	27.9147	29.9425	31.5377	29.7875
360153	0.9761	0.8696	19.0226	19.8499	20.2147	19.7391
360155	1.4482	0.9345	25.3909	26.9127	28.9521	27.1128
360156	1.1513	0.8815	24.0509	24.3281	25.0833	24.5012
360159	1.2600	0.9820	33.1613	29.1529	28.6174	30.0448
360161	1.3687	0.8991	24.3792	25.4433	27.0875	25.6058
360163	1.9109	0.9661	26.9728	28.9742	30.0724	28.6652
360170	1.3064	1.0024	24.3620	28.5474	29.5954	27.6590
360172	1.3789	0.9345	26.3501	27.5669	28.8283	27.5900
360174	1.2823	0.9278	24.9990	26.8586	28.3143	26.7384
360175	1.2416	0.9820	26.5949	28.1531	28.3054	27.6959
360177	1.1565	*	24.4712	*	*	24.4712
360179	1.5935	0.9661	28.8645	30.0311	29.8299	29.5974
360180	2.2518	0.9345	26.1514	29.6633	31.4342	29.1126
360185	1.1985	0.8697	23.7173	25.6800	26.1080	25.1949
360187	1.5390	0.9278	24.8173	24.9353	25.7600	25.1883
360189	1.1090	1.0024	24.2136	26.3756	27.5097	26.0254
360192	1.2911	0.9345	26.7577	26.4616	27.5991	26.9459
360195	1.0872	0.9345	26.1281	25.0922	27.6155	26.2467
360197	1.1402	0.9820	27.0896	28.7580	28.9207	28.2672
360203	1.2426	0.8696	22.1414	24.4433	25.3692	24.0014
360210	1.1670	1.0024	27.8415	28.2976	29.6476	28.6031
360211	1.5603	0.8696	22.5449	25.7053	26.5459	24.7616

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
360212	1.3242	0.9345	25.2756	25.6080	26.6976	25.8756
360218	1.1993	1.0024	27.4288	29.8662	30.0101	29.0792
360230	1.5553	0.9345	27.0223	28.8018	30.0661	28.6838
360234	1.3345	0.9661	24.3625	25.9360	31.0656	27.0903
360236	1.2595	0.9661	35.8143	25.6728	29.5321	29.3317
360239	1.3150	0.9278	25.2474	27.2939	30.7728	27.7368
360241	***	*	24.7001	23.0662	25.7290	24.4912
360242	1.8984	*	*	*	*	*
360245	0.5514	0.9215	19.1884	20.6504	20.3426	20.0855
360247	0.3793	1.0024	19.8891	19.3677	*	19.6148
360253	2.4475	0.9661	30.4276	33.2371	34.3347	32.7151
360259	1.2997	0.9268	25.1338	25.9878	27.2902	26.1980
360260	***	*	27.3903	*	*	27.3903
360261	1.3966	0.8878	22.5431	22.3614	25.6332	23.5172
360262	1.3198	0.9268	27.1680	28.6995	30.1559	28.7640
360263	1.8173	0.9307	20.8884	25.1652	25.4864	23.9919
360264	***	*	*	36.0754	*	36.0754
360265	***	*	*	36.6265	*	36.6265
360266	2.1283	1.0024	*	*	31.7565	31.7565
360267	***	*	*	*	34.0936	34.0936
360268	***	*	*	*	34.0526	34.0526
360269	1.7379	0.9661	*	*	24.8552	24.8552
360270	1.1031	0.8696	*	*	*	*
360271	1.4810	0.9661	*	*	*	*
360273	1.6114	0.8696	*	*	*	*
370001	1.6338	0.8498	27.7245	26.0194	26.8884	26.8557
370002	1.2199	0.7701	20.1479	22.0476	23.6886	21.9874
370004	1.1264	0.8966	25.3919	26.7434	26.8521	26.3099
370006	1.2636	0.8498	20.1063	22.4802	23.9935	22.1050
370007	1.0754	0.7701	17.6547	19.4036	20.3706	19.1471
370008	1.4650	0.8754	24.2978	25.3352	26.6563	25.4723
370011	0.9793	0.8754	19.7821	21.9649	22.3391	21.3305
370013	1.5642	0.8754	24.9294	26.5364	27.2667	26.2291
370014	1.0076	0.8530	25.3576	25.9393	26.4488	25.9310
370015	1.0126	0.8498	23.6694	24.7547	25.5815	24.6941
370016	1.6363	0.8754	25.4062	26.7938	29.8284	27.2551
370018	1.5056	0.8498	23.5336	25.3573	24.6868	24.5173
370019	1.2501	0.7701	21.4474	22.0221	25.2814	22.9584
370020	1.3498	0.7701	18.5046	20.8723	22.7566	20.7450

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
370022	1.2123	0.8070	19.6495	24.6099	22.2289	22.0698
370023	1.3515	0.7791	21.5762	23.5170	24.0376	23.0619
370025	1.2921	0.8498	23.5659	23.9873	24.5547	24.0384
370026	1.4287	0.8754	23.0848	25.8428	25.5172	24.8223
370028	1.8823	0.8754	26.6153	27.8621	28.5619	27.6912
370029	1.1357	0.7701	23.9956	26.8508	28.5309	26.4597
370030	1.0197	0.7701	23.3037	24.1483	25.8212	24.4359
370032	1.4561	0.8754	23.4843	24.8626	26.2642	24.8567
370034	1.2239	0.7701	18.2341	19.5099	20.4106	19.4059
370036	1.1140	0.7701	17.7575	19.2318	19.8162	18.9477
370037	1.6244	0.8754	23.9685	24.9553	25.2350	24.7549
370039	1.0453	0.8498	21.8220	23.0254	23.5745	22.8102
370040	0.9665	0.8052	22.4048	22.8356	26.7395	23.9163
370041	0.8802	0.8498	22.3496	22.6731	22.9834	22.6703
370047	1.3852	0.8754	20.4657	24.1991	24.4766	23.0667
370048	1.0400	0.7701	19.2464	21.4543	22.0627	20.9190
370049	1.3123	0.8754	23.2171	23.8844	22.8755	23.3164
370051	1.0605	0.7701	17.2618	19.8329	19.3222	18.8243
370054	1.2315	0.7701	21.5044	22.4652	25.2142	22.9829
370056	1.8623	0.8405	22.0312	24.3986	25.5453	23.9751
370057	0.9775	0.8498	19.7284	19.8683	22.1337	20.5343
370060	0.9969	0.8498	18.7592	19.9025	23.3858	20.5027
370064	0.8912	*	14.2053	*	*	14.2053
370065	1.0064	0.7797	20.0227	21.2343	23.5815	21.6452
370072	0.8046	0.7959	9.9615	11.7942	13.0963	11.6675
370078	1.5643	0.8498	25.4068	27.8611	26.6972	26.6522
370080	0.8711	0.7701	18.0665	19.9595	22.4113	20.0969
370083	0.8983	0.7752	16.8836	19.2568	20.9878	18.9428
370084	1.0004	0.7701	16.6513	19.6230	20.7326	19.1537
370089	1.3096	0.7701	20.4699	20.6153	22.1523	21.0638
370091	1.5772	0.8498	23.3357	24.1438	25.8697	24.4379
370093	1.6183	0.8754	26.9774	26.0459	27.5356	26.8504
370094	1.4254	0.8754	23.1191	24.5555	26.5265	24.7232
370097	1.3201	0.8405	22.3267	26.3168	26.8138	25.2293
370099	1.0702	0.7701	20.5075	24.9971	26.7206	23.9187
370100	0.9272	0.7801	14.7711	17.9732	19.4002	17.4574
370103	1.0057	0.7701	17.8018	18.8933	19.4273	18.7246
370105	1.9411	0.8754	23.8978	26.7973	26.6399	25.9002
370106	1.4001	0.8754	26.5867	27.8979	28.5957	27.7400

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
370112	0.9493	0.8052	15.4471	16.0592	16.7888	16.1378
370113	1.1439	0.8714	25.3565	26.9720	26.4608	26.2282
370114	1.5812	0.8498	21.7880	23.0006	25.9841	23.5722
370123	***	*	25.4733	*	*	25.4733
370125	***	*	17.1361	*	*	17.1361
370138	1.0409	0.7701	18.3113	20.2528	22.1675	20.1246
370139	0.9462	0.7701	18.5226	19.4287	20.5156	19.5063
370148	1.5466	0.8754	25.2348	27.0904	28.1933	26.9006
370149	1.2410	0.8754	22.3537	23.3493	23.3423	23.0330
370153	1.1460	0.7701	19.8349	23.2778	24.1667	22.4460
370156	1.0006	0.7822	19.4743	25.2562	23.0104	22.5304
370158	0.9453	0.8754	18.5578	20.7641	21.5228	20.2578
370166	0.8431	0.8498	23.1682	25.1107	24.7251	24.3434
370169	0.8651	0.7864	15.8002	16.8252	16.6752	16.4258
370170	0.9138	1.4400	*	*	*	*
370171	0.8794	1.4400	*	*	*	*
370172	0.8574	1.4658	*	*	*	*
370173	0.9221	1.4400	*	*	*	*
370174	0.7942	1.4400	*	*	*	*
370176	1.2163	0.8498	25.0509	24.7655	24.9650	24.9272
370177	***	*	14.7193	*	*	14.7193
370178	0.8848	0.7701	14.6070	16.0179	16.0747	15.5714
370179	0.8038	*	23.5794	*	*	23.5794
370180	1.0048	1.4400	*	*	*	*
370183	0.9349	0.8498	21.8147	24.7103	23.8419	23.4256
370190	1.4244	0.8498	33.1137	29.1568	34.6942	32.5212
370192	1.9787	0.8754	31.4930	27.6367	19.0638	24.5971
370196	***	*	22.6824	22.3498	20.8296	21.9384
370199	0.7713	0.8754	26.0450	23.3989	23.7412	24.3357
370200	1.0462	0.7701	17.6317	20.5175	21.7153	19.8071
370201	1.6809	0.8754	23.3550	23.8090	24.2364	23.7986
370202	1.4316	0.8498	25.1181	26.1132	25.7966	25.6803
370203	2.0618	0.8754	23.5190	22.8869	25.7770	24.0068
370206	1.5795	0.8754	26.0912	26.0353	27.5752	26.5860
370210	2.1527	0.8498	21.2682	23.3786	27.2111	23.9630
370211	1.0812	0.8754	26.5345	27.8737	28.6537	27.7381
370212	1.7251	0.8754	21.0758	19.1720	20.3495	20.1565
370213	***	*	29.3777	*	*	29.3777
370214	0.9301	0.7822	*	20.6217	21.0732	20.8619

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
370215	2.4407	0.8754	32.3589	31.5652	32.4087	32.1115
370216	2.0115	0.8498	*	27.2429	25.8260	26.4854
370217	***	*	*	26.8677	*	26.8677
370218	2.3278	0.8498	*	*	30.3445	30.3445
370220	1.9660	0.8754	*	*	*	*
370222	1.8271	0.8754	*	*	*	*
370223	0.8903	0.8754	*	*	*	*
370224	1.0183	0.8754	*	*	*	*
370225	1.6928	0.8754	*	*	*	*
380001	1.3077	1.1226	30.0103	29.5842	32.0770	30.5857
380002	1.2470	0.9957	27.1861	30.3385	31.5246	29.7051
380004	1.7238	1.1226	30.5172	32.6901	34.5432	32.6120
380005	1.4137	1.0297	30.2210	30.9087	33.2849	31.5054
380007	2.0505	1.1226	33.9969	33.9601	35.1697	34.3879
380008	***	*	25.8356	*	*	25.8356
380009	2.0476	1.1226	31.7042	32.4016	34.5635	32.8913
380010	***	*	30.2957	34.4208	*	32.1520
380014	1.9251	1.0701	29.9648	33.6078	33.1928	32.2201
380017	1.8286	1.1226	32.2447	34.2605	35.3734	33.9502
380018	1.9115	1.0297	28.0701	30.9923	31.8181	30.3581
380020	1.4164	1.1002	28.3563	29.6053	34.6183	30.5329
380021	1.4801	1.1226	29.3295	29.2164	32.6142	30.3295
380022	1.3408	1.0315	29.2642	30.1742	29.6224	29.6961
380023	1.1613	*	26.5439	*	*	26.5439
380025	1.2143	1.1226	33.2105	35.5084	36.4910	35.1206
380027	1.2897	1.0707	25.5161	26.4982	28.0247	26.6752
380029	1.2690	1.0472	26.9967	28.7994	29.4461	28.4964
380033	1.7458	1.1002	30.8767	33.4828	34.0094	32.8334
380037	1.3197	1.1226	30.5818	32.4033	32.7922	31.9693
380038	1.3171	1.1226	34.2303	34.5971	35.1105	34.6431
380039	***	*	32.3959	38.0989	*	34.9720
380040	1.4156	0.9957	32.0103	31.2286	32.9081	32.0782
380047	1.8756	1.0586	29.8627	31.0584	32.8188	31.2891
380050	1.4599	1.0146	25.6190	27.1814	29.7329	27.5476
380051	1.6409	1.0472	29.7219	30.8891	32.8545	31.1841
380052	1.2947	0.9957	24.9476	25.6085	28.6119	26.2866
380056	1.1310	1.0472	25.1475	27.7253	29.1686	27.4847
380060	1.4620	1.1226	30.7041	32.0101	33.8863	32.2260
380061	1.6742	1.1226	29.8217	32.3699	34.5230	32.2744

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
380071	1.3152	1.1226	30.2304	31.7761	31.0901	31.0382
380075	1.3436	1.0297	29.0368	33.8962	31.6884	31.4882
380081	0.6765	*	21.8850	26.8149	*	24.3121
380082	1.2709	1.1226	32.3002	35.6708	35.7821	34.6175
380089	1.3136	1.1226	33.4214	34.6015	35.4850	34.5152
380090	1.3036	1.0707	34.4536	33.0990	35.5535	34.3715
380091	1.3645	1.1226	33.8950	39.9703	40.5066	38.1384
380100	1.6492	1.1226	*	*	*	*
390001	1.5887	0.8357	22.5309	23.6075	24.3251	23.4964
390002	1.2797	0.8390	22.4388	24.7867	25.0860	24.1310
390003	1.1981	0.8357	21.6477	23.3672	24.5099	23.1723
390004	1.5748	0.9230	24.3249	24.4068	25.2424	24.6844
390006	1.9216	0.9115	25.1216	26.8581	28.6926	26.9694
390008	1.1363	0.8413	22.2680	22.8042	22.6297	22.5689
390009	1.8142	0.8503	25.5482	26.7462	26.7234	26.3594
390010	1.1864	0.8390	23.5390	24.5785	24.8196	24.2873
390011	***	*	21.9279	21.4856	20.2291	21.2244
390012	1.2256	1.0892	28.5076	30.7542	32.4856	30.5696
390013	1.3344	0.9115	24.0044	25.0037	26.2323	25.0976
390016	1.2396	0.8697	21.9549	23.2095	24.3488	23.2187
390019	1.1020	1.0003	23.4636	24.0538	25.7515	24.3571
390022	***	*	29.0710	30.3565	29.6308	29.6956
390023	1.2512	1.0892	31.7149	35.4452	34.7787	34.0489
390024	1.0192	1.0892	35.3960	33.5186	38.8750	35.7342
390025	0.4708	1.0892	17.2977	19.1362	20.3878	18.9809
390026	1.2143	1.0892	29.5157	31.8512	31.8309	31.0660
390027	1.7300	1.0892	35.8381	35.5692	39.2158	36.9328
390028	1.6327	0.8390	25.7246	27.1869	27.1451	26.6794
390030	1.1561	1.0003	22.1581	23.6063	24.6343	23.4873
390031	1.2251	0.9413	22.6828	26.2654	27.2033	25.3410
390032	1.2846	0.8390	22.7205	23.9466	24.5243	23.7229
390035	1.1521	1.0892	26.2647	28.4564	29.5417	28.1290
390036	1.4349	0.8390	24.6032	21.6358	24.4917	23.5130
390037	1.4058	0.8390	24.7820	25.4290	25.2296	25.1464
390039	1.1400	0.8357	20.3787	22.0208	23.2300	21.8622
390041	1.2825	0.8390	21.5925	22.9814	24.2257	22.9573
390042	1.3541	0.8390	25.6328	28.3633	28.0996	27.3605
390043	1.2010	0.8357	22.2549	23.2378	24.2087	23.2256
390044	1.6735	1.0765	27.1505	28.7758	29.4057	28.4751

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
390045	1.5824	0.8357	23.0712	23.9343	24.6495	23.8980
390046	1.6539	0.9650	27.2630	29.6574	30.5115	29.1858
390048	1.0779	0.9115	24.9759	28.5342	28.3152	27.3378
390049	1.5927	1.0003	27.1366	29.6121	30.7431	29.2428
390050	2.0709	0.8390	26.6931	27.2599	27.3481	27.1028
390052	1.1795	0.8401	23.3474	24.9510	25.1462	24.4784
390054	***	*	22.8087	24.4435	27.4805	24.7389
390055	***	*	25.6945	*	*	25.6945
390056	1.0637	0.8357	19.5537	23.5077	23.5821	22.1218
390057	1.3198	1.0892	27.9583	29.7982	30.9198	29.6016
390058	1.3192	0.9230	27.4799	26.9546	27.7296	27.3846
390061	1.4184	0.9650	28.4538	29.1318	30.0597	29.1859
390062	1.1289	0.8357	21.4051	21.2999	21.0713	21.2584
390063	1.8024	0.8503	24.7614	26.4998	26.8381	26.0655
390065	1.2588	1.0030	25.2188	27.6249	29.5654	27.4345
390066	1.4275	0.9115	24.2087	25.9645	25.4407	25.2125
390067	1.8076	0.9230	26.3287	29.7234	30.6128	28.8546
390068	1.3348	0.9650	25.8291	26.7358	29.0962	27.1397
390070	1.4189	1.0892	30.9500	33.3185	34.4935	32.9335
390071	1.0314	0.8357	21.8367	24.6462	24.8467	23.7238
390072	1.0757	0.8357	24.9389	25.3029	26.2568	25.5026
390073	1.7402	0.8357	26.3698	25.7822	26.4083	26.2016
390074	***	*	22.8545	23.6500	25.4098	23.9494
390075	***	*	24.6359	*	*	24.6359
390076	1.3948	1.0892	27.9004	31.8500	32.7671	30.8676
390079	1.8369	0.8775	23.3053	22.5607	24.4452	23.4348
390080	1.3297	1.0892	27.2616	28.7063	29.2645	28.4490
390081	1.2608	1.0892	30.3840	31.7569	33.6247	31.9442
390084	1.0972	0.8357	19.8606	23.2039	24.3372	22.4576
390086	1.6555	0.8357	22.5317	23.5141	25.0992	23.7478
390090	1.9867	0.8390	25.2014	27.3528	27.0122	26.5229
390091	1.1445	0.8697	21.5586	21.7010	23.3562	22.1985
390093	1.1573	0.8390	21.4401	22.6082	22.6023	22.2276
390095	1.1958	0.8357	23.6240	22.6150	24.6290	23.6292
390096	1.5985	1.0765	27.0763	28.8258	28.6055	28.1718
390097	1.2460	1.0892	25.6660	26.1741	27.9858	26.5902
390100	1.7084	0.9650	27.7208	30.0132	30.0234	29.3208
390101	1.2968	0.9425	21.9418	23.1497	24.8377	23.3533
390102	1.4439	0.8390	24.8898	24.8369	24.4589	24.7141

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
390103	0.8439	0.8390	20.6775	20.5741	20.4446	20.5656
390104	1.0867	0.8357	19.6428	19.2326	19.6630	19.5084
390107	1.5235	0.8390	24.1386	24.1159	24.6565	24.3172
390108	1.2286	1.0892	27.2661	27.8171	28.5928	27.9029
390109	1.1558	*	19.9156	*	*	19.9156
390110	1.6017	0.8390	23.9808	27.7311	25.3407	25.6183
390111	2.1688	1.0892	32.6510	34.2990	34.8756	33.9665
390112	1.2270	0.8357	19.2126	20.2380	21.5439	20.3238
390113	1.2914	0.8697	22.2591	23.3686	24.2593	23.3085
390114	1.5658	0.8390	24.0473	26.9620	27.9184	26.3018
390115	1.4567	1.0892	27.7333	29.6905	30.8063	29.4311
390116	1.2415	1.0892	30.2722	32.2513	33.2562	31.9776
390117	1.1678	0.8357	20.3946	20.7821	21.5038	20.9016
390118	1.1721	0.8357	21.5001	20.5614	21.8917	21.3378
390119	1.3034	0.8357	22.2746	23.0928	24.3245	23.2322
390121	***	*	23.1408	25.4826	*	24.2748
390122	1.0755	0.8407	22.5786	23.1866	23.3220	23.0325
390123	1.1927	1.0892	28.6269	32.4528	34.0062	31.6506
390125	1.2633	0.8357	20.9456	22.4033	22.8816	22.0906
390127	1.3311	1.0892	30.9374	31.9091	33.6557	32.1824
390128	1.2534	0.8390	23.1539	24.1628	24.1390	23.8230
390130	1.2885	0.8357	24.0685	23.0592	23.2504	23.4713
390131	1.3317	0.8390	22.6306	23.0577	23.5783	23.1078
390132	1.4484	1.0892	27.7250	29.6396	31.1168	29.5034
390133	1.7272	1.0765	28.7162	31.1083	32.9812	31.0147
390135	***	*	24.4738	*	*	24.4738
390136	***	*	22.1415	23.9813	*	23.0891
390137	1.4885	0.8357	23.4877	24.2878	26.1457	24.6489
390138	1.1933	0.9115	24.2769	25.3410	27.4231	25.7128
390139	1.3716	1.0892	30.4246	34.1447	34.0836	32.9187
390142	1.5243	1.0892	32.5786	33.8224	34.5773	33.7222
390145	1.5357	0.8390	23.8041	24.6672	25.6980	24.7299
390146	1.2173	0.8377	25.2460	22.6752	25.1805	24.3872
390147	1.3581	0.8390	25.0971	26.8522	28.6606	26.8148
390150	1.1275	0.8379	24.1855	22.8228	22.7668	23.2856
390151	1.3563	1.1016	27.1539	29.9254	31.4067	29.5927
390153	1.3460	1.0892	30.0585	32.8234	33.2427	32.1641
390154	1.2246	0.8357	20.6982	22.8391	23.3559	22.2880
390156	1.3798	1.0892	31.2571	32.2688	32.8999	32.1222

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
390157	1.2696	0.8390	22.7493	21.5923	22.1112	22.1491
390160	1.2522	0.8390	21.4877	24.0208	22.9696	22.8166
390162	1.4950	1.1570	30.0900	35.5057	34.5809	33.2587
390163	1.2334	0.8390	22.1741	23.2055	22.8341	22.7283
390164	2.1784	0.8390	26.4971	26.3087	27.1950	26.6937
390166	1.1701	0.8390	24.9810	20.9272	23.3255	23.1378
390168	1.5193	0.8390	24.5820	26.1365	26.9816	25.9249
390169	1.4279	0.8357	27.2242	26.5514	26.2643	26.6875
390173	1.1827	0.8357	22.8220	23.9927	25.6455	24.1670
390174	1.7008	1.0892	32.6265	34.2069	34.8999	33.9342
390176	1.0494	0.8390	*	23.9779	24.1247	24.0545
390178	1.3615	0.8991	20.7270	22.6006	23.1452	22.1438
390179	1.4427	1.0892	27.2222	28.0688	30.1219	28.5194
390180	1.4067	1.0892	32.4375	34.9832	35.5291	34.3065
390181	1.1036	0.8641	24.4573	25.9871	26.6021	25.6300
390183	1.1415	0.8357	25.6554	27.0122	27.8358	26.8139
390184	1.1037	0.8390	22.5519	22.7451	23.9736	23.0652
390185	1.2675	0.8357	23.0202	25.4256	27.1119	25.2267
390189	1.1565	0.8357	22.3722	22.6796	23.6215	22.9388
390191	1.1480	*	20.8761	*	*	20.8761
390192	0.9882	0.8357	21.2619	20.5459	23.6171	21.8230
390193	***	*	20.1024	*	*	20.1024
390194	1.1194	1.0003	25.4235	27.5890	26.3152	26.4435
390195	1.6293	1.0892	31.0019	34.2980	34.5594	33.3475
390196	1.6590	*	*	*	*	*
390197	1.3808	1.0003	25.7739	26.8270	27.2455	26.6103
390198	1.0933	0.8503	18.7222	20.5979	20.4350	19.9087
390199	1.1701	0.8357	21.3157	22.3224	23.0046	22.2038
390200	***	*	23.7471	*	*	23.7471
390201	1.3003	0.8357	26.3658	27.0054	27.3542	26.9245
390203	1.6204	1.0892	28.9054	29.4930	29.1370	29.1781
390204	1.3007	1.0892	28.6829	29.5251	30.7346	29.6944
390211	1.2565	0.8991	23.1450	25.1689	26.5052	24.9533
390215	***	*	28.0403	*	*	28.0403
390217	1.2433	0.8390	24.3610	23.5879	24.1886	24.0513
390219	1.3175	0.8390	25.1705	25.4886	26.1196	25.5763
390220	1.1218	1.0892	41.6138	28.9128	30.7435	32.7176
390222	1.2954	1.0892	28.7488	30.9464	31.7361	30.5072
390223	2.0325	1.0892	27.6407	30.2523	34.3280	30.7325

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
390224	***	*	18.7624	*	*	18.7624
390225	1.2242	0.9650	24.9391	27.5803	27.2555	26.6147
390226	1.7798	1.0892	28.5890	32.6658	32.6508	31.2960
390228	1.3965	0.8390	23.3078	23.9845	24.2242	23.8474
390231	1.4031	1.0892	29.2653	30.9339	32.8353	30.9985
390233	1.3802	0.9425	24.8690	25.6904	27.2597	25.9607
390236	0.9660	0.8364	21.9169	22.1144	23.1290	22.3771
390237	1.6164	0.8357	26.9533	27.4944	28.4337	27.5819
390246	1.1272	0.8357	20.1581	25.1956	26.0179	23.4882
390256	1.9087	0.9230	26.3619	28.0617	28.8970	27.8209
390258	1.5082	1.0892	29.4626	30.4142	31.7164	30.6076
390263	1.5401	1.0003	26.0170	28.5864	29.9850	28.3002
390265	1.5075	0.8390	23.4836	24.0675	25.0166	24.2007
390266	1.1586	0.8991	20.3918	20.8789	22.2228	21.1792
390267	1.2789	0.8390	23.1051	24.2428	24.8309	24.0577
390268	1.3894	0.8619	25.0021	25.6643	26.7342	25.8430
390270	1.6238	0.8357	24.1496	24.9510	26.5010	25.2638
390272	0.5343	1.0892	*	*	*	*
390278	0.5326	1.0892	23.6843	26.6664	28.6323	26.3012
390279	***	*	17.0012	*	*	17.0012
390285	1.4953	1.0892	35.0426	36.7163	37.6669	36.3991
390286	1.1875	1.0892	28.1761	29.5281	31.3393	29.6278
390287	***	*	37.6569	39.3176	42.2401	39.3146
390288	***	*	29.7287	30.9701	*	30.3388
390289	***	*	28.8826	30.7583	*	29.8023
390290	1.8423	1.0892	37.9040	38.3776	41.1426	39.1287
390301	***	*	30.9836	*	*	30.9836
390302	2.0384	1.0892	*	*	*	*
390303	***	*	*	27.5580	*	27.5580
390304	1.2278	1.0892	*	30.4832	32.1633	31.3748
390305	***	*	*	*	29.3217	29.3217
390306	***	*	*	*	40.3789	40.3789
390307	1.9734	0.8991	*	*	24.5393	24.5393
390308	***	*	*	*	36.1737	36.1737
390309	***	*	*	*	37.8924	37.8924
390310	***	*	*	*	44.3991	44.3991
390311	2.0736	1.0892	*	*	*	*
390312	1.1657	1.0892	*	*	*	*
390313	1.1458	0.9413	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
400001	1.2874	0.4526	13.1847	13.9386	14.9151	14.0372
400002	1.8558	0.4262	16.7582	15.3833	12.9440	14.8789
400003	1.3831	0.4262	12.8329	13.9258	15.7906	14.1890
400004	1.2271	0.4526	14.3108	12.0923	12.5928	12.8941
400005	1.1236	0.4526	10.7207	10.3505	11.1152	10.7266
400006	1.1844	0.4526	9.2265	8.1841	8.1381	8.5089
400007	1.2015	0.4526	9.2463	11.8203	12.0743	11.0862
400009	1.0128	0.2944	9.3116	9.3834	9.5114	9.4053
400010	0.9325	0.3345	10.0962	9.8132	10.7993	10.2160
400011	1.0606	0.4526	8.5534	9.6641	8.5503	8.9391
400012	1.4705	0.4526	8.3802	12.3362	10.1156	10.1141
400013	1.2469	0.4526	10.3347	11.1414	11.4222	10.9912
400014	1.3700	0.3657	12.2169	10.5286	9.9395	10.8301
400015	1.3221	0.4526	15.6349	13.7043	22.2017	17.0466
400016	1.3958	0.4526	14.7607	16.6472	16.1931	15.8694
400017	0.9861	0.4526	10.2734	10.3123	9.9185	10.1744
400018	1.1688	0.4526	11.6165	11.9184	12.3942	11.9804
400019	1.4371	0.4526	12.8029	12.8380	14.7133	13.3474
400021	1.4337	0.4603	14.1534	14.4549	13.9217	14.1634
400022	1.4167	0.4262	15.9246	14.9089	15.3625	15.3797
400024	0.8912	0.3657	12.4648	10.8439	12.6226	11.9953
400026	1.0823	0.2944	5.8200	9.9262	7.1179	7.2042
400028	1.0970	0.4262	10.9808	11.3260	10.6711	10.9928
400032	1.1389	0.4526	10.2652	10.3736	10.7141	10.4546
400044	1.2868	0.4262	13.7509	14.6420	11.3551	13.0226
400048	1.1723	0.4526	10.4266	9.6416	9.6860	9.9022
400061	1.9960	0.4526	18.9123	18.1303	18.0093	18.3233
400079	1.2424	0.3345	12.7825	9.5296	10.4599	10.7211
400087	1.2021	0.4526	10.6849	11.0377	11.4162	11.0323
400098	1.3680	0.4526	12.8230	13.8034	13.7878	13.3737
400102	1.3126	0.4526	10.2677	10.5879	12.1761	10.9324
400103	1.7531	0.3657	9.3859	10.6971	11.7488	10.5156
400104	1.1987	0.4526	9.3854	11.4322	12.8404	11.2161
400105	1.1555	0.4526	14.0219	15.6626	16.9029	15.5351
400106	1.1103	0.4526	11.4507	13.4097	12.9272	12.5586
400109	1.4443	0.4526	14.2111	14.4386	14.8208	14.4938
400110	1.2255	0.3200	12.3449	11.1812	9.9278	11.1280
400111	1.1556	0.3345	14.5029	14.1718	10.2141	12.6681
400112	1.2246	0.4526	19.3945	10.1512	13.5177	13.3103

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
400113	1.2963	0.4262	9.6778	10.5305	10.9503	10.3752
400114	1.1415	0.4526	11.5478	10.1379	10.8913	10.8234
400115	1.0288	0.4526	13.7392	12.0713	9.6200	11.5296
400117	1.1103	0.4526	12.7600	9.5929	11.6258	11.1092
400118	1.2476	0.4526	12.5743	12.8692	12.7861	12.7465
400120	1.3549	0.4526	12.7955	13.4069	14.0817	13.4544
400121	1.0490	0.4526	8.2197	9.7427	9.1826	9.0004
400122	1.9051	0.4526	11.2324	8.9478	9.5814	10.3491
400123	1.2168	0.3657	12.3041	12.8317	12.5609	12.5625
400124	2.7715	0.4526	16.1812	17.2139	17.9140	17.1104
400125	1.2089	0.4365	11.6386	11.9787	13.5394	12.3736
400126	1.2018	0.4603	9.8008	14.1062	16.5726	12.5522
400127	1.7702	0.4526	*	17.8303	20.7775	19.5304
400128	1.0772	0.4526	*	*	12.3520	12.3520
410001	1.3001	1.1303	28.0816	29.0877	30.0315	29.0712
410004	1.2507	1.1303	27.4209	29.4953	31.3023	29.3085
410005	1.2514	1.1303	30.1606	28.1141	31.4387	29.8829
410006	1.3446	1.0532	29.4395	30.1855	32.8456	30.8320
410007	1.6590	1.1303	31.8548	33.2896	32.0730	32.4076
410008	1.2339	1.0532	29.6092	30.9505	32.5889	31.0411
410009	1.2457	1.0532	29.4094	31.7300	32.8422	31.3631
410010	1.1816	1.1303	32.8599	32.0704	32.7379	32.5467
410011	1.3898	1.1303	30.3787	33.8781	30.1941	31.4075
410012	1.6846	1.1303	32.6009	33.6072	37.0299	34.4554
410013	1.2109	1.1732	35.4624	35.8075	41.0010	37.4278
420002	1.5892	0.9505	28.2848	29.5592	30.5111	29.4596
420004	1.9968	0.9101	27.2620	28.1455	28.9250	28.1335
420005	1.1298	0.8707	23.1943	25.0420	24.6968	24.3261
420006	1.1030	0.9101	24.0811	26.3293	27.7764	26.0571
420007	1.6204	0.9403	25.2650	26.8165	29.0901	27.0758
420009	1.3844	0.9403	25.5079	27.0147	29.9378	27.4921
420010	1.1454	0.8707	23.4562	25.1452	25.5710	24.7565
420011	1.1700	0.9636	21.4029	22.1787	25.5130	23.0432
420015	1.3564	0.9636	26.2154	24.1685	26.3499	25.5708
420016	0.9729	0.8707	17.1229	21.6266	22.5681	20.3115
420018	1.8351	0.8829	24.8024	25.6687	27.5563	26.0448
420019	1.0975	0.8865	22.5312	22.5489	25.4954	23.3967
420020	1.2783	0.9101	25.8883	28.4344	27.5000	27.2263
420023	1.6931	0.9636	26.7263	27.4589	28.9321	27.7092

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
420026	1.8832	0.8829	27.4814	27.8986	28.0647	27.8209
420027	1.5863	0.9403	25.1692	26.4472	28.5621	26.7375
420030	1.2459	0.9101	26.0079	27.8435	28.4433	27.4518
420033	1.1206	0.9636	31.8759	30.4162	31.1608	31.1288
420036	1.2393	0.9342	22.8294	23.8742	24.6505	23.7918
420037	1.2991	0.9636	29.4156	29.8321	30.9556	30.0757
420038	1.2506	0.9636	24.2259	24.6642	26.6435	25.1658
420039	1.1502	0.9395	25.1148	28.2220	26.5582	26.6294
420043	1.1014	0.8864	23.0555	24.0971	25.7951	24.3487
420048	1.2704	0.8829	24.1923	25.9610	26.9625	25.7393
420049	1.2503	0.8707	23.9722	26.0953	25.7060	25.2650
420051	1.6618	0.8707	24.8026	25.9056	26.4710	25.7419
420053	1.1266	0.8742	22.2825	23.2246	24.4793	23.3671
420054	1.1343	0.8707	24.8931	25.6779	25.6444	25.3992
420055	1.0788	0.8707	21.9764	24.0965	25.1738	23.7710
420056	1.3331	0.8707	21.6963	27.7250	28.4512	26.0628
420057	1.1850	0.8707	23.4312	24.9313	26.2489	24.8975
420062	1.0478	0.9342	25.9526	26.7467	25.9569	26.2263
420064	1.1878	0.8707	23.3610	24.3540	24.6507	24.1129
420065	1.4423	0.9101	24.5715	25.5483	26.8118	25.6580
420066	1.0102	0.8707	23.9049	25.1062	25.0932	24.7340
420067	1.3642	0.8890	25.0345	25.8561	26.5658	25.8410
420068	1.3736	0.9598	23.4248	25.6857	27.7315	25.6542
420069	1.1727	0.8707	20.5546	22.3445	23.7494	22.2412
420070	1.3002	0.8898	23.4355	24.7899	27.5988	25.3447
420071	1.4324	0.9403	24.9418	25.2862	27.6371	25.9946
420072	1.0648	0.8707	18.6742	17.8019	21.6587	19.2819
420073	1.3853	0.8829	24.5813	25.5204	26.1120	25.4570
420078	1.9234	0.9636	28.9112	29.5135	30.9001	29.7803
420079	1.4833	0.9101	25.4935	27.5439	28.6374	27.2418
420080	1.4399	0.8890	28.4735	28.6060	31.5670	29.4700
420082	1.5176	0.9598	29.8528	31.2671	33.9874	31.6537
420083	1.4753	0.9403	27.1322	26.4932	28.9007	27.5465
420085	1.5552	0.9156	26.8692	27.8386	29.1127	27.9342
420086	1.4543	0.8829	25.8869	28.0485	27.9523	27.3375
420087	1.8316	0.9101	24.3609	25.4697	26.8409	25.5481
420089	1.3966	0.9101	26.0074	28.1855	29.5862	27.9480
420091	1.4220	0.8707	26.9214	26.0592	27.2520	26.7465
420093	***	*	27.4767	28.0765	33.0474	29.2458

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
420098	1.1886	0.8707	*	30.7532	27.1939	28.6282
420099	***	*	*	*	30.3089	30.3089
420101	1.1325	0.8707	*	*	*	*
430005	1.2980	0.8343	22.3272	22.4111	23.8694	22.8728
430008	1.1437	0.8878	23.3790	24.4277	26.0873	24.5250
430012	1.3084	0.9373	24.0850	24.0326	25.2030	24.4262
430013	1.1850	0.9373	25.1378	25.9828	27.0427	26.0549
430014	1.4182	0.8343	26.4964	26.8752	27.9288	27.1027
430015	1.2660	0.8343	22.7947	23.6296	26.5787	24.3442
430016	1.6461	0.9553	27.8453	28.9376	32.8765	29.8590
430027	1.7908	0.9553	26.2139	26.6044	27.5759	26.8179
430031	***	*	16.0346	*	*	16.0346
430047	1.0090	*	18.8982	*	*	18.8982
430048	1.2826	0.8472	23.0782	24.1969	25.1715	24.1632
430060	0.8255	0.8343	*	13.2618	*	13.2618
430064	1.0352	0.8343	17.5376	18.3125	16.4916	17.3487
430077	1.8125	0.8685	25.1763	25.8572	27.2116	26.0778
430081	0.8813	1.4400	*	*	*	*
430082	0.8159	1.4400	*	*	*	*
430083	0.8773	1.4400	*	*	*	*
430084	0.9191	1.4400	*	*	*	*
430085	0.8887	1.4400	*	*	*	*
430089	1.8643	0.9083	22.5625	22.3335	23.2467	22.7178
430090	1.4823	0.9553	25.8460	26.4862	29.0197	27.2002
430091	2.1535	0.8685	24.3021	25.1105	24.7274	24.7230
430092	1.8619	0.8343	20.9486	21.6478	21.9197	21.5136
430093	0.8376	0.8685	29.5244	27.5326	26.0232	27.6512
430094	1.6473	0.8472	18.9099	22.9091	23.2894	21.6362
430095	2.4536	0.9553	28.1749	31.3409	32.2326	30.5986
430096	1.8925	0.8343	21.6997	21.6713	24.6041	22.6698
440001	1.1429	0.7917	19.3100	21.2398	21.5755	20.7297
440002	1.7517	0.8963	24.6664	25.7434	26.3802	25.6181
440003	1.3286	0.9618	25.9209	28.4862	28.3557	27.6397
440006	1.5104	0.9618	28.5951	29.7146	31.5533	29.9429
440007	1.0213	0.8136	25.8236	19.9754	18.8273	20.7872
440008	1.0650	0.8435	23.4301	23.2126	27.3732	24.8411
440009	1.2235	0.7917	21.5970	23.9279	23.8148	23.1556
440010	0.9454	0.7917	17.1803	19.3669	19.6231	18.7390
440011	1.3468	0.8012	22.5068	23.6154	23.6698	23.2734

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
440012	1.5824	0.7917	22.3029	24.0169	23.7871	23.3709
440015	1.8744	0.8012	23.7422	25.0430	26.0601	24.9723
440016	1.0058	0.8061	22.1645	23.0350	24.5812	23.2195
440017	1.8259	0.7917	22.9364	25.0588	24.6707	24.2298
440018	1.1293	0.7917	23.3445	23.2107	25.0780	23.9426
440019	1.7495	0.8012	25.2553	25.3592	25.2230	25.2804
440020	1.0946	0.8629	23.9475	24.0995	24.7785	24.2807
440024	1.2188	0.8962	23.2717	23.9745	24.7705	24.0299
440025	1.1297	0.8603	20.6798	22.5407	22.6571	21.9869
440026	0.6838	0.9618	26.8986	28.0349	26.8153	27.2470
440029	1.3911	0.9618	28.0779	30.1204	31.2310	29.8864
440030	1.3252	0.7973	22.1217	23.7670	22.2607	22.7230
440031	1.1881	0.7936	19.6684	20.8964	22.6790	21.0762
440032	1.2202	0.7917	18.5277	19.7150	21.0380	19.7424
440033	1.0340	0.7944	20.7917	21.1087	22.7991	21.5097
440034	1.6264	0.8012	23.5403	24.6994	25.5061	24.6085
440035	1.4163	0.9364	24.3752	25.9613	26.2451	25.5505
440039	2.1878	0.9618	28.4678	29.8611	30.1790	29.5489
440040	0.9037	0.7917	17.8509	20.8637	20.8817	19.8822
440041	0.9131	*	17.9409	*	*	17.9409
440046	1.2541	0.9618	26.1341	27.9539	29.7377	27.9640
440047	0.9019	0.8255	21.4280	21.7892	22.8323	22.0491
440048	1.8393	0.9313	27.7560	29.4789	29.3187	28.8706
440049	1.6394	0.9313	25.3043	26.4772	28.8742	26.9261
440050	1.3557	0.7917	23.1363	24.4616	24.9694	24.2238
440051	0.9547	0.7999	21.9108	23.9253	23.4866	23.1295
440052	0.9967	0.7917	21.1133	22.8016	22.6128	22.1807
440053	1.2686	0.9618	25.4345	27.1197	27.8180	26.7576
440054	1.1313	0.7917	21.4400	23.5137	23.7931	22.9260
440056	1.1627	0.8012	22.1067	22.7820	23.2313	22.7147
440057	1.0901	0.7938	16.4451	16.6346	17.2176	16.7762
440058	1.1779	0.7917	22.9263	24.3522	26.0706	24.4599
440059	1.4606	0.7917	26.3551	28.3565	27.9467	27.5547
440060	1.1376	0.8435	23.3014	24.1024	25.0795	24.2308
440061	1.1227	0.7917	21.8274	23.9678	23.7360	23.1109
440063	1.5877	0.7917	22.3256	24.2566	23.9644	23.5409
440064	1.0095	0.8962	22.0955	23.7176	26.1246	23.9669
440065	1.2649	0.9618	22.3247	24.6169	25.8536	24.2955
440067	1.1060	0.7973	23.1089	24.4772	24.6553	24.0987

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
440068	1.1561	0.8962	24.5972	24.8146	26.1071	25.1514
440070	0.9795	0.8026	19.4372	20.0938	21.9166	20.5440
440072	1.1052	0.8963	27.1442	23.9563	25.7089	25.4880
440073	1.4690	0.9364	23.9198	26.3570	27.6154	25.9562
440081	1.1988	0.7969	19.7878	20.7125	20.7688	20.4356
440082	2.1154	0.9618	27.9724	30.6115	32.2479	30.2297
440083	0.9665	0.7917	17.3329	25.6099	23.6356	22.2415
440084	1.1850	0.7942	16.3738	18.6043	18.8699	17.9500
440091	1.7521	0.8962	25.6797	26.5687	28.1989	26.8422
440102	1.1443	0.7917	17.5261	20.7363	21.6762	19.9759
440104	1.7681	0.8962	25.3739	26.5741	27.9756	26.6322
440105	0.8903	0.7917	22.3438	22.9372	22.7962	22.6994
440109	0.9688	0.7987	18.6720	20.8924	21.4629	20.4136
440110	1.1516	0.8012	21.3287	20.9179	22.5929	21.6231
440111	1.2941	0.9618	28.5705	29.0975	28.8453	28.8380
440114	***	*	24.0146	*	*	24.0146
440115	1.0084	0.8255	21.7830	23.1409	23.7107	22.8901
440120	1.5807	0.8012	25.5961	25.7161	24.7572	25.3531
440125	1.6030	0.8012	22.4196	22.8097	23.6328	22.9331
440130	1.1080	0.7917	23.4517	23.9955	25.1262	24.1968
440131	1.2044	0.9313	24.9599	25.6666	26.9649	25.8560
440132	1.2396	0.7917	21.5085	23.9410	24.0708	23.2170
440133	1.7123	0.9618	26.2422	29.2829	29.6093	28.3398
440135	0.9966	0.7917	26.6615	28.1925	27.7037	27.5222
440137	1.0789	0.8655	20.6663	22.2538	22.9547	21.8990
440141	0.9681	0.7917	21.3314	24.2406	24.9917	23.5753
440144	1.3047	0.9364	23.3828	23.9241	25.2293	24.2131
440145	1.0761	*	20.7875	*	*	20.7875
440147	***	*	31.4012	33.1756	34.8199	33.1562
440148	1.1125	0.9364	24.6412	23.9810	22.6188	23.6904
440149	***	*	20.4563	*	*	20.4563
440150	1.3915	0.9618	26.8308	28.1012	29.4381	28.1244
440151	1.1731	0.9364	23.9808	27.1729	28.2203	26.4238
440152	1.9330	0.9313	26.5513	27.1877	28.4612	27.4397
440153	1.0815	0.7924	22.2846	23.6473	24.9388	23.5617
440156	1.6487	0.8962	26.9689	27.7309	28.5645	27.7809
440159	1.5112	0.9313	22.8645	26.9098	25.8289	25.2934
440161	1.8713	0.9618	28.6971	28.7074	29.9894	29.1537
440162	***	*	21.1418	27.6837	24.8705	24.4635

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
440166	***	*	31.0779	35.3064	*	32.7296
440168	0.9656	0.9313	22.8768	28.1215	29.4028	26.9618
440173	1.4384	0.8012	22.8846	23.1167	24.0621	23.3817
440174	0.8948	0.8229	22.0974	25.4829	26.2087	24.7287
440175	1.0346	0.9364	22.7299	24.4848	24.7869	23.9712
440176	1.2755	0.7917	23.6659	22.9631	23.7695	23.4768
440180	1.2910	0.7944	23.3808	24.9841	22.3070	23.4474
440181	0.9194	0.8282	22.7151	24.8857	25.9450	24.5707
440182	0.9950	0.8061	22.3612	24.3302	25.0111	23.9834
440183	1.5965	0.9313	27.1515	29.1982	30.6599	28.9846
440184	0.9643	0.7917	22.3475	24.5786	23.3970	23.4193
440185	1.1494	0.8962	23.9052	25.3817	26.7473	25.4020
440186	0.9670	0.9618	25.7445	27.3733	28.9124	27.3831
440187	1.0855	0.7917	21.3252	24.0723	25.8238	23.7554
440189	1.3573	0.8591	27.5435	28.2621	28.8974	28.1769
440192	1.0837	0.9364	25.7495	27.3917	29.6272	27.6374
440193	1.3504	0.9618	24.4299	24.3622	25.2124	24.6713
440194	1.3046	0.9618	26.6527	29.4706	30.8593	29.1025
440197	1.3634	0.9618	27.1534	29.4275	30.1184	28.8521
440200	0.9727	0.9618	17.7491	21.1860	23.8654	20.9536
440203	***	*	19.3864	23.7451	17.9041	20.1684
440217	1.3218	0.9313	28.5968	28.8641	29.8888	29.1071
440218	2.2001	0.9618	24.6465	23.7257	18.7275	22.2604
440222	1.0526	0.9313	29.7292	28.4664	29.0062	29.0425
440224	0.8974	0.9618	*	*	*	*
440225	0.7954	0.8012	*	24.8328	27.8860	26.2410
440226	1.5468	0.8012	*	26.5831	27.1348	26.8601
440227	1.3258	0.9618	*	*	30.7785	30.7785
440228	1.4404	0.9313	*	*	28.3687	28.3687
450002	1.4187	0.9140	25.7171	28.0936	28.8521	27.4831
450005	1.0716	0.8615	23.5576	24.4933	24.5405	24.1601
450007	1.3075	0.8895	20.7321	23.0026	23.9490	22.5725
450008	1.2921	0.8303	22.9669	24.4701	24.5965	24.0253
450010	1.6531	0.8203	23.7529	25.5503	25.5582	24.9684
450011	1.6887	0.9171	24.8831	26.7418	28.5329	26.6975
450015	1.5297	0.9785	27.4012	29.9193	29.4919	28.9240
450018	1.5190	0.9996	26.7999	30.2383	30.7852	29.2611
450020	0.9712	*	18.3047	*	*	18.3047
450021	1.8798	0.9785	29.1350	29.5658	31.3107	29.9776

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450023	1.4773	0.8198	22.0558	25.4450	25.5346	24.3069
450024	1.6700	0.9140	24.4195	26.9113	28.2047	26.6001
450028	1.6124	0.9192	26.8250	29.1438	29.5792	28.4741
450029	1.6184	0.8501	23.2995	25.0602	26.9361	25.0112
450031	1.4011	0.9785	27.9626	29.0824	30.3542	29.1129
450032	1.2887	0.8551	27.0748	21.5084	25.5785	24.5163
450033	1.6328	0.9192	28.4781	29.2468	27.8680	28.5092
450034	1.5781	0.8615	24.1589	26.5313	27.6929	26.1022
450035	1.4958	0.9996	26.2838	28.0668	28.8049	27.6978
450037	1.6448	0.8871	24.2684	26.6207	28.3403	26.4155
450039	1.4616	0.9681	24.7347	26.7503	28.2081	26.5799
450040	1.8081	0.8641	24.9590	25.4734	26.8412	25.7399
450042	1.7918	0.8593	24.1181	26.6382	26.5429	25.7899
450044	1.7622	0.9785	29.4308	31.0381	29.4293	29.9718
450046	1.6190	0.8456	23.4907	24.8947	25.5903	24.6759
450047	0.8457	0.9192	19.8221	21.8824	23.8457	21.9037
450050	0.8661	*	23.3044	*	*	23.3044
450051	1.9254	0.9785	28.0411	28.8829	29.9038	28.9708
450052	0.9462	0.8198	19.7774	22.6448	23.0007	21.3928
450053	0.9303	*	21.9082	*	*	21.9082
450054	1.7997	0.8303	24.2782	27.5399	26.5599	26.0525
450055	1.0493	0.8198	22.1979	22.9245	23.6382	22.9302
450056	1.7631	0.9501	27.0530	28.3092	31.4971	28.7483
450058	1.5935	0.8895	25.9653	26.6926	26.9918	26.5548
450059	1.3109	0.9501	26.6535	26.8325	27.3856	26.9630
450064	1.4732	0.9681	23.8748	26.8355	28.2786	26.2939
450068	2.1593	0.9996	27.9633	29.5876	30.5001	29.3709
450072	1.2067	0.9996	24.0166	25.8619	27.1081	25.6939
450073	0.8859	0.8198	21.7337	26.9446	26.1567	24.8300
450076	1.6741	*	*	*	*	*
450078	0.9153	0.8198	15.8968	21.4716	20.0758	18.9517
450079	1.6341	0.9785	28.1096	30.2420	30.5968	29.6101
450080	1.2456	0.8871	22.9836	27.9191	26.2439	25.6047
450082	1.1501	0.8198	22.0442	23.9025	24.2018	23.3904
450083	1.8310	0.9181	25.8214	27.4955	32.6462	28.5964
450085	1.0612	0.8198	22.0840	24.3637	25.6440	24.0616
450087	1.4142	0.9681	29.1587	30.0095	31.2668	30.1454
450090	1.2348	0.8847	19.4245	21.3837	21.8839	20.8851
450092	1.1900	0.8198	23.2071	24.9917	26.2781	24.8586

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450094	***	*	25.2434	*	*	25.2434
450096	***	*	24.1618	26.5103	28.1902	26.1065
450097	1.4813	0.9996	26.4965	29.0142	29.8734	28.4576
450098	0.9764	*	22.6626	*	*	22.6626
450099	1.2849	0.9151	26.6796	31.3495	31.7829	29.8766
450101	1.6850	0.8593	23.6905	25.4409	26.7457	25.2723
450102	1.7581	0.9181	24.5503	25.6318	26.4161	25.5272
450104	1.1910	0.8895	23.8469	24.6169	28.8063	25.7441
450107	1.5650	0.9140	25.9326	27.6064	27.8177	27.1285
450108	1.2022	0.8895	19.4935	21.6557	19.3245	20.1295
450113	***	*	54.6663	*	*	54.6663
450119	1.3059	0.9135	25.7008	27.8027	31.1026	28.0194
450121	***	*	25.7051	29.1296	27.7472	27.5367
450123	1.2261	0.8615	21.2154	24.9674	26.2469	24.0865
450124	1.8807	0.9501	27.4198	28.2571	30.9140	28.8720
450126	1.3811	0.9996	28.3032	29.3768	30.5540	29.4686
450128	1.2606	0.9135	23.3633	25.1122	26.3296	24.9399
450130	1.1622	0.8895	21.5226	24.3295	24.3842	23.4132
450131	***	*	23.7098	25.9494	*	24.6979
450132	1.5736	0.9954	28.6954	30.1620	31.9981	30.2616
450133	1.5644	0.9711	26.8344	28.4647	30.0648	28.4860
450135	1.7036	0.9681	26.0755	27.8983	30.1385	28.0791
450137	1.7309	0.9681	30.4254	31.4950	31.9644	31.3195
450143	0.9924	0.9501	21.8705	23.4592	23.6834	23.0250
450144	1.0795	0.8757	21.3289	26.2881	29.2987	25.2285
450147	1.5055	0.8198	23.9771	24.3562	24.7221	24.3818
450148	1.2593	0.9681	25.3498	27.0894	29.6777	27.2884
450151	***	*	22.2915	23.9558	26.2011	24.2451
450152	1.2222	0.8303	22.7463	23.3428	23.1056	23.0676
450154	1.3964	0.8198	21.2021	21.7237	22.9357	21.9527
450155	1.1128	0.8198	18.0588	21.7604	24.8052	21.2762
450162	1.3166	0.8641	30.9903	33.3285	32.9317	32.4581
450163	1.0669	0.8252	23.1400	24.1267	24.7857	24.0374
450165	1.1663	0.8895	24.3242	28.6490	29.1839	27.3457
450176	1.3545	0.9135	20.9297	23.1284	24.4338	22.7670
450177	1.1706	0.8198	21.3322	23.7624	24.4064	23.1608
450178	0.9841	0.9522	24.7301	27.8405	27.1184	26.5678
450184	1.5607	0.9996	26.7821	28.5399	29.5940	28.3021
450187	1.1820	0.9996	25.6787	28.3243	27.7374	27.2569

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450188	0.9375	0.8198	20.4070	23.0595	23.2280	22.2802
450191	1.1684	0.9501	26.0298	26.5863	28.3937	27.0037
450192	1.1362	0.8469	22.5880	24.1186	26.4722	24.4203
450193	2.0940	0.9996	32.2964	34.4545	36.4793	34.4413
450194	1.3690	0.8411	24.8972	22.9605	24.3531	24.0550
450196	1.4362	0.9681	24.7557	24.0161	23.4577	24.1010
450200	1.5854	0.8198	23.5344	23.5012	25.6413	24.1114
450201	0.9698	0.8198	20.9810	23.2510	23.2800	22.5466
450203	1.1783	0.9636	24.1675	26.5237	27.8795	26.2148
450209	1.9545	0.9151	26.0958	27.5668	30.6146	28.0394
450210	0.9541	0.8348	19.9832	21.8722	22.5736	21.5263
450211	1.3225	0.8871	23.8230	28.4581	28.3770	26.9047
450213	1.9145	0.8895	23.9676	25.9169	26.8566	25.6079
450214	1.2450	0.9996	25.9598	27.4357	27.9913	27.1357
450219	0.9693	0.8198	21.7934	21.9207	23.9636	22.5469
450221	1.1310	0.8198	20.3186	19.3793	21.3721	20.3738
450222	1.6699	0.9996	27.4426	30.0314	30.3801	29.2831
450224	1.3681	0.9181	24.1956	26.8302	28.4382	26.4258
450229	1.6509	0.8240	21.4459	24.4450	25.1370	23.6500
450231	1.6694	0.9151	25.2852	27.1674	26.9783	26.4822
450234	1.0257	0.8198	18.4451	20.6889	20.4659	19.9283
450235	1.0130	0.8198	21.5138	23.5212	21.8967	22.3104
450236	1.0587	0.8586	22.0788	23.5426	22.9622	22.8816
450237	1.6285	0.8895	24.8901	25.7939	30.5885	26.8889
450239	0.9810	0.8303	21.1945	21.2586	19.1359	20.4359
450241	1.0079	0.8198	18.7958	20.8732	21.3641	20.3133
450243	0.9797	0.8198	15.4636	15.4510	17.2966	16.0870
450253	0.9237	0.9996	20.6124	24.2435	24.1056	23.0166
450270	1.1787	0.8469	14.4325	15.2190	19.8180	16.4159
450271	1.2139	0.9636	21.7719	22.7035	24.1269	22.9111
450272	1.2109	0.9501	25.7392	26.2576	27.0521	26.3732
450276	***	*	16.6319	*	*	16.6319
450280	1.4744	0.9785	28.7233	29.9730	31.6575	30.1311
450283	1.0394	0.9681	20.9679	22.7938	24.1754	22.6250
450289	1.4188	0.9996	28.5665	32.2645	32.6533	31.2446
450292	1.2700	0.9785	25.0411	26.3242	26.8110	26.0607
450293	0.8636	0.8198	21.3135	23.6413	24.0827	22.9699
450296	1.1003	0.9996	27.9690	30.4324	31.5596	30.0340
450299	1.6637	0.9171	26.4933	27.5797	28.4171	27.4989

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450306	0.9541	0.8240	15.9855	21.4558	22.9486	19.7058
450315	1.8055	0.9785	*	37.1721	*	37.1721
450324	1.5710	0.9681	24.9128	25.1633	26.6093	25.5442
450330	1.2146	0.9996	25.5820	26.0771	27.1100	26.2641
450340	1.3762	0.8658	24.0637	25.0344	25.6791	24.9276
450346	1.4301	0.8615	22.2468	23.6072	23.8720	23.2813
450347	1.1980	0.9996	27.2203	28.7667	30.7825	28.9056
450348	1.0403	0.8198	18.7675	21.6787	21.0484	20.5437
450351	1.2634	0.9636	25.6859	26.5388	29.2560	27.1710
450352	1.1039	0.9785	24.8012	26.2281	27.2983	26.1099
450353	***	*	24.4454	27.0248	27.9576	26.5065
450358	1.9690	0.9996	30.4280	31.4926	32.5922	31.5508
450362	***	*	25.4372	*	*	25.4372
450369	1.0321	0.8198	18.4848	19.9148	22.8525	20.4182
450370	1.1955	0.8433	20.0832	25.5834	26.3235	23.8014
450372	1.3699	0.9785	28.3359	30.8886	29.5022	29.5636
450373	0.8644	0.8198	22.2213	24.8286	27.0726	24.8206
450374	0.9938	*	23.2283	*	*	23.2283
450378	1.4691	0.9996	30.7684	30.3883	32.2278	31.1287
450379	1.3331	0.9785	30.6071	33.7521	35.3807	33.1822
450381	0.9328	*	22.0482	*	*	22.0482
450388	1.6610	0.8895	25.8674	27.4328	27.8155	27.0481
450389	1.1531	0.9681	23.8764	25.6732	26.9638	25.5406
450393	0.5363	0.9681	18.4551	21.9347	*	19.7864
450395	1.0563	0.9996	24.8656	27.5189	26.7743	26.5003
450399	0.8946	0.8198	18.2074	20.3528	22.1731	20.1552
450400	1.0785	0.8198	23.1739	23.6358	26.2871	24.2928
450403	1.3135	0.9785	29.3063	29.0359	29.8643	29.4107
450411	1.0100	0.8198	19.6086	20.9372	21.5746	20.7294
450417	0.8612	*	20.0351	*	*	20.0351
450418	***	*	26.8434	28.4362	*	27.5264
450419	1.2724	0.9681	31.0405	31.9966	34.2427	32.4903
450422	1.2225	0.9785	30.6659	34.4331	31.3454	32.1021
450424	1.3422	0.9996	28.3149	28.2463	30.7228	29.0903
450431	1.5882	0.9501	25.2477	26.3263	27.3926	26.3387
450438	1.1315	0.9996	21.9350	27.8659	26.5223	25.2196
450446	0.6348	0.9996	14.3132	17.0691	17.2871	16.0880
450447	1.2608	0.9681	23.5047	25.4200	26.5238	25.1015
450451	1.1286	0.8733	23.3043	24.6201	26.5477	24.8404

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

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[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450460	0.9645	0.8251	20.5811	22.4227	24.9870	22.7352
450462	1.7180	0.9785	27.8923	29.6069	30.1466	29.2312
450465	1.1121	0.9996	22.4183	26.2759	27.0835	25.3182
450469	1.4937	0.9681	28.7890	26.3262	26.3445	27.1807
450475	1.0922	0.8871	23.5596	23.0942	24.5176	23.7054
450484	1.3677	0.8871	25.3527	26.7242	28.3913	26.8380
450488	1.1516	0.8871	23.9144	22.3981	23.7985	23.3820
450489	0.9930	0.8198	21.4771	23.4806	25.2680	23.4878
450497	1.0142	0.8573	18.8344	22.0918	23.1860	21.3700
450498	0.9453	0.8198	17.7822	18.6563	20.2475	18.8938
450508	1.5958	0.8871	23.9572	28.4471	27.2850	26.5800
450514	***	*	22.6552	26.3704	27.3043	25.5172
450518	1.4357	0.8615	24.1194	28.1755	29.1322	27.1788
450530	1.2777	0.9996	28.7451	29.1349	29.9720	29.2964
450537	1.4003	0.9785	27.5856	27.7757	28.7448	28.0481
450539	1.1985	0.8265	21.0442	23.1829	24.2151	22.7465
450547	0.9648	0.8393	21.6542	23.7820	34.3349	25.8923
450558	1.8257	0.8240	26.1551	26.9407	28.0655	27.0633
450563	1.5242	0.9681	28.7289	30.8332	32.0507	30.6111
450565	1.2522	0.8684	23.8846	26.7942	28.1741	26.2662
450571	1.6028	0.8658	22.7703	25.2108	27.4605	25.0812
450573	1.1240	0.8323	20.1479	22.0797	22.1492	21.5110
450578	0.9614	0.8198	20.2696	22.5167	25.0498	22.6273
450580	1.0846	0.8198	21.1574	22.3886	23.9004	22.4744
450584	1.1124	0.8198	21.0808	20.5257	22.5204	21.3633
450586	0.9374	0.8198	16.1003	18.9107	20.6699	18.6573
450587	1.2013	0.8198	20.4512	23.1202	25.0174	22.8390
450591	1.2595	0.9996	23.9992	25.7031	27.1744	25.6141
450596	1.2190	0.9636	25.3317	27.4011	29.8462	27.4275
450597	0.9772	0.8198	23.1711	24.7853	24.2586	24.0731
450604	1.3501	0.8198	20.9514	24.4743	25.9133	23.8497
450605	0.9405	0.8456	22.2205	20.9276	23.9332	22.2910
450610	1.5912	0.9996	26.8710	27.7317	28.3713	27.6825
450615	0.9878	0.8198	20.3028	21.8442	24.1902	22.0858
450617	1.5092	0.9996	26.5026	28.0225	28.8323	27.8240
450620	1.0024	0.8198	17.7138	18.6183	20.3723	18.9192
450623	1.1755	*	28.3552	*	*	28.3552
450626	***	*	26.8374	*	*	26.8374
450630	1.5459	0.9996	29.6796	29.1462	29.8431	29.5562

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
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** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450634	1.7069	0.9785	28.1705	28.7312	30.3274	29.0806
450638	1.6735	0.9996	29.6184	30.6572	32.4911	30.8650
450639	1.4449	0.9681	29.2669	30.4019	32.6255	30.7775
450641	1.0336	0.8573	17.5845	19.4389	20.2483	19.0723
450643	1.3305	0.8501	21.1205	22.7355	24.4999	22.7584
450644	1.5887	0.9996	29.0186	29.7918	30.7815	29.8996
450646	1.4232	0.9140	23.8908	25.6313	26.8060	25.4375
450647	1.8334	0.9785	30.7334	30.6924	32.4236	31.2797
450651	1.4793	0.9785	32.4822	30.4484	31.9261	31.6022
450653	1.1659	0.8198	23.2603	25.2144	26.1756	24.8558
450654	0.9024	0.8198	19.9992	21.5002	22.5447	21.4234
450656	1.4165	0.8871	23.8280	25.5050	28.1493	25.7182
450658	0.9853	0.8198	20.5398	22.2293	24.7856	22.5185
450659	1.4621	0.9996	30.1727	31.5024	34.2380	31.8910
450661	1.1887	0.9954	23.2989	30.2610	30.0751	27.8684
450662	1.5730	0.9192	28.0913	29.0535	29.0532	28.7293
450665	***	*	18.6054	*	*	18.6054
450668	1.5287	0.9140	26.2375	28.8635	30.6114	28.5378
450669	1.2128	0.9785	27.4507	27.9796	30.2374	28.6058
450670	1.4050	0.9996	25.1575	25.9638	26.4266	25.8773
450672	1.8204	0.9681	27.6359	30.1191	31.8420	29.9422
450674	1.0697	0.9996	28.4416	28.7101	29.8971	29.0121
450675	1.3861	0.9681	28.7765	28.9005	30.9562	29.5682
450677	1.2694	0.9681	27.3728	25.9555	27.2760	26.8379
450678	1.5046	0.9785	30.1500	31.1563	33.3386	31.5036
450683	1.1583	0.9785	24.6609	27.4925	21.1737	24.2967
450684	1.2913	0.9996	27.6789	29.3025	30.2139	29.1278
450686	1.5950	0.8641	23.2367	24.2331	25.8530	24.4614
450688	1.1957	0.9785	27.9057	26.8599	26.9897	27.2212
450690	1.3100	0.9181	28.2531	26.5528	26.1743	27.0377
450694	1.1609	0.8198	23.5789	23.9961	24.0031	23.8670
450697	1.4201	0.8895	23.7155	24.8667	26.4132	25.0106
450698	0.8999	0.8325	18.6494	20.0955	21.5742	20.0867
450702	1.7113	0.8871	25.6147	26.8384	26.3696	26.2787
450709	1.3573	0.9996	25.4855	26.8146	27.1077	26.4651
450711	1.4817	0.9135	28.0104	26.7472	27.5622	27.4437
450713	1.5782	0.9501	27.2801	28.8285	29.4980	28.5539
450715	1.2406	0.9785	28.0365	17.3991	17.0235	19.5811
450716	1.3502	0.9996	30.8440	32.3960	33.7096	32.3143

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450718	1.3791	0.9501	27.3408	27.3215	28.1560	27.6253
450723	1.4671	0.9785	28.0812	28.5103	30.1704	28.9694
450730	1.3698	0.9785	29.9430	31.3324	32.7293	31.3334
450733	***	*	26.4977	*	*	26.4977
450742	1.1911	0.9785	26.1189	27.2023	30.0583	27.8913
450743	1.4606	0.9785	27.3213	28.3362	28.4736	28.0743
450746	0.9233	0.8198	12.4748	20.6343	22.7873	18.2509
450747	1.2814	0.9181	22.2870	23.8314	25.8175	23.8627
450749	0.9915	0.8198	17.8227	20.0487	22.1562	19.9062
450751	***	*	19.3267	18.7456	21.4223	19.9014
450754	0.9275	0.8198	20.8968	22.1819	24.7797	22.6402
450755	0.9393	0.8474	18.0092	19.8988	22.2006	20.0136
450758	***	*	25.6547	28.7342	28.2803	27.5631
450760	1.0564	0.9140	24.6349	24.7489	25.1637	24.8390
450761	0.8818	*	15.7483	*	*	15.7483
450763	1.0706	*	22.4905	*	*	22.4905
450766	1.9348	0.9785	30.0441	30.8004	30.2341	30.3517
450770	1.2421	0.9501	20.3656	24.1647	24.3244	23.0091
450771	1.6716	0.9785	31.3924	30.7105	32.0500	31.3870
450774	1.6363	0.9996	24.9683	27.2080	25.7436	25.9776
450775	1.2932	0.9996	24.4006	28.1428	29.8230	27.3216
450779	1.2689	0.9681	26.9908	29.9674	31.8403	29.6444
450780	2.0442	0.8895	23.9516	26.7611	27.0084	25.8985
450788	1.5555	0.8456	25.4172	26.2840	28.3759	26.7019
450795	1.1878	0.9996	23.7510	25.2007	32.9803	27.3787
450796	1.7336	0.9151	27.9734	36.4073	37.6274	33.9632
450797	1.9643	0.9996	20.5379	24.8950	24.8598	23.1191
450801	1.5000	0.8198	23.0373	24.6328	23.6072	23.7609
450803	1.1830	0.9996	30.6093	28.9235	29.0106	29.5055
450804	1.9178	0.9996	26.0981	27.8775	29.1282	27.7201
450808	1.3367	0.9501	23.8067	21.9793	23.0312	22.9181
450809	1.5667	0.9501	26.3659	26.4223	27.3080	26.7166
450811	1.8166	0.9135	25.8491	27.2584	31.2208	27.9853
450813	1.1710	0.8895	25.5949	20.1710	22.9289	22.7727
450820	1.3250	0.9996	30.5288	31.4666	33.9030	32.1410
450822	1.2857	0.9785	31.1430	32.2968	32.2145	31.9067
450824	2.4889	0.9501	26.7803	31.2375	33.3653	30.5418
450825	1.3904	0.9135	20.2959	20.6457	25.1521	21.9878
450827	1.3878	0.8203	20.9704	23.7554	24.1984	23.0409

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450828	1.3241	0.8198	22.3667	24.4740	24.8236	24.1300
450829	***	*	19.5014	20.6016	19.5842	19.9030
450830	1.0196	0.9522	28.1617	28.5902	27.8005	28.1885
450831	1.4011	0.9996	22.7885	23.3880	23.9467	23.3309
450832	1.2704	0.9996	26.6628	26.5229	27.3290	26.8494
450833	1.3222	0.9785	26.0044	27.0133	27.9649	27.0364
450834	1.5971	0.9171	21.2204	20.9607	27.4844	22.7772
450838	1.1492	0.8323	15.8026	19.5754	18.9620	18.1919
450839	0.9901	0.8551	22.9711	25.8222	27.2199	25.2487
450840	1.2906	0.9785	31.1914	30.1743	32.2538	31.2218
450841	1.9165	0.9192	18.9468	20.9410	20.9424	20.3779
450844	1.3117	0.9996	28.7296	30.7887	33.7978	31.3327
450845	1.8432	0.9140	27.7461	29.4933	29.9265	29.0937
450847	1.2710	0.9996	27.6854	28.5548	29.7356	28.6780
450848	1.3004	0.9996	27.8100	29.5355	30.5546	29.3303
450850	1.1195	0.9711	22.1335	21.9266	31.9606	24.7549
450851	2.5542	0.9785	30.1213	32.6950	35.1102	32.6767
450852	***	*	30.0191	*	*	30.0191
450853	1.9480	0.9785	*	36.1169	37.1043	36.6729
450854	***	*	*	27.1868	*	27.1868
450855	1.5587	0.9192	*	30.8855	32.6916	31.8350
450856	1.9053	0.8895	*	39.0865	37.7362	38.3791
450857	***	*	*	30.4632	*	30.4632
450860	1.9631	0.9996	*	24.0171	29.1075	26.9551
450861	***	*	*	34.9290	*	34.9290
450862	1.4560	0.9996	*	31.2224	31.8095	31.4630
450863	***	*	*	24.8825	*	24.8825
450864	2.0615	0.9181	*	23.3765	24.5049	24.0210
450865	1.0642	0.9501	*	29.1763	29.9559	29.5867
450866	***	*	*	15.2959	*	15.2959
450867	1.1905	0.9501	*	28.2289	29.5879	28.9055
450868	1.8308	0.9954	*	27.9579	25.3486	26.8246
450869	2.0516	0.9135	*	22.6253	26.1616	24.9911
450870	***	*	*	37.4364	*	37.4364
450871	1.8016	0.9501	*	*	28.9150	28.9150
450872	1.3873	0.9681	*	*	27.2833	27.2833
450873	***	*	*	*	14.8821	14.8821
450874	1.5449	0.9785	*	*	34.6083	34.6083
450875	1.6419	0.9151	*	*	23.2763	23.2763

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
450876	2.0787	0.8641	*	*	28.4343	28.4343
450877	1.5503	0.9140	*	*	26.1867	26.1867
450878	2.5573	0.8895	*	*	31.6750	31.6750
450879	1.2943	0.8501	*	*	35.5672	35.5672
450880	1.6570	0.9681	*	*	35.9572	35.9572
450881	***	*	*	*	24.5464	24.5464
450882	***	*	*	*	26.6910	26.6910
450883	2.5235	0.9785	*	*	35.2646	35.2646
450884	0.9920	0.8920	*	*	27.8213	27.8213
450885	1.4958	0.9785	*	*	34.1148	34.1148
450886	1.9602	0.9660	*	*	*	*
450888	1.4699	0.9660	*	*	*	*
450889	1.5257	0.9785	*	*	*	*
450890	2.0976	0.9785	*	*	*	*
450891	1.3643	0.9785	*	*	*	*
450893	1.2413	0.9785	*	*	*	*
450894	1.6453	0.9785	*	*	*	*
450895	***	*	*	*	18.4142	18.4142
460001	1.8844	0.9480	27.0757	28.7150	30.0040	28.5953
460003	1.5188	0.9473	26.1372	31.4135	32.3427	29.8772
460004	1.7340	0.9473	26.4498	28.2040	29.6342	28.1012
460005	1.4367	0.9473	23.5633	25.0239	26.0731	24.8800
460006	1.3712	0.9473	25.4787	27.1392	28.3678	27.0132
460007	1.3738	0.9535	25.6686	27.1308	28.0035	26.9931
460008	1.4051	0.9473	26.5672	29.5907	31.5485	29.1771
460009	1.9306	0.9473	26.2833	27.2885	28.3836	27.3958
460010	2.0966	0.9473	27.4648	29.0063	30.4606	29.0099
460011	1.3219	0.9380	23.4023	24.4402	24.9677	24.2736
460013	1.4123	0.9480	25.2448	27.7381	29.2731	27.3708
460014	1.1347	0.9473	24.1412	28.2647	29.5963	27.3277
460015	1.3642	0.9214	25.6576	27.2506	29.1318	27.3614
460017	1.3017	0.8598	23.0388	24.3030	26.1589	24.4636
460018	0.9383	0.8214	20.3756	22.0517	22.8028	21.8351
460019	1.1628	0.8214	19.9901	24.3756	23.2202	22.4677
460020	1.0138	*	19.5669	18.5159	*	19.0929
460021	1.6953	1.1222	26.3420	28.0291	29.5761	28.1943
460023	1.1931	0.9480	25.3094	26.9512	28.5884	26.9777
460026	1.0465	0.9380	24.1547	26.9295	27.9487	26.3213
460030	1.1801	0.8214	23.4679	23.5942	24.4218	23.8301

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

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Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
460033	0.9138	0.8214	22.0249	25.3422	26.6606	24.7048
460035	0.9489	0.8214	17.5723	20.6322	21.9115	20.1175
460036	1.4454	*	27.2866	*	*	27.2866
460037	0.8447	*	21.1035	*	*	21.1035
460039	1.0867	0.9214	28.5657	29.5651	30.4912	29.5982
460041	1.3585	0.9473	25.2744	26.4640	26.3807	26.0600
460042	1.3922	0.9473	22.9949	24.9454	26.8389	24.8871
460043	1.2796	0.9480	28.2089	28.2008	28.6668	28.3615
460044	1.3080	0.9473	26.6795	27.4928	28.7023	27.6434
460047	1.6733	0.9473	25.7920	28.2336	29.9990	27.9779
460049	1.9973	0.9473	24.5165	26.6702	28.4884	26.6038
460051	1.2366	0.9473	25.5881	27.0160	27.8841	26.8633
460052	1.6315	0.9480	25.3163	26.1629	27.1995	26.2810
460054	1.5951	0.9214	25.8668	24.9926	25.7870	25.5264
470001	1.2942	1.0532	27.7329	28.3017	29.7540	28.6009
470003	1.9037	1.0387	26.4919	28.1137	30.1973	28.2590
470005	1.3059	1.0387	29.8255	30.7872	33.1981	31.2960
470006	1.2524	*	26.9651	*	*	26.9651
470010	***	*	26.1273	*	*	26.1273
470011	1.1763	1.0387	28.3911	28.1330	29.6269	28.7242
470012	1.1997	1.0387	24.3425	26.0225	27.0751	25.8314
470018	1.1137	*	28.3419	*	*	28.3419
470024	1.2029	1.0387	25.2427	27.0394	26.6351	26.3235
490001	1.0895	0.8073	21.9953	23.2174	24.0368	23.1150
490002	1.0523	0.8073	19.5613	20.8609	21.7092	20.6693
490003	***	*	27.3456	*	*	27.3456
490004	1.3086	0.9160	25.4597	27.1676	27.5890	26.7640
490005	1.6441	1.0675	28.5744	29.8215	30.5349	29.6413
490007	2.1955	0.8777	26.2481	27.6572	29.3098	27.7576
490009	2.0115	0.9160	29.0740	30.4722	28.4642	29.2905
490011	1.5273	0.8777	24.5687	26.4766	27.4764	26.2051
490012	1.0133	0.8073	19.2276	21.0605	22.9922	21.0354
490013	1.3388	0.8605	22.4771	24.7521	25.5560	24.2699
490017	1.5006	0.8777	24.6845	25.8216	27.5902	26.0271
490018	1.3285	0.9160	24.5196	26.2510	27.2644	26.0551
490019	1.1901	1.0675	25.9761	25.9885	25.8264	25.9276
490020	1.2418	0.9232	24.8001	27.3142	29.3468	27.1254
490021	1.4767	0.8605	24.6440	25.7938	27.0641	25.8484
490022	1.4239	1.0675	28.0749	32.2676	30.1203	30.1142

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
*   Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
490023	1.3029	1.0675	29.7774	30.3416	30.9920	30.3866
490024	1.7769	0.8888	23.0982	26.1125	27.9689	25.6684
490027	1.0539	0.8073	18.9409	24.0288	23.0017	21.9123
490031	***	*	22.0579	*	*	22.0579
490032	1.9605	0.9232	25.1381	25.2654	28.5897	26.3877
490033	1.1087	1.0675	30.0909	31.2922	31.8282	31.1180
490037	1.2021	0.8073	21.3035	24.7711	25.2859	23.7337
490038	1.2579	0.8073	22.3976	21.8509	22.6504	22.2973
490040	1.4791	1.0675	32.8738	32.6564	34.1841	33.2338
490041	1.5154	0.8777	24.5738	26.0897	27.1613	25.9093
490042	1.2791	0.8746	21.8749	24.4650	25.7333	24.0571
490043	1.2495	1.0675	30.8871	33.7096	35.8872	33.5694
490044	1.4481	0.8777	20.8352	23.3527	23.3793	22.5144
490045	1.2631	1.0675	28.8279	32.0937	30.3772	30.3677
490046	1.5195	0.8777	25.6328	26.6517	27.9604	26.7676
490047	1.2301	*	22.5423	*	*	22.5423
490048	1.4179	0.8888	25.0097	26.2828	27.0620	26.1566
490050	1.4893	1.0675	30.5037	31.3885	32.2993	31.4066
490052	1.6975	0.8777	22.8889	23.5973	25.0046	23.8195
490053	1.2133	0.8073	21.8432	23.3315	23.8004	22.9792
490057	1.6174	0.8777	26.1128	26.6898	27.4918	26.7709
490059	1.6486	0.9232	28.7276	27.3611	30.8669	28.9526
490060	1.0549	0.8073	22.4201	23.6113	24.3192	23.4567
490063	1.8511	1.0675	30.3632	31.3619	31.6069	31.1276
490066	1.3599	0.8777	24.7146	27.8250	29.5917	27.4514
490067	1.2606	0.9232	22.9188	24.9021	25.9497	24.5486
490069	1.6019	0.9232	26.8791	27.3181	29.1527	27.7952
490071	1.3192	0.9232	28.4381	29.7186	31.7061	29.9452
490073	2.0908	1.0675	31.7743	33.1829	34.5774	33.0517
490075	1.4337	0.8296	23.8191	25.2022	25.7323	24.9373
490077	1.4152	0.9160	26.0800	26.6806	28.1506	26.9963
490079	1.2496	0.9078	23.4728	25.3103	25.2340	24.6377
490084	1.1764	0.8260	24.5965	24.9007	25.7657	25.0948
490088	1.0999	0.8605	22.4186	24.1471	25.0619	23.8698
490089	1.1022	0.8888	22.6461	24.9438	25.9902	24.5386
490090	1.1083	0.8073	22.2907	25.1157	25.5418	24.2403
490092	1.0916	0.9232	23.8655	23.3439	25.7405	24.2726
490093	1.4715	0.8777	25.0751	25.6531	26.7886	25.8819
490094	0.9845	0.9232	26.5726	28.2165	28.9155	27.8970

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
490097	1.0621	0.9232	23.8005	26.5322	27.1470	25.8282
490098	1.2546	0.8073	21.7231	23.2782	25.1625	23.3960
490101	1.4004	1.0675	30.4285	31.2377	32.3695	31.3631
490104	0.7733	0.9232	17.3295	*	17.0548	17.1728
490105	0.7209	0.8073	24.7922	25.5329	26.3827	25.5156
490106	0.9111	0.9160	23.0199	23.8334	25.7352	23.7423
490107	1.3334	1.0675	29.7000	32.2672	33.5430	31.8922
490108	1.0741	0.8605	22.4345	22.9076	23.3204	22.8878
490109	0.8787	0.9232	21.9877	22.7854	24.2296	22.9554
490110	1.3515	0.8313	22.5974	24.2887	24.9861	24.0085
490111	1.1948	0.8073	22.0199	22.1476	22.7336	22.3108
490112	1.7163	0.9232	26.6453	27.1932	29.0816	27.6672
490113	1.3106	1.0675	29.5698	31.8177	32.4547	31.3270
490114	1.1470	0.8073	20.9116	22.5255	22.1387	21.8658
490115	1.1538	0.8073	21.4666	22.4058	23.5718	22.4670
490116	1.1780	0.8129	22.9017	24.2258	24.3853	23.8567
490117	1.1514	0.8073	18.0277	19.6398	18.1138	18.6020
490118	1.6635	0.9232	27.4050	27.6749	29.0569	28.0591
490119	1.3033	0.8777	25.2549	26.5756	27.8866	26.6080
490120	1.3991	0.8777	24.4434	25.8795	25.9610	25.4137
490122	1.5535	1.0675	31.0449	32.0743	33.3719	32.1673
490123	1.1537	0.8073	23.9233	24.3490	24.2254	24.1638
490126	1.1649	0.8073	22.2859	23.6690	24.0908	23.3598
490127	1.1300	0.8073	20.4289	21.3735	23.5161	21.6359
490130	1.2701	0.8777	22.8512	23.9982	25.3352	24.0816
490133	***	*	26.5684	*	*	26.5684
490134	0.7623	0.8073	*	*	33.2405	33.2405
490135	0.7016	0.8888	*	*	25.9998	25.9998
490136	1.4665	0.9232	*	*	*	*
490137	1.2895	0.8777	*	*	*	*
500001	1.6372	1.1362	29.3707	31.1605	33.0901	31.2057
500002	1.4288	1.0558	25.3347	27.6400	29.1448	27.3388
500003	1.3314	1.1208	29.6341	30.6939	32.1262	30.7330
500005	1.7738	1.1362	32.0972	33.5117	35.0997	33.5662
500007	1.3436	1.1208	28.0476	29.2869	30.5263	29.3452
500008	1.8910	1.1362	31.8837	32.6052	33.5666	32.7102
500011	1.3636	1.1362	30.6508	31.4514	32.6223	31.5869
500012	1.7458	1.0558	30.6856	30.0509	33.8101	31.3853
500014	1.6966	1.1362	33.7536	36.1380	36.5833	35.5228

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
500015	1.4680	1.1362	32.0592	34.5877	37.5724	34.7448
500016	1.6470	1.1208	31.4222	31.4905	32.9177	31.9513
500019	1.2785	1.0689	28.6669	30.5594	31.6242	30.2721
500021	1.2943	1.1208	30.1690	30.7927	32.4702	31.1942
500024	1.7699	1.1419	30.7917	32.6171	36.1647	33.1801
500025	1.8291	1.1362	34.7252	37.7952	40.6369	37.5370
500026	1.3958	1.1362	33.2937	32.8369	34.5881	33.5880
500027	1.5127	1.1362	34.2175	34.6164	39.2906	36.0226
500030	1.6952	1.1257	32.7446	32.4426	34.9174	33.4028
500031	1.2765	1.1287	31.2186	32.8833	33.2391	32.4932
500033	1.3169	1.0558	29.4627	30.6292	31.8891	30.6527
500036	1.3457	1.0558	27.0072	28.7096	30.5938	28.8242
500037	1.0254	1.0558	26.9969	28.1056	31.2654	28.7446
500039	1.4957	1.1208	29.8808	32.2245	33.5606	31.9348
500041	1.4361	1.1226	26.7829	30.3627	34.2017	30.2993
500044	1.9624	1.0558	30.3164	29.0214	31.0936	30.1182
500049	1.3501	1.0558	27.1819	27.7170	29.8189	28.3097
500050	1.4998	1.1226	29.9791	32.6751	33.7713	32.1383
500051	1.7960	1.1362	31.9406	32.5764	34.7610	33.0994
500052	1.4523	1.1362	*	*	*	*
500053	1.2886	1.0558	28.4130	28.2901	30.2811	28.9866
500054	1.9948	1.0558	30.8067	31.6595	32.5105	31.6694
500058	1.6540	1.0558	30.4699	30.7487	30.7034	30.6484
500060	1.3720	1.1362	34.1523	37.4869	38.7682	36.8223
500064	1.7342	1.1362	31.5371	31.6112	32.3581	31.8431
500072	1.2307	1.0820	33.4863	31.2000	32.5269	32.3949
500077	1.4558	1.0558	29.4199	31.6153	33.2223	31.3945
500079	1.3764	1.1208	29.6623	31.3280	32.5809	31.1946
500084	1.3889	1.1362	29.3484	30.2411	32.7883	30.8053
500088	1.3945	1.1362	33.4302	35.3770	36.7953	35.2133
500108	1.6416	1.1208	29.4244	31.8483	34.3872	31.9459
500119	1.3904	1.0558	30.9999	29.7028	31.2233	30.6358
500122	1.3566	*	30.1396	*	*	30.1396
500124	1.4292	1.1362	31.5438	32.3505	34.4790	32.8210
500129	1.5749	1.1208	30.7536	32.1102	34.4447	32.4986
500134	0.4899	1.1362	26.8607	27.2428	28.1374	27.5278
500138	0.8272	*	*	*	*	*
500139	1.5206	1.1419	31.6591	33.9739	34.6412	33.4188
500141	1.3171	1.1362	30.5456	31.3308	33.7532	31.9223

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
500143	0.4729	1.1419	22.1419	23.6766	25.3099	23.6848
500147	0.8772	*	24.5744	*	*	24.5744
500148	1.1803	1.0558	22.2161	26.4206	37.7830	30.2231
500150	1.2180	1.1226	*	*	*	*
510001	1.9238	0.8390	23.4477	25.2973	25.8693	24.9197
510002	1.2871	0.8746	25.9597	23.8921	23.7270	24.4604
510006	1.3370	0.8255	23.5727	24.9627	24.8777	24.4769
510007	1.7232	0.8878	25.2835	24.7264	27.1149	25.7084
510008	1.3059	0.9255	24.6959	26.3554	27.5241	26.2154
510012	0.9599	0.7692	18.2845	18.8984	20.8455	19.3188
510013	1.1244	0.7568	20.8782	22.7882	22.8779	22.1601
510018	1.0596	0.8393	20.5556	22.4597	23.1043	22.0364
510022	1.8444	0.8393	24.2125	26.9511	26.8328	25.9941
510023	1.2839	0.7889	20.4908	20.6435	21.0940	20.7445
510024	1.8414	0.8407	24.0444	25.5634	26.6621	25.4529
510026	0.9983	0.7568	16.6192	17.9908	19.2025	17.9223
510028	***	*	21.7135	*	*	21.7135
510029	1.3235	0.8393	22.4556	22.7104	24.0872	23.0837
510030	1.0973	0.8255	21.5583	24.3936	24.2007	23.3949
510031	1.4315	0.8393	21.7637	23.2624	24.0237	22.9923
510033	1.7281	0.8258	23.0305	22.6189	24.0796	23.2701
510038	1.0543	0.7568	17.2832	20.6565	20.9180	19.6284
510039	1.2501	0.7568	19.5468	19.8751	20.4719	19.9555
510046	1.3467	0.7732	21.2540	22.1712	22.2935	21.8981
510047	1.1486	0.8390	24.0954	27.1214	27.6859	26.2421
510048	1.1751	0.7568	17.5096	18.8576	22.7930	19.5221
510050	1.6035	0.7568	19.9766	21.0772	21.9009	20.9839
510053	1.1071	0.7568	20.8608	22.3318	21.5338	21.5798
510055	1.5346	0.8878	30.7868	28.4615	29.4111	29.5182
510058	1.3452	0.8258	22.6976	23.9015	25.3248	23.9858
510059	0.7138	0.8393	21.9551	22.1435	20.8847	21.6752
510062	1.1628	0.8393	23.3216	26.2296	26.7066	25.4037
510067	1.1068	0.7568	21.2099	25.0437	25.2130	23.8479
510068	1.1378	*	23.1011	*	*	23.1011
510070	1.2272	0.8393	23.2382	23.5639	23.9742	23.5991
510071	1.3165	0.7732	23.1685	23.4508	23.2954	23.3056
510072	1.1600	0.7568	20.1997	20.5146	19.4370	20.0241
510077	1.0539	0.8724	23.6584	24.5010	25.9515	24.6973
510082	1.1084	0.7568	19.1878	19.9081	20.3279	19.7905

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

*   Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
510085	1.2934	0.8393	23.7174	26.3877	26.2617	25.5462
510086	1.1745	0.7568	17.5933	19.8735	19.2606	18.9127
510089	***	*	27.7061	*	*	27.7061
510090	1.8498	0.8878	*	*	*	*
520002	1.3394	1.0004	24.9950	27.7705	29.0501	27.3208
520004	1.3931	0.9698	25.4639	27.6530	28.9857	27.3816
520008	1.5349	1.0295	29.8353	30.7553	33.8057	31.4985
520009	1.7224	0.9684	26.1503	27.4044	28.8591	27.4837
520011	1.3035	0.9684	25.2747	26.6268	28.0224	26.6546
520013	1.4584	0.9684	26.6225	29.0018	30.1834	28.6561
520017	1.1205	0.9684	24.6677	28.4699	29.3278	27.4748
520019	1.3604	0.9684	26.7433	28.6971	29.8640	28.5157
520021	1.3020	1.0471	26.6935	28.4182	29.1129	28.1504
520027	1.3702	1.0295	27.6771	31.4284	32.4137	30.5716
520028	1.3503	1.0996	25.4164	26.7260	28.0813	26.7500
520030	1.7226	1.0004	27.0184	29.4678	30.5724	29.0613
520033	1.2658	0.9684	25.0853	28.0662	29.0236	27.5164
520034	1.2321	0.9684	23.9850	26.1094	26.8886	25.6368
520035	1.3581	0.9760	24.7767	27.3276	28.1048	26.7464
520037	1.8188	1.0004	29.7234	30.1799	32.2144	30.7303
520038	1.2391	1.0295	26.6470	29.3134	29.6339	28.5933
520040	1.2143	1.0295	27.2325	29.1262	31.2038	29.0319
520041	1.0701	1.1176	22.7595	23.5495	25.3764	23.9562
520044	1.3515	0.9760	26.0191	27.3685	28.2382	27.2573
520045	1.6629	0.9684	26.0030	27.3336	29.2556	27.5277
520048	1.5668	0.9684	25.1724	26.8080	29.1870	26.9823
520049	2.1335	0.9684	25.9256	26.9851	28.0936	26.9958
520051	1.5562	1.0295	28.4880	31.9949	31.5974	30.7556
520057	1.1727	0.9877	25.3745	27.7528	29.1158	27.4376
520059	1.3044	1.0583	28.0907	29.5801	30.4491	29.3858
520060	1.3697	*	23.8817	24.8638	*	24.3767
520062	1.2465	1.0295	28.2215	28.8510	32.8584	30.1184
520063	1.1373	1.0295	27.4100	29.0993	30.3391	28.9452
520064	1.5987	1.0295	28.6101	30.3225	31.5723	30.0470
520066	1.4379	0.9852	27.1657	29.2088	31.0644	29.1283
520068	***	*	24.8184	*	*	24.8184
520070	1.7752	0.9684	24.8935	27.6771	28.2059	26.9824
520071	1.1683	1.0295	27.6202	30.0262	30.6930	29.4715
520075	1.5645	0.9684	27.1699	29.2920	30.1582	28.8342

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
*** Denotes MedPAR data not available for the provider for FY 2006.
[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
520076	1.2406	1.0996	26.1697	27.3335	27.4423	26.9220
520078	1.5171	1.0295	27.5989	29.9837	31.6606	29.7283
520083	1.7370	1.1176	28.8407	30.8826	32.7728	30.8985
520087	1.7712	0.9698	27.3374	28.5810	30.5659	28.8732
520088	1.4096	0.9887	26.9936	30.7450	30.6657	29.5653
520089	1.5712	1.1176	30.0448	33.8793	33.4098	32.4835
520091	1.2971	0.9684	24.6320	25.4593	27.3442	25.8210
520094	***	*	25.7567	*	*	25.7567
520095	1.2937	1.0996	26.7863	30.4216	32.0381	29.8120
520096	1.3783	0.9879	24.5758	27.8896	29.5985	27.4540
520097	1.3976	0.9684	26.3321	29.1479	29.9998	28.4877
520098	2.0355	1.1176	30.6150	32.5785	36.5776	33.3175
520100	1.2798	0.9852	26.2161	29.3243	29.9458	28.5050
520102	1.1728	1.0295	26.8234	29.1680	30.7990	28.9928
520103	1.5495	1.0295	27.9147	30.3165	32.6269	30.3612
520107	1.2792	0.9715	28.3431	28.9878	29.4178	28.9355
520109	1.0392	0.9684	23.3271	24.7228	25.0697	24.3762
520113	1.3272	0.9684	27.4135	31.4708	33.3475	30.7254
520116	1.2669	1.0295	26.9902	27.9688	30.2156	28.3945
520132	***	*	23.1941	25.0006	27.3431	25.0308
520136	1.7249	1.0295	27.7703	30.6522	32.1479	30.1365
520138	1.8879	1.0295	28.4394	30.8016	31.6581	30.2963
520139	1.2893	1.0295	26.5110	28.8870	30.4903	28.6153
520140	0.3793	*	28.4433	31.0043	31.1315	30.2285
520152	1.0907	*	24.9392	29.7308	*	27.4042
520160	1.8662	0.9684	25.7588	27.9548	29.5582	27.7551
520170	1.4782	1.0295	27.2221	30.4309	31.4710	29.7190
520173	1.0829	0.9684	28.0995	29.2429	31.0599	29.4647
520177	1.6194	1.0295	30.7317	31.4555	32.5714	31.6050
520178	1.0240	*	20.2666	*	*	20.2666
520189	1.2042	1.0471	28.4720	28.0014	29.0295	28.4999
520193	1.7002	0.9684	26.0885	27.8113	29.2007	27.7865
520194	1.7148	1.0295	24.9408	30.1668	31.4379	28.8968
520195	0.3556	1.0295	36.6973	36.3116	36.2900	36.4369
520196	1.6798	0.9684	35.1043	36.9266	31.1175	34.0254
520197	***	*	*	*	30.1917	30.1917
520198	1.4193	0.9684	*	*	28.5975	28.5975
520199	2.2776	1.0295	*	*	36.5699	36.5699
520200	0.9180	*	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.

[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.

* Denotes wage data not available for the provider for that year.

** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.

*** Denotes MedPAR data not available for the provider for FY 2006.

[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

Provider No.	Case-mix Index	FY 2008 Wage Index	Average HourlyWage FY 2006	Average Hourly Wage FY 2007	Average Hourly Wage FY 2008	Average Hourly Wage ** (3 years)
520201	0.6866	*	*	*	*	*
520202	1.4495	1.0004	*	*	*	*
530002	1.1272	0.9163	26.8356	28.3063	29.2069	28.1167
530006	1.1827	0.9163	24.9318	27.2421	29.2104	27.0638
530007	***	*	20.4391	*	*	20.4391
530008	1.1673	0.9163	23.8589	24.0090	26.5180	24.7926
530009	0.9202	0.9163	26.8316	24.6719	26.0490	25.8222
530010	1.3058	0.9163	25.8482	25.9852	27.4121	26.4402
530011	1.1124	0.9163	24.8245	27.8772	27.8613	26.9109
530012	1.7060	0.9270	25.2526	26.9582	28.7524	26.9862
530014	1.5520	0.9204	24.5947	26.7156	28.5469	26.6902
530015	1.1541	0.9272	27.6876	29.8310	29.8306	29.0860
530017	1.1052	0.9163	25.3362	29.8503	31.1105	28.7232
530023	***	*	21.3813	*	*	21.3813
530025	1.2402	0.9163	28.6938	24.4392	29.4346	27.4317
530032	1.0159	0.9163	25.7728	23.9004	24.6580	24.7334

[1] Based on salaries adjusted for occupational mix, according to the calculation in section II.D.6 of the preamble to this final rule.
[2] The case-mix index is based on the billed DRGs in the FY 2006 MedPAR file. It is not transfer adjusted.
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2006, 2007, and 2008.
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[3] This provider, 140B10, is part of a multi-campus provider, 140010, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.
[4] This provider, 220B74, is part of a multi-campus provider, 220074, that is comprised of campuses that are located in two different CBSAs. For the FY 2008 wage index, a new provider record was created, designated with a "B" in the 4th position of the provider number, to distinguish between the portion of the wages and hours of the multi-campus facility that is being allocated between the two different CBSAs. Please refer to the FY 2008 final rule, section III.H.I.7 "Geographic Reclassification for Multi-campus Hospitals," for more details on this provision.

**TABLE 3A.--FY 2008 and 3-YEAR* AVERAGE HOURLY
WAGE FOR URBAN AREAS BY CBSA**

[*Based on the salaries and hours computed for Federal FYs 2006, 2007, and 2008.]

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
10180	Abilene, TX	25.5587	24.1347
10380	Aguadilla-Isabela-San Sebastián, PR	10.3758	11.4939
10420	Akron, OH	26.9806	25.8600
10500	Albany, GA	26.5094	25.8668
10580	Albany-Schenectady-Troy, NY	26.8819	25.7665
10740	Albuquerque, NM	30.1667	28.6303
10780	Alexandria, LA	24.6476	23.5446
10900	Allentown-Bethlehem-Easton, PA-NJ	31.0279	29.5473
11020	Altoona, PA	25.8973	25.4013
11100	Amarillo, TX	28.3855	27.1503
11180	Ames, IA	30.9415	28.8521
11260	Anchorage, AK	36.4638	35.0346
11300	Anderson, IN	27.8045	26.0246
11340	Anderson, SC	28.5621	26.7375
11460	Ann Arbor, MI	32.5609	31.5918
11500	Anniston-Oxford, AL	24.7360	23.2901
11540	Appleton, WI	29.2835	27.6497
11700	Asheville, NC	28.5382	27.3722
12020	Athens-Clarke County, GA	31.0062	28.5975
12060	Atlanta-Sandy Springs-Marietta, GA	30.4332	28.9628
12100	Atlantic City, NJ	37.4144	34.9286
12220	Auburn-Opelika, AL	25.0468	23.9133
12260	Augusta-Richmond County, GA-SC	29.7703	28.5720
12420	Austin-Round Rock, TX	29.4701	27.8668
12540	Bakersfield, CA	34.6222	32.1857
12580	Baltimore-Towson, MD	31.1116	29.4296
12620	Bangor, ME	30.6488	29.0740
12700	Barnstable Town, MA	39.1145	37.3027
12940	Baton Rouge, LA	24.8413	24.3034
12980	Battle Creek, MI	31.1795	28.7485
13020	Bay City, MI	27.9569	27.3833
13140	Beaumont-Port Arthur, TX	26.7226	25.3526
13380	Bellingham, WA	34.9174	33.4028

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
13460	Bend, OR	32.8326	31.4061
13644	Bethesda-Gaithersburg-Frederick, MD	32.4274	32.2308
13740	Billings, MT	27.5114	26.3017
13780	Binghamton, NY	28.1250	26.2437
13820	Birmingham-Hoover, AL	27.4679	26.3101
13900	Bismarck, ND	22.4781	21.8382
13980	Blacksburg-Christiansburg-Radford, VA	25.2131	23.9984
14020	Bloomington, IN	28.9157	26.4848
14060	Bloomington-Normal, IL	29.4154	27.2850
14260	Boise City-Nampa, ID	29.4544	27.5816
14484	Boston-Quincy, MA	36.7350	34.6366
14500	Boulder, CO	31.3555	29.5771
14540	Bowling Green, KY	25.0769	24.0241
14740	Bremerton-Silverdale, WA	33.5606	31.9348
14860	Bridgeport-Stamford-Norwalk, CT	39.6328	37.6098
15180	Brownsville-Harlingen, TX	28.5123	28.3113
15260	Brunswick, GA	30.2845	29.1378
15380	Buffalo-Niagara Falls, NY	29.7374	28.1521
15500	Burlington, NC	26.6546	25.6458
15540	Burlington-South Burlington, VT	29.7251	28.0158
15764	Cambridge-Newton-Framingham, MA	34.7914	32.9021
15804	Camden, NJ	32.6688	31.0922
15940	Canton-Massillon, OH	27.6581	26.5075
15980	Cape Coral-Fort Myers, FL	29.4194	27.9207
16180	Carson City, NV	29.0454	29.0240
16220	Casper, WY	28.7524	26.9862
16300	Cedar Rapids, IA	26.9348	25.8164
16580	Champaign-Urbana, IL	28.8930	28.0728
16620	Charleston, WV	26.0325	25.1463
16700	Charleston-North Charleston, SC	28.2298	27.1032
16740	Charlotte-Gastonia-Concord, NC-SC	29.4814	28.2160
16820	Charlottesville, VA	28.4122	28.8815
16860	Chattanooga, TN-GA	27.7980	26.6068
16940	Cheyenne, WY	28.5469	26.6902
16974	Chicago-Naperville-Joliet, IL	32.8395	31.5713
17020	Chico, CA	34.8369	32.3535
17140	Cincinnati-Middletown, OH-KY-IN	29.9631	28.3817

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
17300	Clarksville, TN-KY	25.4903	24.5654
17420	Cleveland, TN	25.3412	24.1819
17460	Cleveland-Elyria-Mentor, OH	28.9854	27.5689
17660	Coeur d'Alene, ID	29.0166	27.8500
17780	College Station-Bryan, TX	28.4470	26.5699
17820	Colorado Springs, CO	29.3604	27.9538
17860	Columbia, MO	26.4800	24.9722
17900	Columbia, SC	27.3857	26.4658
17980	Columbus, GA-AL	27.9721	25.7758
18020	Columbus, IN	29.8540	28.2570
18140	Columbus, OH	31.0923	29.5809
18580	Corpus Christi, TX	26.2254	25.0632
18700	Corvallis, OR	33.1928	32.2201
19060	Cumberland, MD-WV	24.6976	24.8725
19124	Dallas-Plano-Irving, TX	30.3505	29.5230
19140	Dalton, GA	26.6185	26.1940
19180	Danville, IL	28.6709	27.3188
19260	Danville, VA	25.7323	24.9373
19340	Davenport-Moline-Rock Island, IA-IL	27.2974	25.9231
19380	Dayton, OH	28.7765	27.1445
19460	Decatur, AL	24.0785	23.9057
19500	Decatur, IL	25.1658	24.0544
19660	Deltona-Daytona Beach-Ormond Beach, FL	27.7377	27.0495
19740	Denver-Aurora, CO	32.4261	31.4090
19780	Des Moines-West Des Moines, IA	28.4016	27.5535
19804	Detroit-Livonia-Dearborn, MI	31.1865	30.3895
20020	Dothan, AL	22.9406	22.3216
20100	Dover, DE	32.2443	30.0060
20220	Dubuque, IA	27.5285	26.4860
20260	Duluth, MN-WI	31.2690	30.0353
20500	Durham, NC	30.2065	29.1866
20740	Eau Claire, WI	29.1817	27.8615
20764	Edison, NJ	34.3515	32.9651
20940	El Centro, CA	28.4246	26.8343
21060	Elizabethtown, KY	26.7279	25.6690
21140	Elkhart-Goshen, IN	29.5912	28.1606
21300	Elmira, NY	25.8453	24.6049

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
21340	El Paso, TX	28.3494	26.9992
21500	Erie, PA	26.3723	25.6875
21660	Eugene-Springfield, OR	34.1240	32.3054
21780	Evansville, IN-KY	26.2546	25.6722
21820	Fairbanks, AK	33.9375	32.8391
21940	Fajardo, PR	13.5395	12.3736
22020	Fargo, ND-MN	24.6382	24.1984
22140	Farmington, NM	28.7893	25.7109
22180	Fayetteville, NC	30.7591	28.3790
22220	Fayetteville-Springdale-Rogers, AR-MO	27.5174	26.2042
22380	Flagstaff, AZ	35.8287	34.6826
22420	Flint, MI	34.1572	31.9911
22500	Florence, SC	26.5044	25.8220
22520	Florence-Muscle Shoals, AL	23.6943	23.4052
22540	Fond du Lac, WI	30.6657	29.5653
22660	Fort Collins-Loveland, CO	29.6511	28.4243
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	31.2029	30.0377
22900	Fort Smith, AR-OK	24.9751	23.7479
23020	Fort Walton Beach-Crestview-Destin, FL	26.8731	25.7329
23060	Fort Wayne, IN	28.0404	27.6657
23104	Fort Worth-Arlington, TX	29.8878	28.3058
23420	Fresno, CA	34.2409	32.2447
23460	Gadsden, AL	25.2583	23.7861
23540	Gainesville, FL	28.8468	27.7119
23580	Gainesville, GA	29.2134	27.2823
23844	Gary, IN	28.6630	27.6151
24020	Glens Falls, NY	26.4328	25.3769
24140	Goldsboro, NC	28.7544	26.8571
24220	Grand Forks, ND-MN	24.9615	23.5379
24300	Grand Junction, CO	30.0988	28.4999
24340	Grand Rapids-Wyoming, MI	29.0742	27.9446
24500	Great Falls, MT	26.4422	25.6386
24540	Greeley, CO	31.0018	29.1634
24580	Green Bay, WI	29.4031	28.1019
24660	Greensboro-High Point, NC	28.2442	26.8380
24780	Greenville, NC	28.7434	27.6121
24860	Greenville-Mauldin-Easley, SC	29.8863	28.7666

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
25020	Guayama, PR	09.1328	09.2034
25060	Gulfport-Biloxi, MS	26.6981	25.8275
25180	Hagerstown-Martinsburg, MD-WV	28.7052	27.6861
25260	Hanford-Corcoran, CA	33.0818	30.9616
25420	Harrisburg-Carlisle, PA	28.6281	27.5253
25500	Harrisonburg, VA	27.5890	26.7640
25540	Hartford-West Hartford-East Hartford, CT	34.1958	32.5387
25620	Hattiesburg, MS	23.3688	22.3933
25860	Hickory-Lenoir-Morganton, NC	27.8279	26.5091
25980	[1]Hinesville-Fort Stewart, GA	----	----
26100	Holland-Grand Haven, MI	28.1106	26.9710
26180	Honolulu, HI	35.0637	32.9282
26300	Hot Springs, AR	28.2416	26.5594
26380	Houma-Bayou Cane-Thibodaux, LA	24.7360	23.6339
26420	Houston- Sugar Land-Baytown, TX	31.0073	29.6665
26580	Huntington-Ashland, WV-KY-OH	27.5367	26.7655
26620	Huntsville, AL	27.9664	26.7281
26820	Idaho Falls, ID	28.6730	27.2931
26900	Indianapolis-Carmel, IN	30.1393	28.9659
26980	Iowa City, IA	29.2283	28.3310
27060	Ithaca, NY	29.5885	28.8558
27100	Jackson, MI	29.3442	28.0566
27140	Jackson, MS	24.6588	24.0939
27180	Jackson, TN	26.6460	25.9444
27260	Jacksonville, FL	28.1891	27.2668
27340	Jacksonville, NC	25.6349	24.5586
27500	Janesville, WI	30.5583	28.8479
27620	Jefferson City, MO	26.9896	25.3379
27740	Johnson City, TN	23.8863	23.3983
27780	Johnstown, PA	23.6956	24.1225
27860	Jonesboro, AR	24.5432	23.3834
27900	Joplin, MO	28.5715	26.1411
28020	Kalamazoo-Portage, MI	32.5665	31.2119
28100	Kankakee-Bradley, IL	31.4634	30.4290
28140	Kansas City, MO-KS	28.9006	27.7100
28420	Kennewick-Richland-Pasco, WA	30.5718	30.0867
28660	Killeen-Temple-Fort Hood, TX	25.7531	25.4186

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
28700	Kingsport-Bristol-Bristol, TN-VA	24.0579	23.5616
28740	Kingston, NY	29.7092	27.8745
28940	Knoxville, TN	24.8497	24.3151
29020	Kokomo, IN	29.3517	28.2551
29100	La Crosse, WI-MN	30.0819	28.4074
29140	Lafayette, IN	26.9111	25.7888
29180	Lafayette, LA	25.7422	24.7411
29340	Lake Charles, LA	24.1388	23.1811
29404	Lake County-Kenosha County, IL-WI	32.8246	31.3422
29420	[2] Lake Havasu City- Kingman, AZ	28.9483	27.6199
29460	Lakeland, FL	27.4022	26.4654
29540	Lancaster, PA	29.5629	28.7355
29620	Lansing-East Lansing, MI	31.1650	29.4203
29700	Laredo, TX	26.3647	24.4147
29740	Las Cruces, NM	26.4515	25.6132
29820	Las Vegas-Paradise, NV	35.5188	33.5865
29940	Lawrence, KS	25.3394	24.6697
30020	Lawton, OK	26.0678	24.4730
30140	Lebanon, PA	25.4407	25.2125
30300	Lewiston, ID-WA	28.6136	28.2894
30340	Lewiston-Auburn, ME	28.8124	27.4899
30460	Lexington-Fayette, KY	27.9203	26.6486
30620	Lima, OH	28.7203	26.9713
30700	Lincoln, NE	30.6210	29.5883
30780	Little Rock-North Little Rock-Conway, AR	27.7910	27.0607
30860	Logan, UT-ID	28.4789	27.0287
30980	Longview, TX	27.2767	26.0021
31020	Longview, WA	34.2017	30.2993
31084	Los Angeles-Long Beach-Glendale, CA	36.1216	34.6333
31140	Louisville-Jefferson County, KY-IN	28.0031	27.0434
31180	Lubbock, TX	26.8019	25.5836
31340	Lynchburg, VA	26.6920	25.5281
31420	Macon, GA	30.2376	28.6721
31460	Madera, CA	26.0908	25.2915
31540	Madison, WI	34.6626	32.2711
31700	Manchester-Nashua, NH	31.4185	30.1339
31900	Mansfield, OH	28.5643	27.8933

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
32420	Mayagüez, PR	11.3432	11.2956
32580	McAllen-Edinburg-Mission, TX	28.3352	26.4921
32780	Medford, OR	31.9397	30.8471
32820	Memphis, TN-MS-AR	28.8850	27.6299
32900	Merced, CA	37.1577	33.9319
33124	Miami-Miami Beach-Kendall, FL	31.0417	29.1773
33140	Michigan City-La Porte, IN	27.2502	26.8087
33260	Midland, TX	30.1228	28.3740
33340	Milwaukee-Waukesha-West Allis, WI	31.9336	30.3294
33460	Minneapolis-St. Paul-Bloomington, MN-WI	33.7989	32.2480
33540	Missoula, MT	27.0081	26.3798
33660	Mobile, AL	24.6508	23.3350
33700	Modesto, CA	36.9816	35.0810
33740	Monroe, LA	24.4048	23.5973
33780	Monroe, MI	29.3721	28.3183
33860	Montgomery, AL	25.1560	24.3045
34060	Morgantown, WV	26.0767	25.0610
34100	Morristown, TN	22.9838	22.9921
34580	Mount Vernon-Anacortes, WA	31.5882	30.3305
34620	Muncie, IN	24.8045	24.8596
34740	Muskegon-Norton Shores, MI	30.9174	29.4013
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	26.8308	26.0534
34900	Napa, CA	43.2961	38.9739
34940	Naples-Marco Island, FL	29.8301	29.4006
34980	Nashville-Davidson-Murfreesboro- Franklin, TN	29.8314	28.7944
35004	Nassau-Suffolk, NY	39.9385	38.0505
35084	Newark-Union, NJ-PA	36.2043	34.7660
35300	New Haven-Milford, CT	37.0135	35.4050
35380	New Orleans-Metairie-Kenner, LA	27.0196	25.9463
35644	New York-White Plains-Wayne, NY-NJ	41.0297	39.1741
35660	Niles-Benton Harbor, MI	28.3275	26.5614
35980	Norwich-New London, CT	35.5892	34.4004
36084	Oakland-Fremont-Hayward, CA	47.4312	45.4607
36100	Ocala, FL	26.6198	25.7580
36140	Ocean City, NJ	34.3497	32.1653
36220	Odessa, TX	30.8727	29.4951
36260	Ogden-Clearfield, UT	28.0771	26.7568

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
36420	Oklahoma City, OK	27.1496	26.2035
36500	Olympia, WA	35.4177	32.8236
36540	Omaha-Council Bluffs, NE-IA	29.3831	28.0303
36740	Orlando-Kissimmee, FL	28.7946	27.9149
36780	Oshkosh-Neenah, WI	29.0738	27.4065
36980	Owensboro, KY	26.9752	25.9113
37100	Oxnard-Thousand Oaks-Ventura, CA	35.3324	33.6460
37340	Palm Bay-Melbourne-Titusville, FL	29.0918	28.3346
37380	[2] Palm Coast, FL	27.0981	27.5188
37460	Panama City-Lynn Haven, FL	26.1809	24.3132
37620	Parkersburg-Marietta-Vienna, WV-OH	25.6137	24.3192
37700	Pascagoula, MS	26.4851	24.5084
37764	Peabody, MA (Formerly, Essex County, MA)	32.8768	31.1949
37860	Pensacola-Ferry Pass-Brent, FL	25.1928	23.7366
37900	Peoria, IL	29.1064	26.9822
37964	Philadelphia, PA	33.7819	32.4433
38060	Phoenix-Mesa-Scottsdale, AZ	31.3577	29.9786
38220	Pine Bluff, AR	25.2840	25.1920
38300	Pittsburgh, PA	26.0226	25.3927
38340	Pittsfield, MA	31.1782	30.0596
38540	Pocatello, ID	28.4934	27.3130
38660	Ponce, PR	13.2197	13.6539
38860	Portland-South Portland-Biddeford, ME	30.9888	29.7785
38900	Portland-Vancouver-Beaverton, OR-WA	34.8215	33.1817
38940	Port St. Lucie, FL	31.1259	29.6067
39100	Poughkeepsie-Newburgh-Middletown, NY	34.0640	32.4120
39140	Prescott, AZ	30.8935	29.2139
39300	Providence-New Bedford-Fall River, RI-MA	32.6657	31.8184
39340	Provo-Orem, UT	29.4032	28.0289
39380	Pueblo, CO	27.0893	25.6378
39460	Punta Gorda, FL	29.6456	28.1432
39540	Racine, WI	29.7224	27.6182
39580	Raleigh-Cary, NC	29.9696	28.6624
39660	Rapid City, SD	26.9365	25.9833
39740	Reading, PA	29.1988	28.3941
39820	Redding, CA	39.7306	36.7803
39900	Reno-Sparks, NV	34.3107	33.6223

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
40060	Richmond, VA	28.6339	27.1478
40140	Riverside-San Bernardino-Ontario, CA	33.8115	32.2089
40220	Roanoke, VA	27.5669	25.7396
40340	Rochester, MN	32.5362	32.3328
40380	Rochester, NY	27.6600	26.7521
40420	Rockford, IL	30.4079	29.3760
40484	Rockingham County-Strafford County, NH	31.1894	30.1246
40580	Rocky Mount, NC	27.9351	26.4593
40660	Rome, GA	29.6117	28.2895
40900	Sacramento--Arden-Arcade--Roseville, CA	40.5303	38.5061
40980	Saginaw-Saginaw Township North, MI	28.2960	27.0569
41060	St. Cloud, MN	34.2980	31.6169
41100	St. George, UT	29.5761	28.1943
41140	St. Joseph, MO-KS	27.3754	28.2413
41180	St. Louis, MO-IL	27.8586	26.5418
41420	Salem, OR	32.2491	30.6939
41500	Salinas, CA	45.2648	42.3717
41540	Salisbury, MD	27.6311	26.4523
41620	Salt Lake City, UT	29.3832	28.0017
41660	San Angelo, TX	26.8540	25.0310
41700	San Antonio, TX	27.5914	26.4240
41740	San Diego-Carlsbad-San Marcos, CA	34.7234	33.2467
41780	Sandusky, OH	27.1546	26.6090
41884	San Francisco-San Mateo-Redwood City, CA	45.9063	44.5739
41900	San Germán-Cabo Rojo, PR	14.2744	13.8609
41940	San Jose-Sunnyvale-Santa Clara, CA	47.8883	45.2793
41980	San Juan-Caguas-Guaynabo, PR	14.0384	13.4057
42020	San Luis Obispo-Paso Robles, CA	37.0690	33.9137
42044	Santa Ana-Anaheim-Irvine, CA	35.9446	34.0127
42060	Santa Barbara-Santa Maria-Goleta, CA	35.5323	33.4626
42100	Santa Cruz-Watsonville, CA	48.5956	45.3129
42140	Santa Fe, NM	33.1342	31.9538
42220	Santa Rosa-Petaluma, CA	44.8763	41.6974
42260	Sarasota-Bradenton-Venice, FL	30.3046	28.7388
42340	Savannah, GA	27.5761	27.0800
42540	Scranton--Wilkes-Barre, PA	25.8832	24.7503
42644	Seattle-Bellevue-Everett, WA	35.2419	33.6864

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
42680	Sebastian-Vero Beach, FL	30.0959	28.6117
43100	Sheboygan, WI	28.0852	26.7414
43300	Sherman-Denison, TX	26.4590	26.2413
43340	Shreveport-Bossier City, LA	26.5251	25.7648
43580	Sioux City, IA-NE-SD	28.1724	27.0701
43620	Sioux Falls, SD	29.6291	28.1071
43780	South Bend-Mishawaka, IN-MI	29.9101	28.9205
43900	Spartanburg, SC	29.1389	27.2257
44060	Spokane, WA	32.2318	31.1918
44100	Springfield, IL	27.7357	26.2616
44140	Springfield, MA	32.4121	30.4332
44180	Springfield, MO	27.2665	25.2881
44220	Springfield, OH	26.4842	25.0769
44300	State College, PA	26.7342	25.2071
44700	Stockton, CA	36.6289	34.1459
44940	Sumter, SC	27.5988	25.3447
45060	Syracuse, NY	30.8602	28.9261
45104	Tacoma, WA	33.9112	31.9624
45220	Tallahassee, FL	27.9986	26.3273
45300	Tampa-St. Petersburg-Clearwater, FL	28.2697	27.2080
45460	Terre Haute, IN	27.3687	25.3385
45500	Texarkana, TX-Texarkana, AR	24.1336	23.7947
45780	Toledo, OH	28.7454	27.8506
45820	Topeka, KS	26.5404	25.8367
45940	Trenton-Ewing, NJ	33.2313	31.9690
46060	Tucson, AZ	29.2073	27.5084
46140	Tulsa, OK	26.3577	25.0127
46220	Tuscaloosa, AL	26.4577	25.5487
46340	Tyler, TX	28.4760	26.8685
46540	Utica-Rome, NY	27.2131	25.5649
46660	Valdosta, GA	25.4439	25.1429
46700	Vallejo-Fairfield, CA	44.7630	43.6070
47020	Victoria, TX	25.1713	24.3382
47220	Vineland-Millville-Bridgeton, NJ	33.0258	30.4634
47260	Virginia Beach-Norfolk-Newport News, VA-NC	27.2219	26.0009
47300	Visalia-Porterville, CA	31.6363	30.0714
47380	Waco, TX	26.6549	25.4931

CBSA Code	Urban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
47580	Warner Robins, GA	29.8158	26.8114
47644	Warren-Troy-Farmington Hills, MI	31.1197	29.5882
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	33.1099	32.0932
47940	Waterloo-Cedar Falls, IA	27.0432	25.5301
48140	Wausau, WI	30.5724	29.0613
48260	Weirton-Steubenville, WV-OH	24.4665	23.3434
48300	Wenatchee, WA	34.9713	31.3444
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	29.7017	28.7143
48540	Wheeling, WV-OH	21.7324	20.9335
48620	Wichita, KS	27.7241	26.6808
48660	Wichita Falls, TX	25.4414	24.7129
48700	Williamsport, PA	24.6495	23.9559
48864	Wilmington, DE-MD-NJ	33.0826	31.3165
48900	Wilmington, NC	28.9236	28.2353
49020	Winchester, VA-WV	30.5349	29.6413
49180	Winston-Salem, NC	28.1570	26.9279
49340	Worcester, MA	35.2178	32.7401
49420	Yakima, WA	31.6531	29.7148
49500	Yauco, PR	09.9278	11.1280
49620	York-Hanover, PA	29.2356	27.8962
49660	Youngstown-Warren-Boardman, OH-PA	27.8874	25.9939
49700	Yuba City, CA	32.6363	31.5712
49740	Yuma, AZ	31.2815	28.0280

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.

[2] This a new CBSA for fiscal year 2008. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for fiscal year 2006 and fiscal year 2007.

TABLE 3B.--FY 2008 AND 3-YEAR* AVERAGE HOURLY WAGE
FOR RURAL AREAS BY CBSA

(*BASED ON THE SUM OF THE SALARIES AND HOURS COMPUTED
FOR FEDERAL FISCAL YEARS 2006, 2007, AND 2008)

CBSA Code	Nonurban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
01	Alabama	23.4686	22.3386
02	Alaska	37.4766	33.9221
03	Arizona	27.4632	26.0832
04	Arkansas	23.2843	22.1169
05	California	36.3980	33.2793
06	Colorado	29.3035	27.5010
07	Connecticut	34.8710	34.5456
08	Delaware	30.5175	28.9016
10	Florida	26.6208	25.5360
11	Georgia	24.3828	23.0350
12	Hawaii	33.3125	31.5134
13	Idaho	24.2477	23.5535
14	Illinois	25.8829	24.5970
15	Indiana	26.5753	25.3117
16	Iowa	26.2900	25.1302
17	Kansas	24.6910	23.6030
18	Kentucky	24.2238	23.0413
19	Louisiana	23.5288	22.3360
20	Maine	26.0794	25.2187
21	Maryland	27.6405	26.7369
22	Massachusetts	----	----
23	Michigan	27.6315	26.4190
24	Minnesota	28.2328	26.9455
25	Mississippi	23.9977	22.8764
26	Missouri	25.1550	23.7800
27	Montana	25.8521	25.3526
28	Nebraska	27.1868	25.6379
29	Nevada	30.0915	27.4332
30	New Hampshire	32.6655	31.8760
31	New Jersey[1]	----	----
32	New Mexico	27.8053	25.6447
33	New York	25.9034	24.5021
34	North Carolina	26.6853	25.3994
35	North Dakota	22.6685	21.5967
36	Ohio	26.9711	25.8029
37	Oklahoma	23.8499	22.8005

CBSA Code	Nonurban Area	FY 2008 Average Hourly Wage	3-Year Average Hourly Wage
38	Oregon	30.7608	28.9519
39	Pennsylvania	25.8624	24.5739
40	Puerto Rico[1]	----	----
41	Rhode Island[1]	----	----
42	South Carolina	27.0046	25.7091
43	South Dakota	25.8767	24.7974
44	Tennessee	24.3974	23.4911
45	Texas	25.4256	24.0797
46	Utah	25.4798	24.1789
47	Vermont	30.2117	28.6350
49	Virginia	24.9884	23.8157
50	Washington	31.5042	30.3819
51	West Virginia	23.4724	22.6983
52	Wisconsin	30.0360	28.3535
53	Wyoming	28.4210	27.0268

[1]All counties within the State or territory are classified as urban.

TABLE 4A.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA--FY 2008

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF

10180	Abilene, TX
	   Callahan County, TX
	   Jones County, TX
	   Taylor County, TX
		0.8240	0.8758

10380	Aguadilla-Isabela-San Sebastián, PR
	   Aguada Municipio, PR
	   Aguadilla Municipio, PR
	   Añasco Municipio, PR
	   Isabela Municipio, PR
	   Lares Municipio, PR
	   Moca Municipio, PR
	   Rincón Municipio, PR
	   San Sebastián Municipio, PR
		0.3345	0.4724

10420	Akron, OH
	   Portage County, OH
	   Summit County, OH
		0.8699	0.9090

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
10500	Albany, GA		
	Baker County, GA		
	Dougherty County, GA		
	Lee County, GA		
	Terrell County, GA		
	Worth County, GA	0.8666	0.9066
10580	Albany-Schenectady-Troy, NY		
	Albany County, NY		
	Rensselaer County, NY		
	Saratoga County, NY		
	Schenectady County, NY		
	Schoharie County, NY	0.8667	0.9067
10740	Albuquerque, NM		
	Bernalillo County, NM		
	Sandoval County, NM		
	Torrance County, NM		
	Valencia County, NM	0.9725	0.9811
10780	Alexandria, LA		
	Grant Parish, LA		
	Rapides Parish, LA	0.7977	0.8566
10900	Allentown-Bethlehem-Easton, PA-NJ (PA Hospitals)		
	Warren County, NJ		
	Carbon County, PA		
	Lehigh County, PA		
	Northampton County, PA	1.0003	1.0002
10900	[2]Allentown-Bethlehem-Easton, PA-NJ (NJ Hospitals)		
	Warren County, NJ		
	Carbon County, PA		
	Lehigh County, PA		
	Northampton County, PA	1.1616	1.1080
11020	[2]Altoona, PA		
	Blair County, PA	0.8357	0.8843
11100	Amarillo, TX		
	Armstrong County, TX		
	Carson County, TX		
	Potter County, TX		
	Randall County, TX	0.9151	0.9411
11180	Ames, IA		
	Story County, IA	0.9976	0.9984
11260	[2]Anchorage, AK		
	Anchorage Municipality, AK		
	Matanuska-Susitna Borough, AK	1.2083	1.1383
11300	Anderson, IN		
	Madison County, IN	0.8964	0.9278

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
11340	Anderson, SC		
	Anderson County, SC	0.9208	0.9451
11460	Ann Arbor, MI		
	Washtenaw County, MI	1.0498	1.0338
11500	Anniston-Oxford, AL		
	Calhoun County, AL	0.7975	0.8565
11540	[2]Appleton, WI		
	Calumet County, WI		
	Outagamie County, WI	0.9684	0.9783
11700	Asheville, NC		
	Buncombe County, NC		
	Haywood County, NC		
	Henderson County, NC		
	Madison County, NC	0.9201	0.9446
12020	Athens-Clarke County, GA		
	Clarke County, GA		
	Madison County, GA		
	Oconee County, GA		
	Oglethorpe County, GA	0.9996	0.9997

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
12060	[1]Atlanta-Sandy Springs-Marietta, GA		
	Barrow County, GA		
	Bartow County, GA		
	Butts County, GA		
	Carroll County, GA		
	Cherokee County, GA		
	Clayton County, GA		
	Cobb County, GA		
	Coweta County, GA		
	Dawson County, GA		
	DeKalb County, GA		
	Douglas County, GA		
	Fayette County, GA		
	Forsyth County, GA		
	Fulton County, GA		
	Gwinnett County, GA		
	Haralson County, GA		
	Heard County, GA		
	Henry County, GA		
	Jasper County, GA		
	Lamar County, GA		
	Meriwether County, GA		
	Newton County, GA		
	Paulding County, GA		
	Pickens County, GA		
	Pike County, GA		
	Rockdale County, GA		
	Spalding County, GA		
	Walton County, GA	0.9812	0.9871
12100	Atlantic City, NJ		
	Atlantic County, NJ	1.2063	1.1371
12220	Auburn-Opelika, AL		
	Lee County, AL	0.8075	0.8638
12260	Augusta-Richmond County, GA-SC		
	Burke County, GA		
	Columbia County, GA		
	McDuffie County, GA		
	Richmond County, GA		
	Aiken County, SC		
	Edgefield County, SC	0.9598	0.9723

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
12420	[1]Austin-Round Rock, TX		
	Bastrop County, TX		
	Caldwell County, TX		
	Hays County, TX		
	Travis County, TX		
	Williamson County, TX	0.9501	0.9656
12540	[2]Bakersfield, CA		
	Kern County, CA	1.1735	1.1158
12580	[1]Baltimore-Towson, MD		
	Anne Arundel County, MD		
	Baltimore County, MD		
	Carroll County, MD		
	Harford County, MD		
	Howard County, MD		
	Queen Anne's County, MD		
	Baltimore City, MD	1.0030	1.0021
12620	Bangor, ME		
	Penobscot County, ME	0.9881	0.9918
12700	Barnstable Town, MA		
	Barnstable County, MA	1.2611	1.1722
12940	Baton Rouge, LA		
	Ascension Parish, LA		
	East Baton Rouge Parish, LA		
	East Feliciana Parish, LA		
	Iberville Parish, LA		
	Livingston Parish, LA		
	Pointe Coupee Parish, LA		
	St. Helena Parish, LA		
	West Baton Rouge Parish, LA		
	West Feliciana Parish, LA	0.8009	0.8590
12980	Battle Creek, MI		
	Calhoun County, MI	1.0052	1.0036
13020	Bay City, MI		
	Bay County, MI	0.9394	0.9581
13140	Beaumont-Port Arthur, TX		
	Hardin County, TX		
	Jefferson County, TX		
	Orange County, TX	0.8615	0.9029
13380	Bellingham, WA		
	Whatcom County, WA	1.1257	1.0845
13460	Bend, OR		
	Deschutes County, OR	1.0586	1.0398

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
13644	[1]Bethesda-Gaithersburg-Frederick, MD		
	Frederick County, MD		
	Montgomery County, MD	1.1016	1.0685
13740	Billings, MT		
	Carbon County, MT		
	Yellowstone County, MT	0.8870	0.9212
13780	Binghamton, NY		
	Broome County, NY		
	Tioga County, NY	0.9068	0.9352
13820	[1]Birmingham-Hoover, AL		
	Bibb County, AL		
	Blount County, AL		
	Chilton County, AL		
	Jefferson County, AL		
	St. Clair County, AL		
	Shelby County, AL		
	Walker County, AL	0.8855	0.9201
13900	Bismarck, ND		
	Burleigh County, ND		
	Morton County, ND	0.7311	0.8070
13980	Blacksburg-Christiansburg-Radford, VA		
	Giles County, VA		
	Montgomery County, VA		
	Pulaski County, VA		
	Radford City, VA	0.8129	0.8677
14020	Bloomington, IN		
	Greene County, IN		
	Monroe County, IN		
	Owen County, IN	0.9323	0.9531
14060	Bloomington-Normal, IL		
	McLean County, IL	0.9483	0.9643
14260	Boise City-Nampa, ID		
	Ada County, ID		
	Boise County, ID		
	Canyon County, ID		
	Gem County, ID		
	Owyhee County, ID	0.9496	0.9652
14484	[1]Boston-Quincy, MA		
	Norfolk County, MA		
	Plymouth County, MA		
	Suffolk County, MA	1.1843	1.1228
14500	Boulder, CO		
	Boulder County, CO	1.0109	1.0075

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
14540	Bowling Green, KY		
	Edmonson County, KY		
	Warren County, KY	0.8085	0.8645
14740	Bremerton-Silverdale, WA		
	Kitsap County, WA	1.0820	1.0555
14860	Bridgeport-Stamford-Norwalk, CT		
	Fairfield County, CT	1.2778	1.1828
15180	Brownsville-Harlingen, TX		
	Cameron County, TX	0.9192	0.9439
15260	Brunswick, GA		
	Brantley County, GA		
	Glynn County, GA		
	McIntosh County, GA	0.9764	0.9838
15380	[1]Buffalo-Niagara Falls, NY		
	Erie County, NY		
	Niagara County, NY	0.9588	0.9716
15500	[2]Burlington, NC		
	Alamance County, NC	0.8603	0.9021
15540	[2]Burlington-South Burlington, VT		
	Chittenden County, VT		
	Franklin County, VT		
	Grand Isle County, VT	1.0387	1.0263
15764	[1]Cambridge-Newton-Framingham, MA		
	Middlesex County, MA	1.1216	1.0818
15804	[1,2]Camden, NJ		
	Burlington County, NJ		
	Camden County, NJ		
	Gloucester County, NJ	1.1616	1.1080
15940	Canton-Massillon, OH		
	Carroll County, OH		
	Stark County, OH	0.8917	0.9245
15980	Cape Coral-Fort Myers, FL		
	Lee County, FL	0.9485	0.9644
16180	[2]Carson City, NV		
	Carson City, NV	0.9701	0.9794
16220	Casper, WY		
	Natrona County, WY	0.9270	0.9494
16300	Cedar Rapids, IA		
	Benton County, IA		
	Jones County, IA		
	Linn County, IA	0.8684	0.9079

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF

16580	Champaign-Urbana, IL
	    Champaign County, IL
	    Ford County, IL
	    Piatt County, IL
		0.9315	0.9526

16620	Charleston, WV
	    Boone County, WV
	    Clay County, WV
	    Kanawha County, WV
	    Lincoln County, WV
	    Putnam County, WV
		0.8393	0.8869

16700	Charleston-North Charleston, SC
	    Berkeley County, SC
	    Charleston County, SC
	    Dorchester County, SC
		0.9101	0.9375

16740	[1]Charlotte-Gastonia-Concord, NC-SC
	    Anson County, NC
	    Cabarrus County, NC
	    Gaston County, NC
	    Mecklenburg County, NC
	    Union County, NC
	    York County, SC
		0.9505	0.9658

16820	Charlottesville, VA
	    Albemarle County, VA
	    Fluvanna County, VA
	    Greene County, VA
	    Nelson County, VA
	    Charlottesville City, VA
		0.9160	0.9417

16860	Chattanooga, TN-GA
	    Catoosa County, GA
	    Dade County, GA
	    Walker County, GA
	    Hamilton County, TN
	    Marion County, TN
	    Sequatchie County, TN
		0.8962	0.9277

16940	Cheyenne, WY Laramie County, WY	0.9204	0.9448

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
16974	[1]Chicago-Naperville-Joliet, IL		
	Cook County, IL		
	DeKalb County, IL		
	DuPage County, IL		
	Grundy County, IL		
	Kane County, IL		
	Kendall County, IL		
	McHenry County, IL		
	Will County, IL	1.0588	1.0399
17020	[2]Chico, CA		
	Butte County, CA	1.1735	1.1158
17140	[1]Cincinnati-Middletown, OH-KY-IN		
	Dearborn County, IN		
	Franklin County, IN		
	Ohio County, IN		
	Boone County, KY		
	Bracken County, KY		
	Campbell County, KY		
	Gallatin County, KY		
	Grant County, KY		
	Kenton County, KY		
	Pendleton County, KY		
	Brown County, OH		
	Butler County, OH		
	Clermont County, OH		
	Hamilton County, OH		
	Warren County, OH	0.9661	0.9767
17300	Clarksville, TN-KY		
	Christian County, KY		
	Trigg County, KY		
	Montgomery County, TN		
	Stewart County, TN	0.8218	0.8742
17420	Cleveland, TN		
	Bradley County, TN		
	Polk County, TN	0.8171	0.8708
17460	[1]Cleveland-Elyria-Mentor, OH		
	Cuyahoga County, OH		
	Geauga County, OH		
	Lake County, OH		
	Lorain County, OH		
	Medina County, OH	0.9345	0.9547
17660	Coeur d'Alene, ID		
	Kootenai County, ID	0.9355	0.9554

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
17780	College Station-Bryan, TX		
	Brazos County, TX		
	Burleson County, TX		
	Robertson County, TX	0.9171	0.9425
17820	Colorado Springs, CO		
	El Paso County, CO		
	Teller County, CO	0.9466	0.9631
17860	Columbia, MO		
	Boone County, MO		
	Howard County, MO	0.8537	0.8973
17900	Columbia, SC		
	Calhoun County, SC		
	Fairfield County, SC		
	Kershaw County, SC		
	Lexington County, SC		
	Richland County, SC		
	Saluda County, SC	0.8829	0.9182
17980	Columbus, GA-AL		
	Russell County, AL		
	Chattahoochee County, GA		
	Harris County, GA		
	Marion County, GA		
	Muscogee County, GA	0.9019	0.9317
18020	Columbus, IN		
	Bartholomew County, IN	0.9625	0.9742
18140	[1]Columbus, OH		
	Delaware County, OH		
	Fairfield County, OH		
	Franklin County, OH		
	Licking County, OH		
	Madison County, OH		
	Morrow County, OH		
	Pickaway County, OH		
	Union County, OH	1.0024	1.0016
18580	Corpus Christi, TX		
	Aransas County, TX		
	Nueces County, TX		
	San Patricio County, TX	0.8456	0.8915
18700	Corvallis, OR		
	Benton County, OR	1.0701	1.0475
19060	[2]Cumberland, MD-WV (MD Hospitals)		
	Allegany County, MD		
	Mineral County, WV	0.8911	0.9241

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
19060	Cumberland, MD-WV (WV Hospitals) Allegany County, MD Mineral County, WV	0.7962	0.8555
19124	[1]Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9785	0.9852
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8582	0.9006
19180	Danville, IL Vermilion County, IL	0.9244	0.9476
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8296	0.8799
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8893	0.9228
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9278	0.9500
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7832	0.8459
19500	[2]Decatur, IL Macon County, IL	0.8345	0.8835
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8943	0.9264

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
19740	[1]Denver-Aurora, CO		
	Adams County, CO		
	Arapahoe County, CO		
	Broomfield County, CO		
	Clear Creek County, CO		
	Denver County, CO		
	Douglas County, CO		
	Elbert County, CO		
	Gilpin County, CO		
	Jefferson County, CO		
	Park County, CO	1.0454	1.0309
19780	Des Moines-West Des Moines, IA		
	Dallas County, IA		
	Guthrie County, IA		
	Madison County, IA		
	Polk County, IA		
	Warren County, IA	0.9157	0.9415
19804	[1]Detroit-Livonia-Dearborn, MI		
	Wayne County, MI	1.0095	1.0065
20020	[2]Dothan, AL		
	Geneva County, AL		
	Henry County, AL		
	Houston County, AL	0.7567	0.8262
20100	Dover, DE		
	Kent County, DE	1.0396	1.0270
20220	Dubuque, IA		
	Dubuque County, IA	0.8875	0.9215
20260	Duluth, MN-WI		
	Carlton County, MN		
	St. Louis County, MN		
	Douglas County, WI	1.0081	1.0055
20500	Durham, NC		
	Chatham County, NC		
	Durham County, NC		
	Orange County, NC		
	Person County, NC	0.9738	0.9820
20740	[2]Eau Claire, WI		
	Chippewa County, WI		
	Eau Claire County, WI	0.9684	0.9783
20764	[1,2]Edison, NJ		
	Middlesex County, NJ		
	Monmouth County, NJ		
	Ocean County, NJ		
	Somerset County, NJ	1.1616	1.1080

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
20940	[2]El Centro, CA		
	Imperial County, CA	1.1735	1.1158
21060	Elizabethtown, KY		
	Hardin County, KY		
	Larue County, KY	0.8617	0.9031
21140	Elkhart-Goshen, IN		
	Elkhart County, IN	0.9540	0.9683
21300	[2]Elmira, NY		
	Chemung County, NY	0.8416	0.8886
21340	El Paso, TX		
	El Paso County, TX	0.9140	0.9403
21500	Erie, PA		
	Erie County, PA	0.8503	0.8949
21660	Eugene-Springfield, OR		
	Lane County, OR	1.1002	1.0676
21780	[2]Evansville, IN-KY (IN Hospitals)		
	Gibson County, IN		
	Posey County, IN		
	Vanderburgh County, IN		
	Warrick County, IN		
	Henderson County, KY		
	Webster County, KY	0.8568	0.8996
21780	Evansville, IN-KY (KY Hospitals)		
	Gibson County, IN		
	Posey County, IN		
	Vanderburgh County, IN		
	Warrick County, IN		
	Henderson County, KY		
	Webster County, KY	0.8465	0.8922
21820	[2]Fairbanks, AK		
	Fairbanks North Star Borough, AK	1.2083	1.1383
21940	Fajardo, PR		
	Ceiba Municipio, PR		
	Fajardo Municipio, PR		
	Luquillo Municipio, PR	0.4365	0.5668
22020	[2]Fargo, ND-MN (MN Hospitals)		
	Clay County, MN		
	Cass County, ND	0.9113	0.9384
22020	Fargo, ND-MN (ND Hospitals)		
	Clay County, MN		
	Cass County, ND	0.7943	0.8541
22140	Farmington, NM		
	San Juan County, NM	0.9282	0.9503

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
22180	Fayetteville, NC		
	Cumberland County, NC		
	Hoke County, NC	0.9917	0.9943
22220	Fayetteville-Springdale-Rogers, AR-MO		
	Benton County, AR		
	Madison County, AR		
	Washington County, AR		
	McDonald County, MO	0.8871	0.9212
22380	Flagstaff, AZ		
	Coconino County, AZ	1.1551	1.1038
22420	Flint, MI		
	Genesee County, MI	1.1012	1.0682
22500	[2]Florence, SC		
	Darlington County, SC		
	Florence County, SC	0.8707	0.9095
22520	Florence-Muscle Shoals, AL		
	Colbert County, AL		
	Lauderdale County, AL	0.7692	0.8355
22540	Fond du Lac, WI		
	Fond du Lac County, WI	0.9887	0.9922
22660	Fort Collins-Loveland, CO		
	Larimer County, CO	0.9579	0.9710
22744	[1]Fort Lauderdale-Pompano Beach-Deerfield Beach, FL		
	Broward County, FL	1.0247	1.0168
22900	Fort Smith, AR-OK		
	Crawford County, AR		
	Franklin County, AR		
	Sebastian County, AR		
	Le Flore County, OK		
	Sequoyah County, OK	0.8052	0.8621
23020	[2]Fort Walton Beach-Crestview-Destin, FL		
	Okaloosa County, FL	0.8733	0.9114
23060	Fort Wayne, IN		
	Allen County, IN		
	Wells County, IN		
	Whitley County, IN	0.9041	0.9333
23104	[1]Fort Worth-Arlington, TX		
	Johnson County, TX		
	Parker County, TX		
	Tarrant County, TX		
	Wise County, TX	0.9636	0.9749
23420	[2]Fresno, CA		
	Fresno County, CA	1.1735	1.1158

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
23460	Gadsden, AL		
	Etowah County, AL	0.8144	0.8688
23540	Gainesville, FL		
	Alachua County, FL		
	Gilchrist County, FL	0.9301	0.9516
23580	Gainesville, GA		
	Hall County, GA	0.9418	0.9598
23844	Gary, IN		
	Jasper County, IN		
	Lake County, IN		
	Newton County, IN		
	Porter County, IN	0.9241	0.9474
24020	Glens Falls, NY		
	Warren County, NY		
	Washington County, NY	0.8522	0.8963
24140	Goldsboro, NC		
	Wayne County, NC	0.9271	0.9495
24220	[2]Grand Forks, ND-MN (MN Hospitals)		
	Polk County, MN		
	Grand Forks County, ND	0.9113	0.9384
24220	Grand Forks, ND-MN (ND Hospitals)		
	Polk County, MN		
	Grand Forks County, ND	0.8048	0.8618
24300	Grand Junction, CO		
	Mesa County, CO	1.0135	1.0092
24340	Grand Rapids-Wyoming, MI		
	Barry County, MI		
	Ionia County, MI		
	Kent County, MI		
	Newaygo County, MI	0.9374	0.9567
24500	Great Falls, MT		
	Cascade County, MT	0.8761	0.9134
24540	Greeley, CO		
	Weld County, CO	0.9996	0.9997
24580	[2]Green Bay, WI		
	Brown County, WI		
	Kewaunee County, WI		
	Oconto County, WI	0.9684	0.9783
24660	Greensboro-High Point, NC		
	Guilford County, NC		
	Randolph County, NC		
	Rockingham County, NC	0.9106	0.9379

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
24780	Greenville, NC		
	Greene County, NC		
	Pitt County, NC	0.9267	0.9492
24860	Greenville-Mauldin-Easley, SC		
	Greenville County, SC		
	Laurens County, SC		
	Pickens County, SC	0.9636	0.9749
25020	Guayama, PR		
	Arroyo Municipio, PR		
	Guayama Municipio, PR		
	Patillas Municipio, PR	0.2944	0.4328
25060	Gulfport-Biloxi, MS		
	Hancock County, MS		
	Harrison County, MS		
	Stone County, MS	0.8607	0.9024
25180	Hagerstown-Martinsburg, MD-WV		
	Washington County, MD		
	Berkeley County, WV		
	Morgan County, WV	0.9255	0.9484
25260	[2]Hanford-Corcoran, CA		
	Kings County, CA	1.1735	1.1158
25420	Harrisburg-Carlisle, PA		
	Cumberland County, PA		
	Dauphin County, PA		
	Perry County, PA	0.9230	0.9466
25500	Harrisonburg, VA		
	Rockingham County, VA		
	Harrisonburg City, VA	0.8895	0.9229
25540	[1,2]Hartford-West Hartford-East Hartford, CT		
	Hartford County, CT		
	Middlesex County, CT		
	Tolland County, CT	1.2432	1.1608
25620	[2]Hattiesburg, MS		
	Forrest County, MS		
	Lamar County, MS		
	Perry County, MS	0.7752	0.8400
25860	Hickory-Lenoir-Morganton, NC		
	Alexander County, NC		
	Burke County, NC		
	Caldwell County, NC		
	Catawba County, NC	0.8972	0.9284
25980	Hinesville-Fort Stewart, GA		
	Liberty County, GA		
	Long County, GA	0.7861	0.8481

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
26100	Holland-Grand Haven, MI		
	Ottawa County, MI	0.9063	0.9348
26180	Honolulu, HI		
	Honolulu County, HI	1.1305	1.0876
26300	Hot Springs, AR		
	Garland County, AR	0.9105	0.9378
26380	Houma-Bayou Cane-Thibodaux, LA		
	Lafourche Parish, LA		
	Terrebonne Parish, LA	0.7975	0.8565
26420	[1]Houston-Sugar Land-Baytown, TX		
	Austin County, TX		
	Brazoria County, TX		
	Chambers County, TX		
	Fort Bend County, TX		
	Galveston County, TX		
	Harris County, TX		
	Liberty County, TX		
	Montgomery County, TX		
	San Jacinto County, TX		
	Waller County, TX	0.9996	0.9997
26580	Huntington-Ashland, WV-KY-OH		
	Boyd County, KY		
	Greenup County, KY		
	Lawrence County, OH		
	Cabell County, WV		
	Wayne County, WV	0.8878	0.9217
26620	Huntsville, AL		
	Limestone County, AL		
	Madison County, AL	0.9017	0.9316
26820	Idaho Falls, ID		
	Bonneville County, ID		
	Jefferson County, ID	0.9272	0.9496
26900	[1]Indianapolis-Carmel, IN		
	Boone County, IN		
	Brown County, IN		
	Hamilton County, IN		
	Hancock County, IN		
	Hendricks County, IN		
	Johnson County, IN		
	Marion County, IN		
	Morgan County, IN		
	Putnam County, IN		
	Shelby County, IN	0.9717	0.9805

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
26980	Iowa City, IA		
	Johnson County, IA		
	Washington County, IA	0.9423	0.9601
27060	Ithaca, NY		
	Tompkins County, NY	0.9709	0.9800
27100	Jackson, MI		
	Jackson County, MI	0.9460	0.9627
27140	Jackson, MS		
	Copiah County, MS		
	Hinds County, MS		
	Madison County, MS		
	Rankin County, MS		
	Simpson County, MS	0.7950	0.8546
27180	Jackson, TN		
	Chester County, TN		
	Madison County, TN	0.8591	0.9012
27260	[1]Jacksonville, FL		
	Baker County, FL		
	Clay County, FL		
	Duval County, FL		
	Nassau County, FL		
	St. Johns County, FL	0.9089	0.9367
27340	[2]Jacksonville, NC		
	Onslow County, NC	0.8603	0.9021
27500	Janesville, WI		
	Rock County, WI	0.9852	0.9898
27620	Jefferson City, MO		
	Callaway County, MO		
	Cole County, MO		
	Moniteau County, MO		
	Osage County, MO	0.8702	0.9092
27740	[2]Johnson City, TN		
	Carter County, TN		
	Unicoi County, TN		
	Washington County, TN	0.7917	0.8522
27780	[2]Johnstown, PA		
	Cambria County, PA	0.8357	0.8843
27860	Jonesboro, AR		
	Craighead County, AR		
	Poinsett County, AR	0.8503	0.8949
27900	Joplin, MO		
	Jasper County, MO		
	Newton County, MO	0.9211	0.9453

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
28020	Kalamazoo-Portage, MI		
	Kalamazoo County, MI		
	Van Buren County, MI	1.0500	1.0340
28100	Kankakee-Bradley, IL		
	Kankakee County, IL	1.0144	1.0098
28140	[1]Kansas City, MO-KS		
	Franklin County, KS		
	Johnson County, KS		
	Leavenworth County, KS		
	Linn County, KS		
	Miami County, KS		
	Wyandotte County, KS		
	Bates County, MO		
	Caldwell County, MO		
	Cass County, MO		
	Clay County, MO		
	Clinton County, MO		
	Jackson County, MO		
	Lafayette County, MO		
	Platte County, MO		
	Ray County, MO	0.9318	0.9528
28420	[2]Kennewick-Richland-Pasco, WA		
	Benton County, WA		
	Franklin County, WA	1.0558	1.0379
28660	Killeen-Temple-Fort Hood, TX		
	Bell County, TX		
	Coryell County, TX		
	Lampasas County, TX	0.8303	0.8804
28700	[2]Kingsport-Bristol-Bristol, TN-VA (VA Hospitals)		
	Hawkins County, TN		
	Sullivan County, TN		
	Bristol City, VA		
	Scott County, VA		
	Washington County, VA	0.8073	0.8636
28700	[2]Kingsport-Bristol-Bristol, TN-VA (TN Hospitals)		
	Hawkins County, TN		
	Sullivan County, TN		
	Bristol City, VA		
	Scott County, VA		
	Washington County, VA	0.7917	0.8522
28740	Kingston, NY		
	Ulster County, NY	0.9578	0.9709

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
28940	Knoxville, TN		
	Anderson County, TN		
	Blount County, TN		
	Knox County, TN		
	Loudon County, TN		
	Union County, TN	0.8012	0.8592
29020	Kokomo, IN		
	Howard County, IN		
	Tipton County, IN	0.9463	0.9629
29100	La Crosse, WI-MN		
	Houston County, MN		
	La Crosse County, WI	0.9698	0.9792
29140	Lafayette, IN		
	Benton County, IN		
	Carroll County, IN		
	Tippecanoe County, IN	0.8676	0.9073
29180	Lafayette, LA		
	Lafayette Parish, LA		
	St. Martin Parish, LA	0.8322	0.8818
29340	Lake Charles, LA		
	Calcasieu Parish, LA		
	Cameron Parish, LA	0.7783	0.8423
29404	Lake County-Kenosha County, IL-WI		
	Lake County, IL		
	Kenosha County, WI	1.0583	1.0396
29420	Lake Havasu City-Kingman, AZ		
	Mohave County, AZ	0.9333	0.9538
29460	Lakeland, FL		
	Polk County, FL	0.8834	0.9186
29540	Lancaster, PA		
	Lancaster County, PA	0.9650	0.9759
29620	Lansing-East Lansing, MI		
	Clinton County, MI		
	Eaton County, MI		
	Ingham County, MI	1.0047	1.0032
29700	Laredo, TX		
	Webb County, TX	0.8501	0.8947
29740	[2]Las Cruces, NM		
	Dona Ana County, NM	0.8965	0.9279
29820	[1]Las Vegas-Paradise, NV		
	Clark County, NV	1.1452	1.0973
29940	Lawrence, KS		
	Douglas County, KS	0.8170	0.8707

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
30020	Lawton, OK		
	Comanche County, OK	0.8405	0.8878
30140	[2]Lebanon, PA		
	Lebanon County, PA	0.8357	0.8843
30300	[2]Lewiston, ID-WA (WA Hospitals)		
	Nez Perce County, ID		
	Asotin County, WA	1.0558	1.0379
30300	Lewiston, ID-WA (ID Hospitals)		
	Nez Perce County, ID		
	Asotin County, WA	0.9225	0.9463
30340	Lewiston-Auburn, ME		
	Androscoggin County, ME	0.9289	0.9507
30460	Lexington-Fayette, KY		
	Bourbon County, KY		
	Clark County, KY		
	Fayette County, KY		
	Jessamine County, KY		
	Scott County, KY		
	Woodford County, KY	0.9002	0.9305
30620	Lima, OH		
	Allen County, OH	0.9307	0.9520
30700	Lincoln, NE		
	Lancaster County, NE		
	Seward County, NE	0.9872	0.9912
30780	Little Rock-North Little Rock-Conway, AR		
	Faulkner County, AR		
	Grant County, AR		
	Lonoke County, AR		
	Perry County, AR		
	Pulaski County, AR		
	Saline County, AR	0.8960	0.9276
30860	Logan, UT-ID		
	Franklin County, ID		
	Cache County, UT	0.9214	0.9455
30980	Longview, TX		
	Gregg County, TX		
	Rusk County, TX		
	Upshur County, TX	0.8871	0.9212
31020	Longview, WA		
	Cowlitz County, WA	1.1027	1.0692
31084	[1,2]Los Angeles-Long Beach-Glendale, CA		
	Los Angeles County, CA	1.1735	1.1158

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
31140	[1]Louisville-Jefferson County, KY-IN		
	Clark County, IN		
	Floyd County, IN		
	Harrison County, IN		
	Washington County, IN		
	Bullitt County, KY		
	Henry County, KY		
	Jefferson County, KY		
	Meade County, KY		
	Nelson County, KY		
	Oldham County, KY		
	Shelby County, KY		
	Spencer County, KY		
	Trimble County, KY	0.9029	0.9324
31180	Lubbock, TX		
	Crosby County, TX		
	Lubbock County, TX	0.8641	0.9048
31340	Lynchburg, VA		
	Amherst County, VA		
	Appomattox County, VA		
	Bedford County, VA		
	Campbell County, VA		
	Bedford City, VA		
	Lynchburg City, VA	0.8605	0.9022
31420	Macon, GA		
	Bibb County, GA		
	Crawford County, GA		
	Jones County, GA		
	Monroe County, GA		
	Twiggs County, GA	0.9748	0.9827
31460	[2]Madera, CA		
	Madera County, CA	1.1735	1.1158
31540	Madison, WI		
	Columbia County, WI		
	Dane County, WI		
	Iowa County, WI	1.1176	1.0791
31700	[2]Manchester-Nashua, NH		
	Hillsborough County, NH	1.1259	1.0846
31900	Mansfield, OH		
	Richland County, OH	0.9209	0.9451
32420	Mayagüez, PR		
	Hormigueros Municipio, PR		
	Mayagüez Municipio, PR	0.3657	0.5021

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
32580	McAllen-Edinburg-Mission, TX		
	Hidalgo County, TX	0.9135	0.9399
32780	Medford, OR		
	Jackson County, OR	1.0297	1.0202
32820	[1]Memphis, TN-MS-AR		
	Crittenden County, AR		
	DeSoto County, MS		
	Marshall County, MS		
	Tate County, MS		
	Tunica County, MS		
	Fayette County, TN		
	Shelby County, TN		
	Tipton County, TN	0.9313	0.9524
32900	Merced, CA		
	Merced County, CA	1.1980	1.1317
33124	[1]Miami-Miami Beach-Kendall, FL		
	Miami-Dade County, FL	1.0008	1.0005
33140	Michigan City-La Porte, IN		
	LaPorte County, IN	0.8786	0.9152
33260	Midland, TX		
	Midland County, TX	0.9711	0.9801
33340	[1]Milwaukee-Waukesha-West Allis, WI		
	Milwaukee County, WI		
	Ozaukee County, WI		
	Washington County, WI		
	Waukesha County, WI	1.0295	1.0201
33460	[1]Minneapolis-St. Paul-Bloomington, MN-WI		
	Anoka County, MN		
	Carver County, MN		
	Chisago County, MN		
	Dakota County, MN		
	Hennepin County, MN		
	Isanti County, MN		
	Ramsey County, MN		
	Scott County, MN		
	Sherburne County, MN		
	Washington County, MN		
	Wright County, MN		
	Pierce County, WI		
	St. Croix County, WI	1.0896	1.0605
33540	Missoula, MT		
	Missoula County, MT	0.8738	0.9118
33660	Mobile, AL		
	Mobile County, AL	0.7947	0.8544

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
33700	Modesto, CA		
	Stanislaus County, CA	1.2019	1.1342
33740	Monroe, LA		
	Ouachita Parish, LA		
	Union Parish, LA	0.7869	0.8486
33780	Monroe, MI		
	Monroe County, MI	0.9469	0.9633
33860	Montgomery, AL		
	Autauga County, AL		
	Elmore County, AL		
	Lowndes County, AL		
	Montgomery County, AL	0.8111	0.8664
34060	Morgantown, WV		
	Monongalia County, WV		
	Preston County, WV	0.8407	0.8880
34100	[2]Morristown, TN		
	Grainger County, TN		
	Hamblen County, TN		
	Jefferson County, TN	0.7917	0.8522
34580	[2]Mount Vernon-Anacortes, WA		
	Skagit County, WA	1.0558	1.0379
34620	[2]Muncie, IN		
	Delaware County, IN	0.8568	0.8996
34740	Muskegon-Norton Shores, MI		
	Muskegon County, MI	0.9968	0.9978
34820	[2]Myrtle Beach-Conway-North Myrtle Beach, SC		
	Horry County, SC	0.8707	0.9095
34900	Napa, CA		
	Napa County, CA	1.3959	1.2566
34940	Naples-Marco Island, FL		
	Collier County, FL	0.9618	0.9737

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
34980	[1]Nashville-Davidson-Murfreesboro-Franklin, TN		
	Cannon County, TN		
	Cheatham County, TN		
	Davidson County, TN		
	Dickson County, TN		
	Hickman County, TN		
	Macon County, TN		
	Robertson County, TN		
	Rutherford County, TN		
	Smith County, TN		
	Sumner County, TN		
	Trousdale County, TN		
	Williamson County, TN		
	Wilson County, TN	0.9618	0.9737
35004	[1]Nassau-Suffolk, NY		
	Nassau County, NY		
	Suffolk County, NY	1.2877	1.1891
35084	[1]Newark-Union, NJ-PA		
	Essex County, NJ		
	Hunterdon County, NJ		
	Morris County, NJ		
	Sussex County, NJ		
	Union County, NJ		
	Pike County, PA	1.1673	1.1117
35300	[2]New Haven-Milford, CT		
	New Haven County, CT	1.2432	1.1608
35380	[1]New Orleans-Metairie-Kenner, LA		
	Jefferson Parish, LA		
	Orleans Parish, LA		
	Plaquemines Parish, LA		
	St. Bernard Parish, LA		
	St. Charles Parish, LA		
	St. John the Baptist Parish, LA		
	St. Tammany Parish, LA	0.8711	0.9098

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
35644	[1]New York-White Plains-Wayne, NY-NJ		
	Bergen County, NJ		
	Hudson County, NJ		
	Passaic County, NJ		
	Bronx County, NY		
	Kings County, NY		
	New York County, NY		
	Putnam County, NY		
	Queens County, NY		
	Richmond County, NY		
	Rockland County, NY		
	Westchester County, NY	1.3229	1.2112
35660	Niles-Benton Harbor, MI		
	Berrien County, MI	0.9133	0.9398
35980	[2]Norwich-New London, CT		
	New London County, CT	1.2432	1.1608
36084	[1]Oakland-Fremont-Hayward, CA		
	Alameda County, CA		
	Contra Costa County, CA	1.5343	1.3406
36100	[2]Ocala, FL		
	Marion County, FL	0.8733	0.9114
36140	[2]Ocean City, NJ		
	Cape May County, NJ	1.1616	1.1080
36220	Odessa, TX		
	Ector County, TX	0.9954	0.9968
36260	Ogden-Clearfield, UT		
	Davis County, UT		
	Morgan County, UT		
	Weber County, UT	0.9053	0.9341
36420	[1]Oklahoma City, OK		
	Canadian County, OK		
	Cleveland County, OK		
	Grady County, OK		
	Lincoln County, OK		
	Logan County, OK		
	McClain County, OK		
	Oklahoma County, OK	0.8754	0.9129
36500	Olympia, WA		
	Thurston County, WA	1.1419	1.0951

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
36540	Omaha-Council Bluffs, NE-IA		
	Harrison County, IA		
	Mills County, IA		
	Pottawattamie County, IA		
	Cass County, NE		
	Douglas County, NE		
	Sarpy County, NE		
	Saunders County, NE		
	Washington County, NE	0.9473	0.9636
36740	[1]Orlando-Kissimmee, FL		
	Lake County, FL		
	Orange County, FL		
	Osceola County, FL		
	Seminole County, FL	0.9284	0.9504
36780	[2]Oshkosh-Neenah, WI		
	Winnebago County, WI	0.9684	0.9783
36980	Owensboro, KY		
	Daviess County, KY		
	Hancock County, KY		
	McLean County, KY	0.8697	0.9088
37100	[2]Oxnard-Thousand Oaks-Ventura, CA		
	Ventura County, CA	1.1735	1.1158
37340	Palm Bay-Melbourne-Titusville, FL		
	Brevard County, FL	0.9380	0.9571
37380	Palm Coast, FL		
	Flager County, FL	0.8737	0.9117
37460	[2]Panama City-Lynn Haven, FL		
	Bay County, FL	0.8733	0.9114
37620	[2]Parkersburg-Marietta-Vienna, WV-OH (OH Hospitals)		
	Washington County, OH		
	Pleasants County, WV		
	Wirt County, WV		
	Wood County, WV	0.8696	0.9088
37620	Parkersburg-Marietta-Vienna, WV-OH (WV Hospitals)		
	Washington County, OH		
	Pleasants County, WV		
	Wirt County, WV		
	Wood County, WV	0.8258	0.8772
37700	Pascagoula, MS		
	George County, MS		
	Jackson County, MS	0.8539	0.8975
37764	Peabody, MA		
	Essex County, MA	1.0599	1.0406

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
37860	[2]Pensacola-Ferry Pass-Brent, FL		
	Escambia County, FL		
	Santa Rosa County, FL	0.8733	0.9114
37900	Peoria, IL		
	Marshall County, IL		
	Peoria County, IL		
	Stark County, IL		
	Tazewell County, IL		
	Woodford County, IL	0.9385	0.9575
37964	[1]Philadelphia, PA		
	Bucks County, PA		
	Chester County, PA		
	Delaware County, PA		
	Montgomery County, PA		
	Philadelphia County, PA	1.0892	1.0603
38060	[1]Phoenix-Mesa-Scottsdale, AZ		
	Maricopa County, AZ		
	Pinal County, AZ	1.0110	1.0075
38220	Pine Bluff, AR		
	Cleveland County, AR		
	Jefferson County, AR		
	Lincoln County, AR	0.8152	0.8694
38300	[1]Pittsburgh, PA		
	Allegheny County, PA		
	Armstrong County, PA		
	Beaver County, PA		
	Butler County, PA		
	Fayette County, PA		
	Washington County, PA		
	Westmoreland County, PA	0.8390	0.8867
38340	Pittsfield, MA		
	Berkshire County, MA	1.0052	1.0036
38540	Pocatello, ID		
	Bannock County, ID		
	Power County, ID	0.9186	0.9435
38660	Ponce, PR		
	Juana Díaz Municipio, PR		
	Ponce Municipio, PR		
	Villalba Municipio, PR	0.4262	0.5576
38860	Portland-South Portland-Biddeford, ME		
	Cumberland County, ME		
	Sagadahoc County, ME		
	York County, ME	0.9991	0.9994

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
38900	[1]Portland-Vancouver-Beaverton, OR-WA		
	Clackamas County, OR		
	Columbia County, OR		
	Multnomah County, OR		
	Washington County, OR		
	Yamhill County, OR		
	Clark County, WA		
	Skamania County, WA	1.1226	1.0824
38940	Port St. Lucie, FL		
	Martin County, FL		
	St. Lucie County, FL	1.0035	1.0024
39100	Poughkeepsie-Newburgh-Middletown, NY		
	Dutchess County, NY		
	Orange County, NY	1.0982	1.0662
39140	Prescott, AZ		
	Yavapai County, AZ	0.9961	0.9973
39300	[1]Providence-New Bedford-Fall River, RI-MA		
	Bristol County, MA		
	Bristol County, RI		
	Kent County, RI		
	Newport County, RI		
	Providence County, RI		
	Washington County, RI	1.0532	1.0361
39340	Provo-Orem, UT		
	Juab County, UT		
	Utah County, UT	0.9480	0.9641
39380	[2]Pueblo, CO		
	Pueblo County, CO	0.9447	0.9618
39460	Punta Gorda, FL		
	Charlotte County, FL	0.9558	0.9695
39540	[2]Racine, WI		
	Racine County, WI	0.9684	0.9783
39580	Raleigh-Cary, NC		
	Franklin County, NC		
	Johnston County, NC		
	Wake County, NC	0.9663	0.9768
39660	Rapid City, SD		
	Meade County, SD		
	Pennington County, SD	0.8685	0.9080
39740	Reading, PA		
	Berks County, PA	0.9413	0.9594
39820	Redding, CA		
	Shasta County, CA	1.2809	1.1847

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
39900	Reno-Sparks, NV		
	Storey County, NV		
	Washoe County, NV	1.1062	1.0716
40060	[1]Richmond, VA		
	Amelia County, VA		
	Caroline County, VA		
	Charles City County, VA		
	Chesterfield County, VA		
	Cumberland County, VA		
	Dinwiddie County, VA		
	Goochland County, VA		
	Hanover County, VA		
	Henrico County, VA		
	King and Queen County, VA		
	King William County, VA		
	Louisa County, VA		
	New Kent County, VA		
	Powhatan County, VA		
	Prince George County, VA		
	Sussex County, VA		
	Colonial Heights City, VA		
	Hopewell City, VA		
	Petersburg City, VA		
	Richmond City, VA	0.9232	0.9467
40140	[1,2]Riverside-San Bernardino-Ontario, CA		
	Riverside County, CA		
	San Bernardino County, CA	1.1735	1.1158
40220	Roanoke, VA		
	Botetourt County, VA		
	Craig County, VA		
	Franklin County, VA		
	Roanoke County, VA		
	Roanoke City, VA		
	Salem City, VA	0.8888	0.9224
40340	Rochester, MN		
	Dodge County, MN		
	Olmsted County, MN		
	Wabasha County, MN	1.0490	1.0333
40380	[1]Rochester, NY		
	Livingston County, NY		
	Monroe County, NY		
	Ontario County, NY		
	Orleans County, NY		
	Wayne County, NY	0.8918	0.9246

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
40420	Rockford, IL		
	Boone County, IL		
	Winnebago County, IL	0.9804	0.9865
40484	[2]Rockingham County-Strafford County, NH		
	Rockingham County, NH		
	Strafford County, NH	1.1259	1.0846
40580	Rocky Mount, NC		
	Edgecombe County, NC		
	Nash County, NC	0.9007	0.9309
40660	Rome, GA		
	Floyd County, GA	0.9547	0.9688
40900	[1]Sacramento--Arden-Arcade--Roseville, CA		
	El Dorado County, CA		
	Placer County, CA		
	Sacramento County, CA		
	Yolo County, CA	1.3067	1.2010
40980	Saginaw-Saginaw Township North, MI		
	Saginaw County, MI	0.9122	0.9390
41060	St. Cloud, MN		
	Benton County, MN		
	Stearns County, MN	1.1058	1.0713
41100	St. George, UT		
	Washington County, UT	0.9535	0.9679
41140	St. Joseph, MO-KS		
	Doniphan County, KS		
	Andrew County, MO		
	Buchanan County, MO		
	DeKalb County, MO	0.8826	0.9180

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
41180	[1]St. Louis, MO-IL		
	Bond County, IL		
	Calhoun County, IL		
	Clinton County, IL		
	Jersey County, IL		
	Macoupin County, IL		
	Madison County, IL		
	Monroe County, IL		
	St. Clair County, IL		
	Crawford County, MO		
	Franklin County, MO		
	Jefferson County, MO		
	Lincoln County, MO		
	St. Charles County, MO		
	St. Louis County, MO		
	Warren County, MO		
	Washington County, MO		
	St. Louis City, MO	0.8982	0.9291
41420	Salem, OR		
	Marion County, OR		
	Polk County, OR	1.0397	1.0270
41500	Salinas, CA		
	Monterey County, CA	1.4593	1.2954
41540	[2]Salisbury, MD		
	Somerset County, MD		
	Wicomico County, MD	0.8911	0.9241
41620	Salt Lake City, UT		
	Salt Lake County, UT		
	Summit County, UT		
	Tooele County, UT	0.9473	0.9636
41660	San Angelo, TX		
	Irion County, TX		
	Tom Green County, TX	0.8658	0.9060
41700	[1]San Antonio, TX		
	Atascosa County, TX		
	Bandera County, TX		
	Bexar County, TX		
	Comal County, TX		
	Guadalupe County, TX		
	Kendall County, TX		
	Medina County, TX		
	Wilson County, TX	0.8895	0.9229
41740	[1,2]San Diego-Carlsbad-San Marcos, CA		
	San Diego County, CA	1.1735	1.1158

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
41780	Sandusky, OH		
	Erie County, OH	0.8755	0.9130
41884	[1]San Francisco-San Mateo-Redwood City, CA		
	Marin County, CA		
	San Francisco County, CA		
	San Mateo County, CA	1.4800	1.3080
41900	San Germán-Cabo Rojo, PR		
	Cabo Rojo Municipio, PR		
	Lajas Municipio, PR		
	Sabana Grande Municipio, PR		
	San Germán Municipio, PR	0.4603	0.5878
41940	[1]San Jose-Sunnyvale-Santa Clara, CA		
	San Benito County, CA		
	Santa Clara County, CA	1.5439	1.3464

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
41980	[1]San Juan-Caguas-Guaynabo, PR		
	Aguas Buenas Municipio, PR		
	Aibonito Municipio, PR		
	Arecibo Municipio, PR		
	Barceloneta Municipio, PR		
	Barranquitas Municipio, PR		
	Bayamón Municipio, PR		
	Caguas Municipio, PR		
	Camuy Municipio, PR		
	Canóvanas Municipio, PR		
	Carolina Municipio, PR		
	Cataño Municipio, PR		
	Cayey Municipio, PR		
	Ciales Municipio, PR		
	Cidra Municipio, PR		
	Comerío Municipio, PR		
	Corozal Municipio, PR		
	Dorado Municipio, PR		
	Florida Municipio, PR		
	Guaynabo Municipio, PR		
	Gurabo Municipio, PR		
	Hatillo Municipio, PR		
	Humacao Municipio, PR		
	Juncos Municipio, PR		
	Las Piedras Municipio, PR		
	Loíza Municipio, PR		
	Manatí Municipio, PR		
	Maunabo Municipio, PR		
	Morovis Municipio, PR		
	Naguabo Municipio, PR		
	Naranjito Municipio, PR		
	Orocovis Municipio, PR		
	Quebradillas Municipio, PR		
	Río Grande Municipio, PR		
	San Juan Municipio, PR		
	San Lorenzo Municipio, PR		
	Toa Alta Municipio, PR		
	Toa Baja Municipio, PR		
	Trujillo Alto Municipio, PR		
	Vega Alta Municipio, PR		
	Vega Baja Municipio, PR		
	Yabucoa Municipio, PR	0.4526	0.5811
42020	San Luis Obispo-Paso Robles, CA		
	San Luis Obispo County, CA	1.1951	1.1298

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
42044	[1,2]Santa Ana-Anaheim-Irvine, CA		
	Orange County, CA	1.1735	1.1158
42060	[2]Santa Barbara-Santa Maria-Goleta, CA		
	Santa Barbara County, CA	1.1735	1.1158
42100	Santa Cruz-Watsonville, CA		
	Santa Cruz County, CA	1.5667	1.3600
42140	Santa Fe, NM		
	Santa Fe County, NM	1.0682	1.0462
42220	Santa Rosa-Petaluma, CA		
	Sonoma County, CA	1.4469	1.2879
42260	Sarasota-Bradenton-Venice, FL		
	Manatee County, FL		
	Sarasota County, FL	0.9770	0.9842
42340	Savannah, GA		
	Bryan County, GA		
	Chatham County, GA		
	Effingham County, GA	0.8890	0.9226
42540	[2]Scranton--Wilkes-Barre, PA		
	Lackawanna County, PA		
	Luzerne County, PA		
	Wyoming County, PA	0.8357	0.8843
42644	[1]Seattle-Bellevue-Everett, WA		
	King County, WA		
	Snohomish County, WA	1.1362	1.0914
42680	Sebastian-Vero Beach, FL		
	Indian River County, FL	0.9703	0.9796
43100	[2]Sheboygan, WI		
	Sheboygan County, WI	0.9684	0.9783
43300	Sherman-Denison, TX		
	Grayson County, TX	0.8530	0.8968
43340	Shreveport-Bossier City, LA		
	Bossier Parish, LA		
	Caddo Parish, LA		
	De Soto Parish, LA	0.8551	0.8983
43580	Sioux City, IA-NE-SD		
	Woodbury County, IA		
	Dakota County, NE		
	Dixon County, NE		
	Union County, SD	0.9083	0.9363
43620	Sioux Falls, SD		
	Lincoln County, SD		
	McCook County, SD		
	Minnehaha County, SD		
	Turner County, SD	0.9553	0.9692

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9643	0.9754
43900	Spartanburg, SC Spartanburg County, SC	0.9395	0.9582
44060	[2]Spokane, WA Spokane County, WA	1.0558	1.0379
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8942	0.9263
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0450	1.0306
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8791	0.9155
44220	[2]Springfield, OH Clark County, OH	0.8696	0.9088
44300	State College, PA Centre County, PA	0.8619	0.9032
44700	Stockton, CA San Joaquin County, CA	1.1809	1.1206
44940	Sumter, SC Sumter County, SC	0.8898	0.9232
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9950	0.9966
45104	Tacoma, WA Pierce County, WA	1.0933	1.0630
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9027	0.9323
45300	[1]Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9170	0.9424

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
45460	Terre Haute, IN		
	Clay County, IN		
	Sullivan County, IN		
	Vermillion County, IN		
	Vigo County, IN	0.8823	0.9178
45500	[2]Texarkana, TX-Texarkana, AR (TX Hospitals)		
	Miller County, AR		
	Bowie County, TX	0.8198	0.8728
45500	Texarkana, TX-Texarkana, AR (AR Hospitals)		
	Miller County, AR		
	Bowie County, TX	0.7781	0.8421
45780	Toledo, OH		
	Fulton County, OH		
	Lucas County, OH		
	Ottawa County, OH		
	Wood County, OH	0.9268	0.9493
45820	Topeka, KS		
	Jackson County, KS		
	Jefferson County, KS		
	Osage County, KS		
	Shawnee County, KS		
	Wabaunsee County, KS	0.8556	0.8987
45940	[2]Trenton-Ewing, NJ		
	Mercer County, NJ	1.1616	1.1080
46060	Tucson, AZ		
	Pima County, AZ	0.9416	0.9596
46140	Tulsa, OK		
	Creek County, OK		
	Okmulgee County, OK		
	Osage County, OK		
	Pawnee County, OK		
	Rogers County, OK		
	Tulsa County, OK		
	Wagoner County, OK	0.8498	0.8945
46220	Tuscaloosa, AL		
	Greene County, AL		
	Hale County, AL		
	Tuscaloosa County, AL	0.8530	0.8968
46340	Tyler, TX		
	Smith County, TX	0.9181	0.9432
46540	Utica-Rome, NY		
	Herkimer County, NY		
	Oneida County, NY	0.8774	0.9143

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
46660	Valdosta, GA		
	Brooks County, GA		
	Echols County, GA		
	Lanier County, GA		
	Lowndes County, GA	0.8204	0.8732
46700	Vallejo-Fairfield, CA		
	Solano County, CA	1.4432	1.2856
47020	[2]Victoria, TX		
	Calhoun County, TX		
	Goliad County, TX		
	Victoria County, TX	0.8198	0.8728
47220	Vineland-Millville-Bridgeton, NJ		
	Cumberland County, NJ	1.0647	1.0439
47260	[1]Virginia Beach-Norfolk-Newport News, VA-NC		
	Currituck County, NC		
	Gloucester County, VA		
	Isle of Wight County, VA		
	James City County, VA		
	Mathews County, VA		
	Surry County, VA		
	York County, VA		
	Chesapeake City, VA		
	Hampton City, VA		
	Newport News City, VA		
	Norfolk City, VA		
	Poquoson City, VA		
	Portsmouth City, VA		
	Suffolk City, VA		
	Virginia Beach City, VA		
	Williamsburg City, VA	0.8777	0.9145
47300	[2]Visalia-Porterville, CA		
	Tulare County, CA	1.1735	1.1158
47380	Waco, TX		
	McLennan County, TX	0.8593	0.9014
47580	Warner Robins, GA		
	Houston County, GA	0.9613	0.9733
47644	[1]Warren-Troy-Farmington Hills, MI		
	Lapeer County, MI		
	Livingston County, MI		
	Macomb County, MI		
	Oakland County, MI		
	St. Clair County, MI	1.0033	1.0023

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
47894	[1]Washington-Arlington-Alexandria, DC-VA-MD-WV		
	District of Columbia, DC		
	Calvert County, MD		
	Charles County, MD		
	Prince George's County, MD		
	Arlington County, VA		
	Clarke County, VA		
	Fairfax County, VA		
	Fauquier County, VA		
	Loudoun County, VA		
	Prince William County, VA		
	Spotsylvania County, VA		
	Stafford County, VA		
	Warren County, VA		
	Alexandria City, VA		
	Fairfax City, VA		
	Falls Church City, VA		
	Fredericksburg City, VA		
	Manassas City, VA		
	Manassas Park City, VA		
	Jefferson County, WV	1.0675	1.0457
47940	Waterloo-Cedar Falls, IA		
	Black Hawk County, IA		
	Bremer County, IA		
	Grundy County, IA	0.8719	0.9104
48140	Wausau, WI		
	Marathon County, WI	1.0004	1.0003
48260	[2]Weirton-Steubenville, WV-OH (OH Hospitals)		
	Jefferson County, OH		
	Brooke County, WV		
	Hancock County, WV	0.8696	0.9088
48260	Weirton-Steubenville, WV-OH (WV Hospitals)		
	Jefferson County, OH		
	Brooke County, WV		
	Hancock County, WV	0.7889	0.8501
48300	Wenatchee, WA		
	Chelan County, WA		
	Douglas County, WA	1.1275	1.0856
48424	[1]West Palm Beach-Boca Raton-Boynton Beach, FL		
	Palm Beach County, FL	0.9576	0.9708
48540	[2]Wheeling, WV-OH (OH Hospitals)		
	Belmont County, OH		
	Marshall County, WV		
	Ohio County, WV	0.8696	0.9088

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF
48540	[2]Wheeling, WV-OH (WV Hospitals) Belmont County, OH Marshall County, WV Ohio County, WV	0.7568	0.8263
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8938	0.9260
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8203	0.8731
48700	[2]Williamsport, PA Lycoming County, PA	0.8357	0.8843
48864	Wilmington, DE-MD-NJ (DE, MD Hospitals) New Castle County, DE Cecil County, MD Salem County, NJ	1.0666	1.0451
48864	[2]Wilmington, DE-MD-NJ (NJ Hospitals) New Castle County, DE Cecil County, MD Salem County, NJ	1.1616	1.1080
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9325	0.9533
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9845	0.9894
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9078	0.9359
49340	Worcester, MA Worcester County, MA	1.1354	1.0909
49420	[2]Yakima, WA Yakima County, WA	1.0558	1.0379

CBSA Code	Urban Area (Constituent Counties)	Wage Index	GAF

49500	Yauco, PR
	    Guánica Municipio, PR
	    Guayanilla Municipio, PR
	    Peñuelas Municipio, PR
	    Yauco Municipio, PR
		0.3200	0.4583

49620	York-Hanover, PA York County, PA	0.9425	0.9603

49660	Youngstown-Warren-Boardman, OH-PA
	    Mahoning County, OH
	    Trumbull County, OH
	    Mercer County, PA
		0.8991	0.9298

49700	[2]Yuba City, CA
	    Sutter County, CA
	    Yuba County, CA
		1.1735	1.1158

49740	Yuma, AZ Yuma County, AZ	1.0085	1.0058

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2008. New Jersey floor is imputed as discussed in the FY 2005 IPPS final rule (69 FR 49109) and in section III.G.2 of the preamble in this final rule.

TABLE 4B.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT (GAF) FOR RURAL AREAS BY CBSA--FY 2008

CBSA Code	Nonurban Area	Wage Index	GAF
01	Alabama	0.7567	0.8262
02	Alaska	1.2083	1.1383
03	Arizona	0.8854	0.9200
04	Arkansas	0.7516	0.8224
05	California	1.1735	1.1158
06	Colorado	0.9447	0.9618
07	Connecticut	1.2432	1.1608
08	Delaware	1.0104	1.0071
10	Florida	0.8733	0.9114
11	Georgia	0.7861	0.8481
12	Hawaii	1.0740	1.0501
13	Idaho	0.7818	0.8449
14	Illinois	0.8345	0.8835
15	Indiana	0.8568	0.8996

CBSA Code	Nonurban Area	Wage Index	GAF
16	Iowa	0.8476	0.8929
17	Kansas	0.7979	0.8568
18	Kentucky	0.7810	0.8443
19	Louisiana	0.7586	0.8276
20	Maine	0.8408	0.8880
21	Maryland	0.8911	0.9241
22	Massachusetts	0.9705	0.9797
23	Michigan	0.8908	0.9239
24	Minnesota	0.9113	0.9384
25	Mississippi	0.7752	0.8400
26	Missouri	0.8153	0.8695
27	Montana	0.8335	0.8827
28	Nebraska	0.8846	0.9195
29	Nevada	0.9701	0.9794
30	New Hampshire	1.1259	1.0846
31	New Jersey[1]	1.1616	1.1080
32	New Mexico	0.8965	0.9279
33	New York	0.8416	0.8886
34	North Carolina	0.8603	0.9021
35	North Dakota	0.7309	0.8068
36	Ohio	0.8696	0.9088
37	Oklahoma	0.7701	0.8362
38	Oregon	0.9957	0.9971
39	Pennsylvania	0.8357	0.8843
40	Puerto Rico[1]	------	------
41	Rhode Island[1]	------	------
42	South Carolina	0.8707	0.9095
43	South Dakota	0.8343	0.8833
44	Tennessee	0.7917	0.8522
45	Texas	0.8198	0.8728
46	Utah	0.8214	0.8740
47	Vermont	1.0387	1.0263
49	Virginia	0.8073	0.8636
50	Washington	1.0558	1.0379
51	West Virginia	0.7568	0.8263
52	Wisconsin	0.9684	0.9783
53	Wyoming	0.9163	0.9419

[1] All counties in the State or Territory are classified as urban. New Jersey floor is imputed as discussed in the FY 2005 final rule (69 FR 49109) and in section III.G.2 of the preamble in this final rule.

TABLE 4C.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA--FY 2008

CBSA Code	Area	Wage Index	GAF
10500	Albany, GA	0.8666	0.9066
10580	Albany-Schenectady-Troy, NY	0.8667	0.9067
10740	Albuquerque, NM	0.9725	0.9811
10780	Alexandria, LA	0.7977	0.8566
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0003	1.0002
11100	Amarillo, TX	0.9151	0.9411
11180	Ames, IA	0.9222	0.9460
11260	Anchorage, AK	1.2083	1.1383
11460	Ann Arbor, MI	1.0143	1.0098
11500	Anniston-Oxford, AL	0.7975	0.8565
12060	Atlanta-Sandy Springs-Marietta, GA	0.9812	0.9871
12260	Augusta-Richmond County, GA-SC	0.9598	0.9723
12420	Austin-Round Rock, TX	0.9501	0.9656
12580	Baltimore-Towson, MD	1.0030	1.0021
12620	Bangor, ME	0.9881	0.9918
12940	Baton Rouge, LA	0.8009	0.8590
13020	Bay City, MI	0.9394	0.9581
13644	Bethesda-Gaithersburg-Frederick, MD	1.1016	1.0685
13780	Binghamton, NY	0.8775	0.9144
13820	Birmingham-Hoover, AL	0.8724	0.9108
13900	Bismarck, ND	0.7311	0.8070
13980	Blacksburg-Christiansburg-Radford, VA	0.7732	0.8385
14020	Bloomington, IN	0.8823	0.9178
14484	Boston-Quincy, MA	1.1303	1.0875
14740	Bremerton-Silverdale, WA	1.0820	1.0555
14860	Bridgeport-Stamford-Norwalk, CT	1.2341	1.1549
15380	Buffalo-Niagara Falls, NY	0.9588	0.9716
15540	Burlington-South Burlington, VT	0.9584	0.9713
15940	Canton-Massillon, OH	0.8806	0.9166
16180	Carson City, NV	0.9701	0.9794
16620	Charleston, WV	0.8393	0.8869
16700	Charleston-North Charleston, SC	0.9101	0.9375
16740	Charlotte-Gastonia-Concord, NC-SC	0.9342	0.9545
16820	Charlottesville, VA	0.9160	0.9417

CBSA Code	Area	Wage Index	GAF
16860	Chattanooga, TN-GA	0.8962	0.9277
16974	Chicago-Naperville-Joliet, IL	1.0471	1.0320
17140	Cincinnati-Middletown, OH-KY-IN	0.9661	0.9767
17300	Clarksville, TN-KY	0.8095	0.8653
17460	Cleveland-Elyria-Mentor, OH	0.9215	0.9456
17820	Colorado Springs, CO	0.9466	0.9631
17860	Columbia, MO	0.8537	0.8973
17980	Columbus, GA-AL	0.8587	0.9009
18140	Columbus, OH	0.9820	0.9876
18700	Corvallis, OR	1.0315	1.0215
19124	Dallas-Plano-Irving, TX	0.9681	0.9780
19340	Davenport-Moline-Rock Island, IA-IL	0.8893	0.9228
19380	Dayton, OH	0.9278	0.9500
19460	Decatur, AL	0.7832	0.8459
19740	Denver-Aurora, CO	1.0454	1.0309
19804	Detroit-Livonia-Dearborn, MI	1.0095	1.0065
20100	Dover, DE	1.0104	1.0071
20260	Duluth, MN-WI	0.9956	0.9970
20500	Durham, NC	0.9738	0.9820
20764	Edison, NJ	1.1616	1.1080
21060	Elizabethtown, KY	0.7978	0.8567
21500	Erie, PA	0.8416	0.8886
21660	Eugene-Springfield, OR	1.0707	1.0479
21780	Evansville, IN-KY (KY Hospitals)	0.8123	0.8673
21780	Evansville, IN-KY (IN Hospitals)	0.8568	0.8996
22020	Fargo, ND-MN	0.7943	0.8541
22180	Fayetteville, NC	0.9593	0.9719
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8714	0.9100
22380	Flagstaff, AZ	1.1187	1.0798
22420	Flint, MI	1.0243	1.0166
22520	Florence-Muscle Shoals, AL	0.7752	0.8400
22540	Fond du Lac, WI	0.9715	0.9804
22660	Fort Collins-Loveland, CO	0.9579	0.9710
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0247	1.0168
23020	Fort Walton Beach-Crestview-Destin, FL	0.8733	0.9114
23060	Fort Wayne, IN	0.9041	0.9333
23104	Fort Worth-Arlington, TX	0.9636	0.9749
23540	Gainesville, FL	0.9301	0.9516
23844	Gary, IN	0.9241	0.9474
24300	Grand Junction, CO	1.0135	1.0092
24340	Grand Rapids-Wyoming, MI	0.9374	0.9567
24500	Great Falls, MT	0.8761	0.9134
24540	Greeley, CO	0.9744	0.9824

CBSA Code	Area	Wage Index	GAF
24580	Green Bay, WI (MI Hospitals)	0.9357	0.9555
24580	Green Bay, WI (WI Hospitals)	0.9684	0.9783
24660	Greensboro-High Point, NC	0.9106	0.9379
24780	Greenville, NC	0.9267	0.9492
24860	Greenville-Mauldin-Easley, SC	0.9403	0.9587
25060	Gulfport-Biloxi, MS	0.8216	0.8741
25420	Harrisburg-Carlisle, PA	0.9115	0.9385
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.2432	1.1608
25540	Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.1025	1.0691
25860	Hickory-Lenoir-Morganton, NC	0.8814	0.9172
26180	Honolulu, HI	1.1305	1.0876
26420	Houston-Sugar Land-Baytown, TX	0.9996	0.9997
26580	Huntington-Ashland, WV-KY-OH	0.8724	0.9108
26620	Huntsville, AL	0.8629	0.9040
26820	Idaho Falls, ID	0.9272	0.9496
26900	Indianapolis-Carmel, IN	0.9589	0.9717
26980	Iowa City, IA	0.9137	0.9401
27060	Ithaca, NY	0.9709	0.9800
27140	Jackson, MS	0.7950	0.8546
27180	Jackson, TN	0.8435	0.8900
27260	Jacksonville, FL	0.9089	0.9367
27620	Jefferson City, MO	0.8702	0.9092
27780	Johnstown, PA	0.8357	0.8843
27860	Jonesboro, AR	0.8503	0.8949
27900	Joplin, MO	0.8966	0.9280
28020	Kalamazoo-Portage, MI	1.0146	1.0100
28140	Kansas City, MO-KS	0.9318	0.9528
28420	Kennewick-Richland-Pasco, WA (ID Hospitals)	0.9614	0.9734
28420	Kennewick-Richland-Pasco, WA (WA Hospitals)	1.0558	1.0379
28700	Kingsport-Bristol-Bristol, TN-VA	0.7810	0.8443
28740	Kingston, NY	0.9270	0.9494
28940	Knoxville, TN	0.8012	0.8592
29180	Lafayette, LA	0.8322	0.8818
29404	Lake County-Kenosha County, IL-WI	1.0583	1.0396
29460	Lakeland, FL	0.8834	0.9186
29540	Lancaster, PA	0.9650	0.9759
29620	Lansing-East Lansing, MI	0.9906	0.9936
29740	Las Cruces, NM	0.8965	0.9279
29820	Las Vegas-Paradise, NV	1.1222	1.0822
30020	Lawton, OK	0.8070	0.8634
30460	Lexington-Fayette, KY	0.8797	0.9160
30620	Lima, OH	0.9307	0.9520
30700	Lincoln, NE	0.9626	0.9742

CBSA Code	Area	Wage Index	GAF
30780	Little Rock-North Little Rock-Conway, AR	0.8725	0.9108
30860	Logan, UT-ID	0.9214	0.9455
30980	Longview, TX	0.8871	0.9212
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1735	1.1158
31140	Louisville-Jefferson County, KY-IN	0.9029	0.9324
31340	Lynchburg, VA	0.8605	0.9022
31420	Macon, GA	0.9567	0.9701
31540	Madison, WI	1.0996	1.0672
31700	Manchester-Nashua, NH	1.1259	1.0846
32780	Medford, OR	1.0146	1.0100
32820	Memphis, TN-MS-AR	0.8963	0.9278
33124	Miami-Miami Beach-Kendall, FL	1.0008	1.0005
33340	Milwaukee-Waukesha-West Allis, WI	1.0295	1.0201
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0896	1.0605
33540	Missoula, MT	0.8738	0.9118
33700	Modesto, CA	1.2019	1.1342
33740	Monroe, LA	0.7764	0.8409
33860	Montgomery, AL	0.8111	0.8664
34060	Morgantown, WV	0.8255	0.8769
34740	Muskegon-Norton Shores, MI	0.9474	0.9637
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8707	0.9095
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9364	0.9560
35004	Nassau-Suffolk, NY	1.2625	1.1731
35084	Newark-Union, NJ-PA (NJ Hospitals)	1.1616	1.1080
35084	Newark-Union, NJ-PA (PA, NY Hospitals)	1.1570	1.1050
35300	New Haven-Milford, CT	1.2432	1.1608
35380	New Orleans-Metairie-Kenner, LA	0.8711	0.9098
35644	New York-White Plains-Wayne, NY-NJ	1.3001	1.1969
35980	Norwich-New London, CT	1.1732	1.1156
36084	Oakland-Fremont-Hayward, CA	1.5343	1.3406
36140	Ocean City, NJ	1.0498	1.0338
36220	Odessa, TX	0.9522	0.9670
36420	Oklahoma City, OK	0.8754	0.9129
36500	Olympia, WA	1.1287	1.0864
36740	Orlando-Kissimmee, FL	0.9170	0.9424
37700	Pascagoula, MS	0.8539	0.8975
37860	Pensacola-Ferry Pass-Brent, FL	0.8123	0.8673
37900	Peoria, IL	0.9225	0.9463
37964	Philadelphia, PA (DE, PA Hospitals)	1.0765	1.0518
37964	Philadelphia, PA (NJ Hospitals)	1.1616	1.1080
38220	Pine Bluff, AR	0.7955	0.8550
38300	Pittsburgh, PA (PA, WV Hospitals)	0.8390	0.8867
38300	Pittsburgh, PA (OH Hospitals)	0.8696	0.9088

CBSA Code	Area	Wage Index	GAF
38340	Pittsfield, MA	1.0387	1.0263
38860	Portland-South Portland-Biddeford, ME	0.9589	0.9717
38900	Portland-Vancouver-Beaverton, OR-WA	1.1226	1.0824
38940	Port St. Lucie, FL	0.9851	0.9898
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0762	1.0516
39140	Prescott, AZ	0.9576	0.9708
39340	Provo-Orem, UT	0.9380	0.9571
39580	Raleigh-Cary, NC	0.9474	0.9637
39740	Reading, PA	0.9413	0.9594
39820	Redding, CA	1.2651	1.1747
39900	Reno-Sparks, NV	1.0851	1.0575
40060	Richmond, VA	0.9232	0.9467
40220	Roanoke, VA	0.8746	0.9123
40340	Rochester, MN	1.0490	1.0333
40380	Rochester, NY	0.8918	0.9246
40420	Rockford, IL	0.9703	0.9796
40484	Rockingham County, NH	1.0173	1.0118
40660	Rome, GA	0.9388	0.9577
40900	Sacramento--Arden-Arcade--Roseville, CA	1.2918	1.1916
40980	Saginaw-Saginaw Township North, MI	0.8974	0.9285
41060	St. Cloud, MN	1.0322	1.0219
41100	St. George, UT	0.9535	0.9679
41140	St. Joseph, MO-KS	0.8826	0.9180
41180	St. Louis, MO-IL	0.8982	0.9291
41620	Salt Lake City, UT	0.9473	0.9636
41700	San Antonio, TX	0.8895	0.9229
41884	San Francisco-San Mateo-Redwood City, CA	1.4800	1.3080
41980	San Juan-Caguas-Guaynabo, PR	0.4526	0.5811
42044	Santa Ana-Anaheim-Irvine, CA	1.1735	1.1158
42140	Santa Fe, NM	1.0379	1.0258
42220	Santa Rosa-Petaluma, CA	1.4146	1.2681
42260	Sarasota-Bradenton-Venice, FL	0.9770	0.9842
42340	Savannah, GA	0.8890	0.9226
42644	Seattle-Bellevue-Everett, WA	1.1208	1.0812
43300	Sherman-Denison, TX	0.8530	0.8968
43340	Shreveport-Bossier City, LA	0.8551	0.8983
43580	Sioux City, IA-NE-SD	0.8846	0.9195
43620	Sioux Falls, SD	0.9373	0.9566
43780	South Bend-Mishawaka, IN-MI	0.9503	0.9657
43900	Spartanburg, SC	0.9395	0.9582
44060	Spokane, WA	1.0226	1.0154
44180	Springfield, MO	0.8619	0.9032
44940	Sumter, SC	0.8707	0.9095

CBSA Code	Area	Wage Index	GAF
45060	Syracuse, NY	0.9602	0.9726
45220	Tallahassee, FL	0.8454	0.8914
45300	Tampa-St. Petersburg-Clearwater, FL	0.9170	0.9424
45500	Texarkana, TX-Texarkana, AR	0.7781	0.8421
45780	Toledo, OH	0.9268	0.9493
45820	Topeka, KS	0.8452	0.8912
46140	Tulsa, OK	0.8498	0.8945
46220	Tuscaloosa, AL	0.8162	0.8702
46340	Tyler, TX	0.9181	0.9432
46700	Vallejo-Fairfield, CA	1.4267	1.2755
47260	Virginia Beach-Norfolk-Newport News, VA	0.8777	0.9145
47894	Washington-Arlington-Alexandria, DC-VA	1.0675	1.0457
48140	Wausau, WI	1.0004	1.0003
48620	Wichita, KS	0.8717	0.9103
48700	Williamsport, PA	0.8357	0.8843
48864	Wilmington, DE-MD-NJ (NJ Hospitals)	1.1616	1.1080
48864	Wilmington, DE-MD-NJ (DE Hospitals)	1.0666	1.0451
48900	Wilmington, NC	0.9156	0.9414
49180	Winston-Salem, NC	0.9078	0.9359
49340	Worcester, MA	1.1259	1.0846
49660	Youngstown-Warren-Boardman, OH-PA	0.8697	0.9088
04	Rural Arkansas	0.7586	0.8276
05	Rural California	1.1735	1.1158
10	Rural Florida	0.8733	0.9114
14	Rural Illinois	0.8345	0.8835
16	Rural Iowa	0.8476	0.8929
17	Rural Kansas	0.7979	0.8568
22	Rural Massachusetts	0.9705	0.9797
23	Rural Michigan	0.8908	0.9239
24	Rural Minnesota	0.9113	0.9384
25	Rural Mississippi	0.7752	0.8400
26	Rural Missouri	0.8153	0.8695
29	Rural Nevada	0.8706	0.9095
30	Rural New Hampshire	1.0532	1.0361
33	Rural New York	0.8416	0.8886
34	Rural North Carolina	0.8603	0.9021
36	Rural Ohio	0.8696	0.9088
37	Rural Oklahoma	0.7701	0.8362
38	Rural Oregon	0.9957	0.9971
39	Rural Pennsylvania (PA Hospitals)	0.8357	0.8843
39	Rural Pennsylvania (NY Hospitals)	0.8416	0.8886
44	Rural Tennessee	0.7917	0.8522
45	Rural Texas	0.8198	0.8728

CBSA Code	Area	Wage Index	GAF
47	Rural Vermont	0.9427	0.9604
49	Rural Virginia	0.8073	0.8636
50	Rural Washington	1.0558	1.0379
53	Rural Wyoming	0.9009	0.9310

TABLE 4F.--PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA--FY 2008

CBSA Code	Area	Wage Index	GAF	Wage Index – Reclassified Hospitals	GAF – Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.7754	0.8401	--	--
21940	Fajardo, PR	1.0049	1.0034	--	--
25020	Guayama, PR	0.6861	0.7726	--	--
32420	Mayagüez, PR	0.8478	0.8931	--	--
38660	Ponce, PR	0.9869	0.9910	--	--
41900	San Germán-Cabo Rojo, PR	1.0548	1.0372	--	--
41980	San Juan-Caguas-Guaynabo, PR	1.0401	1.0273	1.0401	1.0273
49500	Yauco, PR	0.7432	0.8161	--	--

TABLE 4J.--OUT-MIGRATION ADJUSTMENT--FY 2008

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8(B)) of the Act are designated with an asterisk. We automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act 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. Section 1886(d)(10) hospitals that wished to receive the out-migration adjustment, rather than their reclassification, had to follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of the FY 2008 IPPS proposed rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act were deemed to have waived the out-migration adjustment, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of the proposed rule.

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010009	*	0.0092	MORGAN	01510
010010	*	0.0296	MARSHALL	01470
010012	*	0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010022	*	0.1127	CHEROKEE	01090
010025	*	0.0235	CHAMBERS	01080
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010045	*	0.0222	FAYETTE	01280
010047		0.0127	BUTLER	01060
010052		0.0103	TALLAPOOSA	01610
010054	*	0.0092	MORGAN	01510
010061		0.0541	JACKSON	01350
010065	*	0.0103	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010085	*	0.0092	MORGAN	01510
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0451	PICKENS	01530
010110		0.0214	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150	*	0.0127	BUTLER	01060
010158	*	0.0022	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0198	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0148	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
040100	*	0.0198	WHITE	04720

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
050002		0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050008		0.0026	SAN FRANCISCO	05480
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050016		0.0103	SAN LUIS OBISPO	05500
050042	*	0.0162	TEHAMA	05620
050043		0.0010	ALAMEDA	05000
050047		0.0026	SAN FRANCISCO	05480
050055		0.0026	SAN FRANCISCO	05480
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075		0.0010	ALAMEDA	05000
050076	*	0.0026	SAN FRANCISCO	05480
050084		0.0132	SAN JOAQUIN	05490
050090	*	0.0058	SONOMA	05590
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050133	*	0.0178	YUBA	05680
050136	*	0.0058	SONOMA	05590
050150	*	0.0342	NEVADA	05390
050152		0.0026	SAN FRANCISCO	05480
050167		0.0132	SAN JOAQUIN	05490
050174	*	0.0058	SONOMA	05590
050194		0.0052	SANTA CRUZ	05540
050195		0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211		0.0010	ALAMEDA	05000
050228		0.0026	SAN FRANCISCO	05480
050232		0.0103	SAN LUIS OBISPO	05500
050242		0.0052	SANTA CRUZ	05540
050264		0.0010	ALAMEDA	05000
050283		0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050305		0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320		0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050335		0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050366		0.0015	CALAVERAS	05040

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050407		0.0026	SAN FRANCISCO	05480
050444		0.0233	MERCED	05340
050454		0.0026	SAN FRANCISCO	05480
050457		0.0026	SAN FRANCISCO	05480
050476	*	0.0278	LAKE	05160
050488		0.0010	ALAMEDA	05000
050494	*	0.0342	NEVADA	05390
050506		0.0103	SAN LUIS OBISPO	05500
050512		0.0010	ALAMEDA	05000
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050547	*	0.0058	SONOMA	05590
050633		0.0103	SAN LUIS OBISPO	05500
050667	*	0.0180	NAPA	05380
050668		0.0026	SAN FRANCISCO	05480
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050707		0.0146	SAN MATEO	05510
050714		0.0052	SANTA CRUZ	05540
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060010		0.0153	LARIMER	06340
060027	*	0.0069	BOULDER	06060
060030		0.0153	LARIMER	06340
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
080001	*	0.0063	NEW CASTLE	08010
080003	*	0.0063	NEW CASTLE	08010
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
100102		0.0125	COLUMBIA	10110
100118	*	0.0177	FLAGLER	10170
100156	*	0.0125	COLUMBIA	10110
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100252	*	0.0151	OKEECHOBEE	10460
100290		0.0582	SUMTER	10590
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0805	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
130068		0.0319	KOOTENAI	13270
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140234		0.0315	LA SALLE	14580
150006	*	0.0113	LA PORTE	15450
150015		0.0113	LA PORTE	15450
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0319	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160030		0.0040	STORY	16840
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0336	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.0239	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017		0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0260	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0100	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088	*	0.0387	WEBSTER	19590
190099	*	0.0189	AVOYELLES	19040
190106	*	0.0101	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0101	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0161	CALDWELL	19100
190190		0.0161	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0161	CALDWELL	19100
190257		0.0061	LINCOLN	19300
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0466	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0512	ST. MARYS	21180

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
210043		0.0079	ANNE ARUNDEL	21010
220002		0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011		0.0271	MIDDLESEX	22090
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049		0.0271	MIDDLESEX	22090
220063		0.0271	MIDDLESEX	22090
220070		0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082		0.0271	MIDDLESEX	22090
220084		0.0271	MIDDLESEX	22090
220098		0.0271	MIDDLESEX	22090
220101		0.0271	MIDDLESEX	22090
220105		0.0271	MIDDLESEX	22090
220171		0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230021	*	0.0102	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230047	*	0.0021	MACOMB	23490
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0102	BERRIEN	23100
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230151	*	0.0025	OAKLAND	23620
230174	*	0.0220	OTTAWA	23690
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230223	*	0.0025	OAKLAND	23620
230227	*	0.0021	MACOMB	23490
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250160		0.0446	PANOLA	25530
260059		0.0077	LACLEDE	26520
260064	*	0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116		0.0087	ST. FRANCOIS	26930
260163		0.0087	ST. FRANCOIS	26930
270081		0.0234	MUSSELSHELL	27320
280077		0.0080	DODGE	28260
280123		0.0123	GAGE	28330
290002	*	0.0277	LYON	29090
300011		0.0069	HILLSBOROUGH	30050
300012		0.0069	HILLSBOROUGH	30050
300020		0.0069	HILLSBOROUGH	30050
300034		0.0069	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310010		0.0092	MERCER	31260
310011		0.0115	CAPE MAY	31180
310013	*	0.0268	ESSEX	31200
310018	*	0.0268	ESSEX	31200
310021	*	0.0092	MERCER	31260
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
310044		0.0092	MERCER	31260
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310092		0.0092	MERCER	31260
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310110		0.0092	MERCER	31260
310119	*	0.0268	ESSEX	31200
320003	*	0.0629	SAN MIGUEL	32230
320011		0.0442	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
330004	*	0.0633	ULSTER	33740
330008	*	0.0112	WYOMING	33900
330010		0.0054	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0214	CHENANGO	33080
330047		0.0054	MONTGOMERY	33380
330073	*	0.0134	GENESEE	33290
330094	*	0.0478	COLUMBIA	33200
330103	*	0.0124	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0124	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330167	*	0.0123	NASSAU	33400
330175		0.0249	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0293	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0029	FULTON	33280
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0727	SULLIVAN	33710

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085		0.0250	DAVIDSON	34280
340096		0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340124	*	0.0226	HARNETT	34420
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0308	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0142	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360065	*	0.0075	HURON	36400
360071		0.0035	VAN WERT	36820
360086	*	0.0186	CLARK	36110
360096	*	0.0071	COLUMBIANA	36140
360107	*	0.0119	SANDUSKY	36730
360125	*	0.0134	ASHTABULA	36030
360156		0.0119	SANDUSKY	36730
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0134	ASHTABULA	36030
370014	*	0.0361	BRYAN	37060
370015	*	0.0367	MAYES	37480

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
380029		0.0075	MARION	38230
380051		0.0075	MARION	38230
380056		0.0075	MARION	38230
390008		0.0056	LAWRENCE	39450
390016	*	0.0056	LAWRENCE	39450
390030	*	0.0284	SCHUYLKILL	39650
390031	*	0.0284	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0044	CLEARFIELD	39230
390065	*	0.0523	ADAMS	39000
390066	*	0.0364	LEBANON	39460
390079	*	0.0007	BRADFORD	39130
390086	*	0.0044	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390113	*	0.0050	CRAWFORD	39260
390122		0.0050	CRAWFORD	39260
390138	*	0.0214	FRANKLIN	39350
390146		0.0020	WARREN	39740
390150		0.0022	GREENE	39370
390151	*	0.0214	FRANKLIN	39350
390162	*	0.0200	NORTHAMPTON	39590
390181		0.0284	SCHUYLKILL	39650
390183	*	0.0284	SCHUYLKILL	39650
390201	*	0.1163	MONROE	39550
390236		0.0007	BRADFORD	39130
390313	*	0.0284	SCHUYLKILL	39650
420007	*	0.0027	SPARTANBURG	42410
420009	*	0.0113	OCONEE	42360
420019		0.0158	CHESTER	42110
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0153	UNION	42430
420043		0.0157	CHEROKEE	42100

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
420053		0.0035	NEWBERRY	42350
420062	*	0.0109	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420083	*	0.0027	SPARTANBURG	42410
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440016		0.0144	CARROLL	44080
440024	*	0.0230	BRADLEY	44050
440030		0.0056	HAMBLEN	44310
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060	*	0.0338	GIBSON	44260
440067		0.0056	HAMBLEN	44310
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440153		0.0007	COCKE	44140
440174		0.0312	HAYWOOD	44370
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
450032	*	0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059	*	0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0649	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
450144		0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0150	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0388	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450324	*	0.0132	GRAYSON	45564
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370		0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450393	*	0.0132	GRAYSON	45564
450395	*	0.0440	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0535	SOMERVELL	45893
450460		0.0053	TYLER	45942
450469	*	0.0132	GRAYSON	45564
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582
450547		0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565		0.0486	PALO PINTO	45841
450573		0.0125	JASPER	45690
450596	*	0.0742	HOOD	45653
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0181	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0126	ANDERSON	45000
450838		0.0125	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886		0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910

Provider Number	Reclassified for FY 2008	Out-Migration Adjustment	Qualifying County Name	County Code
460017		0.0384	BOX ELDER	46010
460039	*	0.0384	BOX ELDER	46010
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
490110		0.0184	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0187	JACKSON	51170
510047	*	0.0269	MARION	51240
510077	*	0.0021	MINGO	51290
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520095	*	0.0193	SAUK	52550
520096		0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270

TABLE 5.--LIST OF MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
001	No	No	PRE	SURG	Heart transplant or implant of heart assist system w MCC	23.1117	30.8	45.6
002	No	No	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC	16.2735	16.1	22.8
003	Yes	No	PRE	SURG	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	18.7707	33.4	40.6
004	Yes	No	PRE	SURG	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	11.4219	23.8	29.3
005	No	No	PRE	SURG	Liver transplant w MCC or intestinal transplant	10.6120	17.6	23.5
006	No	No	PRE	SURG	Liver transplant w/o MCC	7.2562	9.1	10.5
007	No	No	PRE	SURG	Lung transplant	8.4002	14.6	17.3
008	No	No	PRE	SURG	Simultaneous pancreas/kidney transplant	5.1726	10.1	11.8
009	No	No	PRE	SURG	Bone marrow transplant	6.4842	18.1	21.7
010	No	No	PRE	SURG	Pancreas transplant	3.8902	9.2	10.5
011	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC	4.1482	12.8	16.2
012	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w CC	3.2472	8.9	10.9
013	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	2.6760	6.1	7.2
020	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w MCC	7.7073	15.2	19.1
021	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w CC	6.7021	13.4	15.5
022	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	5.6085	7.8	9.6
023	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	4.7036	9.0	12.8

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
024	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w/o MCC	3.8978	6.1	8.9
025	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w MCC	4.2362	10.3	13.3
026	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w CC	3.1582	6.5	8.2
027	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC	2.3259	3.5	4.6
028	Yes	Yes	01	SURG	Spinal procedures w MCC	4.2339	10.8	14.7
029	Yes	Yes	01	SURG	Spinal procedures w CC or spinal neurostimulators	2.8356	5.3	7.3
030	Yes	Yes	01	SURG	Spinal procedures w/o CC/MCC	1.7617	2.8	3.7
031	Yes	No	01	SURG	Ventricular shunt procedures w MCC	3.2226	9.2	13.2
032	Yes	No	01	SURG	Ventricular shunt procedures w CC	1.9342	3.8	5.8
033	Yes	No	01	SURG	Ventricular shunt procedures w/o CC/MCC	1.4281	2.3	3.1
034	No	No	01	SURG	Carotid artery stent procedure w MCC	2.5438	4.8	7.3
035	No	No	01	SURG	Carotid artery stent procedure w CC	1.8996	2.0	2.9
036	No	No	01	SURG	Carotid artery stent procedure w/o CC/MCC	1.6977	1.3	1.6
037	No	No	01	SURG	Extracranial procedures w MCC	2.2630	6.0	8.7
038	No	No	01	SURG	Extracranial procedures w CC	1.4686	2.5	3.7
039	No	No	01	SURG	Extracranial procedures w/o CC/MCC	1.0909	1.5	1.8
040	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w MCC	3.2550	10.0	13.6
041	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	2.3595	5.4	7.3
042	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	1.8710	2.5	3.6
052	No	No	01	MED	Spinal disorders & injuries w CC/MCC	1.4329	4.7	7.0
053	No	No	01	MED	Spinal disorders & injuries w/o CC/MCC	1.1172	3.1	4.0
054	Yes	No	01	MED	Nervous system neoplasms w MCC	1.4228	5.3	7.2
055	Yes	No	01	MED	Nervous system neoplasms w/o MCC	1.1213	3.8	5.0

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
056	Yes	No	01	MED	Degenerative nervous system disorders w MCC	1.2820	5.8	7.8
057	Yes	No	01	MED	Degenerative nervous system disorders w/o MCC	0.8951	3.9	4.9
058	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w MCC	1.2669	5.8	8.0
059	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w CC	0.9226	4.3	5.2
060	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.8160	3.4	4.1
061	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w MCC	2.5541	7.3	9.6
062	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w CC	2.0886	5.3	6.3
063	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	1.8642	3.9	4.5
064	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w MCC	1.5470	5.6	7.6
065	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w CC	1.1901	4.3	5.3
066	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	1.0303	3.1	3.8
067	No	No	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w MCC	1.2194	4.7	6.2
068	No	No	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	0.9131	2.8	3.6
069	No	No	01	MED	Transient ischemia	0.7339	2.5	3.1
070	Yes	No	01	MED	Nonspecific cerebrovascular disorders w MCC	1.6212	6.0	7.9
071	Yes	No	01	MED	Nonspecific cerebrovascular disorders w CC	1.2522	4.5	5.6
072	Yes	No	01	MED	Nonspecific cerebrovascular disorders w/o CC/MCC	0.9586	2.9	3.7
073	No	No	01	MED	Cranial & peripheral nerve disorders w MCC	1.1717	4.8	6.4
074	No	No	01	MED	Cranial & peripheral nerve disorders w/o MCC	0.8954	3.4	4.4
075	No	No	01	MED	Viral meningitis w CC/MCC	1.5369	6.0	7.6

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
076	No	No	01	MED	Viral meningitis w/o CC/MCC	1.1439	3.4	4.2
077	No	No	01	MED	Hypertensive encephalopathy w MCC	1.4611	5.6	7.2
078	No	No	01	MED	Hypertensive encephalopathy w CC	1.0996	3.7	4.6
079	No	No	01	MED	Hypertensive encephalopathy w/o CC/MCC	0.9839	2.8	3.4
080	No	No	01	MED	Nontraumatic stupor & coma w MCC	0.9014	3.6	4.9
081	No	No	01	MED	Nontraumatic stupor & coma w/o MCC	0.7161	2.7	3.4
082	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w MCC	1.6724	3.9	6.4
083	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w CC	1.3328	3.7	5.2
084	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	1.1106	2.3	3.1
085	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w MCC	1.6946	5.7	7.9
086	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w CC	1.2337	4.0	5.1
087	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.9235	2.6	3.4
088	No	No	01	MED	Concussion w MCC	1.2968	4.3	6.1
089	No	No	01	MED	Concussion w CC	0.9479	3.0	3.8
090	No	No	01	MED	Concussion w/o CC/MCC	0.7405	2.0	2.5
091	Yes	No	01	MED	Other disorders of nervous system w MCC	1.3242	4.7	6.6
092	Yes	No	01	MED	Other disorders of nervous system w CC	0.9529	3.5	4.4
093	Yes	No	01	MED	Other disorders of nervous system w/o CC/MCC	0.7710	2.6	3.2
094	No	No	01	MED	Bacterial & tuberculous infections of nervous system w MCC	3.1499	9.7	12.5
095	No	No	01	MED	Bacterial & tuberculous infections of nervous system w CC	2.5679	7.2	9.1
096	No	No	01	MED	Bacterial & tuberculous infections of nervous system w/o CC/MCC	2.3482	4.9	6.2
097	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w MCC	2.6665	9.3	11.8

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
098	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w CC	2.0568	6.8	8.5
099	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	1.8177	5.1	6.3
100	Yes	No	01	MED	Seizures w MCC	1.2500	4.7	6.3
101	Yes	No	01	MED	Seizures w/o MCC	0.8258	2.9	3.7
102	No	No	01	MED	Headaches w MCC	0.8710	3.6	5.1
103	No	No	01	MED	Headaches w/o MCC	0.6677	2.5	3.2
113	No	No	02	SURG	Orbital procedures w CC/MCC	1.4141	3.8	5.5
114	No	No	02	SURG	Orbital procedures w/o CC/MCC	1.0292	2.0	2.7
115	No	No	02	SURG	Extraocular procedures except orbit	1.1185	3.3	4.5
116	No	No	02	SURG	Intraocular procedures w CC/MCC	0.8891	2.2	3.4
117	No	No	02	SURG	Intraocular procedures w/o CC/MCC	0.7094	1.5	1.9
121	No	No	02	MED	Acute major eye infections w CC/MCC	0.8800	4.6	5.8
122	No	No	02	MED	Acute major eye infections w/o CC/MCC	0.6608	3.3	4.1
123	No	No	02	MED	Neurological eye disorders	0.7224	2.4	2.9
124	No	No	02	MED	Other disorders of the eye w MCC	0.9308	3.9	5.3
125	No	No	02	MED	Other disorders of the eye w/o MCC	0.6792	2.7	3.5
129	No	No	03	SURG	Major head & neck procedures w CC/MCC or major device	1.7992	3.7	5.1
130	No	No	03	SURG	Major head & neck procedures w/o CC/MCC	1.3987	2.4	3.2
131	No	No	03	SURG	Cranial/facial procedures w CC/MCC	1.6300	4.0	5.8
132	No	No	03	SURG	Cranial/facial procedures w/o CC/MCC	1.2054	2.1	2.6
133	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	1.4331	3.7	5.8
134	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0.9474	1.7	2.1
135	No	No	03	SURG	Sinus & mastoid procedures w CC/MCC	1.5318	4.3	6.4
136	No	No	03	SURG	Sinus & mastoid procedures w/o CC/MCC	1.1094	1.8	2.6

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
137	No	No	03	SURG	Mouth procedures w CC/MCC	1.2677	3.7	5.4
138	No	No	03	SURG	Mouth procedures w/o CC/MCC	0.8474	1.9	2.4
139	No	No	03	SURG	Salivary gland procedures	0.8470	1.4	1.8
146	No	No	03	MED	Ear, nose, mouth & throat malignancy w MCC	1.7734	7.1	10.3
147	No	No	03	MED	Ear, nose, mouth & throat malignancy w CC	1.2182	4.2	5.8
148	No	No	03	MED	Ear, nose, mouth & throat malignancy w/o CC/MCC	1.0070	2.5	3.5
149	No	No	03	MED	Dysequilibrium	0.6154	2.2	2.7
150	No	No	03	MED	Epistaxis w MCC	0.9916	4.0	5.5
151	No	No	03	MED	Epistaxis w/o MCC	0.6227	2.3	2.9
152	No	No	03	MED	Otitis media & URI w MCC	0.8160	3.7	4.7
153	No	No	03	MED	Otitis media & URI w/o MCC	0.6207	2.8	3.4
154	No	No	03	MED	Nasal trauma & deformity w MCC	1.1294	4.8	6.5
155	No	No	03	MED	Nasal trauma & deformity w CC	0.8630	3.5	4.5
156	No	No	03	MED	Nasal trauma & deformity w/o CC/MCC	0.7412	2.5	3.2
157	No	No	03	MED	Dental & Oral Diseases w MCC	1.1909	5.0	6.9
158	No	No	03	MED	Dental & Oral Diseases w CC	0.8653	3.4	4.4
159	No	No	03	MED	Dental & Oral Diseases w/o CC/MCC	0.7361	2.4	3.1
163	Yes	No	04	SURG	Major chest procedures w MCC	4.0452	12.2	15.0
164	Yes	No	04	SURG	Major chest procedures w CC	2.8081	6.9	8.3
165	Yes	No	04	SURG	Major chest procedures w/o CC/MCC	2.4106	4.5	5.4
166	Yes	No	04	SURG	Other resp system O.R. procedures w MCC	3.2677	10.1	13.0
167	Yes	No	04	SURG	Other resp system O.R. procedures w CC	2.4151	6.5	8.1
168	Yes	No	04	SURG	Other resp system O.R. procedures w/o CC/MCC	1.8181	4.0	5.4
175	Yes	No	04	MED	Pulmonary embolism w MCC	1.4152	6.1	7.4
176	Yes	No	04	MED	Pulmonary embolism w/o MCC	1.1580	4.7	5.5

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
177	Yes	No	04	MED	Respiratory infections & inflammations w MCC	1.8444	7.2	9.2
178	Yes	No	04	MED	Respiratory infections & inflammations w CC	1.5636	6.0	7.4
179	Yes	No	04	MED	Respiratory infections & inflammations w/o CC/MCC	1.2754	4.6	5.6
180	No	No	04	MED	Respiratory neoplasms w MCC	1.5550	6.1	8.0
181	No	No	04	MED	Respiratory neoplasms w CC	1.3126	4.5	6.0
182	No	No	04	MED	Respiratory neoplasms w/o CC/MCC	1.1455	3.3	4.3
183	No	No	04	MED	Major chest trauma w MCC	1.2664	5.7	7.2
184	No	No	04	MED	Major chest trauma w CC	0.9611	3.8	4.6
185	No	No	04	MED	Major chest trauma w/o CC/MCC	0.7298	2.7	3.3
186	Yes	No	04	MED	Pleural effusion w MCC	1.4542	5.8	7.5
187	Yes	No	04	MED	Pleural effusion w CC	1.1947	4.2	5.5
188	Yes	No	04	MED	Pleural effusion w/o CC/MCC	0.9745	3.2	4.1
189	No	No	04	MED	Pulmonary edema & respiratory failure	1.3660	4.8	6.2
190	Yes	No	04	MED	Chronic obstructive pulmonary disease w MCC	1.1138	5.1	6.5
191	Yes	No	04	MED	Chronic obstructive pulmonary disease w CC	0.9405	4.2	5.1
192	Yes	No	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC	0.8145	3.4	4.0
193	Yes	No	04	MED	Simple pneumonia & pleurisy w MCC	1.2505	5.5	6.9
194	Yes	No	04	MED	Simple pneumonia & pleurisy w CC	1.0235	4.5	5.3
195	Yes	No	04	MED	Simple pneumonia & pleurisy w/o CC/MCC	0.8398	3.5	4.1
196	Yes	No	04	MED	Interstitial lung disease w MCC	1.3781	5.8	7.3
197	Yes	No	04	MED	Interstitial lung disease w CC	1.1458	4.4	5.4
198	Yes	No	04	MED	Interstitial lung disease w/o CC/MCC	0.9654	3.5	4.3
199	No	No	04	MED	Pneumothorax w MCC	1.4699	6.6	8.5
200	No	No	04	MED	Pneumothorax w CC	1.0753	3.9	5.1
201	No	No	04	MED	Pneumothorax w/o CC/MCC	0.8588	3.2	4.1

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
202	No	No	04	MED	Bronchitis & asthma w CC/MCC	0.7841	3.6	4.5
203	No	No	04	MED	Bronchitis & asthma w/o CC/MCC	0.6252	2.9	3.5
204	No	No	04	MED	Respiratory signs & symptoms	0.6658	2.2	2.9
205	Yes	No	04	MED	Other respiratory system diagnoses w MCC	1.0636	4.2	5.6
206	Yes	No	04	MED	Other respiratory system diagnoses w/o MCC	0.7848	2.7	3.5
207	Yes	No	04	MED	Respiratory system diagnosis w ventilator support 96+ hours	5.1231	12.6	15.0
208	No	No	04	MED	Respiratory system diagnosis w ventilator support <96 hours	2.2463	5.2	7.3
215	No	No	05	SURG	Other heart assist system implant	12.0016	6.3	12.0
216	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	9.3040	15.9	18.7
217	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	7.5813	10.9	12.2
218	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	6.8595	8.3	9.1
219	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	7.2072	11.7	14.5
220	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	5.7278	7.6	8.6
221	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	5.2463	6.0	6.4
222	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	8.0234	10.8	13.3
223	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	6.8809	5.0	6.6
224	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	7.3178	9.2	11.5
225	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	6.2956	4.5	5.7
226	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w MCC	5.9123	6.2	9.4
227	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w/o MCC	5.0411	1.8	2.8

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
228	Yes	No	05	SURG	Other cardiothoracic procedures w MCC	6.7400	12.0	14.6
229	Yes	No	05	SURG	Other cardiothoracic procedures w CC	5.3191	7.9	9.0
230	Yes	No	05	SURG	Other cardiothoracic procedures w/o CC/MCC	4.7847	5.6	6.6
231	No	No	05	SURG	Coronary bypass w PTCA w MCC	7.2993	10.8	13.2
232	No	No	05	SURG	Coronary bypass w PTCA w/o MCC	6.1947	8.0	9.0
233	Yes	No	05	SURG	Coronary bypass w cardiac cath w MCC	6.4496	12.4	14.3
234	Yes	No	05	SURG	Coronary bypass w cardiac cath w/o MCC	4.9216	8.2	8.9
235	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w MCC	5.1381	9.7	11.5
236	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w/o MCC	3.7307	6.1	6.6
237	No	No	05	SURG	Major cardiovasc procedures w MCC or thoracic aortic anuerysm repair	4.4954	7.8	11.2
238	No	No	05	SURG	Major cardiovasc procedures w/o MCC	3.1891	3.4	4.9
239	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w MCC	3.9454	12.1	15.6
240	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w CC	2.9983	8.4	10.5
241	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	2.4709	5.7	6.9
242	Yes	No	05	SURG	Permanent cardiac pacemaker implant w MCC	3.2586	6.9	8.9
243	Yes	No	05	SURG	Permanent cardiac pacemaker implant w CC	2.5483	3.8	5.1
244	Yes	No	05	SURG	Permanent cardiac pacemaker implant w/o CC/MCC	2.1367	2.2	2.9
245	No	No	05	SURG	AICD lead & generator procedures	3.1073	2.1	3.3
246	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	2.9046	3.7	5.5
247	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w/o MCC	2.1255	1.7	2.2
248	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	2.5180	4.3	6.2
249	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	1.8124	1.9	2.5

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
250	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	2.4870	5.3	7.5
251	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	1.7480	2.1	3.0
252	No	No	05	SURG	Other vascular procedures w MCC	2.7564	5.6	8.8
253	No	No	05	SURG	Other vascular procedures w CC	2.2536	4.1	6.0
254	No	No	05	SURG	Other vascular procedures w/o CC/MCC	1.6786	2.0	2.8
255	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w MCC	2.1486	7.3	9.9
256	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w CC	1.6847	5.8	7.5
257	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w/o CC/MCC	1.3990	3.7	4.9
258	No	No	05	SURG	Cardiac pacemaker device replacement w MCC	2.2926	5.5	7.6
259	No	No	05	SURG	Cardiac pacemaker device replacement w/o MCC	1.6553	1.9	2.6
260	No	No	05	SURG	Cardiac pacemaker revision except device replacement w MCC	2.1625	7.2	10.2
261	No	No	05	SURG	Cardiac pacemaker revision except device replacement w CC	1.3212	2.8	3.9
262	No	No	05	SURG	Cardiac pacemaker revision except device replacement w/o CC/MCC	1.1245	1.9	2.5
263	No	No	05	SURG	Vein ligation & stripping	1.4977	3.5	5.5
264	Yes	No	05	SURG	Other circulatory system O.R. procedures	2.4840	5.9	9.0
280	Yes	No	05	MED	Acute myocardial infarction, discharged alive w MCC	1.7391	5.9	7.5
281	Yes	No	05	MED	Acute myocardial infarction, discharged alive w CC	1.3126	4.0	4.9
282	Yes	No	05	MED	Acute myocardia infarction, discharged alive w/o CC/MCC	1.0617	2.6	3.2
283	No	No	05	MED	Acute myocardial infarction, expired w MCC	1.5787	3.4	5.5
284	No	No	05	MED	Acute myocardial infarction, expired w CC	1.2074	2.3	3.5

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
285	No	No	05	MED	Acute myocardial infarction, expired w/o CC/MCC	1.0421	1.6	2.2
286	No	No	05	MED	Circulatory disorders except AMI, w card cath w MCC	1.6667	5.2	7.1
287	No	No	05	MED	Circulatory disorders except AMI, w card cath w/o MCC	1.1412	2.5	3.2
288	Yes	No	05	MED	Acute & subacute endocarditis w MCC	2.9143	9.6	12.2
289	Yes	No	05	MED	Acute & subacute endocarditis w CC	2.3075	7.1	8.7
290	Yes	No	05	MED	Acute & subacute endocarditis w/o CC/MCC	1.9733	5.2	6.6
291	Yes	No	05	MED	Heart failure & shock w MCC	1.2585	5.1	6.6
292	Yes	No	05	MED	Heart failure & shock w CC	1.0134	4.1	5.0
293	Yes	No	05	MED	Heart failure & shock w/o CC/MCC	0.8765	3.1	3.7
294	No	No	05	MED	Deep vein thrombophlebitis w CC/MCC	0.8665	4.6	5.5
295	No	No	05	MED	Deep vein thrombophlebitis w/o CC/MCC	0.6950	3.8	4.4
296	No	No	05	MED	Cardiac arrest, unexplained w MCC	1.1144	2.0	3.3
297	No	No	05	MED	Cardiac arrest, unexplained w CC	0.8490	1.5	1.9
298	No	No	05	MED	Cardiac arrest, unexplained w/o CC/MCC	0.7207	1.2	1.4
299	Yes	No	05	MED	Peripheral vascular disorders w MCC	1.2220	5.2	6.9
300	Yes	No	05	MED	Peripheral vascular disorders w CC	0.9451	4.1	5.1
301	Yes	No	05	MED	Peripheral vascular disorders w/o CC/MCC	0.7183	3.1	3.8
302	No	No	05	MED	Atherosclerosis w MCC	0.8236	3.3	4.4
303	No	No	05	MED	Atherosclerosis w/o MCC	0.6055	2.1	2.6
304	No	No	05	MED	Hypertension w MCC	0.8312	3.9	5.2
305	No	No	05	MED	Hypertension w/o MCC	0.5942	2.3	2.9
306	No	No	05	MED	Cardiac congenital & valvular disorders w MCC	1.2007	4.5	6.5
307	No	No	05	MED	Cardiac congenital & valvular disorders w/o MCC	0.8224	2.7	3.5
308	No	No	05	MED	Cardiac arrhythmia & conduction disorders w MCC	1.0841	4.3	5.8

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
309	No	No	05	MED	Cardiac arrhythmia & conduction disorders w CC	0.8233	3.1	3.9
310	No	No	05	MED	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.6439	2.3	2.8
311	No	No	05	MED	Angina pectoris	0.5118	1.9	2.3
312	No	No	05	MED	Syncope & collapse	0.7197	2.5	3.2
313	No	No	05	MED	Chest pain	0.5489	1.7	2.1
314	Yes	No	05	MED	Other circulatory system diagnoses w MCC	1.5606	5.1	7.1
315	Yes	No	05	MED	Other circulatory system diagnoses w CC	1.1720	3.5	4.6
316	Yes	No	05	MED	Other circulatory system diagnoses w/o CC/MCC	0.9075	2.4	3.0
326	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w MCC	5.1660	13.4	17.2
327	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w CC	3.2941	8.1	10.3
328	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC	1.8017	3.3	4.4
329	Yes	No	06	SURG	Major small & large bowel procedures w MCC	4.5059	12.8	15.9
330	Yes	No	06	SURG	Major small & large bowel procedures w CC	2.8935	8.4	9.8
331	Yes	No	06	SURG	Major small & large bowel procedures w/o CC/MCC	1.8415	5.4	6.0
332	Yes	No	06	SURG	Rectal resection w MCC	3.7139	12.2	14.7
333	Yes	No	06	SURG	Rectal resection w CC	2.5787	7.8	8.9
334	Yes	No	06	SURG	Rectal resection w/o CC/MCC	1.7856	4.9	5.6
335	Yes	No	06	SURG	Peritoneal adhesiolysis w MCC	3.4785	11.8	14.4
336	Yes	No	06	SURG	Peritoneal adhesiolysis w CC	2.4776	7.7	9.3
337	Yes	No	06	SURG	Peritoneal adhesiolysis w/o CC/MCC	1.6984	4.4	5.7
338	No	No	06	SURG	Appendectomy w complicated principal diag w MCC	2.7254	9.1	10.9
339	No	No	06	SURG	Appendectomy w complicated principal diag w CC	1.9805	6.1	7.1

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
340	No	No	06	SURG	Appendectomy w complicated principal diag w/o CC/MCC	1.3849	3.6	4.3
341	No	No	06	SURG	Appendectomy w/o complicated principal diag w MCC	1.8824	5.3	7.3
342	No	No	06	SURG	Appendectomy w/o complicated principal diag w CC	1.3562	3.4	4.3
343	No	No	06	SURG	Appendectomy w/o complicated principal diag w/o CC/MCC	0.9887	1.9	2.3
344	No	No	06	SURG	Minor small & large bowel procedures w MCC	2.5156	9.4	12.0
345	No	No	06	SURG	Minor small & large bowel procedures w CC	1.7028	6.2	7.2
346	No	No	06	SURG	Minor small & large bowel procedures w/o CC/MCC	1.2617	4.4	5.0
347	No	No	06	SURG	Anal & stomal procedures w MCC	1.7658	6.2	8.4
348	No	No	06	SURG	Anal & stomal procedures w CC	1.2781	4.1	5.5
349	No	No	06	SURG	Anal & stomal procedures w/o CC/MCC	0.8629	2.4	3.0
350	No	No	06	SURG	Inguinal & femoral hernia procedures w MCC	1.8330	5.9	8.1
351	No	No	06	SURG	Inguinal & femoral hernia procedures w CC	1.2449	3.4	4.5
352	No	No	06	SURG	Inguinal & femoral hernia procedures w/o CC/MCC	0.8967	1.9	2.4
353	No	No	06	SURG	Hernia procedures except inguinal & femoral w MCC	2.0241	6.6	8.8
354	No	No	06	SURG	Hernia procedures except inguinal & femoral w CC	1.4092	4.0	5.1
355	No	No	06	SURG	Hernia procedures except inguinal & femoral w/o CC/MCC	1.0147	2.3	2.9
356	Yes	No	06	SURG	Other digestive system O.R. procedures w MCC	3.3790	9.6	13.3
357	Yes	No	06	SURG	Other digestive system O.R. procedures w CC	2.4946	6.1	8.0
358	Yes	No	06	SURG	Other digestive system O.R. procedures w/o CC/MCC	1.7333	3.4	4.6
368	No	No	06	MED	Major esophageal disorders w MCC	1.3788	5.1	6.6
369	No	No	06	MED	Major esophageal disorders w CC	1.0839	3.7	4.6

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
370	No	No	06	MED	Major esophageal disorders w/o CC/MCC	0.9558	2.8	3.4
371	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w MCC	1.6263	6.6	8.8
372	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w CC	1.3059	5.5	6.8
373	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	1.1109	4.2	5.0
374	Yes	No	06	MED	Digestive malignancy w MCC	1.7229	6.5	8.8
375	Yes	No	06	MED	Digestive malignancy w CC	1.3337	4.6	6.0
376	Yes	No	06	MED	Digestive malignancy w/o CC/MCC	1.0268	3.1	4.1
377	Yes	No	06	MED	G.I. hemorrhage w MCC	1.3367	5.0	6.5
378	Yes	No	06	MED	G.I. hemorrhage w CC	1.0195	3.7	4.5
379	Yes	No	06	MED	G.I. hemorrhage w/o CC/MCC	0.8476	2.9	3.4
380	Yes	No	06	MED	Complicated peptic ulcer w MCC	1.4334	5.5	7.2
381	Yes	No	06	MED	Complicated peptic ulcer w CC	1.1302	4.2	5.1
382	Yes	No	06	MED	Complicated peptic ulcer w/o CC/MCC	0.9662	3.0	3.6
383	No	No	06	MED	Uncomplicated peptic ulcer w MCC	1.1024	4.6	5.9
384	No	No	06	MED	Uncomplicated peptic ulcer w/o MCC	0.8399	3.2	3.8
385	No	No	06	MED	Inflammatory bowel disease w MCC	1.4936	6.7	9.0
386	No	No	06	MED	Inflammatory bowel disease w CC	1.0766	4.6	5.7
387	No	No	06	MED	Inflammatory bowel disease w/o CC/MCC	0.9488	3.6	4.4
388	Yes	No	06	MED	G.I. obstruction w MCC	1.2860	5.5	7.4
389	Yes	No	06	MED	G.I. obstruction w CC	0.9533	4.0	5.0
390	Yes	No	06	MED	G.I. obstruction w/o CC/MCC	0.7260	3.0	3.6
391	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w MCC	0.9565	4.1	5.5
392	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w/o MCC	0.7121	2.8	3.5
393	No	No	06	MED	Other digestive system diagnoses w MCC	1.3237	5.0	7.0

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
394	No	No	06	MED	Other digestive system diagnoses w CC	1.0257	3.8	4.9
395	No	No	06	MED	Other digestive system diagnoses w/o CC/MCC	0.7874	2.7	3.4
405	Yes	No	07	SURG	Pancreas, liver & shunt procedures w MCC	4.8273	12.8	17.3
406	Yes	No	07	SURG	Pancreas, liver & shunt procedures w CC	3.3149	7.1	9.5
407	Yes	No	07	SURG	Pancreas, liver & shunt procedures w/o CC/MCC	2.2443	4.2	5.5
408	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	3.8540	12.2	15.1
409	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	2.9126	8.2	9.9
410	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	2.0794	5.7	6.8
411	No	No	07	SURG	Cholecystectomy w c.d.e. w MCC	3.4128	10.9	13.1
412	No	No	07	SURG	Cholecystectomy w c.d.e. w CC	2.6382	7.6	8.8
413	No	No	07	SURG	Cholecystectomy w c.d.e. w/o CC/MCC	1.9412	5.2	6.0
414	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	3.0942	9.7	11.9
415	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w CC	2.2749	6.6	7.7
416	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.5398	4.1	4.9
417	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w MCC	2.1361	6.6	8.4
418	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.7104	4.5	5.6
419	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.2400	2.5	3.2
420	No	No	07	SURG	Hepatobiliary diagnostic procedures w MCC	3.4851	10.1	14.2
421	No	No	07	SURG	Hepatobiliary diagnostic procedures w CC	2.2557	5.6	7.8
422	No	No	07	SURG	Hepatobiliary diagnostic procedures w/o CC/MCC	1.9432	3.4	4.5
423	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w MCC	3.9593	11.4	15.5

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
424	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w CC	3.0104	7.8	10.2
425	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	2.5812	4.5	5.6
432	No	No	07	MED	Cirrhosis & alcoholic hepatitis w MCC	1.5033	5.1	6.9
433	No	No	07	MED	Cirrhosis & alcoholic hepatitis w CC	1.1431	3.8	4.9
434	No	No	07	MED	Cirrhosis & alcoholic hepatitis w/o CC/MCC	1.0125	2.8	3.6
435	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w MCC	1.5661	5.8	7.7
436	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w CC	1.2906	4.5	5.9
437	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	1.1709	3.3	4.4
438	No	No	07	MED	Disorders of pancreas except malignancy w MCC	1.4201	5.6	7.7
439	No	No	07	MED	Disorders of pancreas except malignancy w CC	1.0609	4.3	5.4
440	No	No	07	MED	Disorders of pancreas except malignancy w/o CC/MCC	0.8912	3.2	3.9
441	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w MCC	1.3973	5.1	7.0
442	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w CC	1.0935	4.0	5.1
443	Yes	No	07	MED	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.9079	3.1	3.8
444	No	No	07	MED	Disorders of the biliary tract w MCC	1.3744	5.0	6.6
445	No	No	07	MED	Disorders of the biliary tract w CC	1.1030	3.8	4.8
446	No	No	07	MED	Disorders of the biliary tract w/o CC/MCC	0.8521	2.6	3.3
453	No	No	08	SURG	Combined anterior/posterior spinal fusion w MCC	8.4313	12.7	15.9
454	No	No	08	SURG	Combined anterior/posterior spinal fusion w CC	6.5810	6.8	8.4
455	No	No	08	SURG	Combined anterior/posterior spinal fusion w/o CC/MCC	5.7023	4.1	4.7

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
456	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	6.7669	12.1	15.9
457	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	5.4650	6.4	7.8
458	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	4.9437	4.1	4.6
459	Yes	No	08	SURG	Spinal fusion except cervical w MCC	4.8679	7.8	9.6
460	Yes	No	08	SURG	Spinal fusion except cervical w/o MCC	3.4870	3.8	4.3
461	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w MCC	3.8345	6.9	8.5
462	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w/o MCC	3.0993	3.9	4.3
463	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	3.9615	12.3	16.9
464	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	2.8821	7.8	10.4
465	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	2.3417	4.6	6.2
466	Yes	No	08	SURG	Revision of hip or knee replacement w MCC	3.5408	7.6	9.5
467	Yes	No	08	SURG	Revision of hip or knee replacement w CC	2.7523	4.8	5.6
468	Yes	No	08	SURG	Revision of hip or knee replacement w/o CC/MCC	2.4545	3.7	4.0
469	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w MCC	2.6664	7.1	8.4
470	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w/o MCC	1.9871	3.7	4.0
471	No	No	08	SURG	Cervical spinal fusion w MCC	3.4723	7.0	10.1
472	No	No	08	SURG	Cervical spinal fusion w CC	2.4819	2.9	4.3
473	No	No	08	SURG	Cervical spinal fusion w/o CC/MCC	1.9446	1.6	2.0
474	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w MCC	2.8432	9.5	12.5
475	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w CC	2.1308	6.6	8.6

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
476	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	1.6799	3.8	5.0
477	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w MCC	2.6555	9.6	12.5
478	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w CC	1.9836	4.8	6.8
479	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.6784	1.9	2.8
480	Yes	Yes	08	SURG	Hip & femur procedures except major joint w MCC	2.4027	8.0	9.5
481	Yes	Yes	08	SURG	Hip & femur procedures except major joint w CC	1.8485	5.4	6.0
482	Yes	Yes	08	SURG	Hip & femur procedures except major joint w/o CC/MCC	1.5644	4.5	4.9
483	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w CC/MCC	1.9905	3.5	4.4
484	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	1.7376	2.2	2.5
485	No	No	08	SURG	Knee procedures w pdx of infection w MCC	2.9362	10.2	12.4
486	No	No	08	SURG	Knee procedures w pdx of infection w CC	2.3382	6.8	8.1
487	No	No	08	SURG	Knee procedures w pdx of infection w/o CC/MCC	1.7771	5.0	5.8
488	Yes	No	08	SURG	Knee procedures w/o pdx of infection w CC/MCC	1.6584	4.1	5.1
489	Yes	No	08	SURG	Knee procedures w/o pdx of infection w/o CC/MCC	1.4512	2.7	3.1
490	No	No	08	SURG	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	1.4912	3.3	4.7
491	No	No	08	SURG	Back & neck proc exc spinal fusion w/o CC/MCC	1.0066	1.8	2.3
492	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC	2.2413	6.9	8.7
493	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w CC	1.7186	4.4	5.3
494	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1.2752	2.8	3.4

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
495	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w MCC	2.5765	8.3	11.1
496	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w CC	1.7792	4.6	6.0
497	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.2301	2.3	3.1
498	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w CC/MCC	1.7563	5.8	8.2
499	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w/o CC/MCC	1.1887	2.3	3.1
500	Yes	Yes	08	SURG	Soft tissue procedures w MCC	2.4096	8.1	11.3
501	Yes	Yes	08	SURG	Soft tissue procedures w CC	1.5598	4.4	5.9
502	Yes	Yes	08	SURG	Soft tissue procedures w/o CC/MCC	1.0342	2.3	2.9
503	No	No	08	SURG	Foot procedures w MCC	1.7538	6.9	8.9
504	No	No	08	SURG	Foot procedures w CC	1.4058	5.0	6.4
505	No	No	08	SURG	Foot procedures w/o CC/MCC	1.1584	2.6	3.4
506	No	No	08	SURG	Major thumb or joint procedures	1.0877	2.3	3.2
507	No	No	08	SURG	Major shoulder or elbow joint procedures w CC/MCC	1.4296	3.6	5.2
508	No	No	08	SURG	Major shoulder or elbow joint procedures w/o CC/MCC	1.1330	1.7	2.0
509	No	No	08	SURG	Arthroscopy	1.0769	1.9	2.8
510	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w MCC	1.6616	5.0	6.6
511	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.2512	3.1	3.9
512	Yes	No	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0.9602	1.7	2.1
513	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.1748	3.7	5.1
514	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.8313	2.0	2.6
515	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w MCC	2.4858	8.1	10.9

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
516	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w CC	1.8307	4.4	6.0
517	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	1.4192	2.0	2.9
533	Yes	No	08	MED	Fractures of femur w MCC	1.1294	5.1	6.9
534	Yes	No	08	MED	Fractures of femur w/o MCC	0.7560	3.2	4.0
535	Yes	No	08	MED	Fractures of hip & pelvis w MCC	1.0836	4.8	6.4
536	Yes	No	08	MED	Fractures of hip & pelvis w/o MCC	0.7340	3.4	4.0
537	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0.7528	3.8	4.7
538	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.5986	2.6	3.1
539	Yes	No	08	MED	Osteomyelitis w MCC	1.7648	7.7	10.2
540	Yes	No	08	MED	Osteomyelitis w CC	1.4026	5.8	7.2
541	Yes	No	08	MED	Osteomyelitis w/o CC/MCC	1.2101	4.4	5.7
542	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w MCC	1.4877	6.8	8.7
543	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w CC	1.1151	4.8	6.0
544	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	0.9395	3.7	4.5
545	Yes	No	08	MED	Connective tissue disorders w MCC	1.8330	6.5	9.0
546	Yes	No	08	MED	Connective tissue disorders w CC	1.2092	4.3	5.5
547	Yes	No	08	MED	Connective tissue disorders w/o CC/MCC	0.9054	3.2	3.9
548	No	No	08	MED	Septic arthritis w MCC	1.5372	7.0	9.3
549	No	No	08	MED	Septic arthritis w CC	1.1522	5.0	6.2
550	No	No	08	MED	Septic arthritis w/o CC/MCC	0.9567	3.6	4.5
551	Yes	No	08	MED	Medical back problems w MCC	1.1632	5.5	7.2
552	Yes	No	08	MED	Medical back problems w/o MCC	0.7839	3.4	4.2
553	No	No	08	MED	Bone diseases & arthropathies w MCC	0.9199	4.8	6.1

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
554	No	No	08	MED	Bone diseases & arthropathies w/o MCC	0.6475	3.0	3.7
555	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w MCC	0.7886	3.6	4.9
556	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	0.5958	2.5	3.2
557	Yes	No	08	MED	Tendonitis, myositis & bursitis w MCC	1.2171	5.4	6.9
558	Yes	No	08	MED	Tendonitis, myositis & bursitis w/o MCC	0.8480	3.5	4.3
559	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w MCC	1.2104	5.1	7.3
560	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w CC	0.8521	3.6	4.7
561	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	0.6753	2.1	2.7
562	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	1.1163	5.0	6.5
563	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	0.6981	3.1	3.7
564	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w MCC	1.1606	5.3	7.1
565	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w CC	0.9003	4.0	5.1
566	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	0.7790	2.9	3.7
573	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	2.7483	10.1	13.8
574	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w CC	2.0177	7.2	9.5
575	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	1.4216	4.7	5.9
576	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	2.4766	7.8	12.1
577	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.6262	4.1	6.0
578	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	1.0742	2.5	3.4

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
579	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w MCC	2.3093	8.1	11.1
580	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w CC	1.4256	3.6	5.5
581	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w/o CC/MCC	0.9124	1.9	2.6
582	No	No	09	SURG	Mastectomy for malignancy w CC/MCC	0.9432	2.1	2.9
583	No	No	09	SURG	Mastectomy for malignancy w/o CC/MCC	0.7523	1.6	1.8
584	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w CC/MCC	1.2484	3.7	5.7
585	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0.9066	1.7	2.2
592	Yes	No	09	MED	Skin ulcers w MCC	1.4555	6.6	8.9
593	Yes	No	09	MED	Skin ulcers w CC	1.1060	5.2	6.5
594	Yes	No	09	MED	Skin ulcers w/o CC/MCC	0.9335	3.9	4.9
595	No	No	09	MED	Major skin disorders w MCC	1.3997	6.0	8.2
596	No	No	09	MED	Major skin disorders w/o MCC	0.8766	3.8	4.8
597	No	No	09	MED	Malignant breast disorders w MCC	1.4034	5.9	8.2
598	No	No	09	MED	Malignant breast disorders w CC	1.0695	4.2	5.6
599	No	No	09	MED	Malignant breast disorders w/o CC/MCC	0.7232	2.6	3.6
600	No	No	09	MED	Non-malignant breast disorders w CC/MCC	0.8471	4.1	5.4
601	No	No	09	MED	Non-malignant breast disorders w/o CC/MCC	0.6715	3.1	3.8
602	Yes	No	09	MED	Cellulitis w MCC	1.1522	5.5	7.0
603	Yes	No	09	MED	Cellulitis w/o MCC	0.8087	3.9	4.7
604	No	No	09	MED	Trauma to the skin, subcut tiss & breast w MCC	0.9681	4.1	5.4
605	No	No	09	MED	Trauma to the skin, subcut tiss & breast w/o MCC	0.6863	2.8	3.5
606	No	No	09	MED	Minor skin disorders w MCC	0.9223	4.2	5.9
607	No	No	09	MED	Minor skin disorders w/o MCC	0.6505	2.9	3.8
614	No	No	10	SURG	Adrenal & pituitary procedures w CC/MCC	2.1978	5.2	7.3

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
615	No	No	10	SURG	Adrenal & pituitary procedures w/o CC/MCC	1.6502	2.8	3.4
616	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	3.1449	12.6	15.6
617	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	2.2071	7.2	9.0
618	Yes	No	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	1.7554	4.9	6.1
619	No	No	10	SURG	O.R. procedures for obesity w MCC	2.7625	6.4	9.3
620	No	No	10	SURG	O.R. procedures for obesity w CC	1.9294	3.4	4.2
621	No	No	10	SURG	O.R. procedures for obesity w/o CC/MCC	1.6876	2.1	2.4
622	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	2.7257	9.7	13.2
623	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	2.0065	6.8	8.7
624	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	1.6056	4.6	5.9
625	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w MCC	1.5928	5.0	7.5
626	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w CC	1.0183	2.2	3.3
627	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0.8169	1.3	1.5
628	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w MCC	3.0602	7.8	11.8
629	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w CC	2.4730	7.0	8.8
630	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	1.7767	3.7	5.1
637	Yes	No	10	MED	Diabetes w MCC	1.0891	4.6	6.2
638	Yes	No	10	MED	Diabetes w CC	0.8021	3.4	4.3
639	Yes	No	10	MED	Diabetes w/o CC/MCC	0.6742	2.5	3.1
640	Yes	No	10	MED	Nutritional & misc metabolic disorders w MCC	0.9793	4.1	5.6

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
641	Yes	No	10	MED	Nutritional & misc metabolic disorders w/o MCC	0.7248	3.1	3.9
642	No	No	10	MED	Inborn errors of metabolism	1.0616	3.8	5.3
643	Yes	No	10	MED	Endocrine disorders w MCC	1.3926	6.0	7.8
644	Yes	No	10	MED	Endocrine disorders w CC	1.0638	4.3	5.4
645	Yes	No	10	MED	Endocrine disorders w/o CC/MCC	0.8310	3.2	3.9
652	No	No	11	SURG	Kidney transplant	3.0654	6.6	7.9
653	Yes	No	11	SURG	Major bladder procedures w MCC	4.5710	13.3	16.8
654	Yes	No	11	SURG	Major bladder procedures w CC	3.1860	8.8	10.1
655	Yes	No	11	SURG	Major bladder procedures w/o CC/MCC	2.7075	5.8	6.6
656	No	No	11	SURG	Kidney & ureter procedures for neoplasm w MCC	2.6603	8.4	10.8
657	No	No	11	SURG	Kidney & ureter procedures for neoplasm w CC	1.8997	5.1	6.1
658	No	No	11	SURG	Kidney & ureter procedures for neoplasm w/o CC/MCC	1.6556	3.3	3.8
659	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w MCC	2.8119	8.2	11.3
660	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w CC	2.0605	4.8	6.5
661	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1.4004	2.6	3.3
662	No	No	11	SURG	Minor bladder procedures w MCC	2.0375	7.3	10.5
663	No	No	11	SURG	Minor bladder procedures w CC	1.4254	3.6	5.3
664	No	No	11	SURG	Minor bladder procedures w/o CC/MCC	1.0388	1.6	2.1
665	No	No	11	SURG	Prostatectomy w MCC	2.1393	9.3	12.2
666	No	No	11	SURG	Prostatectomy w CC	1.4691	4.3	6.3
667	No	No	11	SURG	Prostatectomy w/o CC/MCC	0.9335	2.0	2.7
668	No	No	11	SURG	Transurethral procedures w MCC	1.7208	6.3	8.6
669	No	No	11	SURG	Transurethral procedures w CC	1.2079	3.1	4.4

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
670	No	No	11	SURG	Transurethral procedures w/o CC/MCC	0.8838	1.9	2.5
671	No	No	11	SURG	Urethral procedures w CC/MCC	1.2808	3.9	5.8
672	No	No	11	SURG	Urethral procedures w/o CC/MCC	0.8422	1.9	2.5
673	No	No	11	SURG	Other kidney & urinary tract procedures w MCC	2.5235	6.0	10.2
674	No	No	11	SURG	Other kidney & urinary tract procedures w CC	2.1024	4.0	6.6
675	No	No	11	SURG	Other kidney & urinary tract procedures w/o CC/MCC	1.7196	1.4	1.9
682	Yes	No	11	MED	Renal failure w MCC	1.4664	5.3	7.3
683	Yes	No	11	MED	Renal failure w CC	1.1942	4.5	5.7
684	Yes	No	11	MED	Renal failure w/o CC/MCC	0.9835	3.1	3.8
685	No	No	11	MED	Admit for renal dialysis	0.8599	2.4	3.5
686	No	No	11	MED	Kidney & urinary tract neoplasms w MCC	1.4513	6.0	8.1
687	No	No	11	MED	Kidney & urinary tract neoplasms w CC	1.1147	4.0	5.3
688	No	No	11	MED	Kidney & urinary tract neoplasms w/o CC/MCC	0.8577	2.5	3.2
689	Yes	No	11	MED	Kidney & urinary tract infections w MCC	1.0587	5.0	6.4
690	Yes	No	11	MED	Kidney & urinary tract infections w/o MCC	0.8000	3.6	4.3
691	No	No	11	MED	Urinary stones w esw lithotripsy w CC/MCC	1.1508	3.0	4.2
692	No	No	11	MED	Urinary stones w esw lithotripsy w/o CC/MCC	0.9457	1.8	2.3
693	No	No	11	MED	Urinary stones w/o esw lithotripsy w MCC	1.0459	3.9	5.2
694	No	No	11	MED	Urinary stones w/o esw lithotripsy w/o MCC	0.7110	2.0	2.6
695	No	No	11	MED	Kidney & urinary tract signs & symptoms w MCC	0.9422	4.3	5.7
696	No	No	11	MED	Kidney & urinary tract signs & symptoms w/o MCC	0.6276	2.6	3.2
697	No	No	11	MED	Urethral stricture	0.7223	2.4	3.3
698	Yes	No	11	MED	Other kidney & urinary tract diagnoses w MCC	1.3017	5.1	6.8

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
699	Yes	No	11	MED	Other kidney & urinary tract diagnoses w CC	1.0352	3.8	4.9
700	Yes	No	11	MED	Other kidney & urinary tract diagnoses w/o CC/MCC	0.8232	2.7	3.5
707	No	No	12	SURG	Major male pelvic procedures w CC/MCC	1.5521	3.5	4.5
708	No	No	12	SURG	Major male pelvic procedures w/o CC/MCC	1.1858	2.0	2.4
709	No	No	12	SURG	Penis procedures w CC/MCC	1.6134	3.6	6.5
710	No	No	12	SURG	Penis procedures w/o CC/MCC	1.2986	1.5	1.9
711	No	No	12	SURG	Testes procedures w CC/MCC	1.6051	5.3	7.8
712	No	No	12	SURG	Testes procedures w/o CC/MCC	1.0842	2.1	3.0
713	No	No	12	SURG	Transurethral prostatectomy w CC/MCC	0.9850	2.9	4.2
714	No	No	12	SURG	Transurethral prostatectomy w/o CC/MCC	0.6710	1.7	2.0
715	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w CC/MCC	1.5300	3.8	6.1
716	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	1.1310	1.3	1.5
717	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w CC/MCC	1.5653	5.0	7.5
718	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	1.0329	2.1	2.7
722	No	No	12	MED	Malignancy, male reproductive system w MCC	1.2827	5.6	7.4
723	No	No	12	MED	Malignancy, male reproductive system w CC	1.0603	4.2	5.4
724	No	No	12	MED	Malignancy, male reproductive system w/o CC/MCC	0.7677	2.5	3.3
725	No	No	12	MED	Benign prostatic hypertrophy w MCC	0.9071	4.4	5.7
726	No	No	12	MED	Benign prostatic hypertrophy w/o MCC	0.6886	2.8	3.5
727	No	No	12	MED	Inflammation of the male reproductive system w MCC	1.0083	5.1	6.5
728	No	No	12	MED	Inflammation of the male reproductive system w/o MCC	0.7241	3.3	4.0
729	No	No	12	MED	Other male reproductive system diagnoses w CC/MCC	0.9542	3.7	5.1

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
730	No	No	12	MED	Other male reproductive system diagnoses w/o CC/MCC	0.7058	2.4	3.2
734	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	2.0185	5.8	7.6
735	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	1.3798	3.0	3.5
736	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	3.2108	11.5	13.9
737	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	2.1022	6.2	7.4
738	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	1.6754	3.5	3.9
739	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	2.2081	7.9	10.2
740	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	1.4577	4.4	5.2
741	No	No	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	1.0308	2.8	3.1
742	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w CC/MCC	1.2422	3.5	4.6
743	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0.8672	2.1	2.3
744	No	No	13	SURG	D&C, conization, laparascopy & tubal interruption w CC/MCC	1.1896	4.0	5.8
745	No	No	13	SURG	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0.8660	2.1	2.5
746	No	No	13	SURG	Vagina, cervix & vulva procedures w CC/MCC	1.0488	3.0	4.1
747	No	No	13	SURG	Vagina, cervix & vulva procedures w/o CC/MCC	0.8499	1.7	1.9
748	No	No	13	SURG	Female reproductive system reconstructive procedures	0.7916	1.5	1.8
749	No	No	13	SURG	Other female reproductive system O.R. procedures w CC/MCC	2.2813	7.1	9.8
750	No	No	13	SURG	Other female reproductive system O.R. procedures w/o CC/MCC	1.4993	2.6	3.3

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
754	No	No	13	MED	Malignancy, female reproductive system w MCC	1.5596	6.4	8.9
755	No	No	13	MED	Malignancy, female reproductive system w CC	1.1608	4.2	5.6
756	No	No	13	MED	Malignancy, female reproductive system w/o CC/MCC	0.7702	2.5	3.3
757	No	No	13	MED	Infections, female reproductive system w MCC	1.4328	6.8	8.9
758	No	No	13	MED	Infections, female reproductive system w CC	1.1147	4.9	6.1
759	No	No	13	MED	Infections, female reproductive system w/o CC/MCC	0.9609	3.7	4.6
760	No	No	13	MED	Menstrual & other female reproductive system disorders w CC/MCC	0.6910	2.9	3.8
761	No	No	13	MED	Menstrual & other female reproductive system disorders w/o CC/MCC	0.5569	2.0	2.5
765	No	No	14	SURG	Cesarean section w CC/MCC	0.9943	4.1	5.3
766	No	No	14	SURG	Cesarean section w/o CC/MCC	0.7664	3.0	3.2
767	No	No	14	SURG	Vaginal delivery w sterilization &/or D&C	0.7246	2.5	2.9
768	No	No	14	SURG	Vaginal delivery w O.R. proc except steril &/or D&C	1.7348	4.7	5.8
769	No	No	14	SURG	Postpartum & post abortion diagnoses w O.R. procedure	1.9114	3.2	5.7
770	No	No	14	SURG	Abortion w D&C, aspiration curettage or hysterotomy	0.7336	1.6	2.6
774	No	No	14	MED	Vaginal delivery w complicating diagnoses	0.5914	2.6	3.2
775	No	No	14	MED	Vaginal delivery w/o complicating diagnoses	0.4461	2.1	2.3
776	No	No	14	MED	Postpartum & post abortion diagnoses w/o O.R. procedure	0.6460	2.6	3.5
777	No	No	14	MED	Ectopic pregnancy	0.7087	1.8	2.1
778	No	No	14	MED	Threatened abortion	0.3744	2.0	2.8
779	No	No	14	MED	Abortion w/o D&C	0.6013	1.7	2.6
780	No	No	14	MED	False labor	0.2845	1.3	2.7

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
781	No	No	14	MED	Other antepartum diagnoses w medical complications	0.5689	2.7	3.9
782	No	No	14	MED	Other antepartum diagnoses w/o medical complications	0.4297	1.7	2.8
789	No	No	15	MED	Neonates, died or transferred to another acute care facility	1.4250	*	*
790	No	No	15	MED	Extreme immaturity or respiratory distress syndrome, neonate	4.6990	*	*
791	No	No	15	MED	Prematurity w major problems	3.2093	*	*
792	No	No	15	MED	Prematurity w/o major problems	1.9364	*	*
793	No	No	15	MED	Full term neonate w major problems	3.2966	*	*
794	No	No	15	MED	Neonate w other significant problems	1.1668	*	*
795	No	No	15	MED	Normal newborn	0.1580	*	*
799	No	No	16	SURG	Splenectomy w MCC	3.9513	10.7	14.3
800	No	No	16	SURG	Splenectomy w CC	2.7617	6.4	8.2
801	No	No	16	SURG	Splenectomy w/o CC/MCC	2.3252	3.7	4.8
802	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w MCC	2.7940	9.1	12.8
803	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w CC	1.8259	4.7	6.5
804	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	1.4754	2.4	3.2
808	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	1.6171	6.0	8.0
809	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w CC	1.2031	3.9	5.0
810	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	1.0741	3.1	3.9
811	No	No	16	MED	Red blood cell disorders w MCC	1.0006	4.0	5.5
812	No	No	16	MED	Red blood cell disorders w/o MCC	0.7780	2.8	3.7
813	No	No	16	MED	Coagulation disorders	1.3426	3.8	5.2
814	No	No	16	MED	Reticuloendothelial & immunity disorders w MCC	1.3226	5.3	7.2

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
815	No	No	16	MED	Reticuloendothelial & immunity disorders w CC	1.0233	3.9	4.9
816	No	No	16	MED	Reticuloendothelial & immunity disorders w/o CC/MCC	0.7990	2.7	3.4
820	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w MCC	4.4970	13.8	18.4
821	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w CC	2.6847	5.4	7.8
822	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	1.5989	2.7	3.7
823	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w MCC	3.5188	12.0	15.4
824	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w CC	2.5164	6.6	8.8
825	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	1.6201	3.3	4.7
826	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	3.9780	13.0	17.4
827	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	2.4230	5.7	7.5
828	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	1.5109	2.9	3.7
829	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	2.4894	6.9	10.5
830	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	1.6396	2.5	3.5
834	No	No	17	MED	Acute leukemia w/o major O.R. procedure w MCC	3.6361	8.9	14.7
835	No	No	17	MED	Acute leukemia w/o major O.R. procedure w CC	2.5626	5.3	8.2
836	No	No	17	MED	Acute leukemia w/o major O.R. procedure w/o CC/MCC	2.1785	3.4	5.1
837	No	No	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	4.7788	17.2	22.7
838	No	No	17	MED	Chemo w acute leukemia as sdx w CC or high dose chemo agent	2.9919	6.2	9.0

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
839	No	No	17	MED	Chemo w acute leukemia as sdx w/o CC/MCC	2.3980	4.9	6.1
840	Yes	No	17	MED	Lymphoma & non-acute leukemia w MCC	2.1454	6.8	9.6
841	Yes	No	17	MED	Lymphoma & non-acute leukemia w CC	1.6444	5.0	6.6
842	Yes	No	17	MED	Lymphoma & non-acute leukemia w/o CC/MCC	1.2188	3.2	4.3
843	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w MCC	1.6341	6.3	8.7
844	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w CC	1.2403	4.5	6.0
845	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	0.9664	3.3	4.3
846	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	1.6523	5.8	8.5
847	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	1.0296	2.7	3.3
848	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0.9116	2.3	2.9
849	No	No	17	MED	Radiotherapy	1.2663	4.3	6.0
853	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w MCC	5.1840	12.8	16.8
854	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w CC	3.9291	9.1	11.2
855	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	3.3662	5.6	7.3
856	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w MCC	3.9257	12.1	16.2
857	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w CC	2.4919	6.8	8.9
858	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	2.0996	4.7	6.0
862	Yes	No	18	MED	Postoperative & post-traumatic infections w MCC	1.5454	6.2	8.3
863	Yes	No	18	MED	Postoperative & post-traumatic infections w/o MCC	1.0560	4.2	5.2

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
864	No	No	18	MED	Fever of unknown origin	0.8240	3.2	4.1
865	No	No	18	MED	Viral illness w MCC	1.2074	4.9	6.8
866	No	No	18	MED	Viral illness w/o MCC	0.7527	2.8	3.5
867	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w MCC	2.1971	7.2	9.9
868	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w CC	1.5258	4.6	5.9
869	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w/o CC/MCC	1.3611	3.5	4.4
870	Yes	No	18	MED	Septicemia w MV 96+ hours	5.7579	12.6	15.3
871	Yes	No	18	MED	Septicemia w/o MV 96+ hours w MCC	1.7484	5.6	7.7
872	Yes	No	18	MED	Septicemia w/o MV 96+ hours w/o MCC	1.3783	4.7	5.8
876	No	No	19	SURG	O.R. procedure w principal diagnoses of mental illness	2.4632	6.9	11.4
880	No	No	19	MED	Acute adjustment reaction & psychosocial dysfunction	0.6085	2.4	3.2
881	No	No	19	MED	Depressive neuroses	0.5198	3.1	4.2
882	No	No	19	MED	Neuroses except depressive	0.5685	3.1	4.4
883	No	No	19	MED	Disorders of personality & impulse control	0.8999	4.6	7.4
884	Yes	No	19	MED	Organic disturbances & mental retardation	0.8431	4.0	5.4
885	No	No	19	MED	Psychoses	0.7783	5.5	7.6
886	No	No	19	MED	Behavioral & developmental disorders	0.6983	4.0	5.9
887	No	No	19	MED	Other mental disorder diagnoses	0.8341	3.1	4.6
894	No	No	20	MED	Alcohol/drug abuse or dependence, left ama	0.3571	2.1	3.0
895	No	No	20	MED	Alcohol/drug abuse or dependence w rehabilitation therapy	0.7557	8.2	10.5
896	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.0419	4.8	6.6
897	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.6145	3.3	4.1
901	No	No	21	SURG	Wound debridements for injuries w MCC	2.8534	9.3	14.4

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
902	No	No	21	SURG	Wound debridements for injuries w CC	1.8611	5.7	7.9
903	No	No	21	SURG	Wound debridements for injuries w/o CC/MCC	1.4966	3.5	4.9
904	No	No	21	SURG	Skin grafts for injuries w CC/MCC	2.5246	7.2	12.2
905	No	No	21	SURG	Skin grafts for injuries w/o CC/MCC	1.5926	3.5	4.7
906	No	No	21	SURG	Hand procedures for injuries	0.9803	2.2	3.3
907	Yes	No	21	SURG	Other O.R. procedures for injuries w MCC	3.1030	8.1	11.7
908	Yes	No	21	SURG	Other O.R. procedures for injuries w CC	2.1865	5.0	6.9
909	Yes	No	21	SURG	Other O.R. procedures for injuries w/o CC/MCC	1.4112	2.7	3.6
913	No	No	21	MED	Traumatic injury w MCC	1.0631	4.6	6.2
914	No	No	21	MED	Traumatic injury w/o MCC	0.6890	2.7	3.4
915	No	No	21	MED	Allergic reactions w MCC	0.8660	3.3	4.7
916	No	No	21	MED	Allergic reactions w/o MCC	0.4986	1.7	2.1
917	Yes	No	21	MED	Poisoning & toxic effects of drugs w MCC	1.1717	3.7	5.2
918	Yes	No	21	MED	Poisoning & toxic effects of drugs w/o MCC	0.6886	2.1	2.7
919	No	No	21	MED	Complications of treatment w MCC	1.2830	4.4	6.2
920	No	No	21	MED	Complications of treatment w CC	0.9797	3.2	4.3
921	No	No	21	MED	Complications of treatment w/o CC/MCC	0.7101	2.3	2.9
922	No	No	21	MED	Other injury, poisoning & toxic effect diag w MCC	1.1338	4.1	6.0
923	No	No	21	MED	Other injury, poisoning & toxic effect diag w/o MCC	0.7071	2.4	3.3
927	No	No	22	SURG	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	12.3042	23.0	28.8
928	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w CC/MCC	4.3956	12.1	16.2
929	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w/o CC/MCC	2.3533	5.6	7.7
933	No	No	22	MED	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	2.6626	2.7	5.9

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
934	No	No	22	MED	Full thickness burn w/o skin grft or inhal inj	1.3745	4.7	6.8
935	No	No	22	MED	Non-extensive burns	1.1605	3.7	5.5
939	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w MCC	2.1672	7.5	10.9
940	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w CC	1.6823	4.4	6.4
941	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	1.3531	2.3	3.0
945	Yes	No	23	MED	Rehabilitation w CC/MCC	1.1005	8.4	10.3
946	Yes	No	23	MED	Rehabilitation w/o CC/MCC	1.0143	7.0	7.9
947	Yes	No	23	MED	Signs & symptoms w MCC	0.8767	3.8	5.0
948	Yes	No	23	MED	Signs & symptoms w/o MCC	0.6542	2.7	3.4
949	No	No	23	MED	Aftercare w CC/MCC	0.7323	2.5	4.1
950	No	No	23	MED	Aftercare w/o CC/MCC	0.5948	2.4	3.4
951	No	No	23	MED	Other factors influencing health status	0.6109	2.1	3.8
955	No	No	24	SURG	Craniotomy for multiple significant trauma	5.1028	8.5	12.2
956	Yes	Yes	24	SURG	Limb reattachment, hip & femur proc for multiple significant trauma	3.4854	7.6	9.5
957	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w MCC	5.7960	10.5	16.0
958	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w CC	4.4786	7.9	10.5
959	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w/o CC/MCC	3.6988	4.9	6.1
963	No	No	24	MED	Other multiple significant trauma w MCC	2.2985	6.3	9.3
964	No	No	24	MED	Other multiple significant trauma w CC	1.7015	5.0	6.3
965	No	No	24	MED	Other multiple significant trauma w/o CC/MCC	1.4108	3.3	4.1
969	No	No	25	SURG	HIV w extensive O.R. procedure w MCC	5.1395	13.5	18.7
970	No	No	25	SURG	HIV w extensive O.R. procedure w/o MCC	3.6849	6.6	9.5
974	No	No	25	MED	HIV w major related condition w MCC	2.1382	7.4	10.4

MS-DRG	FY 2008 Final Rule Post-Acute DRG	FY 2008 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
975	No	No	25	MED	HIV w major related condition w CC	1.5918	5.3	7.3
976	No	No	25	MED	HIV w major related condition w/o CC/MCC	1.3357	3.8	4.9
977	No	No	25	MED	HIV w or w/o other related condition	1.0387	3.8	5.3
981	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w MCC	4.5168	11.9	15.3
982	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w CC	3.5417	7.8	10.0
983	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	2.9737	3.9	5.4
984	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	2.7217	11.7	14.6
985	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w CC	2.0865	7.4	9.7
986	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.6706	3.5	5.1
987	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	2.8500	9.9	13.2
988	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w CC	2.0134	5.9	8.0
989	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	1.6310	2.9	4.1
998	No	No		**	Principal diagnosis invalid as discharge diagnosis	N/A	*	*
999	No	No		**	Ungroupable	N/A	*	*

MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.

Note: If there is no value or asterisk in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to obtain a meaningful computation of these statistics.

TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
040.41	Infant botulism	Y CC	15 18	791[1], 793[1] 867, 868, 869
040.42	Wound botulism	Y CC	18	867, 868, 869
058.10	Roseola infantum, unspecified	N	15 18	791[1], 793[1] 865, 866
058.11	Roseola infantum due to human herpesvirus 6	N	15 18	791[1], 793[1] 865, 866
058.12	Roseola infantum due to human herpesvirus 7	N	15 18	791[1], 793[1] 865, 866
058.21	Human herpesvirus 6 encephalitis	Y MCC	1 15 25	23,24,97, 98, 99 791[1], 793[1] 974, 975, 976
058.29	Other human herpesvirus encephalitis	Y MCC	1 15 25	23, 24, 97, 98, 99 791[1], 793[1] 974, 975, 976
058.81	Human herpesvirus 6 infection	N	9	606, 607
058.82	Human herpesvirus 7 infection	N	9	606, 607
058.89	Other human herpesvirus infection	N	9	606, 607
079.83	Parvovirus B19	Y CC	18	865, 866
200.30	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
200.31	Marginal zone lymphoma, lymph nodes of head, face, and neck	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.32	Marginal zone lymphoma, intrathoracic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825,840, 841, 842
			25	974, 975, 976
200.33	Marginal zone lymphoma, intraabdominal lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.34	Marginal zone lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.35	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.36	Marginal zone lymphoma, intrapelvic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.37	Marginal zone lymphoma, spleen	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.38	Marginal zone lymphoma, lymph nodes of multiple sites	Y CC	17	820, 821, 822, 823, 824, 825,840, 841, 842
			25	974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
200.40	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.41	Mantle cell lymphoma, lymph nodes of head, face, and neck	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.42	Mantle cell lymphoma, intrathoracic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.43	Mantle cell lymphoma, intra-abdominal lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.44	Mantle cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.45	Mantle cell lymphoma,lymph nodes of inguinal region and lower limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.46	Mantle cell lymphoma, intrapelvic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841,842
			25	974, 975, 976
200.47	Mantle cell lymphoma, spleen	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.48	Mantle cell lymphoma, lymph nodes of multiple sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
200.50	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.51	Primary central nervous system lymphoma, lymph nodes of head, face, and neck	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.52	Primary central nervous system lymphoma, intrathoracic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.53	Primary central nervous system lymphoma, intra-abdominal lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.54	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.55	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.56	Primary central nervous system lymphoma, intrapelvic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.57	Primary central nervous system lymphoma, spleen	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.58	Primary central nervous system lymphoma, lymph nodes of multiple sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
200.60	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.61	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.62	Anaplastic large cell lymphoma, intrathoracic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.63	Anaplastic large cell lymphoma, intra-abdominal lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.64	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.65	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.66	Anaplastic large cell lymphoma, intrapelvic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.67	Anaplastic large cell lymphoma, spleen	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.68	Anaplastic large cell lymphoma, lymph nodes of multiple sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
200.70	Large cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.71	Large cell lymphoma, lymph nodes of head, face, and neck	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841,842
			25	974, 975, 976
200.72	Large cell lymphoma, intrathoracic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.73	Large cell lymphoma, intra-abdominal lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841,842
			25	974, 975, 976
200.74	Large cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841,842
			25	974, 975, 976
200.75	Large cell lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.76	Large cell lymphoma, intrapelvic lymph nodes	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.77	Large cell lymphoma, spleen	Y CC	17	820,821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
200.78	Large cell lymphoma, lymph nodes of multiple sites	Y CC	17	820,821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
202.70	Peripheral T cell lymphoma, unspecified site, extranodal and solid organ sites	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.71	Peripheral T cell lymphoma, lymph nodes of head, face, and neck	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.72	Peripheral T cell lymphoma, intrathoracic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.73	Peripheral T cell lymphoma, intra-abdominal lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.74	Peripheral T cell lymphoma, lymph nodes of axilla and upper limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.75	Peripheral T cell lymphoma, lymph nodes of inguinal region and lower limb	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.76	Peripheral T cell lymphoma, intrapelvic lymph nodes	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976
202.77	Peripheral T cell lymphoma, spleen	Y CC	17 25	820, 821, 822, 823, 824, 825, 840, 841, 842 974, 975, 976

Diagnosis Code	Description	CC	MDC	MS-DRG
202.78	Peripheral T cell lymphoma, lymph nodes of multiple sites	Y CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
			25	974, 975, 976
233.30	Carcinoma in situ, unspecified female genital organ	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.31	Carcinoma in situ,vagina	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.32	Carcinoma in situ,vulva	N	13	739, 740, 741, 744, 745, 754, 755, 756
233.39	Carcinoma in situ,other female genital organ	N	13	739, 740, 741, 744, 745, 754, 755, 756
255.41	Glucocorticoid deficiency	Y CC	10	643, 644, 645
255.42	Mineralocorticoid deficiency	Y CC	10	643, 644, 645
258.01	Multiple endocrine neoplasia [MEN] type I	N	10	643, 644, 645
258.02	Multiple endocrine neoplasia [MEN] type IIA	N	10	643, 644, 645
258.03	Multiple endocrine neoplasia [MEN] type IIB	N	10	643, 644, 645
284.81	Red cell aplasia (acquired)(adult)(with thymoma)	Y MCC	16 25	808, 809, 810 977
284.89	Other specified aplastic anemias	Y MCC	16 25	808, 809, 810 977
288.66	Bandemia	N	16	814, 815, 816
315.34	Speech and language developmental delay due to hearing loss	N	19	886
331.5	Idiopathic normal pressure hydrocephalus (INPH)	Y CC	1	56, 57
359.21	Myotonic muscular dystrophy	N	1	91, 92, 93
359.22	Myotonia congenita	N	1	91, 92, 93

Diagnosis Code	Description	CC	MDC	MS-DRG
359.23	Myotonic chondrodystrophy	N	1	91, 92, 93
359.24	Drug induced myotonia	N	1	91, 92, 93
359.29	Other specified myotonic disorder	N	1	91, 92, 93
364.81	Floppy iris syndrome	N	2	124, 125
364.89	Other disorders of iris and ciliary body	N	2	124, 125
388.45	Acquired auditory processing disorder	N	19	886
389.05	Conductive hearing loss, unilateral	N	3	154, 155, 156
389.06	Conductive hearing loss, bilateral	N	3	154, 155, 156
389.13	Neural hearing loss, unilateral	N	3	154, 155, 156
389.17	Sensory hearing loss, unilateral	N	3	154, 155, 156
389.20	Mixed hearing loss, unspecified	N	3	154, 155, 156
389.21	Mixed hearing loss, unilateral	N	3	154, 155, 156
389.22	Mixed hearing loss, bilateral	N	3	154, 155, 156
414.2	Chronic total occlusion of coronary artery	N	5	302, 303
415.12	Septic pulmonary embolism	Y MCC	4 15	175,176 791[1], 793[1]
423.3	Cardiac tamponade	Y CC	5	314, 315, 316
440.4	Chronic total occlusion of artery of the extremities	N	5	299, 300, 301
449	Septic arterial embolism	Y CC	5 15	299, 300, 301 791[1], 793[1]
488	Influenza due to identified avian influenza virus	N	3	152, 153
525.71	Osseointegration failure of dental implant	N	PRE 3	11, 12, 13 157, 158, 159
525.72	Post-osseointegration biological failure of dental implant	N	PRE 3	11, 12, 13 157, 158, 159
525.73	Post-osseointegration mechanical failure of dental implant	N	PRE 3	11, 12, 13 157, 158, 159
525.79	Other endosseous dental implant failure	N	PRE 3	11, 12, 13 157, 158, 159
569.43	Anal sphincter tear (healed) (old)	N	6	393, 394, 395

Diagnosis Code	Description	CC	MDC	MS-DRG
624.01	Vulvar intraepithelial neoplasia I [VIN I]	N	13	742, 743, 760, 761
624.02	Vulvar intraepithelial neoplasia II [VIN II]	N	13	742, 743, 760, 761
624.09	Other dystrophy of vulva	N	13	742, 743, 760, 761
664.60	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,unspecified as to episode of care or not applicable	N	14	765, 766, 767, 768, 774, 775
664.61	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,delivered, with or without mention of antepartum condition	Y CC	14	765, 766, 767, 768, 774,775
664.64	Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,postpartum condition or complication	Y CC	14	769, 776
733.45	Aseptic necrosis of bone, jaw	Y CC	8	553, 554
787.20	Dysphagia, unspecified	N	6	391, 392
787.21	Dysphagia, oral phase	N	6	391, 392
787.22	Dysphagia, oropharyngeal phase	N	6	391, 392
787.23	Dysphagia, pharyngeal phase	N	6	391, 392
787.24	Dysphagia, pharyngoesophageal phase	N	6	391, 392
787.29	Other dysphagia	N	6	391, 392
789.51	Malignant ascites	Y CC	23	947, 948
789.59	Other ascites	Y CC	23	947, 948
999.31*	Infection due to central venous catheter	Y CC	5	314, 315, 316
999.39*	Infection following other infusion, injection, transfusion, or vaccination	Y CC	15 18	791[1], 793[1] 856, 857, 858, 867, 868, 869
V12.53	Personal history of sudden cardiac arrest	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
V12.54	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits	N	23	951
V13.22	Personal history of cervical dysplasia	N	17	843, 844, 845
V16.52	Family history of malignant neoplasm,bladder	N	23	951
V17.41	Family history of sudden cardiac death (SCD)	N	23	951
V17.49	Family history of other cardiovascular diseases	N	23	951
V18.11	Family history of multiple endocrine neoplasia [MEN] syndrome	N	23	951
V18.19	Family history of other endocrine and metabolic diseases	N	23	951
V25.04	Counseling and instruction in natural family planning to avoid pregnancy	N	23	951
V26.41	Procreative counseling and advice using natural family planning	N	23	951
V26.49	Other procreative management, counseling and advice	N	23	951
V26.81	Encounter for assisted reproductive fertility procedure cycle	N	23	951
V26.89	Other specified procreative management	N	23	951
V49.85	Dual sensory impairment	N	23	951
V68.01	Disability examination	N	23	951
V68.09	Other issue of medical certificates	N	23	951
V72.12	Encounter for hearing conservation and treatment	N	15 23	795[2] 951
V73.81	Special screening examination, Human papillomavirus (HPV)	N	23	951
V84.81	Genetic susceptibility to multiple endocrine neoplasia [MEN]	N	23	951
V84.89	Genetic susceptibility to other disease	N	23	951

MCC – Major Complication or Comorbidity in MS-DRGs.
New codes 629.82, 629.83, 629.84 and V17.40 that were listed in the proposed rule have been deleted.
They will not be implemented on October 1, 2007.

[1] Secondary diagnosis of major problem.
[2] On "Only secondary diagnosis" list.

* These diagnosis codes were discussed at the March 22-23, 2007 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, 2007.

TABLE 6B.—NEW PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.19	Disruption of blood brain barrier via infusion [BBBD]	N		
00.94*	Intra-operative neurophysiologic monitoring	N		
01.10	Intracranial pressure monitoring	N		
01.16	Intracranial oxygen monitoring	N		
01.17	Brain temperature monitoring	N		
07.83*	Thoracoscopic partial excision of thymus	Y	1	40, 41, 42
			4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
07.84*	Thoracoscopic total excision of thymus	Y	1	40, 41, 42
			4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959

Procedure Code	Description	O.R.	MDC	MS-DRG
07.95*	Thoracoscopic incision of thymus	Y	1	40, 41, 42
			4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
07.98*	Other and unspecified thoracoscopic operations on thymus	Y	1	40, 41, 42
			4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
32.20*	Thoracoscopic excision of lesion or tissue of lung	Y	4	163, 164, 165
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
32.30*	Thoracoscopic segmental resection of lung	Y	4	163, 164, 165
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
32.39*	Other and unspecified segmental resection of lung	Y	4	163, 164, 165
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
32.41	Thoracoscopic lobectomy of lung	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959

Procedure Code	Description	O.R.	MDC	MS-DRG
32.49	Other lobectomy of lung	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959
32.50*	Thoracoscopic pneumonectomy	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959
32.59*	Other and unspecified pneumonectomy	Y	4	163, 164, 165
			21	907, 908, 909
			24	957, 958, 959
33.20	Thoracoscopic lung biopsy	Y	4	166, 167, 168
			5	264
			8	515, 516, 517
			11	673, 674, 675
			17	823, 824, 825, 829, 830
34.06	Thoracoscopic drainage of pleural cavity	Y	4	166, 167, 168
34.20	Thoracoscopic pleural biopsy	Y	4	166, 167, 168
34.52	Thoracoscopic decortication of lung	Y	4	163, 164, 165
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
50.13*	Transjugular liver biopsy	N		
50.14*	Laparoscopic liver biopsy	Y	6	356, 357, 358
			7	420, 421, 422
			9	579, 580, 581
			11	673, 674, 675
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959

Procedure Code	Description	O.R.	MDC	MS-DRG
70.53	Repair of cystocele and rectocele with graft or prosthesis	Y	6	329, 330, 331
			11	653, 654, 655
			13	748
70.54	Repair of cystocele with graft or prosthesis	Y	11	662, 663, 664
			13	748
70.55	Repair of rectocele with graft or prosthesis	Y	6	329, 330, 331
			13	748
70.63	Vaginal construction with graft or prosthesis	Y	13	748
70.64	Vaginal reconstruction with graft or prosthesis	Y	13	748
			21	907, 908, 909
			24	957, 958, 959
70.78	Vaginal suspension and fixation with graft or prosthesis	Y	11	662, 663, 664
			13	748
70.93	Other operations on cul-de-sac with graft or prosthesis	Y	13	746, 747
70.94	Insertion of biological graft	N		
70.95	Insertion of synthetic graft or prosthesis	N		
84.80*	Insertion or replacement of interspinous process device(s)	Y	1	28, 29, 30
			8	490
			21	907, 908, 909
			24	957, 958, 959
84.81*	Revision of interspinous process device(s)	Y	8	515, 516, 517
			21	907, 908, 909
			24	957, 958, 959
84.82*	Insertion or replacement of pedicle-based dynamic stabilization device(s)	Y	1	28, 29, 30
			8	490
			21	907, 908, 909
			24	957, 958, 959
84.83*	Revision of pedicle-based dynamic stabilization device(s)	Y	8	515, 516, 517
			21	907, 908, 909
			24	957, 958, 959

Procedure Code	Description	O.R.	MDC	MS-DRG
84.84*	Insertion or replacement of facet replacement device(s)	Y	1	28, 29, 30
			8	490
			21	907, 908, 909
			24	957, 958, 959
84.85*	Revision of facet replacement device(s)	Y	8	515, 516, 517
			21	907, 908, 909
			24	957, 958, 959
88.59	Intra-operative fluorescence vascular angiography	N		
92.41*	Intra-operative electron radiation therapy	N		

*These procedure codes were discussed at the March 22-23, 2007 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, 2007.

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	CMS DRG
233.3	Carcinoma in situ, other and unspecified female genital organs	N	13	354, 355, 363, 366, 367
255.4	Corticoadrenal insufficiency	Y	10	300, 301
258.0	Polyglandular activity in multiple endocrine adenomatosis	N	10	300, 301
284.8	Other specified aplastic anemias	Y	16	574
			25	490
359.2	Myotonic disorders	N	1	34, 35
364.8	Other disorders of iris and ciliary body	N	2	46, 47, 48
389.2	Mixed conductive and sensorineural hearing loss	N	3	73, 74
624.0	Dystrophy of vulva	N	13	358, 359, 369
787.2	Dysphagia	N	6	182, 183, 184
789.5	Ascites	Y	23	463, 464

Diagnosis Code	Description	CC	MDC	CMS DRG
999.3*	Complications of medical care, not elsewhere classified, Other infection	Y	15	387^1, 389^1
			18	423, 579
V17.4	Family history of other cardiovascular diseases	N	23	467
V18.1	Family history of other endocrine and metabolic diseases	N	23	467
V26.4	Procreative management,general counseling and advice	N	23	467
V26.8	Other specified procreative management	N	23	467
V68.0	Issue of medical certificates	N	23	467
V84.8	Genetic susceptibility to other disease	N	23	467

The DRG assignments listed are based on the current code assignment in the CMS DRGs.
[1] Secondary diagnosis of major problem.
*This diagnosis code was discussed at the March 22-23, 2007 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, 2007.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	CMS-DRG
32.3*	Segmental resection of lung	Y	4	75
			21	442, 443
			24	486
32.4	Lobectomy of lung	Y	4	75
			21	442, 443
			24	486
32.5*	Complete pneumonectomy	Y	4	75
			21	442, 443
			24	486
84.58*	Implantation of interspinous process decompression device	Y	1	531, 532
			8	499, 500
			21	442, 443
			24	486

The DRG assignments listed are based on the current code assignment in the CMS DRGs.

* These procedure codes were discussed at the March 22-23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be deleted on October 1, 2007.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	MS-DRG
005.1	Botulism food poisoning	Y	18	867, 868, 869
359.3	Periodic paralysis	N	1	91, 92, 93
389.14	Central hearing loss	N	3	154, 155, 156
389.18	Sensorineural hearing loss, bilateral	N	3	154, 155, 156
389.7	Deaf, nonspeaking, not elsewhere classifiable	N	3	154, 155, 156

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.18*	Infusion of immunosuppressive antibody therapy	N		
00.74	Hip bearing surface, metal-on-polyethylene	N		
00.75	Hip bearing surface, metal-on-metal	N		
00.76	Hip bearing surface, ceramic-on- ceramic	N		
00.77	Hip bearing surface, ceramic-on-polyethylene	N		
07.81*	Other partial excision of thymus	Y	1	40, 41, 42
			4	163, 64, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959

Procedure Code	Description	O.R.	MDC	MS-DRG
07.82*	Other total excision of thymus	Y	1	40, 41, 42
			4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
07.92*	Other incision of thymus	Y	4	163, 164, 165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
07.99*	Other and unspecified operations on thymus	Y	4	163, 164,165
			10	628, 629, 630
			16	802, 803, 804
			17	820, 821, 822, 826, 827, 828
34.24	Other pleural biopsy	N		
39.8	Operations on carotid body, carotid sinus and other vascular bodies	Y	1	37, 38, 39
			4	166, 167, 168
			5	252, 253, 254
53.41	Repair of umbilical hernia with graft or prosthesis	Y	6	353, 354, 355 987, 988, 989
53.61	Incisional hernia repair with graft or prosthesis	Y	6	353, 354, 355
			21	907, 908, 909
			24	957, 958, 959 987, 988, 989

Procedure Code	Description	O.R.	MDC	MS-DRG
53.69	Repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353, 354, 355 987, 988, 989
99.14	Injection or infusion of gamma globulin	N		

*These procedure codes were discussed at the March 22-23, 2007 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, 2007.

TABLE 6G - ADDITIONS TO THE CC EXCLUSIONS LIST

  CCs that are added to the list are in 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.

*0010	00589	0092	00865	32351	71123
0010	0085	*0029	00866	32352	71124
0011	0090	0020	00867	32361	71125
0019	0092	0021	00869	32362	71126
0050		0022	0090	32363	71127
0053	07422	0023	0092	32371	71128
0054	09884	0029	1230	32372	71129
00581	09885	0030	*0031	32381	71130
00589	1230	0040	0031	32382	71131
0090	3911	0050	0050	34120	71132
0092	*0021	0053	0053	34121	71133
*0011	0020	0054	0054	34122	71134
0010	0021	00581	00581	*00322	71135
0011	0022	00589	00589	00322	71136
0019	0023	0085	0090	0050	71137
0040	0029	0090	0092	0053	71138
0050	0050	0092	0223	0054	71139
0053	0053	1230	77189	00581	71140
0054	0054	*0030	*00320	00589	71141
00581	00581	0030	0050	0090	71142
00589	00589	0040	0053	0092	71143
0085	0090	0050	0054	*00323	71144
0090	0092	0052	00581	00323	71145
0092	*0022	0053	00589	0050	71146
1230	0020	0054	0090	0053	71147
*0019	0021	00581	0092	0054	71148
0010	0022	00589	*00321	00581	71149
0011	0023	0062	00321	00589	71150
0019	0029	0071	0050	0090	71151
0050	0050	0072	0053	0092	71152
0053	0053	0074	0054	09850	71153
0054	0054	0075	00581	09851	71154
00581	00581	0078	00589	09852	71155
00589	00589	0079	0090	09853	71156
0090	0090	00800	0092	09859	71157
0092	0092	00801	0470	71110	71158
*0020	*0023	00802	0471	71111	71159
0020	0020	00803	0478	71112	71170
0021	0021	00804	0479	71113	71171
0022	0022	00809	0490	71114	71172
0023	0023	0081	0491	71115	71173
0029	0029	0082	09181	71116	71174
0030	0050	0083	09882	71117	71175
0040	0053	0085	10081	71118	71176
0050	0054	00861	32301	71119	71177
0053	00581	00862	32302	71120	71178
0054	00589	00863	32341	71121	71179
00581	0090	00864	32342	71122	71180

71181	00589	0092	00581	0054	00581
71182	0090	*0048	00589	00581	00589
71183	0092	0050	0062	00589	0090
71184	*0038	0053	0071	0062	0092
71185	0038	0054	0072		*00589
71186	0050	00581	0074	0071	0050
71187	0053	00589	0075	0072	0053
71188	0054	0090	0078	0074	0054
71189	00581	0092	0079	0075	00581
71190	00589	*0049	00800	0078	00589
71191	0090	0030	00801	0079	0090
71192	0092	0040	00802	00800	0092
71193	*0039	0050	00803	00801	*0059
71194	0039	0052	00804	00802	0050
71195	0050	0053	00809	00803	0053
71196	0053	0054	0081	00804	0054
71197	0054	00581	0082	00809	00581
71198	00581	00589	0083	0081	00589
71199	00589	0062	0085	0082	0090
*00324	0090	0071	00861	0083	0092
00324	0092	0072	00862	0085	*0060
0050	*0040	0074	00863	00861	0040
0053	0040	0075	00864	00862	0050
0054	0050	0078	00865	00863	0053
00581	0053	0079	00866	00864	0054
00589	0054	00800	00867	00865	00581
0090	00581	00801	00869	00866	00589
0092	00589	00802	0090	00867	0060
37602	0090	00803	0092	00869	0061
37603	0092	00804	04041	0090	0062
73011	*0041	00809	04042	0092	0068
73012	0050	0081	1230	04041	0071
73013	0053	0082	*0051	04042	0072
73014	0054	0083	0030	1230	0074
73015	00581	0085	0040	*0053	0075
73016	00589	00861	0050	0050	0078
73017	0090	00862	0051	0053	0079
73018	0092	00863	0052	0054	0085
73019	*0042	00864	0053	00581	00861
73021	0050	00865	0054	00589	00862
73022	0053	00866	00581	0090	00863
73023	0054	00867	00589	0092	00864
73024		00869	0090	*0054	00865
73025	00581	0090	0092	0050	00866
73026	00589	0092	04041	0053	00867
73027	0090	1230	04042	0054	00869
73028	0092	*0050	1230	00581	0090
73029	*0043	0030	*0052	00589	0092
*00329	0050	0040	0030	0090	1230
00329	0053	0050	0040	0092	*0061
0050	0054	0051	0050	*00581	0040
0053	00581	0052	0051	0050	0050
0054	00589	0053	0052	0053	0053
00581	0090	0054	0053	0054	0054

00581	0053	0072	0053	00581	00866
00589	0054	0074	0054	00589	00867
0060	00581	0075	00581	0062	00869
0061	00589	0078	00589	0071	0090
0062	0063	0079	0062	0072	0092
0068	0068	0085	0071	0074	1230
0071	0090	00861	0072	0075	*0078
0072	0092	00862	0074	0078	0040
0074	*0064	00863	0075	0079	0050
0075	0050	00864	0078	0085	0053
0078	0053	00865	0079	00861	0054
0079	0054	00866	0085	00862	00581
0085	00581	00867	00861	00863	00589
00861	00589	00869	00862	00864	0062
00862	0064	0090	00863	00865	0071
00863	0068	0092	00864	00866	0072
00864	0090	1230	00865	00867	0074
00865	0092	*0070	00866	00869	0075
00866	*0065	0050	00867	0090	0078
00867	0050	0053	00869	0092	0079
	0053	0054	0090	1230	0085
00869	0054	00581	0092	*0075	00861
0090	00581	00589	1230	0030	00862
0092	00589	0090	*0073	0040	00863
1230	0065	0092	0040	0050	00864
*0062	0068	*0071	0050	0052	00865
0040	0090	0040	0053	0053	00866
0050	0092	0050	0054	0054	00867
0053	*0066	0053	00581	00581	00869
0054	0050	0054	00589	00589	0090
00581	0053	00581	0062	0060	0092
00589	0054	00589	0071	0061	1230
0062	00581	0062	0072	0062	*0079
0068	00589	0071	0074	0071	0040
0071	0090	0072	0075	0072	0050
0072	0092	0074	0078	0074	0053
0074	*0068	0075	0079	0075	0054
0075	0050	0078	0085	0078	00581
0078	0053	0079	00861	0079	00589
0079	0054	0085	00862	00800	0062
0085	00581	00861	00863	00801	0071
00861	00589	00862	00864	00802	0072
00862	0068	00863	00865	00803	0074
00863	0090	00864	00866	00804	0075
00864	0092	00865	00867	00809	0078
00865	*0069	00866	00869	0081	0079
00866	0040	00867	0090	0082	0085
00867	0050	00869	0092	0083	00861
00869	0053	0090	1230	0085	00862
0090	0054	0092	*0074	00861	00863
0092	00581	1230	0040	00862	00864
1230	00589	*0072	0050	00863	00865
*0063	0062	0040	0053	00864	00866
0050	0071	0050	0054	00865	00867

00869	0079	00869	0075	00866	0072
0090	00800	0090	0078	00867	0074
0092	00801	0092	0079	00869	0075
1230	00802	1230	00800	0090	0078
*00800	00803	*00803	00801	0092	0079
0030	00804	0030	00802	1230	00800
0050	00809	0050	00803	*0081	00801
0052	0081	0052	00804	0030	00802
0053	0082	0053	00809	0040	00803
0054	0083	0054	0081	0050	00804
00581	0085	00581	0082	0052	00809
00589	00861	00589	0083	0053	0081
0062	00862	0062	0085	0054	0082
0071	00863	0071	00861	00581	0083
0072	00864	0072	00862	00589	0085
0074	00865	0074	00863	0062	00861
0075	00866	0075	00864	0071	00862
0078	00867	0078	00865	0072	00863
0079	00869	0079	00866	0074	00864
00800	0090		00867	0075	00865
00801	0092	00800	00869	0078	00866
00802	1230	00801	0090	0079	00867
00803	*00802	00802	0092	00800	00869
00804	0030	00803	1230	00801	0090
00809	0050	00804	*00809	00802	0092
0081	0052	00809	0030	00803	1230
0082	0053	0081	0050	00804	*0083
0083	0054	0082	0052	00809	0030
0085	00581	0083	0053	0081	0040
00861	00589	0085	0054	0082	0050
00862	0062	00861	00581	0083	0052
00863	0071	00862	00589	0085	0053
00864	0072	00863	0062	00861	0054
00865	0074	00864	0071	00862	00581
00866	0075	00865	0072	00863	00589
00867	0078	00866	0074	00864	0062
00869	0079	00867	0075	00865	0071
0090	00800	00869	0078	00866	0072
0092	00801	0090	0079	00867	0074
1230	00802	0092	00800	00869	0075
*00801	00803	1230	00801	0090	0078
0030	00804	*00804	00802	0092	0079
0050	00809	0030	00803	1230	00800
0052	0081	0050	00804	*0082	00801
0053	0082	0052	00809	0030	00802
0054	0083	0053	0081	0040	00803
00581	0085	0054	0082	0050	00804
00589	00861	00581	0083	0052	00809
0062	00862	00589	0085	0053	0081
0071	00863	0062	00861	0054	0082
0072	00864		00862	00581	0083
0074	00865	0071	00863	00589	0085
0075	00866	0072	00864	0062	00861
0078	00867	0074	00865	0071	00862

00863	0071	00863	0062	0083	0052
00864	0072	00864	0071	0085	0053
00865	0074	00865	0072	00861	0054
00866	0075	00866	0074	00862	00581
00867	0078	00867	0075	00863	00589
00869	0079	00869	0078	00864	0062
0090	00800	0090	0079	00865	0071
0092	00801	0092	00800	00866	0072
1230	00802	1230	00801	00867	0074
*00841	00803	*00844	00802	00869	0075
0030	00804	0030	00803	0090	0078
0050	00809	0050	00804	0092	0079
0052	0081	0052	00809	04041	00800
0053	0082	0053	0081	04042	00801
0054	0083	0054	0082	1230	00802
00581	0085	00581	0083	*00847	00803
00589	00861	00589	0085	0030	00804
0062	00862	0062	00861	0050	00809
0071	00863	0071	00862	0052	0081
0072	00864	0072	00863	0053	0082
0074	00865	0074	00864	0054	0083
0075	00866	0075	00865	00581	0085
0078	00867	0078	00866	00589	00861
0079	00869	0079	00867	0062	00862
00800	0090	00800	00869	0071	00863
00801	0092	00801	0090	0072	00864
00802	1230	00802	0092	0074	00865
00803	*00843	00803	04041	0075	00866
00804	0030	00804	04042	0078	00867
00809	0050	00809	1230	0079	00869
0081	0052	0081	*00846	00800	0090
0082	0053	0082	0030	00801	0092
0083	0054	0083	0050	00802	1230
0085	00581	0085	0051	00803	*0085
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00865	0074	00865	00589	0083	0053
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0074	01002	*01001	01704	01701	01285
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01221	01081	01001	01705	01235	01095
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	01091	01011	4802	01285	01225
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01233	01094	01014	5183	01701	01231
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01235		01016	00322	01703	01233
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01705	01235	01096	01080	01001	01706
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	01281	01222	01083	01004	0730
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01001	01706	01280	01221	01082	01003
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01016	01000	01705	01236	01220	01081
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01232	01093	01014	*01122	01703	01234
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01016	01000	01705	01236	01220	01081
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01094	01015	00322	01704	01235	01096
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01002	01706	01236	01095	01015	00322
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01096	01016	00322	01702	01232	01093
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01286	01230	01091	01012	4809	01701
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01704	01235	01096	01080	01001	01706
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01706	01280	01221	01082	01003	0221
0203	01281	01222	01083	01004	0730
0221	01282	01223	01084	01005	4800
0730	01283	01224	01085	01006	4801
4800	01284	01225	01086	01010	4802
4801	01285	01226	01090	01011	4808
4802	01286	01230	01091	01012	4809
4808	01700	01231	01092	01013	5183
4809	01701	01232	01093	01014	*01165
5183	01702	01233	01094	01015	00322
*01161	01703	01234	01095	01016	01000
00322	01704	01235	01096	01080	01001
01000	01705	01236	01220	01081	01002
01001	01706	01280	01221	01082	01003
01002	0203	01281	01222	01083	01004
01003	0221	01282	01223	01084	01005
01004	0730	01283	01224	01085	01006
01005	4800	01284	01225	01086	01010
01006	4801	01285	01226	01090	01011
01010	4802	01286	01230	01091	01012
01011	4808	01700	01231	01092	01013
01012	4809	01701	01232	01093	01014
01013	5183	01702	01233	01094	01015
01014	*01162	01703	01234	01095	01016
01015	00322	01704	01235	01096	01080
01016	01000	01705	01236	01220	01081

01082	01003	0221	01282	01223	01084
01083	01004	0730	01283	01224	01085
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01085	01006	4801	01285	01226	01090
01086	01010	4802	01286	01230	01091
01090	01011	4808	01700	01231	01092
01091	01012	4809	01701	01232	01093
01092	01013	5183	01702	01233	01094
01093	01014	*01170	01703	01234	01095
01094	01015	00322	01704	01235	01096
01095	01016	01000	01705	01236	01220
01096	01080	01001	01706	01280	01221
01220	01081	01002	0203	01281	01222
01221	01082	01003	0221	01282	01223
01222	01083	01004	0730	01283	01224
01223	01084	01005	4800	01284	01225
01224	01085	01006	4801	01285	01226
01225	01086	01010	4802	01286	01230
01226	01090	01011	4808	01700	01231
01230	01091	01012	4809	01701	01232
01231	01092	01013	5183	01702	01233
01232	01093	01014	*01171	01703	01234
01233	01094	01015	00322	01704	01235
01234	01095	01016	01000	01705	01236
01235	01096	01080	01001	01706	01280
01236	01220	01081	01002	0203	01281
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01281	01222	01083	01004	0730	01283
01282	01223	01084	01005	4800	01284
01283	01224	01085	01006	4801	01285
01284	01225	01086	01010	4802	01286
01285	01226	01090	01011	4808	01700
01286	01230	01091	01012	4809	01701
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01701	01232	01093	01014	*01172	01703
01702	01233	01094	01015	00322	01704
01703	01234	01095	01016	01000	01705
01704	01235	01096	01080	01001	01706
01705	01236	01220	01081	01002	0203
01706	01280	01221	01082	01003	0221
0203	01281	01222	01083	01004	0730
0221	01282	01223	01084	01005	4800
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4809	01701	01232	01093	01014	*01173
5183	01702	01233	01094	01015	00322
*01166	01703	01234	01095	01016	01000
00322	01704	01235	01096	01080	01001
01000	01705	01236	01220	01081	01002
01001	01706	01280	01221	01082	01003
01002	0203	01281	01222	01083	01004

01005	0730	01283	01223	01082	01002
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01012	4808	01700	01230	01086	01006
01013	4809	01701	01231	01090	01010
01014	5183	01702	01232	01091	01011
01015	*01174	01703	01233	01092	01012
01016	00322	01704	01234	01093	01013
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01081	01001	01706	01236	01095	01015
01082	01002	0203	01280	01096	01016
01083	01003	0204	01281	01220	01080
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01085	01005	0730	01283	01222	01082
01086	01006	4800	01284	01223	01083
01090	01010	4801	01285	01224	01084
01091	01011	4802	01286	01225	01085
01092	01012	4808	01700	01226	01086
01093	01013	4809	01701	01230	01090
01094	01014	5183	01702	01231	01091
01095	01015	*01175	01703	01232	01092
01096	01016	00322	01704	01233	01093
01220	01080	01000	01705	01234	01094
01221	01081	01001	01706	01235	01095
01222	01082	01002	0203	01236	01096
01223	01083	01003	0204	01280	01220
01224	01084	01004	0221	01281	01221
01225	01085	01005	0730	01282	01222
01226	01086	01006	4800	01283	01223
01230	01090	01010	4801	01284	01224
01231	01091	01011	4802	01285	01225
01232	01092	01012	4808	01286	01226
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01234	01094	01014	5183	01701	01231
01235	01095	01015	*01176	01702	01232
01236	01096	01016	00322	01703	01233
01280	01220	01080	01000	01704	01234
01281	01221	01081		01705	01235
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01284	01224	01084	01003	0204	01281
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01286	01226	01086	01005	0730	01283
01700	01230	01090	01006	4800	01284
01701	01231	01091	01010	4801	01285
01702	01232	01092	01011	4802	
01703	01233	01093	01012	4808	01286
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01706	01236	01096	01015	*01180	01702
0203	01280	01220	01016	00322	01703
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0221	01282	01222	01081	01001	01705

01706	01236	01096	01016	00322	01704
0203	01280	01220	01080	01000	01705
0204	01281	01221	01081	01001	01706
0221	01282	01222	01082	01002	0203
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4801	01285	01225	01085	01005	0730
4802	01286	01226	01086	01006	4800
4808	01700	01230	01090	01010	4801
4809	01701	01231	01091	01011	4802
5183	01702	01232	01092	01012	4808
*01181	01703	01233	01093	01013	4809
00322	01704	01234	01094	01014	5183
01000	01705	01235	01095	01015	*01185
01001	01706	01236	01096	01016	00322
01002	0203	01280	01220	01080	01000
01003	0204	01281	01221	01081	01001
01004	0221	01282	01222	01082	01002
01005	0730	01283	01223	01083	01003
01006	4800	01284	01224	01084	01004
01010	4801	01285	01225	01085	01005
01011	4802	01286	01226	01086	01006
01012	4808	01700	01230	01090	01010
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01014	5183	01702	01232	01092	01012
01015	*01182	01703	01233	01093	01013
01016	00322	01704	01234	01094	01014
01080	01000	01705	01235	01095	01015
01081	01001	01706	01236	01096	01016
01082	01002	0203	01280	01220	01080
01083	01003	0204	01281	01221	01081
01084	01004	0221	01282	01222	01082
01085	01005	0730	01283	01223	01083
01086	01006	4800	01284	01224	01084
01090	01010	4801	01285	01225	01085
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01092	01012	4808	01700	01230	01090
01093	01013	4809	01701	01231	01091
01094	01014	5183	01702	01232	01092
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01096	01016	00322	01704	01234	01094
01220	01080	01000	01705	01235	01095
01221	01081	01001	01706	01236	
01222	01082	01002	0203	01280	01096
01223	01083	01003	0204	01281	01220
01224	01084	01004	0221	01282	01221
01225	01085	01005	0730	01283	01222
01226	01086	01006	4800	01284	01223
01230	01090	01010	4801	01285	01224
01231	01091	01011	4802	01286	01225
01232	01092	01012	4808	01700	01226
01233	01093	01013	4809	01701	01230
01234	01094	01014	5183	01702	01231
01235	01095	01015	*01184	01703	01232

01233	01093	01013	4809	01701	01231
01234	01094	01014	5183	01702	01232
01235	01095	01015	*01191	01703	01233
01236	01096	01016	00322	01704	01234
01280	01220	01080	01000	01705	01235
01281	01221	01081	01001	01706	01236
01282	01222	01082	01002	0203	01280
01283	01223	01083	01003	0204	01281
01284	01224	01084	01004	0221	01282
01285	01225	01085	01005	0730	01283
01286	01226	01086	01006	4800	01284
01700	01230	01090	01010	4801	01285
01701	01231	01091	01011	4802	01286
01702	01232	01092	01012	4808	01700
01703	01233	01093	01013	4809	01701
01704	01234	01094	01014	5183	01702
01705	01235	01095	01015	*01192	01703
01706	01236	01096	01016	00322	01704
0203	01280	01220	01080	01000	01705
0204	01281	01221	01081	01001	01706
0221	01282	01222	01082	01002	0203
0730	01283	01223	01083	01003	0204
4800	01284	01224	01084	01004	0221
4801	01285	01225	01085	01005	0730
4802	01286	01226	01086	01006	4800
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4809	01701	01231	01091	01011	4802
5183	01702	01232	01092	01012	4808
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00322	01704	01234	01094	01014	5183
01000	01705	01235	01095	01015	*01193
01001	01706	01236	01096	01016	00322
01002	0203	01280	01220	01080	01000
01003	0204	01281	01221	01081	01001
01004	0221	01282	01222	01082	01002
01005	0730	01283	01223	01083	01003
01006	4800	01284	01224	01084	01004
01010	4801	01285	01225	01085	01005
01011	4802	01286	01226	01086	
01012	4808	01700	01230	01090	01006
01013	4809	01701	01231	01091	01010
01014	5183	01702	01232	01092	01011
01015	*01190	01703	01233	01093	01012
01016	00322	01704	01234	01094	01013
01080	01000	01705	01235	01095	01014
01081	01001	01706	01236	01096	01015
01082	01002	0203	01280	01220	01016
01083	01003	0204	01281	01221	01080
01084	01004	0221	01282	01222	01081
01085	01005	0730	01283	01223	01082
01086	01006	4800	01284	01224	01083
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01092	01012	4808	01700	01230	01086

01090	01010	4801	01284	01225	01085
01091	01011	4802	01285	01226	01086
01092	01012	4808	01286		01090
01093	01013	4809	01700	01230	01091
01094	01014	5183	01701	01231	01092
01095	01015	*01195	01702	01232	01093
01096	01016	00322	01703	01233	01094
01220	01080	01000	01704	01234	
01221	01081	01001	01705	01235	01095
01222	01082	01002	01706	01236	01096
01223	01083	01003	0203	01280	01220
01224	01084	01004	0221	01281	01221
01225	01085	01005	0730	01282	01222
01226	01086	01006	4800	01283	01223
01230	01090	01010	4801	01284	01224
01231	01091	01011	4802	01285	01225
01232	01092	01012	4808	01286	01226
01233	01093	01013	4809	01700	01230
01234	01094	01014	5183	01701	01231
01235	01095	01015	*01196	01702	01232
01236	01096	01016	00322	01703	01233
01280	01220	01080	01000	01704	01234
01281	01221	01081	01001	01705	01235
01282	01222	01082	01002	01706	01236
01283	01223	01083	01003	0203	01280
01284	01224	01084	01004	0221	01281
01285	01225	01085	01005	0730	01282
01286	01226	01086	01006	4800	01283
01700	01230	01090	01010	4801	01284
01701	01231	01091	01011	4802	01285
01702	01232	01092	01012	4808	01286
01703	01233	01093	01013	4809	01700
01704	01234	01094	01014	5183	01701
01705	01235	01095	01015	*01200	01702
01706	01236	01096	01016	00322	01703
0203	01280	01220	01080	01000	01704
0204	01281	01221	01081	01001	01705
0221	01282	01222	01082	01002	01706
0730	01283	01223	01083	01003	0203
4800	01284	01224	01084	01004	0221
4801	01285	01225	01085	01005	0730
4802	01286	01226	01086	01006	4800
4808	01700	01230	01090	01010	4801
4809	01701	01231	01091	01011	4802
5183	01702	01232	01092	01012	4808
*01194	01703	01233	01093	01013	4809
00322		01234	01094	01014	5183
01000	01704	01235	01095	01015	*01201
01001	01705	01236	01096	01016	00322
01002	01706	01280	01220	01080	01000
01003	0203	01281	01221	01081	01001
01004	0221		01222	01082	01002
01005	0730	01282	01223	01083	01003
01006	4800	01283	01224	01084	01004

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01010	4801	01284	01224	01085	01006
01011	4802	01285	01225	01086	01010
01012	4808	01286	01226	01090	01011
01013	4809	01700	01230	01091	01012
01014	5183	01701	01231	01092	01013
01015	*01202	01702	01232	01093	01014
01016	00322	01703	01233	01094	01015
01080	01000	01704	01234	01095	01016
01081	01001	01705	01235	01096	01080
01082	01002	01706	01236	01220	01081
	01003	0203	01280	01221	01082
01083	01004	0221	01281	01222	01083
01084	01005	0730	01282	01223	01084
01085	01006	4800	01283	01224	01085
01086	01010	4801	01284	01225	01086
01090		4802	01285	01226	01090
01091	01011	4808	01286	01230	01091
01092	01012	4809	01700	01231	01092
01093	01013	5183	01701	01232	01093
01094	01014	*01203	01702	01233	01094
01095	01015		01703	01234	01095
01096	01016	00322	01704	01235	01096
01220	01080	01000	01705	01236	01220
01221	01081	01001	01706	01280	01221
01222	01082	01002	0203	01281	01222
01223	01083	01003	0221	01282	01223
01224	01084	01004	0730	01283	01224
01225	01085	01005	4800	01284	01225
01226	01086	01006	4801	01285	01226
01230	01090	01010	4802	01286	01230
01231	01091	01011	4808	01700	01231
01232	01092	01012	4809	01701	01232
01233	01093	01013	5183	01702	01233
01234	01094	01014	*01204	01703	01234
01235	01095	01015	00322	01704	01235
01236	01096	01016	01000	01705	01236
01280	01220	01080	01001	01706	01280
01281	01221	01081	01002	0203	01281
01282	01222	01082	01003	0221	01282
01283	01223	01083	01004	0730	01283
01284	01224	01084	01005	4800	01284
01285	01225	01085	01006	4801	01285
01286	01226	01086	01010	4802	01286
01700	01230	01090	01011	4808	01700
01701	01231	01091	01012	4809	01701
01702	01232	01092	01013	5183	01702
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01704	01234	01094	01015	00322	01704
01705	01235	01095	01016	01000	01705
01706	01236	01096	01080	01001	01706
0203	01280	01220	01081	01002	0203
0221	01281	01221	01082	01003	0221

0730	01283	01224	01085	01006	4801
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4801	01285	01226	01090	01011	4808
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4808	01700	01231	01092	01013	5183
4809	01701	01232	01093	01014	*01213
5183	01702	01233	01094	01015	00322
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00322	01704	01235	01096	01080	01001
01000	01705	01236	01220	01081	01002
01001	01706	01280	01221	01082	01003
01002	0203	01281	01222	01083	01004
01003	0221	01282	01223	01084	01005
01004	0730	01283	01224	01085	01006
01005	4800	01284	01225	01086	01010
01006	4801	01285	01226	01090	01011
01010	4802	01286	01230	01091	01012
01011	4808	01700	01231	01092	01013
01012	4809	01701	01232	01093	01014
01013	5183	01702	01233	01094	01015
01014	*01210	01703	01234	01095	01016
01015	00322	01704	01235	01096	01080
01016	01000	01705	01236	01220	01081
01080	01001	01706	01280	01221	01082
01081	01002	0203	01281	01222	01083
01082	01003	0221	01282	01223	01084
01083	01004	0730	01283	01224	01085
01084	01005	4800	01284	01225	01086
01085	01006	4801	01285	01226	01090
01086	01010	4802	01286	01230	01091
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01092	01013	5183	01702	01233	01094
01093	01014	*01211	01703	01234	01095
01094	01015	00322	01704	01235	01096
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01096	01080	01001	01706	01280	01221
01220	01081	01002	0203	01281	01222
01221	01082	01003	0221	01282	01223
01222	01083	01004	0730	01283	01224
01223	01084	01005	4800	01284	01225
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01226	01090	01011	4808	01700	01231
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01231	01092	01013	5183	01702	01233
01232	01093	01014	*01212	01703	01234
01233	01094	01015	00322	01704	01235
01234	01095	01016	01000	01705	01236
01235	01096	01080	01001	01706	01280
01236	01220	01081	01002	0203	01281
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01281	01222	01083	01004	0730	01283
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01285	01226	01090	01011	4808	01701
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01702	01233	01094	01015	01000	01705
01703	01234	01095	01016	01001	01706
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01705	01236	01220	01081	01003	46451
01706	01280	01221	01082	01004	*01221
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0221	01282	01223	01084	01006	01001
0730	01283	01224	01085	01010	01002
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4808	01700	01231	01092	01014	01006
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01004	0730	01283	01224	01086	01081
01005	4800	01284	01225	01090	01082
01006	4801	01285	01226	01091	01083
01010	4802	01286	01230	01092	01084
01011	4808	01700	01231	01093	01085
01012	4809	01701	01232	01094	01086
01013	5183	01702	01233	01095	01090
01014	*01215	01703	01234	01096	01091
01015	00322	01704	01235	01220	01092
01016	01000	01705	01236	01221	01093
01080	01001	01706	01280	01222	01094
01081	01002	0203	01281	01223	01095
01082	01003	0221	01282	01224	01096
01083	01004	0730	01283	01225	01220
01084	01005	4800	01284	01226	01221
01085	01006	4801	01285	01230	01222
01086	01010	4802	01286	01231	01223
01090	01011	4808	01700	01232	01224
01091	01012	4809	01701	01233	01225
01092	01013	5183	01702	01234	01226
01093	01014	*01216	01703	01235	01230
01094	01015	00322	01704	01236	01231
01095	01016	01000	01705	01280	01232
01096	01080	01001	01706	01281	01233
01220	01081	01002	0203	01282	01234
01221	01082	01003	0221	01283	01235
01222	01083	01004	0730	01284	01236
01223	01084	01005	4800	01285	01280
01224	01085	01006	4801	01286	01281
01225	01086	01010	4802	01700	01282

01283	01235	01230	01222	01094	01086
01284	01236	01231	01223	01095	01090
01285	01280	01232	01224	01096	01091
01286	01281	01233	01225	01220	01092
01700	01282	01234	01226	01221	01093
01701	01283	01235	01230	01222	01094
01702	01284	01236	01231	01223	01095
01703	01285	01280	01232	01224	01096
01704	01286	01281	01233	01225	01220
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01706	01701	01283	01235	01230	01222
46401	01702	01284	01236	01231	01223
46451	01703	01285	01280	01232	01224
*01222	01704	01286	01281	01233	01225
01000	01705	01700	01282	01234	01226
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01002	46401	01702	01284	01236	01231
01003	46451	01703	01285	01280	01232
01004	*01223	01704	01286	01281	01233
01005	01000	01705	01700	01282	01234
01006	01001	01706	01701	01283	01235
01010	01002	46401	01702	01284	01236
01011	01003	46451	01703	01285	01280
01012	01004	*01224	01704	01286	01281
01013	01005	01000	01705	01700	01282
01014	01006	01001	01706	01701	01283
01015	01010	01002	46401	01702	01284
01016	01011	01003	46451	01703	01285
01080	01012	01004	*01225	01704	01286
01081	01013	01005	01000	01705	01700
01082	01014	01006	01001	01706	01701
01083	01015	01010	01002	46401	01702
01084	01016	01011	01003	46451	01703
01085	01080	01012	01004	*01226	01704
01086	01081	01013	01005	01000	01705
01090	01082	01014	01006	01001	01706
01091	01083	01015	01010	01002	46401
01092	01084	01016	01011	01003	46451
01093	01085	01080	01012	01004	*01230
01094	01086	01081	01013	01005	01000
01095	01090	01082	01014	01006	01001
01096	01091	01083	01015	01010	01002
01220	01092	01084	01016	01011	01003
01221	01093	01085	01080	01012	01004
01222	01094	01086	01081	01013	01005
01223	01095	01090	01082	01014	01006
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01225	01220	01092	01084	01016	01011
01226	01221	01093	01085	01080	01012
01230	01222	01094	01086	01081	01013
01231	01223	01095	01090	01082	01014
01232	01224	01096	01091	01083	01015
01233	01225	01220	01092	01084	01016
01234	01226	01221	01093	01085	01080

01081	01013	01005	01000	01705	01700
01082	01014	01006	01001	01706	01701
01083	01015	01010	01002	46401	01702
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01085	01080	01012	01004	*01234	01704
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01092	01084	01016	01011	01003	46451
01093	01085	01080	01012	01004	*01235
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01096	01091	01083	01015	01010	01002
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01222	01094	01086	01081	01013	01005
01223	01095	01090	01082	01014	01006
01224	01096	01091	01083	01015	01010
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01226	01221	01093	01085	01080	01012
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01234	01226	01221	01093	01085	01080
01235	01230	01222	01094	01086	01081
01236	01231	01223	01095	01090	01082
01280	01232	01224	01096	01091	01083
01281	01233	01225	01220	01092	01084
01282	01234	01226	01221	01093	01085
01283	01235	01230	01222	01094	01086
01284	01236	01231	01223	01095	01090
01285	01280	01232	01224	01096	01091
01286	01281	01233	01225	01220	01092
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01701	01283	01235	01230	01222	01094
01702	01284	01236	01231	01223	01095
01703	01285	01280	01232	01224	01096
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01000	01705	01700	01282	01234	01226
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01002	46401	01702	01284	01236	01231
01003	46451	01703	01285	01280	01232
01004	*01232	01704	01286	01281	01233
01005	01000	01705	01700	01282	01234
01006	01001	01706	01701	01283	01235
01010	01002	46401	01702	01284	01236
01011	01003	46451	01703	01285	01280
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01284	01236	01230	01086	01005	46401
01285	01280	01231	01090	01006	46451
01286	01281	01232	01091	01010	4800
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01701	01283	01234	01093	01012	4802
01702	01284	01235	01094	01013	4808
01703	01285	01236	01095	01014	4809
01704	01286	01280	01096	01015	5183
01705	01700	01281	01220	01016	*01283
01706	01701	01282	01221	01080	00322
46401	01702	01283	01222	01081	01000
46451	01703	01284	01223	01082	01001
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01000	01705	01286	01225	01084	01003
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01002	46401	01701	01230	01086	01005
01003	46451	01702	01231	01090	01006
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01005	00322	01704	01233	01092	01011
01006	01000	01705	01234	01093	01012
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01012	01003	0221	01280	01096	01015
01013	01004	0730	01281	01220	01016
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01015	01006	46451	01283	01222	01081
01016	01010	4800	01284	01223	01082
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01081	01012	4802	01286	01225	01084
01082	01013	4808	01700	01226	01085
01083	01014	4809	01701	01230	01086
01084	01015	5183	01702	01231	01090
01085	01016	*01281	01703	01232	01091
01086	01080	00322	01704	01233	01092
01090	01081	01000	01705	01234	01093
01091	01082	01001	01706	01235	01094
01092	01083	01002	0203	01236	01095
01093	01084	01003	0221	01280	01096
01094	01085	01004	0730	01281	01220
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01096	01090	01006	46451	01283	01222
01220	01091	01010	4800	01284	01223
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01223	01094	01013	4808	01700	01226
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01226	01220	01016	*01282	01703	01232
01230	01221	01080	00322	01704	01233
01231	01222	01081	01000	01705	01234
01232	01223	01082	01001	01706	01235
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01282	01221	01080	00322	01704	01233
01283	01222	01081	01000	01705	01234
01284	01223	01082	01001	01706	01235
01285	01224	01083	01002	0203	01236
01286	01225	01084	01003	0221	01280
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01701	01230	01086	01005	46401	01282
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01703	01232	01091	01010	4800	01284
01704	01233	01092	01011	4801	01285
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01706	01235	01094	01013	4808	01700
0203	01236	01095	01014	4809	01701
0221	01280	01096	01015	5183	
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46451	01283	01222	01081	01000	01704
4800	01284	01223	01082	01001	01705
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4808	01700	01226	01085	01004	0471
4809	01701	01230	01086	01005	0478
5183	01702	01231	01090	01006	0479
*01284	01703	01232	01091	01010	0490
00322	01704	01233	01092	01011	0491
01000	01705	01234	01093	01012	09181
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01003	0221	01280	01096	01015	32301
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01006	46451	01283	01222	01081	32342
01010	4800	01284	01223	01082	32351
01011	4801	01285	01224	01083	32352
01012	4802	01286	01225	01084	32361
01013	4808	01700	01226	01085	32362
01014	4809	01701	01230	01086	32363
01015	5183	01702	01231	01090	32371
01016	*01285	01703	01232	01091	32372
01080	00322	01704	01233	01092	32381
01081	01000	01705	01234	01093	32382
01082	01001	01706	01235	01094	34120
01083	01002	0203	01236	01095	34121
01084	01003	0221	01280	01096	34122
01085	01004	0730	01281	01220	*01301
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01093	01012	4802	01286	01225	01003
01094	01013	4808	01700	01226	01004
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01006	0490	01223	01002	0470	01096
01010	0491	01224	01003	0471	01220
01011	09181	01225	01004	0478	01221
01012	09882	01226	01005	0479	01222
01013	10081	01230	01006	0490	01223
01014	32301	01231	01010	0491	01224
01015	32302	01232	01011	09181	01225
01016	32341	01233	01012	09882	01226
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01082	32352	01236	01015	32302	01231
01083	32361	01280	01016	32341	01232
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01086	32371	01283	01082	32352	01235
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01091	32381	01285	01084	32362	01280
01092	32382	01286	01085	32363	01281
01093	34120	01700	01086	32371	01282
01094	34121	01701	01090	32372	01283
01095	34122	01702	01091	32381	01284
01096	*01302	01703	01092	32382	01285
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01223	01002	0470	01096	*01304	01702
01224	01003	0471	01220	00321	01703
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01226	01005	0479	01222	01001	01705
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01232	01011	09181	01225	01004	0471
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01235	01014	32301	01231	01010	0490
01236	01015	32302	01232	01011	0491
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01285	01084	32362	01281	01080	32341
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01703	01092	32382	01286	01085	32362
01704	01093	34120	01700	01086	32363
01705	01094	34121	01701	01090	32371
01706	01095	34122	01702	01091	32372
0470	01096	*01303	01703	01092	32381
0471	01220	00321	01704	01093	32382
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01000	01705	01094	34121	01701	01086
01001	01706	01095	34122	01702	01090
01002	0470	01096	*01310	01703	01091
01003	0471	01220	00321	01704	01092
01004	0478	01221	01000	01705	01093
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01013	10081	01230	01006	0490	01222
01014	32301	01231	01010	0491	01223
01015	32302	01232	01011	09181	01224
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01081	32351	01235	01014	32301	01230
01082	32352	01236	01015	32302	01231
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01092	32382	01286	01085	32363	01281
01093	34120	01700	01086	32371	01282
01094	34121	01701	01090	32372	01283
01095	34122	01702	01091	32381	01284
01096	*01306	01703	01092	32382	01285
01220	00321	01704	01093	34120	01286
01221	01000	01705	01094	34121	01700
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01223	01002	0470	01096	*01311	01702
01224	01003	0471	01220	00321	01703
01225	01004	0478	01221	01000	01704
01226	01005	0479	01222	01001	01705
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01231	01010	0491	01224	01003	0470
01232	01011	09181	01225	01004	0471
01233	01012	09882	01226	01005	0478
01234	01013	10081	01230	01006	0479
01235	01014	32301	01231	01010	0490
01236	01015	32302	01232	01011	0491
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32372	01284	01083	32361	01280	01015
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01000	01705	01094	34121	01701	01086
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32302	01232	01012	01006	01003	01000
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32363	01282	01082	01016	01013	01010
32371	01283	01083	01080	01014	01011
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34122	01702	01092	01086	01083	01080
*01316	01703	01093	01090	01084	01081
00321	01704	01094	01091	01085	01082
01000	01705	01095	01092	01086	01083
01001	01706	01096	01093	01090	01084
01002	0470	01220	01094	01091	01085
01003	0471	01221	01095	01092	01086
01004	0478	01222	01096	01093	01090
01005	0479	01223	01220	01094	01091
01006	0490	01224	01221	01095	01092
01010	0491	01225	01222	01096	01093
01011	09181	01226	01223	01220	01094
01012	09882	01230	01224	01221	01095
01013	10081	01231	01225	01222	01096
01014	32301	01232	01226	01223	01220
01015	32302	01233	01230	01224	01221
01016	32341	01234	01231	01225	01222
01080	32342	01235	01232	01226	01223
01081	32351	01236	01233	01230	01224
01082	32352	01280	01234	01231	01225
01083	32361	01281	01235	01232	01226
01084	32362	01282	01236	01233	01230
01085	32363	01283	01280	01234	01231
01086	32371	01284	01281	01235	01232
01090	32372	01285	01282	01236	01233
01091	32381	01286	01283	01280	01234
01092	32382	01700	01284	01281	01235
01093	34120	01701	01285	01282	01236
01094	34121	01702	01286	01283	01280
01095	34122	01703	01700	01284	01281
01096	*01320	01704	01701	01285	01282
01220	01000	01705	01702	01286	01283
01221	01001	01706	01703	01700	01284
01222	01002	*01321	01704	01701	01285
01223	01003	01000	01705	01702	01286
01224	01004	01001	01706	01703	01700

01701	01285	01282	01236	01233	01230
01702	01286	01283	01280	01234	01231
01703	01700	01284	01281	01235	01232
01704	01701	01285	01282	01236	01233
01705	01702	01286	01283	01280	01234
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*01324	01704	01701	01285	01282	01236
01000	01705	01702	01286	01283	01280
01001	01706	01703	01700	01284	01281
01002	*01325	01704	01701	01285	01282
01003	01000	01705	01702	01286	01283
01004	01001	01706	01703	01700	01284
01005	01002	*01326	01704	01701	01285
01006	01003	01000	01705	01702	01286
01010	01004	01001	01706	01703	01700
01011	01005	01002	*01330	01704	01701
01012	01006	01003	01000	01705	01702
01013	01010	01004	01001	01706	01703
01014	01011	01005	01002	*01331	01704
01015	01012	01006	01003	01000	01705
01016	01013	01010	01004	01001	01706
01080	01014	01011	01005	01002	*01332
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01092	01086	01083	01080	01014	01011
01093	01090	01084	01081	01015	01012
01094	01091	01085	01082	01016	01013
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01096	01093	01090	01084	01081	01015
01220	01094	01091	01085	01082	01016
01221	01095	01092	01086	01083	01080
01222	01096	01093	01090	01084	01081
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01232	01226	01223	01220	01094	01091
01233	01230	01224	01221	01095	01092
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01235	01232	01226	01223	01220	01094
01236	01233	01230	01224	01221	01095
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01283	01280	01234	01231	01225	01222
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01231	01225	01222	01096	01093	01090
01232	01226	01223	01220	01094	01091
01233	01230	01224	01221	01095	01092
01234	01231	01225	01222	01096	01093
01235	01232	01226	01223	01220	01094
01236	01233	01230	01224	01221	01095
01280	01234	01231	01225	01222	01096
01281	01235	01232	01226	01223	01220
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01286	01283	01280	01234	01231	01225
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01704	01701	01285	01282	01236	01233
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01005	01002	*01335	01704	01701	01285
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01013	01010	01004	01001	01706	01703
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01092	01086	01083	01080	01014	01011
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01096	01093	01090	01084	01081	01015
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01222	01096	01093	01090	01084	01081
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01224	01221	01095	01092	01086	01083
01225	01222	01096	01093	01090	01084
01226	01223	01220	01094	01091	01085
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01231	01225	01222	01096	01093	01090
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01234	01231	01225	01222	01096	01093
01235	01232	01226	01223	01220	01094
01236	01233	01230	01224	01221	01095
01280	01234	01231	01225	01222	01096
01281	01235	01232	01226	01223	01220
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01702	01286	01283	01280	01234	01231
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01000	01705	01702	01286	01283	01280
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01006	01003	01000	01705	01702	01286
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01005	01002	*01352	01704	01701	01285
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01223	01220	01094	01091	01085	01082
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01235	01232	01226	01223	01220	01094
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01233	01230	01224	32302	01232	32351
01234	01231	01225	3231	01233	32352
01235	01232	01226	3232	01234	32361
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01282	01236	01233	32352	01281	32372
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01014	01011	0621	01016	0628	01084
01015	01012	0622	01080	0629	01085
01016	01013	0623	01081	0630	01086
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01082	01016	0628	01084	0638	01092
01083	01080	0629	01085	0639	01093
01084	01081	0630	01086	064	01094
01085	01082	0631	01090	0662	01095
01086	01083	0632	01091	0663	01096
01090	01084	0638	01092	06640	01220
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01093	01090	0662	01095	06649	01223
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01096	01093	06641	01221	0869	01226
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01236	32363	01284	3239	01702	01002
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01281	32372	01286	*01364	01704	01004
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01703	01003	0463	01011	0621	01016
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0463	01011	0621	01016	0628	01084
048	01012	0622	01080	0629	01085
0498	01013	0623	01081	0630	01086
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0628	01084	0638	01092	06640	01220
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048	01012	0621	01016	01012	01005
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0629	01085	0638	01092	01085	01081
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0632	01091	0662		01091	01084
0638	01092	0663	01095	01092	01085
0639	01093	06640	01096	01093	01086
064	01094	06641	01220	01094	01090
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0663	01096	06649	01222	01095	01092
06640	01220	0737	01223	01096	01093
06641	01221	0819	01224	01220	01094
06642	01222	0869	01225	01221	
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0737	01224	32301	01230	01223	01096
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124	01230	3232	01233	01226	01222
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32371	01284	3239	01701	01284	01280
32372	01285	7712	01702	01285	01281
32381	01286	*01380	01703	01286	01282
32382	01700	01000	01704	01700	01283
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01005	01001	01705	01701	01284	01280
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01010	01003	*01385	01703	01286	01282
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01083	01016	01012	01005	01001	01705
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01223	01096	01093	01086	01082	01015
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01225	01221		01091	01084	01080
01226	01222	01095	01092	01085	01081
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01236	01232	01225	01221		01091
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01224	01220	01094	01090	01083	01016
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01236	01232	01225	01221		01091
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01703	01283	01233	01223	01093	01083
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01096	01702	01705	01081	01704	01080
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01704	01080	01704	01080	01704	01080
01705	01081	01705	01081	01705	
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01083	*01622	01083	*01625	01083	01706
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58289	5831	58881	01000	01002	01005
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5830	5881	*01633	01002	01004	01010
5831	58881	01000	01003	01005	01011
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01083	01086	01092	01094	01700	01703
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01086	01092	01095	01700	01703	01706
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01091	01094	01700	01702	01705	27411
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01703	01706	5820	5822	58289	5831
01704	0786	5821	5824	5829	5832
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0786	5821	58281	5829	5832	59001
27411	5822	58289	5830	5881	*01640
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01092	01005	01091	01003	01090	01003
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01004	01091	01004	01091	01003	01086
01005	01092	01005	01092	01004	01090
01006	01093	01006	01093	01005	01091
01010	01094	01010	01094	01006	01092
01011	01095	01011	01095	01010	01093
01012	01096	01012	01096	01011	01094
01013	01700	01013	01700	01012	01095
01014	01701	01014	01701	01013	01096
01015	01702	01015	01702	01014	01700
01016	01703	01016	01703	01015	01701
01080	01704	01080	01704	01016	01702
01081	01705	01081	01705	01080	01703
01082	01706	01082	01706	01081	01704
01083	*01654	01083	*01660	01082	01705
01084	01000	01084	01000	01083	01706
01085	01001	01085	01001	01084	6147
01086	01002	01086	01002	01085	*01663
01090	01003	01090	01003	01086	01000
01091	01004	01091	01004	01090	01001
01092	01005	01092	01005	01091	01002
01093	01006	01093	01006	01092	01003
01094	01010	01094	01010	01093	01004
01095	01011	01095	01011	01094	01005
01096	01012	01096	01012	01095	01006
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01701	01014	01701	01014	01700	01011
01702	01015	01702	01015	01701	01012
01703	01016	01703	01016	01702	01013
01704	01080	01704	01080	01703	01014
01705	01081	01705	01081	01704	01015
01706	01082	01706	01082	01705	01016
*01653	01083	*01656	01083	01706	01080
01000	01084	01000	01084	6147	01081
01001	01085	01001	01085	*01662	01082
01002	01086	01002	01086	01000	01083
01003	01090	01003	01090	01001	01084
01004	01091	01004	01091	01002	01085
01005	01092	01005	01092	01003	01086
01006	01093	01006	01093	01004	01090
01010	01094	01010	01094	01005	01091
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01015	01702	01015	01702	01013	01096
01016	01703	01016	01703	01014	01700
01080	01704	01080	01704	01015	01701
01081	01705	01081	01705	01016	01702
01082	01706	01082	01706	01080	01703
01083	*01655	01083	6147	01081	01704
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6147	01081	01704	01014	01700	01011
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01015	01701	01012	01094	01005	01091
01016	01702	01013	01095	01006	01092
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01081	01704	01015	01700	01011	01094
01082	01705	01016	01701	01012	01095
01083	01706	01080	01702	01013	01096
01084	6147	01081	01703	01014	01700
01085	*01666		01704	01015	01701
01086	01000	01082	01705	01016	01702
01090	01001	01083	01706	01080	01703
01091	01002	01084	6147	01081	01704
01092	01003	01085	*01672	01082	01705
01093	01004	01086	01000	01083	01706
01094	01005	01090	01001	01084	6147
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01096	01010	01092	01003	01086	01000
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01704	01015	01700	01011	01094	01005
01705	01016	01701	01012	01095	01006
01706	01080	01702	01013	01096	01010
6147	01081	01703	01014	01700	01011
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01000	01083	01705	01016	01702	01013
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01003	01086	*01671	01082	01705	01016
01004	01090	01000	01083	01706	01080
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01012	01095	01005	01091	01002	01085
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01014	01700	01010	01093	01004	01090
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01096	01010	01012	01014	01015	01015
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01701	01012	01014	01016	01080	01080
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01703	01014	01016	01081	01082	01082
01704	01015	01080	01082	01083	01083
01705	01016	01081	01083	01084	01084
01706	01080	01082	01084	01085	01085
6147	01081	01083	01085	01086	01086
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01005	01091	01093	01095	01096	01096
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01011	01094	01096	01700	01702	01702
01012	01095	01700	01701	01703	01703
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01014	01700	01702	01703	01705	01705
01015	01701	01703	01704	01706	01706
01016	01702	01704	01705	0786	0786
01080	01703	01705	01706	27411	27411
01081	01704	01706	0786	5820	5820
01082	01705	0786	27411	5821	5821
01083	01706	27411	5820	5822	5822
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01085	27411	5821	5822	58281	58281
01086	5820	5822	5824	58289	58289
01090	5821	5824	58281	5829	5829
01091	5822	58281	58289	5830	5830
01092	5824	58289	5829	5831	5831
01093	58281	5829	5830	5832	5832
01094	58289	5830	5831	5881	5881
01095	5829	5831	5832	58881	58881
01096	5830	5832	5881	59001	59001
01700	5831	5881	58881	6147	6147
01701	5832	58881	59001	*01694	*01695
01702	5881	59001	6147	01000	01000
01703	58881	6147	*01693	01001	01001
01704	59001	*01692	01000	01002	01002
01705	6147	01000	01001	01003	01003
01706	*01691	01001	01002	01004	01004
6147	01000	01002	01003	01005	01005
*01690	01001	01003	01004	01006	01006
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01003	01005	01010	01011		01013

01014	01016	01081	01704	01014	01700
01015	01080	01082	01705	01015	01701
01016	01081	01083	01706	01016	01702
01080	01082	01084	6824	01080	01703
01081	01083	01085	*01702	01081	01704
01082	01084	01086	01000	01082	01705
01083	01085	01090	01001	01083	01706
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01085	01090	01092	01003	01085	*01705
01086	01091	01093	01004	01086	01000
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01092	01094	01096	01010	01092	01003
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01701	01703	01705		01701	01012
01702	01704	01706	01016	01702	01013
01703	01705	6824	01080	01703	01014
01704	01706	*01701	01081	01704	01015
01705	0786	01000	01082	01705	01016
01706	27411	01001	01083	01706	01080
0786	5820	01002	01084	6824	01081
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5822	58281	01006	01091	01002	01085
5824	58289	01010	01092	01003	01086
58281	5829	01011	01093	01004	01090
58289	5830	01012	01094	01005	01091
5829	5831	01013	01095	01006	01092
5830	5832	01014	01096	01010	01093
5831	5881	01015	01700	01011	01094
5832	58881	01016	01701	01012	01095
5881	59001	01080	01702	01013	01096
58881	6147	01081	01703	01014	01700
59001	*01700	01082	01704	01015	01701
6147	01000	01083	01705	01016	01702
*01696	01001	01084	01706	01080	01703
01000	01002	01085	6824	01081	01704
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01002	01004	01090	01000	01083	01706
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01004	01006	01092	01002	01085	*01706
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01083	01706	01082	01706	01082	01705
01084	*01711	01083	*01714	01083	01706
01085	01000	01084	01000	01084	*01720
01086	01001	01085	01001	01085	01000
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01094	01006	01093	01006	01093	01005
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01706	01081	01705	01081	01705	01080
6824	01082	01706	01082	01706	01081
*01710	01083	*01713	01083	*01716	01082
01000	01084	01000	01084	01000	01083
01001	01085	01001	01085	01001	01084
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01005	01092	01005	01092	01005	01091
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01011	01095	01011	01095	01011	01094
01012	01096	01012	01096	01012	01095
01013	01700	01013	01700	01013	01096
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01015	01702	01015	01702		01701
01016	01703	01016	01703	01015	01702
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01081	01705	01081	01705	01080	01704
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01084	01000	01084	01000	01083	01706
01085	01001	01085	01001	01084	*01721
01086	01002	01086	01002	01085	01000
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01093	01006	01093	01006	01092	01004

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01010	01094	01010	01094	01010	01091
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01012	01096	01012	01096	01012	01093
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01015	01702	01015	01702	01015	01096
01016	01703	01016	01703	01016	01700
01080	01704	01080	01704	01080	01701
01081	01705	01081	01705	01081	01702
01082	01706	01082	01706	01082	01703
01083	*01723	01083	*01726	01083	01704
01084	01000	01084	01000	01084	01705
01085	01001	01085	01001	01085	01706
01086	01002	01086	01002	01086	09483
01090	01003	01090	01003	01090	0950
01091	01004	01091	01004	01091	*01732
01092	01005	01092	01005	01092	01000
01093	01006	01093	01006	01093	01001
01094	01010	01094	01010	01094	01002
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01702	01015	01702	01015	01702	01010
01703	01016	01703	01016	01703	01011
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01705	01081	01705	01081	01705	01013
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01000	01084	01000	01084	0950	01016
01001	01085	01001	01085	*01731	01080
01002	01086	01002	01086		01081
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01012	01096	01012	01096	01006	01091
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01014	01701	01014	01701	01011	01093
01015	01702	01015	01702	01012	01094
01016	01703	01016	01703	01013	01095
01080	01704	01080	01704	01014	01096
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01082	01706	01082	01706	01016	01701
01083	*01724	01083	*01730	01080	01702
01084	01000	01084	01000	01081	01703
01085	01001	01085	01001	01082	01704
01086	01002	01086	01002	01083	01705
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01005	01090	*01736	01081	01703	01011
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01015	01700	01006	01091	01000	01081
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01082	01704	01013	01095	01004	01085
01083	01705	01014	01096	01005	01086
01084	01706	01015	01700	01006	01090
01085	09483	01016	01701	01010	01091
01086	0950	01080	01702	01011	01092
01090	*01735	01081	01703	01012	01093
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01096	01005	01090	*01741	01081	01702
01700	01006	01091	01000	01082	01703
01701	01010	01092	01001	01083	01704
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01000	01082	01704	01013	01095	01003
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01005	01090	*01740	01081	01703	01011
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01014	01096	01005	01090	*01743	01080
01015	01700	01006	01091	01000	01081
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01085	01706	01015	01702	01015	01702
	38300	01016	01703	01016	01703
01086	38302	01080	01704	01080	01704
01090	*01746	01081	01705	01081	01705
01091	01000	01082	01706	01082	01706
01092	01001	01083	*01752	01083	*01755
01093	01002	01084	01000	01084	01000
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01096	01005	01090	01003	01090	01003
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01704	01013	01095	01011	01095	01011
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01706	01015	01700	01013	01700	01013
38300	01016	01701	01014	01701	01014
38302	01080	01702	01015	01702	01015
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01000	01082	01704	01080	01704	01080
01001	01083	01705	01081	01705	01081
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01003	01085	*01751	01083	*01754	01083
01004	01086	01000	01084	01000	01084
01005	01090	01001	01085	01001	01085
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01011	01093	01004	01091	01004	01091
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01085	38300	01081	01705	01081	01705
01086	38302	01082	01706	01082	01706
01090	*01750	01083	*01753	01083	*01756
01091	01000	01084	01000	01084	01000
01092	01001	01085	01001	01085	01001
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01094	01003	01090	01003	01090	01003
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01700	01006	01093	01006	01093	01006
01701	01010	01094	01010	01094	01010
01702	01011	01095	01011	01095	01011
01703	01012	01096	01012	01096	01012

01013	01700	01005	01086	25541	01016
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01015	01702	01006	01091	*01765	01081
01016	01703	01010	01092	01000	01082
01080	01704	01011	01093	01001	01083
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01082	01706	01013	01094	01003	01085
01083	25541	01014	01095	01004	01086
01084	25542	01015	01096	01005	01090
01085	*01761	01016	01700	01006	01091
01086	01000	01080	01701	01010	01092
01090	01001	01081	01702	01011	01093
01091	01002	01082	01703	01012	01094
01092	01003	01083	01704	01013	01095
01093	01004	01084	01705	01014	01096
01094	01005	01085	01706	01015	01700
01095	01006	01086	25541	01016	01701
01096	01010	01090	25542	01080	01702
01700	01011	01091	*01764	01081	01703
01701	01012	01092	01000	01082	01704
01702	01013	01093	01001	01083	01705
01703	01014	01094	01002	01084	01706
01704	01015	01095	01003	01085	25541
01705	01016	01096	01004	01086	25542
01706	01080	01700	01005	01090	*01770
*01760	01081	01701	01006	01091	01000
01000	01082	01702	01010	01092	01001
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01002	01084	01704	01012	01094	01003
01003	01085	01705	01013	01095	01004
01004	01086	01706	01014	01096	01005
01005	01090	25541	01015	01700	01006
01006	01091	25542	01016	01701	01010
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01016	01701	01005	01086	25542	01080
01080	01702	01006	01090	*01766	01081
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01086	25542	01015	01096	01005	01090
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01703	01016	01703	01016	01703	
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01705	01081	01705	01081	01705	01080
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01001	01085	01001	01085	01001	01084
01002	01086	01002	01086	01002	01085
01003	01090	01003	01090	01003	01086
01004	01091	01004	01091	01004	01090
01005	01092	01005	01092	01005	01091
01006	01093	01006	01093	01006	01092
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01012	01096	01012	01096	01012	01095
01013	01700	01013	01700	01013	01096
01014	01701	01014	01701	01014	01700
01015	01702	01015	01702	01015	01701
01016	01703	01016	01703	01016	01702
01080	01704	01080	01704	01080	01703
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01082	01706	01082	01706	01082	01705
01083	*01773	01083	*01776	01083	01706
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01085	01001	01085	01001	01085	01000
01086	01002	01086	01002	01086	01001
01090	01003	01090	01003	01090	01002
01091	01004	01091	01004	01091	01003
01092	01005	01092	01005	01092	01004
01093	01006	01093	01006	01093	01005
01094	01010	01094	01010	01094	01006
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01096	01012	01096	01012	01096	01011
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01701	01014	01701	01014	01701	01013
01702	01015	01702	01015	01702	01014
01703	01016	01703	01016	01703	01015
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01705	01081	01705	01081	01705	01080
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*01772	01083	*01775	01083	*01781	01082
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01004	01091	01004	01091	01004	01090
01005	01092	01005	01092	01005	01091
01006	01093	01006	01093	01006	01092
01010	01094	01010	01094	01010	01093
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01012	01096	01012	01096	01012	01095
01013	01700	01013	01700	01013	01096

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01704	01016	01703	01015	5831	71157
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	01081	01705	01080	5881	71159
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*01783	01083	*01786	01082	59001	71171
01000	01084	01000	01083	6147	71172
01001	01085	01001	01084	6824	71173
01002	01086	01002	01085	71110	71174
01003	01090	01003	01086	71111	71175
01004	01091	01004	01090	71112	71176
01005	01092	01005	01091	71113	71177
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01010	01094	01010	01093	71115	71179
01011	01095	01011	01094	71116	71180
01012	01096	01012	01095	71117	71181
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01014	01701	01014	01700	71119	71183
01015	01702	01015	01701	71120	71184
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01082	01706	01082	01705	71124	71188
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01090	01003	01090	0786	71129	71193
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01092	01005	01092	09851	71131	71195
01093	01006	01093	09852	71132	71196
01094	01010	01094	09853	71133	71197
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01703	01016	01703	37603	71139	73014
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01705	01081	01705	38302	71141	73016
01706	01082	01706	46451	71142	73017
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01002	01086	01001	4808	71146	73022
01003	01090	01002	4809	71147	73023
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01005	01092	01004	5820	71149	73025
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01010	01094	01006	5822	71151	73027
01011	01095	01010	5824	71152	73028

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01003	5183	71148	73023	25542	71136
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01006	5822	71150	73026	37603	71139
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01014	5830	71155	00322	4801	71144
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0786	71129	71192	01095	71117	71181
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09859	71134	71197	01703	71122	71186
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25542	71136	71199	01705	71124	71188
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37603	71139	73013	0221	71127	71191
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	38300	71140	73015	0786	71129
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01011	01004	01000	01704	01700	01283
01012	01005	01001	01705	01701	01284
01013	01006	01002	01706	01702	01285
01014	01010	01003	*01881	01703	01286
01015	01011	01004	01000	01704	01700
01016	01012	01005	01001	01705	01701
01080	01013	01006	01002	01706	01702

01703	01286	01282	01235	01231	01224
01704	01700	01283	01236	01232	01225
01705	01701	01284	01280	01233	01226
01706	01702	01285	01281	01234	01230
*01883	01703	01286	01282	01235	01231
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01002	01706	01702	01285	01281	01234
01003	*01884	01703	01286	01282	01235
01004	01000	01704	01700	01283	01236
01005	01001	01705	01701	01284	01280
01006	01002	01706	01702	01285	01281
01010	01003	*01885	01703	01286	01282
01011	01004	01000	01704	01700	01283
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01013	01006	01002	01706	01702	01285
01014	01010	01003	*01886	01703	01286
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01016	01012	01005	01001	01705	01701
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01081	01014	01010	01003	*01890	01703
01082	01015	01011	01004	01000	01704
01083	01016	01012	01005	01001	01705
01084	01080	01013	01006	01002	01706
01085	01081	01014	01010	01003	*01891
01086	01082	01015	01011	01004	01000
01090	01083	01016	01012	01005	01001
01091	01084	01080	01013	01006	01002
01092	01085	01081	01014	01010	01003
01093	01086	01082	01015	01011	01004
01094	01090	01083	01016	01012	01005
	01091	01084	01080	01013	01006
01095	01092	01085	01081	01014	01010
01096	01093	01086	01082	01015	01011
01220	01094	01090	01083	01016	01012
01221		01091	01084	01080	01013
01222	01095	01092	01085	01081	01014
01223	01096	01093	01086	01082	01015
01224	01220	01094	01090	01083	01016
01225	01221		01091	01084	01080
01226	01222	01095	01092	01085	01081
01230	01223	01096	01093	01086	01082
01231	01224	01220	01094	01090	01083
01232	01225	01221		01091	01084
01233	01226	01222	01095	01092	01085
01234	01230	01223	01096	01093	01086
01235	01231	01224	01220	01094	01090
01236	01232	01225	01221		01091
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01282	01235	01231	01224	01220	01094
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01231	01224	01220	01094	01090	01083
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01236	01232	01225	01221		01091
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01085	01081	01014	01010	01003	*0200
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0201	*0208	4802	0278	*0312	03289
0202	0200	4808	0279	0311	0329
0203	0201	4809	*0271	0312	*03281
*0202	0202	5183	0270	0318	0320
0031	0203	*0222	0272	0319	0321
0200	0208	0222	0278	*0318	0322
0201	*0209	0229	0279	0311	0323
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0203	0201	0031	0270	0318	03284
0223	0202	0223	0272	0319	03285
77189	0203	0229	0278	*0319	03289
*0203	0209	77189	0279	0311	0329
00322	*0210	*0228	*0278	0312	*03282
0200	0210	0228	0270	0318	0320
0201	0218	0229	0272	0319	0321
0202	0219	*0229	0278	*0320	0322
0203	*0211	0229	0279	0320	0323
0221	0211	*0230	*0279	0321	03281
0730	0218	0238	0270	0322	03282
4800	0219	0239	0272	0323	03284
4801	*0212	*0231	0278	03281	03285
4802	0218	0238	0279	03284	03289
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4809	*0213	*0232	0300	03289	*03283
5183	00322	0238	*0301	0329	0320
*0204	0203	0239	0301	*0321	0321
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0200	0218	0238	0302	0321	0323
0201	0219	0239	*0303	0322	03281
0202	0221	*0238	0303	0323	03283
0203	0730	0238	*0308	03281	03284
0221	4800	0239	0308	03284	03285
0730	4801	*0239	*0309	03285	03289
4800	4802	0238	0309	03289	0329
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4802	4809	*024	00322	*0322	09886
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*0205	0219	*0260	0312	0322	0321
00322	*0219	0260	0318	0323	0322
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0205	0229	0261	4802	0329	03289
0221	*0221	0269	4808	*0323	0329
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03284	0478	71125	71189	77189	0392
03285	0479	71126	71190	*03849	0393
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03281	32341	71134	71198	*0389	0040
03284	32342	71135	71199	0031	0050
03285	32351	71136	*0380	0223	0051
03289	32352	71137	0031	77189	0052
0329	32361	71138	0223	*0390	0053
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0320	32363	71140	*03810	0398	00581
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0322	32372	71142	0223	*0391	00841
0323	32381	71143	77189	00322	00842
03281	32382	71144	*03811	0203	00843
03284	34120	71145	0031	0221	00844
03285	34121	71146	0223	0391	00845
03289	34122	71147	77189	0398	00846
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0338	*03642	71152	*0382	4802	04041
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0330	09885	71155	77189	5183	*04042
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0338	*03682	71157	0031	0392	0040
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*0339	71110	71174	*03841	*0394	00589
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0338	71113	71177	77189	0399	00843
0339	71114	71178	*03842	*0398	00844
*0340	71115	71179	0031	0390	00845
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*035	71119	71183	0031	0394	0090
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*04082	0031	*04185	04510	0460	0469
6824	0223	0031	04511	0461	*0468
*04089	6824	0223	04512	0463	0460
0031	77189	6824	04513	0468	0461
0223	*0412	77189	*04510	0469	0463
04081	0031	*04186	04500	048	0468
6824	0223	0223	04501	0498	0469
77189	6824	6824	04502	0499	048
*04100	77189	77189	04503	0620	
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0223	0031	0031	04511	0622	0499
6824	0223	0223	04512	0623	0620
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*04101	77189	77189	*04511	0625	0622
0031	*0414	*0419	04500	0628	0623
0223	0031	0031	04501	0629	0624
6824	0223	0223	04502	0630	0625
77189	6824	6824	04503	0631	0628
*04102	77189	77182	04510	0632	0629
0031	*0415	77189	04511	0638	0630
0223	0031	*042	04512	0639	0631
6824	0223	07953	04513	064	0632
77189	6824	*04500		0662	0638
*04103	77189	04500	*04512	0663	0639
0031	*0416	04501	04500	06640	064
0223	0031	04502	04501	06641	0662
6824	0223	04503	04502	06642	0663
77189	6824	04510	04503	06649	06640
*04104	77189	04511	04510	0737	06641
0031	*0417	04512	04511	0819	06642
0223	0031	04513	04512	0869	06649
6824	0223	*04501	04513	124	0737
77189	6824	04500	*04513	32301	0819
*04105	77189	04501	04500	32302	0869
0031	*04181	04502	04501	3231	124
0223	0031	04503	04502	3232	32301
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*04109	77189	04512	04511	32351	3232
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0223	0031	*04502	04513	32361	32342
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*04110	77189	04502	0461	32371	32361
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6824	0223	04511	0469	32382	32371
77189	6824	04512	*0461	3239	32372
*04111	77189	04513	0460	7712	32381
0031	*04184	*04503	0461	*0463	32382
0223	0031	04500	0463	0460	3239
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0470	00321	0461	0479	00321	0869
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09181	0491	0621	0620	0491	32341
09882	09181	0622	0621	09181	32342
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32301	10081	0624	0623	10081	32352
32302	32301	0625	0624	32301	32361
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32351	32342	0630	0629	32342	32371
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32361	32352	0632	0631	32352	32381
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32372	32371	0662	064	32371	*0499
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	32342	32363	32352	0630	0509
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0632	0629	32372	34122	32302	*0538
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0639	0631	32382	32301	32342	32302
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32372	0819	05449	06641	32371	06640
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0629	05449	0623	05443	0622	71118
0630	*05443	0624	05444	0623	71119
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0639	05443	0630	32301	0629	71123
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71140	*0578	0621	0630	0663	0869
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71142	0463	0623	0632	06641	32301
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0819	0819	32363	05314	0620	0629
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124	124	32372	05379	0622	0631
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0471	07953	0862	0821	0862	0850
0478	07981	0863	0822	0863	0851
0479	0819	0864	0823	0864	0852
0490	0869	0865	08240	0865	0853
0491	09181	0869	08241	0869	0854
0700	09882	0870	08249	0870	0855
0701	10081	0871	0828	0871	0859
0787	124	0879	0829	0879	0861
07951	32301	0880	0830	0880	0862
07952	32302	08881	0831	08881	0863
07953	3231	08882	0850	08882	0864
07981	3232	*0810	0851	*0819	0865

0869	0811	0838	0870	0823	0854
0870	0812	0839	0871	08240	0855
0871	0819	0850	0879	08241	0859
0879	0820	0851	0880	08249	0861
0880	0821	0852	08881	0828	0862
08881	0822	0853	08882	0829	0863
08882	0823	0854	*08240	0830	0864
124	08240	0855	080	0831	0865
3231	08241	0859	0810	0832	0869
3232	08249	0861	0811	0838	0870
3239	0828	0862	0812	0839	0871
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080	0831	0865	0821	0852	08881
0810	0832	0869	0822	0853	08882
0811	0838	0870	0823	0854	*0828
0812	0839	0871	08240	0855	080
0819	0850	0879	08241	0859	0810
0820	0851	0880	08249	0861	0811
0821	0852	08881	0828	0862	0812
0822	0853	08882	0829	0863	0819
0823	0854	*0823	0830	0864	0820
08240	0855	080	0831	0865	0821
08241	0859	0810	0832	0869	0822
08249	0861	0811	0838	0870	0823
0828	0862	0812	0839	0871	08240
0829	0863	0819	0850	0879	08241
0830	0864	0820	0851	0880	08249
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0832	0869	0822	0853	08882	0829
0838	0870	0823	0854	*08249	0830
0839	0871	08240	0855	080	0831
0850	0879	08241	0859	0810	0832
0851	0880	08249	0861	0811	0838
0852	08881	0828	0862	0812	0839
0853	08882	0829	0863	0819	0850
0854	*0822	0830	0864	0820	0851
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0865	0821	0852	08881	0828	0862
0869	0822	0853	08882	0829	0863
0870	0823	0854	*08241	0830	0864
0871	08240	0855	080	0831	0865
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08881	0828	0862	0812	0839	0871
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0823	0853	0871	08240	06642	0845
08240	0854	0879	08241	06649	0846
08241	0855	0880	08249	0737	0848
08249	0859	08881	0828	080	0849
0828	0861	08882	0829	0810	0850
0829	0862	*0832	0830	0811	0851
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0838	0869	0812	0839	0820	0855
0839	0870	0819	0850	0821	0859
0850	0871	0820	0851	0822	0861
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0870	0819	0839	0871	0851	0845
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08241	0852	08881	0628	124	08882
08249	0853	08882	0629	3231	*0842
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080	0850	0880	0917	0919	09485
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36401	*37603	*37753	37772	38300	29591
36402	37601	37751	37773	38302	29592
36403	37603	37752	*3779	*38333	29593
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36401	37732	37762	*38014	*38845	29640
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0075	3232	01153	1304	5183	*4954
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9503	9516	82332	90221	86342	8245
9509	9517	82382	90255	86343	8247
*9501	9518	82390	90256	86344	8249
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*9503	9514	82534	90221	90255	86320
9500	9515	82535	90255	90256	86321
9501	9516	86120	90256	90281	86329
9502	9517	86121	90281	90282	86340
9503	9518	8620	90282	90289	86341
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9502	8620	86329	71911	80702	86346
9503	8628	86340	71912	80841	86349
9509	*9588	86341	71913	8090	86380
*9510	72973	86342	71914	8091	86381
9510	80700	86343	71915	82120	86382
*9511	80701	86344	71918	82121	86383
9511	80702	86345	71919	82122	86384
*9512	80703	86346	80700	82123	86385
9512	80841	86349	80701	82129	86389
*9513	8090	86380	80702	82130	90140
9513	8091	86381	*95892	82131	90221
*9514	82120	86382	71910	82132	90255
9514	82121	86383	71915	82133	90256
*9515	82122	86384	71916	82139	90281
9515	82123	86385	71917	8221	90282
*9516	82129	86389	71918	82300	90289
9516	82130	8702	71919	82302	9029
*9517	82131	8715	80700	82310	*9596
9517	82132	8716	80701	82311	80841
*9518	82133	87212	80702	82312	8090

8091	82133	87212	8241	90282	*9921
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82121	8221	87262	8245	9029	*9922
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82130	82311	87271	82531	0463	*9924
82131	82312	87279	82532	048	9920
82132	82320	87323	82533	0498	*9925
82133	82322	8742	82534	0499	9920
82139	82330	8744	82535	0620	*9926
8221	82331	90140	86100	0621	9920
82300	82332	90221	86120	0622	*9927
82302	82382	90255	86121	0623	9920
82310	82390	90256	8620	0624	*9928
82311	82391	90281	8628	0625	9920
82312	82392	90282	8630	0628	*9929
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82331	8247	*9599	86340	0632	*9934
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82392	82533	80703	86345	0663	9933
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8247	86121	82120	86381	124	9947
8249	8620	82121	86382	3231	*99550
8251	8628	82122	86383	3232	99550
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82534	86329	82131	8702	9910	99554
82535	86340	82132	8715	9913	99555
*9598	86341	82133	8716	*9911	99559
72973	86342	82139	87212	9911	99581
80700	86343	8221	87261	9913	99583
80701	86344	82300	87262	*9912	99584
80702	86345	82302	87263	9912	99585
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82120	86382	82322	87323	9912	99553
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82122	86384	82331	8744	9914	99555
82123	86385	82332	90140	*9914	99559
82129	86389	82382	90221	9913	99581
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82131	8715	82391	90256	*9920	99584
82132	8716	82392	90281	9920	99585

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99551	99581	99560	99566	99550	0202
99552	99583	99561	99567	99551	0223
99553	99584	99562	99568	99552	*99661
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99581	99560	99566	99560	99559	3911
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99584	99562	99568	99562	99581	99931
99585	99563	99569	99563	99583	99939
*99553	99564	*99565	99564	99584	*99664
99550	99565	9950	99565	99585	77182
99551	99566	99560	99566	*99584	*9987
99552	99567	99561	99567	99550	03283
99553	99568	99562	99568	99551	
99554	99569	99563	99569	99552	0952
99555	*99561	99564	*99580	99553	09886
99559	9950	99565	99550	99554	09956
99581	99560	99566	99551	99555	*9990
99583	99561	99567	99552	99559	9990
99584	99562	99568	99553	99581	*99931
99585	99563	99569	99554	99583	99931
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99550	99565	9950	99559	99585	*99939
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99554	99569	99563	99584	99552	0031
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99552	99567	99561	99581	0031	6824
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99581	99560	99566	99550	0202	*V094
99583	99561	99567	99551	0223	0031
99584	99562	99568	99552	*99592	0223
99585	99563	99569	99553	0031	6824
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99551	99566	99560	99559	*99593	0031
99552	99567	99561	99581	0031	0223
99553	99568	99562	99583	0202	6824
99554	99569	99563	99584	0223	*V0951

0031	1716	V850
0223	1717	V854
6824	1718	*V8535
*V096	1719	V850
0031	1760	V854
0223	1761	*V8536
6824	1762	V850
*V0970	1763	V854
0031	1768	*V8537
0223	1769	V850
6824	1943	V854
*V0971	1944	*V8538
0031	2385	V850
0223	2386	V854
6824	*V6284	*V8539
*V0980	29011	V850
0031	2903	V854
0223	2930	*V854
6824	*V778	V850
*V0981	V850	*V8551
0031	*V850	V850
0223	V850	V854
6824	V854	*V8552
*V0990	*V851	V850
0031	V850	V854
0223	V854	*V8553
6824	*V8521	V850
*V0991	V850	V854
0031	V854	*V8554
0223	*V8522	V850
6824	V850	V854
*V4574	V854	
5934	*V8523	
*V551	V850	
V551	V854	
*V580	*V8524	
1580	V850	
1588	V854	
1589	*V8525	
1700	V850	
1701	V854	
1702	*V8530	
1703	V850	
1704	V854	
1705	*V8531	
1706	V850	
1707	V854	
1708	*V8532	
1709	V850	
1710	V854	
1712	*V8533	
1713	V850	
1714	V854	
1715	*V8534	

TABLE 6H.--DELETIONS TO THE CC EXCLUSIONS LIST

CCs that are deleted from the list are in 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.

```
*01100      4956      4952    *01120      4956      4953
 4950        515      4953     4950        515      4954
 4951       5178      4954     4951       5178      4955
 4952     *01105      4955     4952     *01125      4956
 4953       4950      4956     4953       4950       515
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0552	*1889	24290	24200	24290	24200
0558	5960	2580	24210	2580	24210

24220	2581	24220	2581	24220	2581
24230	2588	24230	2588	24230	2588
24240	2589	24240	2589	24240	2589
24280	*2441	24280	*2454	24280	*25000
24290	24200	24290	24200	24290	25001
2580	24210	2580	24210	2580	25002
2581	24220	2581	24220	2581	25003
2588	24230	2588	24230	2588	25041
2589	24240	2589	24240	2589	25042
*24290	24280	*2450	24280	*2462	25043
24200	24290	24200	24290	24200	25051
24210	2580	24210	2580	24210	25052
24220	2581	24220	2581	24220	25053
24230	2588	24230	2588	24230	25061
24240	2589	24240	2589	24240	25062
24280	*2442	24280	*2458	24280	25063
24290	24200	24290	24200	24290	25071
2580	24210	2580	24210	2580	25072
2581	24220	2581	24220	2581	25073
2588	24230	2588	24230	2588	25081
2589	24240	2589	24240	2589	25082
*24291	24280	*2451	24280	*2463	25083
24200	24290	24200	24290	24200	25091
24210	2580	24210	2580	24210	25092
24220	2581	24220	2581	24220	25093
24230	2588	24230	2588	24230	2580
24240	2589	24240	2589	24240	2581
24280	*2443	24280	*2459	24280	2588
24290	24200	24290	24200	24290	2589
2580	24210	2580	24210	2580	*25001
2581	24220	2581	24220	2581	25001
2588	24230	2588	24230	2588	25002
2589	24240	2589	24240	2589	25003
*243	24280	*2452	24280	*2468	25041
24200	24290	24200	24290	24200	25042
24210	2580	24210	2580	24210	25043
24220	2581	24220	2581	24220	25051
24230	2588	24230	2588	24230	25052
24240	2589	24240	2589	24240	25053
24280	*2448	24280	*2460	24280	25061
24290	24200	24290	24200	24290	25062
2580	24210	2580	24210	2580	25063
2581	24220	2581	24220	2581	25071
2588	24230	2588	24230	2588	25072
2589	24240	2589	24240	2589	25073
*2440	24280	*2453	24280	*2469	25081
24200	24290	24200	24290	24200	25082
24210	2580	24210	2580	24210	25083
24220	2581	24220	2581	24220	25091
24230	2588	24230	2588	24230	25092
24240	2589	24240	2589	24240	25093
24280	*2449	24280	*2461	24280	2580
24290	24200	24290	24200	24290	2581
2580	24210	2580	24210	2580	2588

2589	25001	25003	25042	25051	25053
*25002	25002	25041	25043	25052	25061
25001	25003	25042	25051	25053	25062
25002	25041	25043	25052	25061	25063
25003	25042	25051	25053	25062	25071
25041	25043	25052	25061	25063	25072
25042	25051	25053	25062	25071	25073
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25052	25061	25063	25072	25081	25083
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25063	25072	25081	25083	25092	2580
25071	25073	25082	25091	25093	2581
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25073	25082	25091	25093	2581	2589
25081	25083	25092	2580	2588	*25031
25082	25091	25093	2581	2589	25001
25083	25092	2580	2588	*25023	25002
25091	25093	2581	2589	25001	25003
25092	2580	2588	*25021	25002	25041
25093	2581	2589	25001	25003	25042
2580	2588	*25013	25002	25041	25043
2581	2589	25001	25003	25042	25051
2588	*25011	25002	25041	25043	25052
2589	25001	25003	25042	25051	25053
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25001	25003	25042	25051	25053	25062
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25061	25063	25072	25081	25083	25092
25062	25071	25073	25082	25091	25093
25063	25072	25081	25083	25092	2580
25071	25073	25082	25091	25093	2581
25072	25081	25083	25092	2580	2588
25073	25082	25091	25093	2581	2589
25081	25083	25092	2580	2588	*25032
25082	25091	25093	2581	2589	25001
25083	25092	2580	2588	*25030	25002
25091	25093	2581	2589	25001	25003
25092	2580	2588	*25022	25002	25041
25093	2581	2589	25001	25003	25042
2580	2588	*25020	25002	25041	25043
2581	2589	25001	25003	25042	25051
2588	*25012	25002	25041	25043	25052
2589	25001	25003	25042	25051	25053
*25010	25002	25041	25043	25052	25061

25062	25071	25051	25001	25001	25001
25063	25072	25052	25002	25002	25002
25071	25073	25053	25003	25003	25003
25072	25081	25061	25041	25041	25041
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25083	25092	25072	25052	25052	25052
25091	25093	25073	25053	25053	25053
25092	2580	25081	25061	25061	25061
25093	2581	25082	25062	25062	25062
2580	2588	25083	25063	25063	25063
2581	2589	25091	25071	25071	25071
2588	5851	25092	25072	25072	25072
2589	5852	25093	25073	25073	25073
*25033	5853	2580	25081	25081	25081
25001	5859	2581	25082	25082	25082
25002	*25041	2588	25083	25083	25083
25003	25001	2589	25091	25091	25091
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25042	25003	5852	25093	25093	25093
25043	25041	5853	2580	2580	2580
25051	25042	5859	2581	2581	2581
25052	25043	*25043	2588	2588	2588
25053	25051	25001	2589	2589	2589
25061	25052	25002	37702	37702	340
25062	25053	25003	*25051	*25053	34510
25063	25061	25041	25001	25001	35800
25071	25062	25042	25002	25002	*25061
25072	25063	25043	25003	25003	25001
25073	25071	25051	25041	25041	25002
25081	25072	25052	25042	25042	25003
25082	25073	25053	25043	25043	25041
25083	25081	25061	25051	25051	25042
25091	25082	25062	25052	25052	25043
25092	25083	25063	25053	25053	25051
25093	25091	25071	25061	25061	25052
2580	25092	25072	25062	25062	25053
2581	25093	25073	25063	25063	25061
2588	2580	25081	25071	25071	25062
2589	2581	25082	25072	25072	25063
*25040	2588	25083	25073	25073	25071
25001	2589	25091	25081	25081	25072
25002	5851	25092	25082	25082	25073
25003	5852	25093	25083	25083	25081
25041	5853	2580	25091	25091	25082
25042	5859	2581	25092	25092	25083
25043	*25042	2588	25093	25093	25091
25051	25001	2589	2580	2580	25092
25052	25002	5851	2581	2581	25093
25053	25003	5852	2588	2588	2580
25061	25041	5853	2589	2589	2581
25062	25042	5859	37702	37702	
25063	25043	*25050	*25052	*25060	2588

2589	25093	25082	25071	25002	25092
340	2580	25083	25072	25003	25093
34510	2581	25091	25073	25041	2580
35800	2588	25092	25081	25042	2581
*25062	2589	25093	25082	25043	2588
25001	340	2580	25083	25051	2589
25002	34510	2581	25091	25052	340
25003	35800	2588	25092	25053	35800
25041	*25070	2589	25093	25061	37702
25042	25001	4465	2580	25062	4465
25043	25002	4510	2581	25063	4510
25051	25003	4512	2588	25071	4512
25052	25041	*25072	2589	25072	5851
25053	25042	25001	4465	25073	5852
25061	25043	25002	4510	25081	5853
25062	25051	25003	4512	25082	5859
25063	25052	25041	*25080	25083	*25083
25071	25053	25042	25001	25091	25001
25072	25061	25043	25002	25092	25002
25073	25062	25051	25003	25093	25003
25081	25063	25052	25041	2580	25041
25082	25071	25053	25042	2581	25042
25083	25072	25061	25043	2588	25043
25091	25073	25062	25051	2589	25051
25092	25081	25063	25052	340	25052
25093	25082	25071	25053	35800	25053
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2581	25091	25073	25062	4465	25062
2588	25092	25081	25063	4510	25063
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340	2580	25083	25072	5851	25072
34510	2581	25091	25073	5852	25073
35800	2588	25092	25081	5853	25081
*25063	2589	25093	25082	5859	25082
25001	4465	2580	25083	*25082	25083
25002	4510	2581	25091	25001	25091
25003	4512	2588	25092	25002	25092
25041	*25071	2589	25093	25003	25093
25042	25001	4465	2580	25041	2580
25043	25002	4510	2581	25042	2581
25051	25003	4512	2588	25043	2588
25052	25041	*25073	2589	25051	2589
25053	25042	25001	340	25052	340
25061	25043	25002	35800	25053	35800
25062	25051	25003	37702	25061	37702
25063	25052	25041	4465	25062	4465
25071	25053	25042	4510	25063	4510
25072	25061	25043	4512	25071	4512
25073	25062	25051	5851	25072	5851
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25082	25071	25053	5853	25081	5853
25083	25072	25061	5859	25082	5859
25091	25073	25062	*25081	25083	*25090
25092	25081	25063	25001	25091	25001

25002	25092	25002	25092	2580	2588
25003	25093	25003	25093	2581	2589
25041	2580	25041	2580	2588	*25201
25042	2581	25042	2581	2589	2521
25043	2588	25043	2588	*2513	2580
25051	2589	25051	2589	25001	2581
25052	340	25052	*2511	25002	2588
25053	35800	25053	25001	25003	2589
25061	37702	25061	25002	25041	*25202
25062	4465	25062	25003	25042	2521
25063	4510	25063	25041	25043	2580
25071	4512	25071	25042	25051	2581
25072	5851	25072	25043	25052	2588
25073	5852	25073	25051	25053	2589
25081	5853	25081	25052	25061	*25208
25082	5859	25082	25053	25062	2521
25083	*25092	25083	25061	25063	2580
25091	25001	25091	25062	25071	2581
25092	25002	25092	25063	25072	2588
25093	25003	25093	25071	25073	2589
2580	25041	2580	25072	25081	*2521
2581	25042	2581	25073	25082	2521
2588	25043	2588	25081	25083	2580
2589	25051	2589	25082	25091	2581
340	25052	340	25083	25092	2588
35800	25053	35800	25091	25093	2589
37702	25061	37702	25092	2580	*2528
4465	25062	4465	25093	2581	2521
4510	25063	4510	2580	2588	2580
4512	25071	4512	2581	2589	2581
5851	25072	5851	2588	*2514	2588
5852	25073	5852	2589	2580	2589
5853	25081	5853	*2512	2581	*2529
5859	25082	5859	25001	2588	2521
*25091	25083	*2510	25002	2589	2580
25001	25091	25001	25003	*2515	2581
25002	25092	25002	25041	2580	2588
25003	25093	25003	25042	2581	2589
25041	2580	25041	25043	2588	*2530
25042	2581	25042	25051	2589	2580
25043	2588	25043	25052	*2518	2581
25051	2589	25051	25053	2580	2588
25052	340	25052	25061	2581	2589
25053	35800	25053	25062	2588	*2531
25061	37702	25061	25063	2589	2580
25062	4465	25062	25071	*2519	2581
25063	4510	25063	25072	2580	2588
25071	4512	25071	25073	2581	2589
25072	5851	25072	25081	2588	*2532
25073	5852	25073	25082	2589	2580
25081	5853	25081	25083	*25200	2581
25082	5859	25082	25091	2521	2588
25083	*25093	25083	25092	2580	2589
25091	25001	25091	25093	2581	*2533

2580	*2550	2588	2589	2588	2580
2581	2580	2589	*2569	2589	2581
2588	2581	*2556	2580	*2591	2588
2589	2588	2554	2581	2580	2589
*2534	2589	2580	2588	2581	*2598
2580	*25510	2581	2589	2588	24200
2581	2580	2588	*2570	2589	24210
2588	2581	2589	2580	*2592	24220
2589	2588	*2558	2581	2580	24230
*2535	2589	2554	2588	2581	24240
2580	*25511	2580	2589	2588	24280
2581	2580	2581	*2571	2589	24290
2588	2581	2588	2580	*2593	25001
2589	2588	2589	2581	2580	25002
*2536	2589	*2559	2588	2581	25003
2580	*25512	2554	2589	2588	25041
2581	2580	2580	*2572	2589	25042
2588	2581	2581	2580	*2594	25043
2589	2588	2588	2581	2580	25051
*2537	2589	2589	2588	2581	25052
2580	*25513	*2560	2589	2588	25053
2581	2580	2580	*2578		25061
2588	2581	2581	2580	2589	25062
2589	2588	2588	2581	*2595	25063
*2538	2589	2589	2588	24200	25071
2580	*25514	*2561	2589	24210	25072
2581	2580	2580	*2579	24220	25073
2588	2581	2581	2580	24230	25081
2589	2588	2588	2581	24240	25082
*2539	2589	2589	2588	24280	25083
2580	*2552	*2562	2589	24290	25091
2581	2580	2580	*2580	25001	25092
2588	2581	2581	2580	25002	25093
2589	2588	2588	2581	25003	2521
*2540	2589	2589	2588	25041	2554
2580	*2553	*25631	2589	25042	2580
2581	2554	2580	*2581	25043	2581
2588	2580	2581	2580	25051	2588
2589	2581	2588	2581	25052	2589
*2541	2588	2589	2588	25053	*2599
2580	2589	*25639	2589	25061	24200
2581	*2554	2580	*2588	25062	24210
2588	2553	2581	2580	25063	24220
2589	2554	2588	2581	25071	24230
*2548	2555	2589	2588	25072	24240
2580	2556	*2564	2589	25073	24280
2581	2580	2580	*2589	25081	24290
2588	2581	2581	2580	25082	25001
2589	2588	2588	2581	25083	25002
*2549	2589	2589	2588	25091	25003
2580	*2555	*2568	2589	25092	25041
2581	2554	2580	*2590	25093	25042
2588	2580	2581	2580	2521	25043
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25052	*2738	27652	2794	2799	28260
25053	2733	2766	2798	*2798	28261
25061	*2739	2767	2799	2794	28263
25062	2733	2769	*27903	2798	28268
25063	*27410	*27650	2794	2799	2832
25071	5851	27650	2798	*2799	2848
25072	5852	27651	2799	2794	2850
25073	5853	27652	*27904	2798	*2810
25081	5859	2766	2794	2799	2800
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25083	*27411	2769	2799	2800	2818
25091	59960	*27651	*27905	2814	28241
25092		27650	2794	2818	28249
25093	59969	27651	2798	28241	28260
2521	78820	27652	2799	28249	28261
2554	78829	2766	*27906	28260	28263
2580	*27419	2767	2794	28261	28268
2581	5851	2769	2798	28263	2832
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2589	5853	27650	*27909	2832	2850
*260	5859	27651	2794	2848	*2811
2630	5909	27652	2798	2850	2800
2631	*2760	2766	2799	*2801	2814
*261	27650	2767	*27910	2800	2818
2630	27651	2769	2794	2814	28241
2631	27652	*2766	2798	2818	28249
*262	2766	27650	2799	28241	28260
2630	2767	27651	*27911	28249	28261
2631	2769	27652	2794	28260	28263
*2630	*2761	2766	2798	28261	28268
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2630	2766	27650	2798	2848	*2812
2631	2767	27651	2799	2850	2800
*2632	2769	27652	*27913	*2808	2814
2630	*2762	2766	2794	2800	2818
2631	27650	2767	2798	2814	28241
*2638	27651	2769	2799	2818	28249
2630	27652	*2768	*27919	28241	28260
2631	2766	27650	2794	28249	28261
*2639	2767	27651	2798	28260	28263
2630	2769	27652	2799	28261	28268
2631	*2763	2766	*2792	28263	2832
*2690		2767	2794	28268	2848
2690	27650	2769	2798	2832	2850
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2733	27652	27650	*2793	2850	2800
*2731	2766	27651	2794	*2809	2814
2733	2767	27652	2798	2800	2818
*2732	2769	2766	2799	2814	28241
2733	*2764	2767	*2794	2818	28249
*2733	27650	2769	2794	28241	28260
2733	27651	*27902	2798	28249	28261

28263	2832	2850	2800	2818	28249
28268	2848	*28242	2814	28241	28260
2832	2850	2800	2818	28249	28261
2848	*2821	2814	28241	28260	28263
2850	2800	2818	28249	28261	28268
*2814	2814	28241	28260	28263	2832
2800	2818	28249	28261	28268	2848
2814	28241	28260	28263	2832	2850
2818	28249	28261	28268	2848	*2830
28241	28260	28263	2832	2850	2800
28249	28261	28268	2848	*28269	2814
28260	28263	2832	2850	2800	2818
28261	28268	2848	*28262	2814	28241
28263	2832	2850	2800	2818	28249
28268	2848	*28249	2814	28241	28260
2832	2850	2800	2818	28249	28261
2848	*2822	2814	28241	28260	28263
2850	2800	2818	28249	28261	28268
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2800	2818	28249	28261	28268	2848
2814	28241	28260	28263	2832	2850
2818	28249	28261	28268	2848	*28310
28241	28260	28263	2832	2850	2800
28249	28261	28268	2848	*2827	2814
28260	28263	2832	2850	2800	2818
28261	28268	2848	*28263	2814	28241
28263	2832	2850	2800	2818	28249
28268	2848	*2825	2814	28241	28260
2832	2850	2800	2818	28249	28261
2848	*2823	2814	28241	28260	28263
2850	2800	2818	28249	28261	28268
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2800	2818	28249	28261	28268	2848
2814	28241	28260	28263	2832	2850
2818	28249	28261	28268	2848	*28311
28241	28260	28263	2832	2850	2800
28249	28261	28268	2848	*2828	2814
28260	28263	2832	2850	2800	2818
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76503	*77430	77439	7791	7772	76504
76504	7740	7745	78039	7791	76505
76505	7741	*7750	*7791	*77983	76506

76507	78039	78829	30300	*79981	85109
76508	78820	*7889	30301	78039	85140
7730	78829	78820	30302	78820	85141
7731	7895	78829	30390	78829	85149
7732	79902	*78930	30391	7895	85400
7740	*78097	7895	30392	79902	85401
7741	78039	*78931	30400	*79989	85409
7742	78820	7895	30402	78039	*80004
77430	78829	*78932	30410	78820	8500
77431	7895	7895	30412	78829	8509
77439	79902	*78933	30420	7895	85100
7745	*78099	7895	30422	79902	85101
7755	78039	*78934	30440	*80000	85109
7756	78820	7895	30442	8500	85140
7771	78829	*78935	30450	8509	85141
7772	7895	7895	30452	85100	85149
7791	79902	*78936	30460	85101	85400
*78031	*78603	7895	30462	85109	85401
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*78032	*78604	7895	30472	85140	*80005
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78039	5964	*78940	30490	85400	85100
*78091	5981	7895	30492	85401	85101
78039	5982	*78941	30500	85409	85109
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7895	59969	7895	30530	8509	85149
79902	*78820	*78943	30531	85100	85400
*78092	78820	7895	30532	85101	85401
78039	78829	*78944	30540	85109	85409
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79902	*78829	*78946	30551	85400	85100
*78093	78820	7895	30552	85401	85101
78039	78829	*78947	30560	85409	85109
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78829	78820	*78949	30562	8500	85141
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79902	*78862	*7895	30571	85100	85400
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78820	*78863	7895	30591	85140	*80009
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7895	78829	2911	*7980	85149	8509
79902	*78864	2914	79902	85400	85100
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*78096	78820	29384	79902	85101	85401

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85409	85109	85409	85109	85409	85101
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*80044	85140	*80055	85140	*80066	85140
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85140	*80051	85140	*80062	85140	
85141	8500	85141	8500	85141	*80073
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85109	85409	85109	85409	85109	85401
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85141	8500	85141	8500	85141	*80074
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85109	85409	85109	85409	85109	85401
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85409	85109	85409	85109	85409	85101
*80049	85140	*80060	85140	*80071	85109
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85409	85109	85401	85101	85401	85101
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85141	8500	85140	*80130	85140	*80141
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85140	*80150	85140	85409	85109	85409
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85141	8500	85140	*80164	85140	*80175
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*80180	85140	*80191	85140	85409	85109
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85409	85109	85409	85109	85401	85101
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8500	85141	8500	85141	*80303	85140
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85409	85109	85409	85109	85401	85101
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85141	*80316	85140	*80329	85140	85409
85149	8500	85141	8500	85141	*80340
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85140	85409	85109	85409	85109	85401
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85149	8500	85141	8500	85141	*80341
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	85141	8500	85141	8500	85140
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85149	8509	85149	8500	85141	8500
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85401	85101	85401	85100	85400	85100
85409	85109	85409	85101	85401	85101
*85170	85140	*85181	85109	85409	85109
8500	85141	8500	85140	*85192	85140
8509	85149	8509	85141	8500	85141
85100	85400	85100	85149	8509	85149
85101	85401	85101	85400	85100	85400
85109	85409	85109	85401	85101	85401
85140	*85175	85140	85409	85109	85409
85141	8500	85141	*85186	85140	*85199
85149	8509	85149	8500	85141	8500
85400	85100		8509	85149	8509
85401	85101	85400	85100	85400	85100
85409	85109	85401	85101	85401	85101
*85171	85140	85409	85109	85409	85109
8500	85141	*85182	85140	*85193	85140
8509	85149	8500	85141	8500	85141
85100	85400	8509	85149	8509	85149
85101	85401	85100	85400	85100	85400
85109	85409	85101	85401	85101	85401
85140	*85176	85109	85409	85109	85409
85141	8500	85140	*85189	85140	*85200
85149	8509	85141	8500	85141	8500
85400	85100	85149	8509	85149	8509
85401	85101	85400	85100	85400	85100
85409	85109	85401	85101	85401	85101
*85172	85140	85409	85109	85409	85109
8500	85141	*85183	85140	*85194	85140
8509	85149	8500	85141	8500	85141
85100	85400	8509	85149	8509	85149
85101	85401	85100	85400	85100	85400
85109	85409	85101	85401	85101	85401
85140	*85179	85109	85409	85109	85409
85141	8500	85140	*85190	85140	*85201
85149	8509	85141	8500	85141	8500
85400	85100	85149	8509	85149	8509
85401	85101	85400	85100	85400	85100
85409	85109	85401	85101	85401	85101

85109	85409	85109	85409	85101	85400
85140	*85206	85140		85109	85401
85141	8500	85141	*85219	85140	85409
85149	8509	85149	8500	85141	*85231
85400	85100	85400	8509	85149	8500
85401	85101	85401	85100	85400	8509
85409	85109	85409	85101	85401	85100
*85202	85140	*85213	85109	85409	85101
8500	85141	8500	85140	*85225	85109
8509	85149	8509	85141	8500	85140
85100	85400	85100	85149	8509	85141
85101	85401	85101	85400	85100	85149
85109	85409	85109	85401	85101	85400
85140	*85209	85140	85409	85109	85401
85141	8500	85141	*85221	85140	85409
85149	8509	85149	8500	85141	*85232
85400	85100	85400	8509	85149	8500
85401	85101	85401	85100	85400	8509
85409	85109	85409	85101	85401	85100
*85203	85140	*85214	85109	85409	85101
8500	85141	8500	85140	*85226	85109
8509	85149	8509	85141	8500	85140
85100	85400	85100	85149	8509	85141
85101	85401	85101	85400	85100	85149
85109	85409	85109	85401	85101	85400
85140	*85210	85140	85409	85109	85401
85141	8500	85141	*85222	85140	85409
85149	8509	85149	8500	85141	*85233
85400	85100	85400	8509	85149	8500
85401	85101	85401	85100	85400	8509
85409	85109	85409	85101	85401	85100
*85204	85140	*85215	85109	85409	85101
8500	85141	8500	85140	*85229	85109
8509	85149	8509	85141	8500	85140
85100	85400	85100	85149	8509	85141
85101	85401	85101	85400	85100	85149
85109	85409	85109	85401		85400
85140	*85211	85140	85409	85101	85401
85141	8500	85141	*85223	85109	85409
85149	8509	85149	8500	85140	*85234
85400	85100	85400	8509	85141	8500
85401	85101	85401	85100	85149	8509
85409	85109	85409	85101	85400	85100
*85205	85140	*85216	85109	85401	85101
8500	85141	8500	85140	85409	85109
8509	85149	8509	85141	*85230	85140
85100	85400	85100	85149	8500	85141
85101	85401	85101	85400	8509	85149
85109	85409	85109	85401	85100	85400
85140	*85212	85140	85409	85101	85401
85141	8500	85141	*85224	85109	85409
85149	8509	85149	8500	85140	*85235
85400	85100	85400	8509	85141	8500
85401	85101	85401	85100	85149	8509

85100	85400	85100	85400	85100	85400
85101	85401	85101	85401	85101	85401
85109	85409	85109	85409	85109	85409
85140	*85242	85140	*85253	85140	*85304
85141	8500	85141	8500	85141	8500
85149	8509	85149	8509	85149	8509
85400	85100	85400	85100	85400	85100
85401	85101	85401	85101	85401	85101
85409	85109	85409	85109	85409	85109
*85236	85140	*85249	85140	*85300	85140
8500	85141	8500	85141	8500	
8509	85149	8509	85149	8509	85141
85100	85400	85100	85400	85100	85149
85101	85401	85101	85401	85101	85400
85109	85409	85109	85409	85109	85401
85140	*85243	85140	*85254	85140	85409
85141	8500	85141	8500	85141	*85305
85149	8509	85149	8509	85149	8500
85400	85100	85400	85100	85400	8509
85401	85101	85401	85101	85401	85100
85409	85109	85409	85109	85409	85101
*85239	85140	*85250	85140	*85301	85109
8500	85141	8500	85141	8500	85140
8509	85149	8509	85149	8509	85141
85100	85400	85100	85400	85100	85149
85101	85401	85101	85401	85101	85400
85109	85409	85109	85409	85109	85401
85140	*85244	85140	*85255	85140	85409
85141	8500	85141	8500	85141	*85306
85149	8509	85149	8509	85149	8500
85400	85100	85400	85100	85400	8509
85401	85101	85401	85101	85401	85100
85409	85109	85409	85109	85409	85101
*85240	85140	*85251	85140	*85302	85109
8500	85141	8500	85141	8500	85140
8509	85149	8509	85149	8509	85141
85100	85400	85100	85400	85100	85149
85101	85401	85101	85401	85101	85400
85109	85409	85109	85409	85109	85401
85140	*85245	85140	*85256	85140	85409
85141	8500	85141	8500	85141	*85309
85149	8509	85149	8509	85149	8500
85400	85100	85400	85100	85400	8509
85401	85101	85401	85101	85401	85100
85409	85109	85409	85109	85409	85101
*85241	85140	*85252	85140	*85303	85109
8500	85141	8500	85141	8500	85140
8509	85149	8509	85149	8509	85141
85100	85400	85100	85400	85100	85149
85101	85401	85101	85401	85101	85400
85109	85409	85109	85409	85109	85401
85140	*85246	85140	*85259	85140	85409
85141	8500	85141	8500	85141	*85310
85149	8509	85149	8509	85149	8500

8509	85149	8509	85149	8500	85141
85100	85400	85100	85400	8509	85149
85101	85401	85101	85401	85100	85400
85109	85409	85109	85409	85101	85401
85140	*85315	85140	*85406	85109	85409
85141	8500	85141	8500	85140	*85419
85149	8509	85149	8509	85141	8500
85400	85100	85400	85100	85149	8509
85401	85101	85401	85101	85400	85100
85409	85109	85409	85109	85401	85101
*85311	85140	*85402	85140	85409	85109
8500	85141	8500	85141	*85413	85140
8509	85149	8509	85149	8500	85141
85100	85400	85100	85400	8509	85149
85101	85401	85101	85401	85100	85400
85109	85409	85109	85409	85101	85401
85140	*85316	85140	*85409	85109	85409
85141	8500	85141	8500	85140	*8700
85149	8509	85149	8509	85141	8714
85400	85100	85400	85100	85149	*8701
85401	85101	85401	85101	85400	8714
85409	85109	85409	85109	85401	*8702
*85312	85140	*85403	85140	85409	8714
8500	85141	8500	85141	*85414	*8703
8509	85149	8509	85149	8500	8714
85100	85400	85100	85400	8509	*8704
85101	85401	85101	85401	85100	8714
85109	85409	85109	85409	85101	*8708
85140	*85319	85140	*85410	85109	8714
85141	8500	85141		85140	*8709
85149	8509	85149	8500	85141	8714
85400	85100	85400	8509	85149	*8710
85401	85101	85401	85100	85400	8714
85409	85109	85409	85101	85401	*8711
*85313	85140	*85404	85109	85409	8714
8500	85141	8500	85140	*85415	*8712
8509	85149	8509	85141	8500	8714
85100	85400	85100	85149	8509	*8713
85101	85401	85101	85400	85100	8714
85109	85409	85109	85401	85101	*8714
85140	*85400	85140	85409	85109	8714
85141	8500	85141	*85411	85140	*8715
85149	8509	85149	8500	85141	8714
85400	85100	85400	8509	85149	*8716
85401	85101	85401	85100	85400	8714
85409	85109	85409	85101	85401	*8717
*85314	85140	*85405	85109	85409	8714
8500	85141	8500	85140	*85416	*8719
8509	85149	8509	85141	8500	8714
85100	85400	85100	85149	8509	*87340
85101	85401	85101	85400	85100	8739
85109	85409	85109	85401	85101	*87341
85140	*85401	85140	85409	85109	8739
85141	8500	85141	*85412	85140	*87342

8739	85140	85100	8509	9533	8500
*87343	85141	85101	85100	9534	8509
8739	85149	85109	85101	9535	85100
*87344	85400	85140	85109	9538	85101
8739	85401	85141	85140	9539	85109
*87349	85409	85149	85141	*95890	85140
8739	*8739	85400	85149	8500	85141
*87350	8500	85401	85400	8509	85149
8739	8509	85409	85401	85100	85400
*87351	85100	*9051	85409	85101	85401
8739	85101	9529	8714	85109	85409
*87352	85109	*9251	8739	85140	8714
8739	85140	8500	9290	85141	8739
*87353	85141	8509	*9528	85149	9290
8739	85149	85100	9529	85400	9529
*87354	85400	85101	*9529	85401	9530
8739	85401	85109	9529	85409	9531
*87359	85409	85140	*9538	8714	9532
8739	8739	85141	9530	8739	9533
*87360	*8748	85149	9531	9290	9534
8739	8739	85400	9532	9529	9535
	*8749	85401	9533	9530	9538
*87361	8739	85409	9534	9531	9539
8739	*8798	*9252	9535	9532	*95893
*87362	8500	8500	9538	9533	8500
8739	8509	8509	9539	9534	8509
*87363	85100	85100	*9539	9535	85100
8739	85101	85101	9530	9538	85101
*87364	85109	85109	9531	9539	85109
8739	85140	85140	9532	*95891	85140
*87365	85141	85141	9533	8500	85141
8739	85149	85149	9534	8509	85149
*87369	85400	85400	9535	85100	85400
8739	85401	85401	9538	85101	85401
*87370	85409	85409	9539	85109	85409
8739	8714	*92611	*9588	85140	8714
*87371	8739	9529	8500	85141	8739
8739	*8799	*9290	8509	85149	9290
*87372	8500	8500	85100	85400	9529
8739	8509	8509	85101	85401	9530
*87373	85100	85100	85109	85409	9531
8739	85101	85101	85140	8714	9532
*87374	85109	85109	85141	8739	9533
8739	85140	85140	85149	9290	9534
*87375	85141	85141	85400	9529	9535
8739	85149	85149	85401	9530	9538
*87379	85400	85400	85409	9531	9539
8739	85401	85401	8714	9532	*95899
*8738	85409	85409	8739	9533	8500
8500	8714	8714	9290	9534	8509
8509	8739	8739	9529	9535	85100
85100	*9050	9290	9530	9538	85101
85101	8500	*9299	9531	9539	85109
85109	8509	8500	9532	*95892	85140

85141	85100	99670	99670	9975	*9993
85149	85101	*99604	*99664	*99771	9993
85400	85109	99670	99670	53640	*V090
85401	85140	*99609	*99665	53649	6800
85409	85141	99670	99670	*99772	6801
8714	85149	*9961	*99666	9975	6802
8739	85400	99670	99670	*99791	6803
9290	85401	*9962	*99667	53640	6804
9529	85409	99670	99670	53649	6805
9530	8714	*99630	*99668	99670	6806
9531		99670	99670	99700	6807
9532	8739	*99639	*99669	9975	6808
9533	9290	99670	99670	99889	6809
9534	9529	*99640	*99670	9989	*V091
9535	9530	99670	99670	*99799	6800
9538	9531	*99641	*99671	53640	6801
9539	9532	99670	99670	53649	6802
*95901	9533	*99642	V422	99670	6803
8500	9534	99670	*99672	99700	6804
8509	9535	*99643	99670	9975	6805
85100	9538	99670	*99673	99889	6806
85101	9539	*99644	99670	9989	6807
85109	*9599	99670	V451	*99881	6808
85140	8500	*99645	*99674	53640	6809
85141	8509	99670	99670	53649	*V092
85149	85100	*99646	*99675	99670	6800
85400	85101	99670		99700	6801
85401	85109	*99647	99670	9975	6802
85409	85140	99670	*99676	99889	6803
*95909	85141	*99649	99670	9989	6804
8500	85149	99670	*99677	*99883	6805
8509	85400	*99651	99670	53640	6806
85100	85401	99670	*99678	53649	6807
85101	85409	*99652	99670	99670	6808
85109	8714	99670	*99679	99700	6809
85140	8739	*99653	99670	9975	*V093
85141	9290	99670	*99680	99889	6800
85149	9529	*99654	V4289	9989	6801
85400	9530	99670	*99687	*99889	6802
85401	9531	*99655	V4289	53640	6803
85409	9532	99670	*99689	53649	6804
*95911	9533	*99656	V4289	99670	6805
9529		99670	*99700	99700	6806
*95912	9534	*99657	99700	9975	6807
9529	9535	99670	*99701	99889	6808
*95913	9538	*99659	99700	9989	6809
9529	9539	99670	*99702	*9989	*V094
*95914	*99600	*99660	99700	53640	6800
9529	99670	99670	*99709	53649	6801
*95919	*99601	*99661	99700	99670	6802
9529	99670	99670	*9974	99700	6803
*9598	*99602	*99662	53640	9975	6804
8500	99670	99670	53649	99889	6805
8509	*99603	*99663	*9975	9989	6806

6807	6806	V2389	V2383	V2381
6808	6807	V239	V2384	V2382
6809	6808	*V221	V2389	V2383
*V0950	6809	V237	V239	V2384
6800	*V0980	V2381	*V2349	V2389
6801	6800	V2382	V237	V239
6802	6801	V2383	V2381	*V2389
6803	6802	V2384	V2382	V237
6804	6803	V2389	V2383	V2381
6805	6804	V239	V2384	V2382
6806	6805	*V222	V2389	V2383
6807	6806	V237	V239	V2384
6808	6807	V2381	*V235	V2389
6809	6808	V2382	V237	V239
*V0951	6809	V2383	V2381	*V239
6800	*V0981	V2384	V2382	V237
6801	6800	V2389	V2383	V2381
6802	6801	V239	V2384	V2382
6803	6802	*V230	V2389	V2383
6804	6803	V237	V239	V2384
6805	6804	V2381	*V237	V2389
6806	6805	V2382	V237	V239
6807	6806	V2383	V2381	*V422
6808	6807	V2384	V2382	V422
6809	6808	V2389	V2383	*V4289
*V096	6809	V239	V2384	V422
6800	*V0990	*V231	V2389	V4289
6801	6800	V237	V239	*V429
6802	6801	V2381	*V2381	V422
6803	6802	V2382	V237	V4289
6804	6803	V2383	V2381	*V451
6805	6804	V2384	V2382	V451
6806	6805	V2389	V2383	*V4983
6807	6806	V239	V2384	V4983
6808	6807	*V232	V2389	
6809	6808	V237	V239	
*V0970	6809	V2381	*V2382	
6800	*V0991	V2382	V237	
6801	6800	V2383	V2381	
6802	6801	V2384	V2382	
6803	6802	V2389	V2383	
6804	6803	V239	V2384	
6805	6804	*V233	V2389	
6806	6805	V237	V239	
6807	6806	V2381	*V2383	
6808	6807	V2382	V237	
6809	6808	V2383	V2381	
*V0971	6809	V2384	V2382	
6800	*V220	V2389	V2383	
6801	V237	V239	V2384	
6802	V2381	*V2341	V2389	
6803	V2382	V237	V239	
6804	V2383	V2381	*V2384	
6805	V2384	V2382	V237	

TABLE 7A.-- MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE MARCH 2007 GROUPER V24.0 CMS DRGs

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	25,131	9.4313	2	4	7	12	19
2	9,628	4.2481	1	2	3	6	8
3	3	31.6667	2	2	42	51	51
6	256	2.9608	1	1	2	4	6
7	14,480	9.0468	2	4	7	11	18
8	3,103	2.7051	1	1	2	3	6
9	1,792	6.0107	1	2	4	7	11
10	18,959	5.7670	2	3	4	7	11
11	2,790	3.6250	1	1	3	5	7
12	59,298	5.3199	2	3	4	6	9
13	7,739	4.8765	2	3	4	6	8
14	264,219	5.2662	2	3	4	6	10
15	13,996	3.8492	1	2	3	5	7
16	20,216	6.2530	2	3	5	8	12
17	3,152	3.2056	1	1	2	4	6
18	34,068	5.1279	2	3	4	6	10
19	7,541	3.3149	1	2	3	4	6
21	2,094	6.1833	2	3	5	8	12
22	3,399	5.1278	2	2	4	6	10
23	10,464	3.7091	1	2	3	5	7
26	33	2.8750	1	1	2	3	5
27	6,296	4.6766	1	1	3	6	10
28	21,433	5.4849	1	2	4	7	11
29	6,780	3.0806	1	1	2	4	6
31	5,116	3.7875	1	2	3	5	7
32	1,745	2.2458	1	1	2	3	4
34	29,554	4.6998	1	2	4	6	9
35	7,840	2.9365	1	1	2	4	5
36	302	1.9455	1	1	1	1	2
37	1,199	4.0918	1	1	3	5	9
38	56	2.3846	1	1	2	3	4
39	306	2.2586	1	1	1	2	4
40	1,124	4.4811	1	2	4	5	8
42	1,642	2.5714	1	1	1	2	4
43	130	3.0156	1	1	2	4	5
44	1,283	4.8950	2	3	4	6	9
45	2,879	2.9292	1	2	2	4	5
46	4,048	3.9677	1	2	3	5	8
47	1,288	2.9741	1	1	2	4	6
49	2,479	4.2539	1	2	3	5	8
50	2,000	1.7953	1	1	1	2	3

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
51	178	2.7910	1	1	1	3	6
52	185	1.5301	1	1	1	2	2
53	1,919	3.8786	1	1	2	5	9
55	1,254	2.7630	1	1	1	3	6
56	375	2.5627	1	1	2	3	5
57	740	3.4384	1	1	2	4	7
58	1	1.0000	1	1	1	1	1
59	113	2.5221	1	1	1	3	5
60	5	3.4000	1	1	1	6	8
61	213	5.8774	1	1	4	7	13
62	1	4.0000	4	4	4	4	4
63	2,607	4.5492	1	2	3	6	9
64	3,108	6.1176	1	2	4	7	12
65	39,649	2.7318	1	1	2	3	5
66	7,805	3.2004	1	1	2	4	6
67	349	3.5948	1	2	3	4	7
68	14,613	3.7088	1	2	3	5	7
69	3,579	2.7922	1	2	2	3	5
70	22	2.4545	1	1	2	3	4
71	65	3.8125	1	2	3	5	7
72	1,398	3.3912	1	2	3	4	6
73	9,912	4.3625	1	2	3	6	8
75	46,315	9.3605	3	4	7	12	19
76	45,317	10.1339	3	5	8	13	19
77	1,784	4.4012	1	2	4	6	9
78	52,438	5.9444	2	4	5	7	10
79	151,130	7.8794	3	4	6	10	14
80	5,970	5.2160	2	3	4	6	9
81	8	3.1250	1	2	3	3	4
82	61,331	6.5291	2	3	5	8	13
83	7,240	5.0375	2	3	4	6	9
84	1,346	3.0015	1	2	3	4	5
85	22,437	6.0961	2	3	5	8	12
86	1,440	3.3698	1	2	3	4	6
87	105,232	6.2370	2	3	5	8	11
88	378,958	4.7587	2	3	4	6	9
89	472,756	5.3886	2	3	4	7	10
90	34,464	3.5882	1	2	3	4	6
91	43	5.0930	1	2	3	6	8
92	16,046	5.8190	2	3	5	7	11
93	1,120	3.5820	1	2	3	5	6
94	13,688	5.8577	2	3	5	7	11
95	1,410	3.4328	1	2	3	4	7
96	52,901	4.1779	1	2	3	5	7
97	21,402	3.2642	1	2	3	4	6

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
98	11	4.6364	1	2	4	6	7
99	20,929	3.0894	1	1	2	4	6
100	5,463	2.0814	1	1	2	3	4
101	24,319	4.1850	1	2	3	5	8
102	4,235	2.4307	1	1	2	3	5
103	988	37.8279	9	13	25	47	83
104	19,397	14.5499	6	8	12	18	25
105	32,104	9.9315	4	6	8	11	18
106	3,285	10.8958	5	7	9	13	19
108	9,268	10.4271	4	6	8	13	19
110	56,637	7.8089	1	3	6	10	16
111	10,448	2.7745	1	1	2	4	6
113	30,753	12.4596	4	6	10	15	24
114	7,290	8.1490	2	4	7	10	15
117	7,097	4.0233	1	1	2	5	9
118	7,994	3.0067	1	1	2	4	7
119	793	5.4823	1	1	4	8	12
120	30,375	9.0225	1	3	6	12	19
121	132,870	5.9605	2	3	5	8	11
122	47,937	3.2303	1	1	3	4	6
123	24,196	4.6425	1	1	3	6	11
124	111,282	4.4078	1	2	3	6	9
125	85,682	2.6793	1	1	2	3	5
126	5,197	10.7631	3	6	8	13	20
127	632,794	5.0454	2	3	4	6	9
128	3,390	4.9852	2	3	4	6	8
129	3,268	2.6096	1	1	1	3	6
130	84,710	5.2355	1	3	4	7	10
131	20,557	3.6402	1	2	3	5	6
132	85,172	2.7460	1	1	2	3	5
133	5,023	2.0883	1	1	2	3	4
134	38,372	3.0023	1	1	2	4	6
135	7,010	4.2221	1	2	3	5	8
136	900	2.4872	1	1	2	3	5
138	207,864	3.8413	1	2	3	5	7
139	68,246	2.3922	1	1	2	3	4
140	25,370	2.3401	1	1	2	3	4
141	126,247	3.3956	1	2	3	4	6
142	44,621	2.4528	1	1	2	3	4
143	223,237	2.1145	1	1	2	3	4
144	107,318	5.8453	1	2	4	7	12
145	5,085	2.5058	1	1	2	3	5
146	9,743	9.6593	4	6	8	11	17
147	2,423	5.3166	2	4	5	7	8
149	18,595	5.4424	3	4	5	7	8

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
150	23,520	10.4472	3	6	9	13	19
151	5,168	4.9323	1	2	4	7	9
152	4,910	7.7955	3	4	6	9	13
153	1,853	4.7348	2	3	4	6	7
155	5,811	3.7807	1	2	3	5	8
156	3	19.0000	2	2	16	39	39
157	8,167	5.5270	1	2	4	7	11
158	3,274	2.6225	1	1	2	3	5
159	19,093	5.0841	1	2	4	6	10
160	10,896	2.5844	1	1	2	3	5
161	9,755	4.5095	1	2	3	6	9
162	4,431	2.0711	1	1	1	3	4
163	7	4.7143	2	3	4	5	7
164	6,034	7.6391	3	4	6	9	14
165	2,336	3.8898	1	2	4	5	7
166	5,502	4.2153	1	2	3	5	8
167	4,870	2.0816	1	1	2	3	4
168	1,653	4.5972	1	2	3	6	9
169	862	2.1583	1	1	2	3	4
170	17,875	10.3572	2	4	8	13	21
171	1,388	3.8916	1	2	3	5	8
172	32,418	6.7337	2	3	5	8	13
173	1,955	3.4441	1	1	3	4	6
174	240,894	4.6420	2	2	4	6	8
175	25,028	2.8115	1	2	2	3	5
176	13,344	5.0520	2	3	4	6	9
177	7,771	4.4075	2	2	4	5	8
178	2,294	3.1007	1	2	3	4	5
179	14,696	5.7497	2	3	4	7	11
180	90,205	5.2286	2	3	4	6	10
181	23,385	3.2729	1	2	3	4	6
182	284,288	4.0583	1	2	3	5	8
183	73,204	2.8163	1	1	2	4	5
184	81	3.5556	1	2	2	4	7
185	6,071	4.4178	1	2	3	5	9
186	4	4.7500	3	3	3	6	7
187	655	3.9908	1	2	3	5	8
188	85,371	5.3017	1	2	4	6	10
189	11,855	2.9775	1	1	2	4	6
190	9	5.1111	1	2	4	5	9
191	10,286	12.1607	3	6	9	15	25
192	1,303	5.2928	1	3	5	7	9
193	3,726	12.0478	4	6	10	15	22
194	431	6.6136	3	4	6	8	11
195	2,436	10.2609	4	6	9	13	18

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
196	505	5.5549	2	3	5	7	9
197	15,282	8.9193	3	5	7	11	16
198	3,595	4.2656	2	3	4	5	7
199	1,330	8.7641	2	3	6	11	19
200	891	10.4065	2	4	7	13	21
201	2,625	13.0693	3	6	10	16	26
202	26,642	6.0702	2	3	5	7	12
203	30,604	6.3715	2	3	5	8	12
204	67,196	5.3052	2	3	4	6	10
205	32,076	5.7548	2	3	4	7	11
206	1,771	3.8392	1	2	3	5	7
207	37,953	5.1883	1	2	4	6	10
208	8,748	2.8981	1	1	2	4	5
210	127,328	6.5376	3	4	5	7	11
211	23,386	4.5191	3	3	4	5	7
212	6	4.6667	1	1	2	8	8
213	8,148	9.2665	2	4	7	12	18
216	19,791	5.4380	1	1	3	8	12
217	14,674	11.9337	3	5	8	15	24
218	31,163	5.4241	2	3	4	7	10
219	20,018	3.1029	1	2	3	4	5
220	5	6.5000	1	1	2	4	4
223	11,983	3.3894	1	1	2	4	7
224	8,755	1.9509	1	1	1	2	3
225	6,196	5.1605	1	2	4	7	10
226	7,243	6.3625	1	3	4	8	13
227	4,761	2.5699	1	1	2	3	5
228	2,624	4.2102	1	1	3	5	9
229	979	2.3154	1	1	2	3	4
230	2,438	5.7623	1	2	4	7	12
232	480	2.9430	1	1	1	3	7
233	22,424	5.9435	1	2	5	8	12
234	10,689	2.4816	1	1	1	3	6
235	4,507	4.5416	1	2	4	6	8
236	41,531	4.3734	2	3	4	5	7
237	1,836	3.7021	1	2	3	5	7
238	9,574	8.0098	2	4	6	9	15
239	37,495	5.9298	2	3	5	7	11
240	12,594	6.4175	2	3	5	8	12
241	2,415	3.5871	1	2	3	4	6
242	2,616	6.3669	2	3	5	8	12
243	98,427	4.4708	1	2	4	6	8
244	16,911	4.3383	1	2	3	5	8
245	5,216	3.0312	1	1	3	4	5
246	1,297	3.5771	1	2	3	4	6

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
247	21,405	3.3455	1	2	3	4	6
248	17,580	4.7555	2	3	4	6	8
249	13,366	3.9374	1	1	3	5	8
250	4,475	3.8692	1	2	3	5	7
251	1,923	2.7432	1	1	3	3	5
253	25,870	4.5355	2	3	4	5	8
254	9,313	3.0799	1	2	3	4	5
255	1	3.0000	3	3	3	3	3
256	7,739	5.0466	1	2	4	6	9
257	12,277	2.5477	1	1	2	3	5
258	10,259	1.6863	1	1	1	2	3
259	2,463	2.9923	1	1	1	3	7
260	2,003	1.3551	1	1	1	1	2
261	1,523	2.1103	1	1	1	2	4
262	569	4.8768	1	2	4	6	10
263	20,967	10.2150	3	5	7	12	20
264	3,496	5.9813	2	3	5	7	11
265	3,986	6.3149	1	2	4	8	14
266	2,126	3.0918	1	1	2	4	6
267	215	4.9346	1	2	3	5	9
268	1,018	3.3734	1	1	2	4	7
269	11,532	8.0441	2	4	6	10	16
270	2,567	3.7101	1	1	3	5	7
271	20,085	6.7420	2	3	5	8	12
272	5,806	5.6625	2	3	4	7	10
273	1,106	3.7945	1	2	3	5	7
274	2,256	6.1463	2	3	5	8	11
275	191	2.9050	1	1	2	3	5
276	1,455	4.4663	1	2	4	6	8
277	122,645	5.3563	2	3	4	7	9
278	31,770	3.8934	2	2	3	5	7
279	9	2.5556	1	1	3	4	4
280	19,679	3.9461	1	2	3	5	7
281	6,054	2.8113	1	1	2	3	5
283	6,894	4.3785	1	2	3	5	8
284	1,776	2.9858	1	1	2	4	5
285	8,387	9.8055	3	5	8	13	18
286	3,030	5.2288	1	2	4	6	10
287	5,038	9.5913	3	5	7	11	18
288	9,255	3.3157	1	2	2	4	6
289	5,844	2.5231	1	1	1	2	5
290	12,189	2.0053	1	1	1	2	3
291	51	1.5200	1	1	1	2	2
292	7,680	10.0354	2	4	8	12	19
293	325	4.6852	1	2	3	6	9

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
294	95,358	4.1796	1	2	3	5	8
295	4,608	3.6299	1	2	3	4	7
296	209,892	4.4834	1	2	3	5	8
297	36,469	2.9933	1	2	3	4	5
298	82	3.3537	1	2	2	4	7
299	1,589	5.2780	1	2	4	6	10
300	21,925	5.7484	2	3	5	7	11
301	3,625	3.3959	1	2	3	4	6
302	10,721	7.8878	4	5	6	9	13
303	19,684	6.0530	2	3	5	7	11
304	13,865	7.8471	2	3	6	10	16
305	2,903	2.9119	1	2	2	4	5
306	5,219	5.8804	1	2	3	8	14
307	1,657	1.9212	1	1	2	2	3
308	5,083	5.4260	1	2	3	7	12
309	2,789	1.6113	1	1	1	2	3
310	24,767	4.5591	1	2	3	6	10
311	5,064	1.8171	1	1	1	2	3
312	1,378	4.8198	1	1	3	6	10
313	483	2.1206	1	1	2	3	4
315	35,069	6.7590	1	1	4	9	16
316	233,845	5.9901	2	3	5	7	11
317	2,526	3.4968	1	1	2	4	7
318	5,851	5.7865	1	3	4	7	11
319	337	2.8234	1	1	2	4	5
320	228,348	4.9126	2	3	4	6	9
321	29,956	3.4930	1	2	3	4	6
322	80	3.2875	1	2	3	4	6
323	19,348	3.0716	1	1	2	4	6
324	3,880	1.9113	1	1	1	2	3
325	9,350	3.6738	1	2	3	5	7
326	2,325	2.4998	1	1	2	3	4
327	5	2.6000	1	1	2	2	6
328	531	3.4356	1	1	2	4	6
329	49	1.6531	1	1	1	2	2
330	1	1.0000	1	1	1	1	1
331	56,142	5.4154	1	2	4	7	10
332	3,224	3.0420	1	1	2	4	6
333	306	5.5065	1	2	3	7	13
334	9,289	3.9511	1	2	3	5	7
335	12,822	2.2583	1	1	2	3	4
336	25,296	3.1764	1	1	2	3	6
337	19,205	1.7798	1	1	2	2	3
338	615	5.5668	1	2	4	8	12
339	1,138	5.6484	1	1	3	7	12

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
340	1	1.0000	1	1	1	1	1
341	2,815	3.1900	1	1	1	3	7
342	455	3.3890	1	1	2	4	7
344	2,043	2.9843	1	1	1	3	7
345	1,260	5.1809	1	2	3	6	11
346	3,420	5.6788	2	3	4	7	11
347	217	2.9299	1	1	1	4	6
348	4,289	4.0382	1	2	3	5	7
349	504	2.5668	1	1	2	3	5
350	7,262	4.4271	2	2	4	5	8
352	1,138	4.2251	1	2	3	5	9
353	2,814	5.7246	2	3	4	6	11
354	7,329	5.4921	2	3	4	6	10
355	4,668	2.9265	2	2	3	3	4
356	21,423	1.8025	1	1	1	2	3
357	5,260	7.8391	3	4	6	9	15
358	19,769	3.8000	1	2	3	4	7
359	26,817	2.2435	1	2	2	3	3
360	13,806	2.3374	1	1	2	3	4
361	268	3.0784	1	1	2	3	6
362	2	1.5000	1	1	2	2	2
363	1,809	4.1390	1	2	3	4	9
364	1,660	3.9054	1	1	3	5	8
365	1,529	7.8041	2	3	5	10	18
366	4,716	6.2386	1	3	4	8	12
367	440	3.0308	1	1	2	3	5
368	4,146	6.5766	2	3	5	8	12
369	3,707	3.1123	1	1	2	4	6
370	2,429	5.2575	2	3	4	5	8
371	2,869	3.3973	2	3	3	4	4
372	1,493	3.2390	2	2	2	3	4
373	5,378	2.3207	1	2	2	3	3
374	123	2.8537	1	2	2	3	5
375	10	5.8000	2	3	4	8	9
376	499	3.5524	1	2	2	4	7
377	88	5.6782	1	2	3	6	11
378	181	2.0608	1	1	2	3	3
379	497	2.7591	1	1	2	3	5
380	107	2.6449	1	1	1	2	4
381	188	2.6330	1	1	1	2	6
382	50	2.6600	1	1	1	1	3
383	3,082	3.8501	1	1	3	4	7
384	129	2.7752	1	1	1	2	5
386	1	65.0000	65	65	65	65	65
389	1	7.0000	7	7	7	7	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
392	1,943	9.1889	2	4	6	11	20
394	2,707	6.9819	1	2	5	9	15
395	102,692	4.0561	1	2	3	5	8
396	15	3.0667	1	2	2	3	6
397	15,199	5.1973	1	2	4	6	10
398	6,435	5.2248	1	2	4	7	10
399	1,003	3.1210	1	1	2	4	6
401	6,358	10.9924	2	5	9	14	22
402	1,191	3.9840	1	1	3	5	8
403	30,729	7.8057	2	3	6	10	16
404	3,414	3.9800	1	2	3	5	8
406	2,211	9.6383	2	4	7	12	20
407	558	3.3986	1	2	3	4	6
408	1,918	8.5727	1	2	5	10	19
409	1,515	5.9874	1	3	4	6	12
410	28,076	3.7196	1	2	3	4	6
411	3	5.0000	1	1	2	12	12
412	8	3.0000	1	1	2	5	5
413	4,931	6.7113	2	3	5	8	13
414	456	3.6674	1	2	3	4	7
417	35	6.2000	1	2	4	7	14
418	29,523	6.0100	2	3	5	7	11
419	17,335	4.2610	1	2	3	5	8
420	2,722	3.0898	1	2	3	4	5
421	11,518	4.1047	1	2	3	5	8
422	55	3.4815	1	2	3	4	6
423	9,086	8.0894	2	3	6	10	16
424	985	11.3610	1	4	8	14	23
425	10,770	3.2202	1	1	2	4	6
426	5,083	4.1506	1	2	3	5	7
427	1,825	4.4489	1	2	3	5	7
428	841	7.4118	1	2	4	8	13
429	23,577	5.4058	2	3	4	6	9
430	83,653	7.6171	2	3	6	9	13
431	414	5.9390	1	2	4	6	9
432	446	4.5925	1	2	3	5	8
433	5,079	2.9767	1	1	2	3	4
439	1,771	8.8932	1	3	5	9	17
440	4,836	8.1083	2	3	5	9	17
441	754	3.2943	1	1	2	4	6
442	18,906	8.6115	2	3	6	10	17
443	3,296	3.3745	1	1	3	4	7
444	5,837	4.0427	1	2	3	5	8
445	2,126	2.6778	1	1	2	3	5
446	1	1.0000	1	1	1	1	1

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
447	6,374	2.5062	1	1	2	3	5
449	42,610	3.6921	1	1	3	4	7
450	7,159	1.9949	1	1	1	2	4
451	2	4.0000	2	2	6	6	6
452	29,623	4.8122	1	2	3	6	9
453	5,106	2.8213	1	1	2	3	5
454	4,544	4.0475	1	2	3	5	8
455	803	2.4770	1	1	2	3	4
461	2,236	5.6670	1	2	4	7	12
462	10,305	9.4779	4	5	7	9	11
463	33,817	3.8352	1	2	3	5	7
464	7,616	2.9074	1	1	2	4	5
465	193	3.1746	1	1	2	3	6
466	1,183	3.9942	1	1	2	4	6
467	1,019	3.7708	1	1	2	3	6
468	52,003	12.1213	3	6	9	15	23
470	19	3.3684	2	2	3	4	6
471	15,412	4.5818	3	3	4	5	7
473	8,326	11.7260	2	3	6	15	31
476	2,617	9.4923	2	4	8	13	19
477	26,701	8.6649	1	3	7	11	17
479	28,698	2.2900	1	1	1	3	5
480	930	19.3817	6	9	13	23	42
481	1,389	21.8301	10	15	20	24	33
482	4,742	11.2108	4	6	8	13	21
484	457	12.2105	2	6	10	16	23
485	3,773	9.4954	4	5	7	11	18
486	2,851	12.6014	2	6	10	16	25
487	5,168	6.6943	1	3	5	8	13
488	839	16.9509	4	7	13	21	34
489	13,781	8.2563	2	3	6	10	16
490	5,119	5.2595	1	2	4	6	10
491	23,975	2.9996	1	2	2	3	5
492	3,954	13.6789	3	5	6	23	32
493	60,423	5.9498	2	3	5	8	11
494	22,581	2.7089	1	1	2	4	5
495	378	17.2566	8	10	14	20	29
496	4,285	8.4126	3	4	6	10	17
497	32,795	5.5022	3	3	4	6	9
498	22,332	3.5496	2	2	3	4	5
499	34,590	4.0072	1	2	3	5	8
500	44,952	2.0954	1	1	2	3	4
501	3,051	9.3862	4	5	7	11	17
502	694	5.4046	2	3	5	7	9
503	5,501	3.8369	1	2	3	5	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
504	188	28.7861	9	15	25	38	52
505	160	5.9114	1	1	2	6	12
506	1,000	14.8004	3	7	12	19	29
507	280	7.3718	2	3	6	11	15
508	563	7.3826	2	3	5	9	14
509	146	4.6763	1	2	3	5	8
510	1,721	6.0481	1	2	4	7	12
511	510	3.8270	1	1	3	5	8
512	583	11.8045	6	7	9	13	20
513	182	10.4890	6	7	9	12	16
515	57,972	3.5777	1	1	1	4	9
518	25,043	2.4104	1	1	1	3	5
519	14,023	4.5367	1	1	2	6	11
520	17,615	1.8731	1	1	1	2	3
521	33,931	5.3752	1	2	4	6	8
522	5,512	10.5479	3	4	5	7	9
523	15,764	3.7672	1	2	3	4	5
524	104,648	3.0672	1	2	3	4	6
525	154	12.0260	1	2	7	16	34
528	1,731	16.5380	5	9	15	21	29
529	5,136	6.8812	1	2	4	8	16
530	3,247	2.8688	1	1	2	3	5
531	5,321	9.2281	2	3	7	12	19
532	3,018	3.6205	1	1	3	5	7
533	40,612	3.5337	1	1	2	4	8
534	34,525	1.6712	1	1	1	2	3
535	8,653	8.7874	2	4	7	11	17
536	7,826	7.1736	2	3	6	9	14
537	9,526	6.5102	1	3	5	8	13
538	5,106	2.8812	1	1	2	4	6
539	4,776	10.5928	2	3	7	14	23
540	1,424	3.4040	1	1	2	4	7
541	24,418	40.6333	16	23	34	49	71
542	22,162	29.3309	11	17	24	35	50
543	5,726	11.3068	2	4	9	15	23
544	444,140	4.3213	3	3	4	5	7
545	44,068	5.0758	3	3	4	6	8
546	3,637	7.8084	3	4	6	9	14
547	29,849	12.1407	6	8	10	14	20
548	26,598	8.6902	5	6	8	10	13
549	12,969	10.1156	5	6	8	12	18
550	29,780	6.6674	4	5	6	8	10
551	51,330	6.0799	1	2	5	8	12
552	78,735	3.3420	1	1	2	4	7
553	44,667	8.8671	1	3	7	12	18

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
554	78,338	5.1191	1	2	3	7	11
555	37,904	4.6521	1	2	3	6	9
556	17,924	1.9017	1	1	1	2	4
557	129,504	3.9574	1	2	3	5	8
558	185,260	1.7497	1	1	1	2	3
559	4,850	6.8469	2	4	5	8	13
560	3,401	10.0047	3	5	8	13	19
561	2,983	9.4530	3	5	8	12	18
562	53,381	4.7061	1	2	4	6	9
563	20,263	3.1483	1	2	3	4	6
564	16,650	3.3843	1	2	3	4	6
565	46,695	14.9666	6	9	13	18	25
566	80,036	7.2764	1	3	6	10	14
567	10,028	15.6091	6	8	12	19	29
568	16,182	11.0602	2	5	8	14	22
569	59,084	14.2085	5	8	12	18	26
570	69,076	9.8967	4	6	8	12	18
571	11,056	4.8116	2	2	4	6	9
572	55,040	6.9411	2	3	5	8	13
573	6,500	10.8933	4	6	8	12	19
574	27,832	5.7540	2	3	4	7	11
575	13,964	15.2777	6	8	13	19	26
576	297,949	7.1004	2	3	6	9	14
577	11,261	2.3454	1	1	1	2	5
578	39,116	15.6778	5	8	12	19	29
579	19,915	10.6805	3	5	8	13	21
	11,792,587						

TABLE 7B.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERENTILE LENGTHS OF STAY FY 2006 MEDPAR UPDATE MARCH 2007 GROUPER V25.0 MS-DRGS

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	652	45.5567	10	18	32	57	96
2	336	22.8304	8	10	15	27	46
3	24,550	40.6297	16	23	34	49	71
4	22,030	29.2666	11	17	24	35	50
5	634	23.5221	7	10	17	29	51
6	296	10.5135	6	7	9	12	17
7	378	17.2566	8	10	14	20	29
8	583	11.8045	6	7	9	13	20
9	1,389	21.8301	10	15	20	24	33

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
10	182	10.4890	6	7	9	12	16
11	1,301	16.1742	6	8	13	20	28
12	1,961	10.9218	4	6	9	13	19
13	1,480	7.2324	3	4	7	9	12
20	910	19.0868	6	11	18	25	34
21	571	15.4823	7	10	14	20	25
22	250	9.6225	3	5	9	13	16
23	3,571	12.7811	3	5	10	17	26
24	2,177	8.8745	1	3	7	12	18
25	8,513	13.3366	4	7	11	17	25
26	12,081	8.1992	3	4	7	10	15
27	14,221	4.6096	1	2	4	6	9
28	1,633	14.6554	4	7	11	18	27
29	3,097	7.3448	2	3	6	10	14
30	3,609	3.7074	1	1	3	5	7
31	1,062	13.1723	3	5	10	18	26
32	3,069	5.7546	1	2	4	7	13
33	4,254	3.0634	1	1	2	4	6
34	825	7.2676	1	2	6	10	14
35	2,918	2.9170	1	1	2	3	7
36	7,515	1.5828	1	1	1	1	3
37	4,807	8.6796	2	3	7	11	18
38	16,551	3.6657	1	1	2	5	8
39	53,705	1.8335	1	1	1	2	3
40	4,593	13.6251	4	6	10	17	26
41	8,017	7.3476	2	3	6	9	14
42	5,229	3.5723	1	1	2	5	8
52	1,200	7.0253	2	3	5	8	12
53	593	3.9746	1	2	3	5	7
54	4,763	7.2143	2	3	5	9	14
55	16,986	5.0092	1	2	4	6	10
56	8,007	7.7908	2	4	6	9	14
57	51,293	4.9238	2	3	4	6	8
58	798	8.0163	2	4	6	9	16
59	2,687	5.2069	2	3	4	6	9
60	4,254	4.0790	2	2	4	5	7
61	1,374	9.6435	2	5	8	12	18
62	2,325	6.3388	3	4	5	8	11
63	1,151	4.5426	2	3	4	6	8
64	56,608	7.6480	2	3	6	10	15
65	115,679	5.2835	2	3	4	7	9
66	91,935	3.7778	1	2	3	5	7
67	1,409	6.2038	2	3	5	8	12
68	12,587	3.5853	1	2	3	5	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
69	104,648	3.0672	1	2	3	4	6
0	7,180	7.9051	2	4	6	10	15
71	10,352	5.5978	2	3	4	7	10
72	5,837	3.7341	1	2	3	5	7
73	8,739	6.4320	2	3	5	8	13
74	32,871	4.3650	1	2	3	5	8
75	1,233	7.5899	3	4	6	10	14
76	861	4.1754	2	2	3	5	8
77	1,112	7.1772	2	3	6	9	14
78	1,388	4.5779	2	2	4	6	8
79	899	3.4370	1	2	3	4	6
80	2,109	4.8807	1	2	4	6	9
81	8,355	3.4116	1	2	3	4	6
82	1,675	6.4225	1	1	4	9	15
83	2,083	5.2018	1	2	4	7	10
84	2,538	3.0977	1	1	2	4	6
85	5,392	7.9164	2	3	6	10	16
86	10,952	5.0955	1	3	4	6	9
87	11,869	3.3660	1	2	3	4	6
88	732	6.1274	1	3	4	7	12
89	2,839	3.7800	1	2	3	5	7
90	3,290	2.4551	1	1	2	3	5
91	6,782	6.5786	2	3	5	8	13
92	15,510	4.4400	1	2	4	5	8
93	15,104	3.2086	1	2	3	4	6
94	1,543	12.5251	4	7	11	16	23
95	1,104	9.1098	3	5	8	12	16
96	754	6.1680	2	3	5	8	11
97	1,274	11.8508	4	6	10	16	22
98	1,068	8.5052	3	5	7	11	15
99	641	6.2684	2	3	5	8	11
100	16,087	6.2910	2	3	5	8	12
101	57,584	3.7147	1	2	3	5	7
102	1,379	5.0736	1	2	3	6	10
103	15,278	3.2312	1	2	3	4	6
113	598	5.5321	1	2	4	7	11
114	601	2.6588	1	1	2	3	5
115	1,124	4.4811	1	2	4	5	8
116	748	3.4154	1	1	2	4	6
117	1,558	1.9488	1	1	1	1	2
121	612	5.8164	2	3	5	7	11
122	671	4.0511	1	2	3	5	7
123	2,879	2.9292	1	2	2	4	5
124	687	5.2617	1	2	4	6	10

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
125	4,779	3.4889	1	2	3	4	7
129	1,407	5.0928	1	2	4	6	10
130	1,072	3.1502	1	1	2	4	6
131	904	5.7709	1	2	4	7	11
132	918	2.6312	1	1	2	3	5
133	2,062	5.8060	1	2	4	7	12
134	3,797	2.1470	1	1	1	2	4
135	431	6.4419	1	2	5	8	13
136	504	2.5516	1	1	1	3	6
137	848	5.3554	1	2	4	7	11
138	931	2.4391	1	1	2	3	5
139	1,721	1.7952	1	1	1	2	3
146	702	10.3233	2	4	7	13	19
147	1,467	5.7570	1	2	4	7	11
148	939	3.5184	1	1	2	4	7
149	39,649	2.7318	1	1	2	3	5
150	946	5.4508	1	2	4	7	11
151	6,859	2.8897	1	1	2	4	5
152	2,377	4.7012	1	2	4	6	9
153	16,251	3.3586	1	2	3	4	6
154	1,865	6.4604	2	3	5	8	12
155	4,447	4.5269	1	2	4	6	8
156	4,998	3.1613	1	2	3	4	6
157	1,169	6.8720	2	3	5	9	14
158	3,177	4.4338	1	2	3	6	8
159	2,384	3.0715	1	1	2	4	6
163	13,518	14.9887	5	8	13	19	27
164	18,509	8.3443	3	5	7	10	15
165	14,288	5.3509	2	3	5	7	9
166	20,428	13.0045	4	7	10	16	24
167	21,107	8.1304	3	4	7	10	15
168	5,566	5.3600	1	2	4	7	10
175	12,045	7.4063	3	4	6	9	13
176	40,393	5.5083	2	4	5	7	9
177	57,709	9.1913	3	5	8	12	17
178	72,756	7.4385	3	4	6	9	13
179	26,648	5.6435	2	3	5	7	10
180	22,681	7.9583	2	4	6	10	15
181	32,515	5.9571	2	3	5	8	12
182	6,137	4.2633	1	2	3	6	8
183	1,683	7.1768	2	4	6	9	14
184	4,287	4.6476	2	3	4	6	8
185	2,616	3.2524	1	2	3	4	6
186	8,607	7.5299	2	4	6	10	14

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
187	10,397	5.4614	2	3	4	7	11
188	4,873	4.1095	1	2	3	5	8
189	105,233	6.2370	2	3	5	8	11
190	57,533	6.4769	2	3	5	8	12
191	126,916	5.0839	2	3	4	6	9
192	194,511	4.0376	2	2	3	5	7
193	88,975	6.8748	2	4	6	9	13
194	274,931	5.3303	2	3	5	7	9
195	143,367	4.1461	2	2	4	5	7
196	5,190	7.3424	2	4	6	9	14
197	7,120	5.4098	2	3	5	7	10
198	4,857	4.2758	1	2	4	5	8
199	3,289	8.5018	3	4	7	11	16
200	8,332	5.1418	1	2	4	7	10
201	3,477	4.0916	1	2	3	5	8
202	33,053	4.4693	2	2	4	6	8
203	41,262	3.4712	1	2	3	4	6
204	26,393	2.8814	1	1	2	4	5
205	5,841	5.6256	1	3	4	7	11
206	22,713	3.4881	1	2	3	4	7
207	46,696	14.9666	6	9	13	18	25
208	80,038	7.2763	1	3	6	10	14
215	154	12.0260	1	2	7	16	34
216	8,460	18.6820	8	11	16	23	32
217	7,967	12.2103	6	8	11	15	20
218	2,970	9.0567	5	6	8	11	14
219	10,122	14.4709	6	8	11	18	27
220	14,319	8.5997	5	6	7	10	14
221	7,663	6.4206	4	5	6	7	9
222	2,869	13.2588	5	7	11	17	24
223	5,784	6.5683	1	3	6	9	12
224	1,931	11.5132	4	6	9	14	22
225	5,895	5.7509	2	3	5	7	11
226	7,086	9.4049	1	3	8	13	19
227	50,886	2.7659	1	1	1	3	7
228	3,103	14.6322	6	8	12	18	26
229	4,361	9.0317	4	6	8	11	15
230	1,804	6.5506	3	4	6	8	11
231	1,485	13.2042	5	7	11	16	24
232	1,800	8.9917	5	6	8	11	14
233	17,013	14.2907	7	9	12	17	24
234	39,434	8.8844	5	6	8	10	13
235	9,687	11.4952	5	7	9	14	21
236	33,062	6.6047	4	5	6	8	10

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
237	23,038	11.1783	2	5	9	14	22
238	44,047	4.8558	1	2	4	7	10
239	13,928	15.5736	5	8	12	19	29
240	13,892	10.5067	3	6	8	13	19
241	2,933	6.9207	3	4	6	8	13
242	17,269	8.9297	3	4	7	11	17
243	40,665	5.1161	1	2	4	7	10
244	66,031	2.9236	1	1	2	4	6
245	6,100	3.2570	1	1	2	4	7
246	41,369	5.4900	1	2	4	7	12
247	273,395	2.2293	1	1	1	3	5
248	5,567	6.1648	1	2	5	8	13
249	29,411	2.5265	1	1	2	3	5
250	5,786	7.5358	1	3	6	10	15
251	40,107	2.9564	1	1	2	4	6
252	44,977	8.7562	1	3	6	12	19
253	52,589	6.0291	1	2	4	8	13
254	54,137	2.8061	1	1	2	4	6
255	2,631	9.9444	2	4	8	13	19
256	3,964	7.5188	2	4	6	10	14
257	695	4.9395	1	2	4	7	10
258	604	7.5710	2	3	6	10	15
259	7,390	2.6352	1	1	2	3	6
260	873	10.2099	2	4	8	13	21
261	2,926	3.9415	1	1	3	5	8
262	3,298	2.4562	1	1	2	3	5
263	793	5.4823	1	1	4	8	12
264	30,375	9.0225	1	3	6	12	19
280	61,214	7.4518	2	4	6	9	14
281	62,199	4.8944	2	3	4	6	9
282	57,400	3.2473	1	1	3	4	6
283	16,074	5.4700	1	1	3	7	12
284	5,105	3.4644	1	1	2	4	7
285	3,017	2.2286	1	1	1	3	5
286	23,416	7.0662	2	3	6	9	14
287	173,552	3.1960	1	1	2	4	6
288	3,271	12.2393	4	7	10	15	22
289	1,477	8.7390	3	5	7	11	15
290	449	6.6540	2	3	5	8	12
291	185,221	6.6250	2	3	5	8	13
292	245,842	4.9694	2	3	4	6	9
293	201,752	3.6863	1	2	3	5	6
294	1,757	5.5435	2	3	5	7	9
295	1,633	4.3838	2	3	4	6	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
296	1,849	3.2595	1	1	1	4	8
297	897	1.9406	1	1	1	2	4
298	522	1.4489	1	1	1	1	2
299	17,629	6.8540	2	3	6	9	13
300	49,709	5.1087	2	3	4	7	9
301	37,931	3.7859	1	2	3	5	7
302	7,954	4.3585	1	2	3	5	8
303	82,241	2.5502	1	1	2	3	5
304	2,137	5.2303	1	2	4	7	10
305	36,235	2.8712	1	1	2	4	5
306	1,393	6.4830	2	3	5	8	12
307	6,517	3.4997	1	2	3	4	7
308	33,848	5.7543	1	3	4	7	11
309	85,559	3.9165	1	2	3	5	7
310	156,708	2.7567	1	1	2	4	5
311	25,370	2.3401	1	1	2	3	4
312	170,871	3.1499	1	2	3	4	6
313	223,238	2.1145	1	1	2	3	4
314	60,733	7.1134	2	3	5	9	14
315	33,454	4.5725	1	2	4	6	9
316	18,221	3.0111	1	1	2	4	6
326	11,638	17.2269	6	9	14	22	32
327	11,374	10.2860	3	6	9	13	19
328	9,012	4.4444	1	2	3	6	9
329	48,463	15.9021	6	9	13	20	29
330	68,609	9.8383	4	6	8	12	17
331	29,683	6.0198	3	4	5	7	10
332	1,899	14.7387	6	8	12	18	26
333	6,507	8.9062	4	6	8	10	15
334	3,760	5.5993	2	4	5	7	9
335	7,204	14.3612	6	8	12	18	25
336	12,829	9.2615	3	5	8	12	16
337	8,655	5.6547	1	3	5	8	11
338	1,517	10.8864	4	6	9	14	19
339	3,296	7.1173	3	4	6	9	12
340	3,557	4.2751	2	2	4	6	7
341	879	7.2608	2	3	5	10	15
342	2,668	4.2975	1	2	3	6	8
343	6,825	2.2682	1	1	2	3	4
344	899	12.0022	4	6	9	15	23
345	3,098	7.2494	3	4	6	9	12
346	2,766	4.9869	2	3	5	6	8
347	1,577	8.3621	2	4	7	11	16
348	4,310	5.4832	1	2	4	7	11

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
349	5,554	3.0422	1	1	2	4	6
350	1,802	8.0522	2	4	6	11	16
351	4,671	4.5384	1	2	4	6	9
352	8,873	2.4406	1	1	2	3	5
353	3,082	8.7554	2	4	7	11	17
354	9,068	5.0871	1	3	4	7	9
355	16,686	2.8741	1	1	2	4	5
356	8,432	13.2866	3	6	10	17	26
357	8,349	8.0433	2	4	6	10	16
358	2,482	4.5864	1	2	4	6	9
368	3,078	6.6334	2	3	5	8	13
369	4,865	4.5727	2	3	4	6	8
370	3,113	3.3837	1	2	3	4	6
371	16,988	8.7626	3	4	7	11	17
372	23,793	6.8007	2	4	6	8	13
373	14,261	5.0064	2	3	4	6	9
374	9,560	8.8091	2	4	7	11	17
375	20,262	6.0325	2	3	5	8	11
376	4,554	4.0862	1	2	3	5	8
377	50,940	6.4763	2	3	5	8	12
378	119,194	4.4546	2	3	4	6	8
379	95,794	3.4227	1	2	3	4	6
380	2,940	7.2202	2	4	5	9	14
381	5,711	5.1154	2	3	4	6	9
382	4,694	3.6166	1	2	3	5	6
383	1,311	5.8562	2	3	5	7	11
384	8,755	3.8483	1	2	3	5	7
385	2,119	9.0047	3	4	7	11	18
386	7,460	5.7384	2	3	5	7	11
387	5,117	4.4158	2	2	4	6	8
388	18,446	7.4271	2	3	6	9	14
389	47,969	5.0467	2	3	4	6	9
390	47,176	3.5860	1	2	3	4	6
391	47,998	5.4705	2	2	4	7	11
392	309,576	3.5460	1	2	3	4	7
393	24,127	6.9736	2	3	5	9	14
394	48,220	4.8901	1	2	4	6	9
395	24,889	3.3693	1	2	3	4	6
405	3,961	17.3051	5	8	13	22	34
406	5,427	9.4785	2	5	8	12	18
407	2,201	5.4683	1	3	5	7	10
408	1,686	15.0856	6	8	12	19	28
409	1,775	9.9041	4	6	8	12	17
410	696	6.8038	3	4	6	8	11

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
411	986	13.1239	5	7	11	16	23
412	1,100	8.8135	4	5	8	11	15
413	855	6.0458	2	4	5	8	10
414	5,653	11.8583	5	7	10	15	21
415	7,175	7.6965	3	5	7	9	13
416	6,049	4.8541	2	3	4	6	8
417	16,760	8.4056	3	4	7	10	16
418	28,699	5.6203	2	3	5	7	10
419	37,545	3.1565	1	1	3	4	6
420	739	14.2182	3	6	11	18	27
421	1,120	7.8479	2	3	6	10	16
422	362	4.4680	1	2	4	6	8
423	1,536	15.5134	4	7	12	20	29
424	939	10.2495	3	5	8	13	19
425	150	5.6149	1	3	5	7	10
432	16,502	6.8906	2	3	5	8	13
433	9,190	4.8530	1	2	4	6	9
434	951	3.5768	1	2	3	5	6
435	12,049	7.6790	2	3	6	10	15
436	14,223	5.8718	2	3	5	8	11
437	4,332	4.3679	1	2	3	6	9
438	14,544	7.7403	2	3	6	10	16
439	26,026	5.4173	2	3	4	7	10
440	26,628	3.8636	1	2	3	5	7
441	14,101	7.0004	2	3	5	9	14
442	13,238	5.1119	2	3	4	6	10
443	6,508	3.8369	1	2	3	5	7
444	12,603	6.6379	2	3	5	8	13
445	17,466	4.7804	2	2	4	6	9
446	16,635	3.3170	1	2	3	4	6
453	854	15.9027	6	8	13	20	28
454	1,710	8.3647	3	4	6	10	15
455	1,721	4.7391	2	3	4	6	8
456	772	15.8846	5	7	12	19	30
457	2,089	7.8140	3	4	6	9	14
458	1,289	4.6337	2	3	4	6	7
459	3,217	9.6149	4	5	7	11	18
460	51,397	4.3318	2	3	4	5	7
461	1,073	8.4762	4	5	7	9	15
462	14,339	4.2905	3	3	4	5	7
463	5,325	16.8522	5	7	12	21	33
464	6,596	10.3724	3	5	8	13	20
465	2,753	6.1608	1	3	5	8	12
466	3,917	9.4940	3	5	7	11	18

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
467	14,368	5.6062	3	3	4	6	9
468	21,516	4.0483	3	3	4	5	6
469	29,924	8.4449	3	5	7	10	15
470	414,313	4.0233	3	3	4	4	6
471	2,244	10.1173	2	4	8	13	20
472	6,654	4.3227	1	1	3	6	10
473	22,740	1.9847	1	1	1	2	4
474	2,864	12.5383	4	6	10	16	24
475	3,719	8.5570	3	4	7	11	16
476	1,566	4.9635	1	2	4	6	10
477	2,264	12.5080	4	6	10	15	23
478	7,389	6.8456	1	3	6	9	14
479	10,143	2.8312	1	1	1	4	7
480	26,057	9.4641	4	5	8	11	17
481	74,787	5.9956	3	4	5	7	9
482	49,933	4.8792	3	4	4	6	7
483	6,585	4.3756	2	2	3	5	8
484	17,391	2.4770	1	2	2	3	4
485	1,157	12.4541	5	7	10	15	23
486	2,070	8.1209	3	5	7	10	14
487	1,350	5.7587	3	4	5	7	10
488	2,548	5.0916	2	3	4	6	9
489	6,227	3.0966	1	2	3	4	5
490	21,725	4.7077	1	2	3	6	10
491	57,817	2.2583	1	1	2	3	4
492	4,772	8.7485	3	5	7	11	16
493	16,865	5.3415	2	3	4	7	9
494	29,549	3.3618	1	2	3	4	6
495	1,895	11.0768	3	5	8	14	21
496	5,514	5.9973	2	3	5	8	11
497	7,223	3.1410	1	1	2	4	6
498	1,262	8.2075	2	3	6	10	15
499	1,176	3.1422	1	1	2	4	6
500	1,364	11.2693	3	5	8	14	21
501	3,962	5.9171	2	3	5	7	12
502	6,678	2.9232	1	1	2	3	6
503	745	8.8694	2	4	7	11	17
504	2,281	6.4435	2	3	5	8	12
505	3,170	3.3561	1	1	3	4	7
506	932	3.2432	1	1	2	4	7
507	841	5.1726	1	2	4	6	10
508	2,736	2.0217	1	1	2	2	4
509	681	2.8383	1	1	2	3	6
510	996	6.6087	2	3	5	8	12

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
511	4,189	3.9410	1	2	3	5	7
512	12,149	2.1159	1	1	2	3	4
513	1,110	5.1250	1	2	4	7	10
514	1,187	2.5940	1	1	2	3	5
515	3,603	10.8592	3	5	9	14	20
516	11,526	5.9497	1	3	5	8	11
517	17,984	2.8981	1	1	2	4	7
533	840	6.8864	2	3	5	9	13
534	3,667	4.0041	1	2	3	5	7
535	6,910	6.3778	2	3	5	8	12
536	34,621	3.9732	1	3	3	5	7
537	696	4.6657	2	3	4	6	8
538	1,140	3.1150	1	2	3	4	5
539	3,422	10.2180	3	5	8	12	19
540	4,343	7.2446	3	4	6	9	13
541	1,809	5.6586	2	3	5	7	10
542	6,210	8.7037	3	4	7	11	17
543	18,875	5.9810	2	3	5	7	11
544	12,411	4.4645	2	3	4	6	8
545	4,078	9.0047	2	4	7	11	18
546	6,186	5.5263	2	3	4	7	10
547	4,746	3.9204	1	2	3	5	7
548	597	9.3137	3	4	7	11	17
549	1,151	6.2279	2	3	5	8	11
550	868	4.5088	1	3	4	6	8
551	9,600	7.2310	2	3	6	9	14
552	88,827	4.1724	1	2	3	5	7
553	2,835	6.0790	2	3	5	7	11
554	20,589	3.7203	1	2	3	5	7
555	2,011	4.9083	1	2	4	6	10
556	19,394	3.1832	1	2	3	4	6
557	3,207	6.9418	2	4	6	8	13
558	14,373	4.2654	2	2	4	5	7
559	1,658	7.3092	2	3	5	9	14
560	4,230	4.7453	1	2	4	6	9
561	7,478	2.7344	1	1	2	3	5
562	5,065	6.5166	2	3	5	8	12
563	36,518	3.7146	1	2	3	4	6
564	1,633	7.1141	2	3	5	9	14
565	3,411	5.1043	2	3	4	6	9
566	2,695	3.7195	1	2	3	5	7
573	5,730	13.8472	4	6	10	16	28
574	12,495	9.5050	3	5	7	11	18
575	6,238	5.9317	2	3	5	7	10

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
576	563	12.1226	2	4	8	15	26
577	2,311	6.0022	1	2	4	8	12
578	3,238	3.4145	1	1	2	4	7
579	3,366	11.0955	3	5	8	14	22
580	11,047	5.4644	1	2	4	7	12
581	12,294	2.5715	1	1	2	3	6
582	5,804	2.8655	1	1	2	3	6
583	9,404	1.8207	1	1	1	2	3
584	802	5.7129	1	2	4	8	12
585	1,709	2.1908	1	1	1	2	4
592	4,054	8.8697	3	4	7	11	16
593	13,169	6.4859	2	4	5	8	11
594	2,863	4.8992	2	3	4	6	9
595	1,096	8.1848	2	4	6	10	16
596	5,816	4.8319	2	2	4	6	9
597	565	8.1924	2	3	6	10	14
598	1,523	5.5806	2	3	4	7	10
599	359	3.6082	1	1	3	4	6
600	612	5.3781	2	3	4	7	10
601	843	3.8038	1	2	3	5	7
602	21,567	7.0322	2	4	6	9	13
603	132,865	4.7352	2	3	4	6	8
604	2,664	5.4212	1	3	4	7	10
605	23,070	3.4788	1	2	3	4	6
606	1,380	5.8848	1	2	4	7	11
607	7,290	3.7550	1	2	3	5	7
614	1,434	7.2972	2	3	5	8	14
615	1,596	3.3733	1	2	3	4	6
616	1,151	15.5480	6	8	13	19	27
617	6,965	9.0012	3	5	8	11	16
618	271	6.0970	2	3	5	8	11
619	675	9.2815	3	4	6	10	21
620	2,010	4.2210	2	2	3	5	7
621	6,570	2.4256	1	1	2	3	4
622	1,242	13.2047	4	6	9	16	27
623	3,403	8.6979	3	5	7	10	15
624	393	5.8852	2	3	5	7	10
625	1,110	7.5343	2	2	5	9	17
626	2,754	3.2536	1	1	2	4	7
627	14,220	1.5421	1	1	1	2	2
628	3,305	11.8138	2	4	9	15	24
629	4,148	8.8483	3	5	7	11	16
630	552	5.1379	1	2	4	7	10
637	16,527	6.1871	2	3	5	7	12

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
638	46,959	4.2747	1	2	3	5	8
639	36,496	3.0760	1	2	3	4	6
640	56,340	5.6229	1	2	4	7	11
641	190,108	3.8600	1	2	3	5	7
642	1,589	5.2780	1	2	4	6	10
643	5,101	7.7768	2	4	6	10	15
644	12,255	5.4336	2	3	4	7	10
645	8,194	3.9185	1	2	3	5	7
652	10,721	7.8878	4	5	6	9	13
653	1,591	16.7536	6	9	13	20	31
654	3,392	10.0608	5	7	8	12	17
655	1,517	6.5971	3	4	7	8	10
656	3,746	10.7713	4	5	8	13	21
657	7,960	6.0560	3	4	5	7	10
658	7,978	3.8343	2	3	4	5	6
659	4,490	11.3196	3	5	8	14	22
660	8,000	6.5269	2	3	5	8	13
661	4,278	3.3237	1	2	3	4	6
662	1,007	10.5180	2	4	8	13	21
663	2,297	5.2587	1	2	4	7	11
664	4,568	2.0629	1	1	1	2	4
665	693	12.1688	3	6	10	15	22
666	2,406	6.3360	1	2	4	9	14
667	3,777	2.6993	1	1	2	3	6
668	3,775	8.6210	2	4	7	11	17
669	13,328	4.3579	1	2	3	6	9
670	12,728	2.4749	1	1	2	3	5
671	918	5.7961	1	2	4	8	12
672	943	2.4862	1	1	2	3	5
673	12,702	10.1687	1	3	7	13	22
674	13,867	6.5518	1	2	4	9	14
675	8,401	1.9467	1	1	1	2	4
682	76,732	7.3062	2	3	6	9	14
683	128,569	5.6890	2	3	5	7	10
684	28,562	3.8061	1	2	3	5	7
685	2,527	3.4998	1	1	2	4	7
686	1,602	8.0589	2	4	6	10	15
687	3,478	5.2671	1	2	4	7	10
688	1,109	3.2229	1	1	2	4	6
689	56,092	6.3682	2	3	5	8	12
690	202,328	4.2998	2	2	4	5	8
691	910	4.1474	1	2	3	5	9
692	655	2.2508	1	1	2	3	4
693	2,262	5.1834	1	2	4	7	10

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
694	19,406	2.5707	1	1	2	3	5
695	992	5.7202	2	3	4	7	11
696	10,693	3.2297	1	2	3	4	6
697	588	3.3111	1	1	2	4	6
698	21,307	6.7858	2	3	5	8	13
699	27,179	4.8652	1	2	4	6	9
700	11,199	3.4601	1	2	3	4	7
707	6,060	4.5306	2	2	3	5	8
708	16,051	2.3801	1	1	2	3	4
709	796	6.4598	1	1	3	8	15
710	2,019	1.8983	1	1	1	2	3
711	956	7.8312	1	3	6	10	16
712	798	2.9533	1	1	2	3	7
713	12,037	4.1562	1	2	3	5	9
714	32,775	1.9941	1	1	2	2	3
715	665	6.0695	1	2	4	8	14
716	1,378	1.4989	1	1	1	1	2
717	671	7.5195	1	3	5	9	15
718	604	2.6794	1	1	2	3	5
722	887	7.4415	2	3	6	9	14
723	2,096	5.3802	2	3	4	7	10
724	657	3.3380	1	1	3	4	6
725	814	5.6609	2	3	4	7	11
726	3,986	3.5251	1	2	3	4	6
727	1,111	6.5452	2	3	5	8	12
728	6,264	4.0490	1	2	3	5	7
729	604	5.1327	1	2	4	7	10
730	537	3.1857	1	1	2	4	6
734	1,530	7.5975	3	4	5	9	15
735	1,284	3.4875	1	2	3	4	6
736	847	13.9062	5	8	12	17	25
737	3,495	7.3976	3	4	6	9	13
738	918	3.9344	2	3	4	5	6
739	981	10.2071	4	5	7	13	20
740	4,653	5.1719	2	3	4	6	9
741	6,363	3.1178	2	2	3	4	5
742	11,722	4.5771	2	2	3	5	8
743	34,864	2.3419	1	2	2	3	3
744	1,639	5.7572	1	2	4	7	12
745	2,100	2.5449	1	1	2	3	5
746	2,675	4.0979	1	2	3	5	8
747	11,131	1.9143	1	1	2	2	3
748	21,423	1.8025	1	1	1	2	3
749	1,050	9.8475	2	4	7	13	21

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
750	479	3.3103	1	2	3	4	6
754	1,102	8.8578	2	4	6	11	18
755	3,248	5.6431	1	2	4	7	11
756	806	3.2886	1	1	2	4	6
757	1,329	8.9057	3	4	7	11	17
758	1,666	6.0838	2	3	5	7	11
759	1,151	4.5863	2	2	4	6	8
760	1,825	3.7577	1	2	3	5	7
761	1,882	2.4767	1	1	2	3	5
765	2,623	5.2840	2	3	4	5	8
766	2,675	3.2388	2	2	3	4	4
767	123	2.8537	1	2	2	3	5
768	10	5.8000	2	3	4	8	9
769	88	5.6782	1	2	3	6	11
770	188	2.6330	1	1	1	2	6
774	1,493	3.2390	2	2	2	3	4
775	5,378	2.3207	1	2	2	3	3
776	499	3.5524	1	2	2	4	7
777	181	2.0608	1	1	2	3	3
778	497	2.7591	1	1	2	3	5
779	107	2.6449	1	1	1	2	4
780	50	2.6600	1	1	1	1	3
781	3,082	3.8501	1	1	3	4	7
782	129	2.7752	1	1	1	2	5
790	1	65.0000	65	65	65	65	65
793	1	7.0000	7	7	7	7	7
799	631	14.2979	4	7	11	19	28
800	731	8.2312	3	4	6	10	17
801	581	4.8451	2	2	4	6	9
802	696	12.9164	3	6	10	16	26
803	1,032	6.5325	1	3	5	8	13
804	979	3.2444	1	1	2	4	7
808	8,292	7.9993	2	4	6	10	15
809	15,830	5.0060	2	2	4	6	9
810	3,710	3.9202	1	2	3	5	7
811	18,558	5.5472	1	2	4	7	11
812	84,150	3.7268	1	2	3	5	7
813	15,199	5.1973	1	2	4	6	10
814	1,655	7.1680	2	3	5	9	15
815	3,494	4.9013	1	2	4	6	9
816	2,289	3.3961	1	2	3	4	6
820	1,492	18.4047	5	8	14	24	36
821	2,598	7.7857	1	3	6	10	16
822	2,119	3.6957	1	1	3	5	8

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
823	2,456	15.3824	5	8	13	19	28
824	3,136	8.7831	2	4	7	12	17
825	1,946	4.7330	1	2	3	6	10
826	566	17.3852	5	8	13	22	34
827	1,355	7.5495	2	4	6	9	15
828	853	3.7051	1	2	3	5	7
829	1,389	10.4658	2	4	7	14	22
830	524	3.5462	1	1	2	4	7
834	5,306	14.6560	2	4	9	23	35
835	1,459	8.1996	1	3	5	9	20
836	1,561	5.0528	1	2	3	6	10
837	1,641	22.6943	5	9	23	30	39
838	942	9.0446	3	4	5	7	25
839	1,371	6.0687	3	4	5	6	8
840	15,295	9.5887	2	4	7	12	20
841	11,381	6.5776	2	3	5	8	13
842	7,469	4.2783	1	2	3	6	8
843	1,501	8.7016	2	4	7	11	17
844	2,900	6.0297	2	3	5	8	12
845	997	4.2753	1	2	3	5	8
846	2,504	8.4896	2	3	5	10	19
847	23,868	3.2756	1	2	3	4	6
848	1,704	2.9316	1	1	2	4	5
849	1,515	5.9874	1	3	4	6	12
853	31,699	16.7841	5	8	13	21	31
854	6,958	11.1833	4	6	9	14	20
855	429	7.3077	2	4	6	10	14
856	6,230	16.1966	5	7	12	20	32
857	10,308	8.8878	3	4	7	11	17
858	3,375	5.9762	2	3	5	7	11
862	7,498	8.3120	2	4	6	10	16
863	22,027	5.2255	2	3	4	7	9
864	20,089	4.1010	1	2	3	5	7
865	2,035	6.8455	2	3	5	8	14
866	9,506	3.5183	1	2	3	4	6
867	5,408	9.8846	3	4	7	13	19
868	2,523	5.9071	2	3	5	7	10
869	1,155	4.3735	2	2	3	5	8
870	13,968	15.2784	6	8	13	19	26
871	205,298	7.6922	2	4	6	10	15
872	92,712	5.7913	2	3	5	7	10
876	981	11.3738	1	4	8	14	23
880	10,771	3.2201	1	1	2	4	6
881	5,083	4.1506	1	2	3	5	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
882	1,825	4.4489	1	2	3	5	7
883	841	7.4118	1	2	4	8	13
884	23,580	5.4065	2	3	4	6	9
885	83,653	7.6171	2	3	6	9	13
886	414	5.9390	1	2	4	6	9
887	446	4.5925	1	2	3	5	8
894	5,079	2.9767	1	1	2	3	4
895	10,306	10.5223	3	4	6	8	9
896	5,570	6.6093	2	3	5	8	12
897	39,332	4.1198	1	2	3	5	6
901	925	14.4242	3	5	9	17	30
902	2,220	7.9436	2	3	6	9	16
903	1,691	4.8673	1	2	4	6	10
904	984	12.2029	2	4	7	13	22
905	787	4.7253	1	2	4	6	8
906	754	3.2943	1	1	2	4	6
907	8,177	11.6843	3	5	8	14	24
908	8,576	6.8610	2	3	5	8	13
909	5,449	3.5868	1	1	3	5	7
913	836	6.1739	2	3	5	8	12
914	7,129	3.3884	1	2	3	4	6
915	932	4.6541	1	2	3	6	10
916	5,442	2.1384	1	1	2	3	4
917	14,534	5.1977	1	2	4	6	11
918	35,238	2.7248	1	1	2	3	5
919	10,709	6.2394	1	3	4	8	13
920	14,309	4.3065	1	2	3	5	8
921	9,716	2.9383	1	1	2	4	5
922	1,034	6.0448	1	2	4	8	13
923	4,313	3.2778	1	1	2	4	6
927	188	28.7861	9	15	25	38	52
928	826	16.1693	4	8	13	20	31
929	454	7.6987	2	3	6	11	15
933	160	5.9114	1	1	2	6	12
934	709	6.8459	1	3	5	8	13
935	2,231	5.5423	1	2	4	7	11
939	435	10.9206	2	4	8	14	22
940	735	6.4044	1	3	5	8	14
941	1,065	3.0321	1	1	2	4	6
945	6,307	10.2789	4	6	8	11	14
946	3,998	7.8844	3	5	6	7	8
947	6,629	4.9880	1	2	4	6	10
948	34,805	3.4130	1	2	3	4	6
949	857	4.1317	1	1	2	4	7

DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
950	519	3.4320	1	1	2	4	5
951	1,019	3.7708	1	1	2	3	6
955	457	12.2105	2	6	10	16	23
956	3,773	9.4954	4	5	7	11	18
957	1,326	16.0023	2	7	13	20	30
958	1,227	10.4857	3	6	9	13	19
959	298	6.0949	2	3	5	8	10
963	1,516	9.2677	1	4	7	13	19
964	2,543	6.2813	2	3	5	8	11
965	1,109	4.1285	1	2	3	5	8
969	679	18.7115	5	8	14	23	37
970	160	9.4654	2	4	7	12	20
974	6,395	10.4471	2	4	7	13	21
975	4,561	7.2542	2	3	5	9	14
976	2,825	4.8614	1	2	4	6	8
977	5,119	5.2595	1	2	4	6	10
981	26,495	15.2659	5	8	12	19	28
982	19,350	9.9611	3	5	8	13	19
983	6,154	5.3856	1	2	4	7	11
984	671	14.5768	5	8	13	18	27
985	1,110	9.7085	2	5	9	13	18
986	836	5.1092	1	2	3	7	11
987	8,060	13.1893	4	6	11	17	25
988	12,328	7.9772	2	4	7	10	15
989	6,176	4.1332	1	1	3	6	9
999	17	2.7333	1	2	8	18	24
	11,795,587						

TABLE 8A.--STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS--JULY 2007

State	Urban	Rural
Alabama	0.257	0.337
Alaska	0.421	0.751
Arizona	0.282	0.404
Arkansas	0.333	0.356
California	0.227	0.328
Colorado	0.289	0.443
Connecticut	0.411	0.526
Delaware	0.494	0.514
District of Columbia*	0.352	----

State	Urban	Rural
Florida	0.244	0.287
Georgia	0.337	0.391
Hawaii	0.376	0.45
Idaho	0.473	0.541
Illinois	0.312	0.4
Indiana	0.401	0.455
Iowa	0.369	0.448
Kansas	0.292	0.438
Kentucky	0.376	0.375
Louisiana	0.301	0.355
Maine	0.492	0.466
Maryland	0.732	0.794
Massachusetts*	0.475	----
Michigan	0.369	0.457
Minnesota	0.384	0.524
Mississippi	0.308	0.37
Missouri	0.328	0.37
Montana	0.423	0.49
Nebraska	0.342	0.455
Nevada	0.221	0.475
New Hampshire	0.453	0.465
New Jersey*	0.183	----
New Mexico	0.383	0.376
New York	0.356	0.523
North Carolina	0.43	0.414
North Dakota	0.43	0.473
Ohio	0.354	0.531
Oklahoma	0.304	0.391
Oregon	0.462	0.418
Pennsylvania	0.271	0.428
Puerto Rico*	0.455	----
Rhode Island*	0.391	----
South Carolina	0.283	0.314
South Dakota	0.346	0.441
Tennessee	0.306	0.379
Texas	0.26	0.344
Utah	0.42	0.566
Vermont	0.54	0.637
Virginia	0.361	0.364

State	Urban	Rural
Washington	0.397	0.448
West Virginia	0.476	0.471
Wisconsin	0.425	0.475
Wyoming	0.431	0.571

[*]All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals are located in those areas as of July 2007.

TABLE 8B.--STATEWIDE AVERAGE CAPITAL
COST-TO-CHARGE RATIOS--JULY 2007

State	Ratio
Alabama	0.024
Alaska	0.037
Arizona	0.024
Arkansas	0.026
California	0.015
Colorado	0.029
Connecticut	0.029
Delaware	0.035
District of Columbia	0.023
Florida	0.023
Georgia	0.029
Hawaii	0.03
Idaho	0.039
Illinois	0.025
Indiana	0.037
Iowa	0.029
Kansas	0.03
Kentucky	0.029
Louisiana	0.027
Maine	0.033
Maryland	0.055
Massachusetts	0.032
Michigan	0.029
Minnesota	0.029
Mississippi	0.027
Missouri	0.027
Montana	0.036
Nebraska	0.039
Nevada	0.022
New Hampshire	0.035
New Jersey	0.013
New Mexico	0.032
New York	0.028
North Carolina	0.036
North Dakota	0.039
Ohio	0.029
Oklahoma	0.029

State	Ratio
Oregon	0.033
Pennsylvania	0.022
Puerto Rico	0.034
Rhode Island	0.02
South Carolina	0.025
South Dakota	0.032
Tennessee	0.03
Texas	0.026
Utah	0.035
Vermont	0.042
Virginia	0.036
Washington	0.031
West Virginia	0.033
Wisconsin	0.037
Wyoming	0.045

TABLE 8C.--STATEWIDE AVERAGE TOTAL
COST-TO-CHARGE RATIOS FOR LTCHS--JULY 2007

State	Urban	Rural
Alabama	0.279	0.368
Alaska	0.454	0.811
Arizona	0.306	0.435
Arkansas	0.356	0.388
California	0.241	0.349
Colorado	0.316	0.49
Connecticut	0.439	0.574
Delaware	0.528	0.553
District of Columbia*	0.374	----
Florida	0.266	0.318
Georgia	0.364	0.426
Hawaii	0.404	0.487
Idaho	0.512	0.585
Illinois	0.337	0.432
Indiana	0.438	0.499
Iowa	0.393	0.488
Kansas	0.318	0.479
Kentucky	0.405	0.405
Louisiana	0.328	0.383

State	Urban	Rural
Maine	0.526	0.495
Maryland**	0.444	0.347
Massachusetts*	0.506	----
Michigan	0.398	0.491
Minnesota	0.411	0.564
Mississippi	0.334	0.399
Missouri	0.353	0.403
Montana	0.454	0.533
Nebraska	0.378	0.502
Nevada	0.242	0.535
New Hampshire	0.487	0.502
New Jersey*	0.197	----
New Mexico	0.415	0.41
New York	0.383	0.559
North Carolina	0.466	0.45
North Dakota	0.465	0.52
Ohio	0.381	0.572
Oklahoma	0.332	0.424
Oregon	0.496	0.448
Pennsylvania	0.292	0.46
Puerto Rico*	0.489	----
Rhode Island*	0.411	----
South Carolina	0.307	0.341
South Dakota	0.375	0.479
Tennessee	0.336	0.412
Texas	0.285	0.375
Utah	0.453	0.62
Vermont	0.584	0.676
Virginia	0.4	0.401
Washington	0.428	0.48
West Virginia	0.509	0.504
Wisconsin	0.462	0.516
Wyoming	0.467	0.626

*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 2007.
**National average IPPS total cost-to-charge ratios, as discussed in section VI.E. of this final rule.

TABLE 9A.--HOSPITAL RECLASSIFICATIONS AND

REDESIGNATIONS - FY 2008

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
010005	01	26620	
010009	19460	26620	
010010	01	13820	
010012	01	40660	
010022	01	12060	LUGAR
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010044	01	13820	
010045	01	13820	
010054	19460	26620	
010059	19460	26620	
010065	01	13820	
010083	01	33660	
010085	19460	26620	
010090	33660	37700	
010100	01	37860	
010101	01	13820	LUGAR
010118	01	46220	
010126	01	33860	
010143	01	13820	
010150	01	33860	
010158	01	19460	
010164	01	11500	LUGAR
020008	02	11260	
030007	39140	22380	LUGAR
030033	03	22380	
030055	29420	39140	
030101	29420	29820	
040014	04	30780	
040017	04	22220	
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	26	
040041	04	30780	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
040069	04	32820	
040071	38220	30780	
040076	04	30780	LUGAR
040080	04	27860	
040085	04	32820	
040088	04	33740	
040091	04	45500	
040100	04	30780	
040119	04	30780	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	36084	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050129	40140	31084	
050133	49700	40900	
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050193	42044	31084	
050197	41884	36084	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	
050245	40140	31084	
050272	40140	31084	
050279	40140	31084	
050291	42220	41884	
050292	40140	42044	
050298	40140	31084	
050300	40140	31084	
050301	05	42220	
050327	40140	31084	
050329	40140	42044	
050348	42044	31084	
050367	46700	36084	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050476	05	42220	
050494	05	40900	
050510	41884	36084	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	36084	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050584	40140	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050609	42044	31084	
050616	37100	31084	
050667	34900	46700	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050720	42044	31084	
050749	37100	31084	
060001	24540	19740	
060003	14500	19740	
060012	39380	17820	
060023	24300	19740	
060027	14500	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070004	07	25540	
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
070011	07	25540	
070015	25540	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080001	48864	37964	
080003	48864	37964	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090011	47894	13644	
100002	48424	22744	
100014	19660	36740	
100017	19660	36740	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100047	39460	42260	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	42260	
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	
100109	10	36740	
100118	37380	27260	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100156	10	23540	
100157	29460	45300	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	23540	
100234	48424	22744	
100236	39460	42260	
100239	45300	42260	
100249	10	45300	
100252	10	42680	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100292	10	23020	LUGAR
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110095	11	10500	
110121	11	45220	
110122	46660	45220	
110125	11	31420	
110128	11	42340	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
110146	11	27260	
110150	11	12060	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
120028	12	26180	
130002	13	29	
130003	30300	28420	
130049	17660	44060	
130067	13	26820	LUGAR
140B10	29404	16974	
140012	14	16974	
140015	14	41180	
140032	14	41180	
140033	29404	16974	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140058	14	41180	
140064	14	37900	
140084	29404	16974	
140100	29404	16974	
140110	14	16974	
140130	29404	16974	
140143	14	16974	
140155	28100	16974	
140160	14	40420	
140161	14	16974	
140164	14	41180	
140186	28100	16974	
140202	29404	16974	
140233	40420	16974	
140291	29404	16974	
150002	23844	16974	
150004	23844	16974	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150023	45460	26900	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	14020	
150045	15	23060	
150048	15	17140	
150051	14020	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150090	23844	16974	
150091	15	23060	
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150115	15	21780	
150125	23844	16974	
150126	23844	16974	
150133	15	23060	
150146	15	23060	
150147	23844	16974	
160001	16	11180	
160016	16	11180	
160057	16	26980	
160064	16	47940	
160080	16	19340	
160089	16	26980	
160147	16	11180	
170006	17	27900	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170023	17	48620	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
170033	17	48620	
170058	17	28140	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
170190	17	45820	
170193	17	48620	
180002	18	49	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180019	18	17140	
180024	18	31140	
180027	18	17300	
180029	18	30460	
180044	18	26580	
180048	18	31140	
180049	18	30460	
180050	18	28700	
180066	18	34980	
180069	18	26580	
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	17300	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190086	19	33740	
190088	19	43340	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
190099	19	12940	
190106	19	10780	
190144	19	43340	
190164	19	45	
190167	19	29180	
190184	19	33740	
190191	19	29180	
190208	19	04	
190218	19	43340	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
200063	20	38860	
220008	39300	14484	
220010	37764	14484	
220020	39300	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220174	37764	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	11460	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	
230089	19804	11460	
230092	27100	11460	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	13020	
230106	24340	34740	
230119	19804	11460	
230121	23	29620	LUGAR
230130	47644	22420	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230222	23	13020	
230223	47644	22420	
230227	47644	19804	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
230236	24340	34740	
230244	19804	11460	
230254	47644	22420	
230257	47644	19804	
230264	47644	19804	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	11460	
240030	24	41060	
240064	24	20260	
240069	24	40340	
240071	24	40340	
240075	24	41060	
240088	24	41060	
240093	24	33460	
240187	24	33460	
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250044	25	22520	
250069	25	46220	
250078	25620	25060	
250079	25	27140	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
250104	25	46220	
250117	25	25060	LUGAR
260009	26	28140	
260015	26	27860	
260017	26	27620	
260022	26	16	
260025	26	41180	
260050	26	41140	
260064	26	17860	
260074	26	17860	
260094	26	44180	
260110	26	41180	
260113	26	14	
260119	26	27860	
260175	26	28140	
260183	26	41180	
260186	26	27620	
270003	27	24500	
270017	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280061	28	53	
280065	28	24540	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290019	16180	39900	
300001	30	31700	
300014	40484	31700	
300018	40484	31700	
300019	30	15764	
310002	35084	35644	
310009	35084	35644	
310013	35084	35644	
310014	15804	37964	
310015	35084	35644	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
310017	35084	35644	
310018	35084	35644	
310021	45940	35084	
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310039	20764	35644	
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	14860	
330027	35004	35644	
330049	39100	14860	
330067	39100	14860	
330073	33	40380	LUGAR
330079	33	47	
330085	33	45060	
330094	33	28740	
330103	33	39	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
330106	35004	35644	
330126	39100	35644	
330136	33	45060	
330157	33	45060	
330167	35004	35644	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330198	35004	35644	
330224	28740	39100	
330225	35004	35644	
330229	33	21500	
330235	33	45060	LUGAR
330239	33	21500	
330250	33	15540	
330259	35004	35644	
330277	33	27060	
330331	35004	35644	
330332	35004	35644	
330372	35004	35644	
330386	33	35084	
340004	24660	49180	
340008	34	16740	
340010	24140	39580	
340013	34	16740	
340015	34	16740	
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340050	34	22180	
340051	34	25860	
340068	34	48900	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
340091	24660	49180	
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340124	34	39580	LUGAR
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350003	35	13900	
350006	35	13900	
350009	35	22020	
360008	36	26580	
360010	36	15940	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	26580	
360065	36	45780	
360078	10420	17460	
360079	19380	17140	
360086	44220	19380	
360095	36	45780	
360096	36	49660	LUGAR
360107	36	45780	
360121	36	45780	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360245	36	17460	LUGAR
360253	19380	17140	
370004	37	27900	
370006	37	46140	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370022	37	30020	
370025	37	46140	
370026	37	36420	
370047	37	36420	
370049	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380050	38	32780	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	36	
390030	39	10900	
390031	39	39740	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	12580	
390066	30140	25420	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
390071	39	48700	LUGAR
390079	39	13780	
390086	39	27780	
390091	39	49660	
390093	39	38300	
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	25420	
390151	39	13644	
390162	10900	35084	
390246	39	48700	
390313	39	39740	LUGAR
400048	25020	41980	
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16770	
420027	11340	24860	
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420062	42	16740	
420067	42	42340	
420068	42	16700	
420069	42	44940	LUGAR
420071	42	24860	
420080	42	42340	
420083	43900	24860	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
420085	34820	48900	
420098	42	34820	
430012	43	43620	
430013	43	43620	
440002	27180	32820	
440008	44	27180	
440020	44	26620	
440024	17420	16860	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440060	44	27180	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440144	44	34980	
440148	44	34980	
440151	44	34980	
440175	44	34980	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	43340	
450039	23104	19124	
450059	41700	12420	
450064	23104	19124	
450080	45	30980	
450087	23104	19124	
450099	45	11100	
450135	23104	19124	
450137	23104	19124	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450196	45	19124	
450211	45	30980	
450214	45	26420	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450393	43300	19124	
450395	45	26420	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450563	23104	19124	
450596	45	23104	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450813	45	41700	
450830	45	36220	
450839	45	43340	
450872	23104	19124	
450880	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460011	46	39340	
460021	41100	29820	
460026	46	39340	
460039	46	30860	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	31340	
490018	49	16820	
490019	49	47894	
490042	13980	40220	
490079	49	49180	
490092	49	40060	
490097	49	40060	
490106	49	16820	
490109	47260	40060	
500002	50	28420	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
510001	34060	38300	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510030	51	34060	
510046	51	13980	
510047	51	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
510077	51	26580	
520002	52	48140	
520021	29404	16974	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	29404	
520071	52	33340	LUGAR
520076	52	31540	
520095	52	31540	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
520189	29404	16974	
530015	53	26820	

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT - FY 2008

Provider No.	Geographic CBSA	Redesignated Rural Area
050192	23420	05
050528	32900	05
050618	40140	05
100048	37860	10
100134	27260	10
140167	14	14
170137	29940	17
220051	38340	22
230078	35660	23
250017	25	25
250126	32820	25
260006	41140	26
260195	44180	26
330044	46540	33
330268	10580	33
360125	36	36

Provider No.	Geographic CBSA	Redesignated Rural Area
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390185	42540	39
390201	39	39
440135	34980	44
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
500148	48300	50

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 MEDICARE SEVERITY- DIAGNOSIS-RELATED GROUP (MS-DRG) JULY 2007[1]

MS-DRG	Number of Cases	Threshold
1	652	$344,972
2	335	$178,084
3	24,400	$248,259
4	21,825	$149,229
5	634	$167,704
6	296	$92,307
7	378	$134,547
8	583	$92,298
9	1,388	$97,039
10	182	$73,445
11	1,297	$71,635
12	1,956	$51,554
13	1,476	$36,941
20	910	$138,402
21	566	$108,066
22	249	$74,805
23	3,564	$81,024

MS-DRG	Number of Cases	Threshold
24	2,168	$57,356
25	8,493	$77,715
26	12,059	$52,351
27	14,191	$41,285
28	1,623	$74,169
29	3,089	$45,899
30	3,592	$30,000
31	1,061	$60,326
32	3,064	$35,479
33	4,237	$28,788
34	821	$58,372
35	2,911	$41,566
36	7,454	$36,543
37	4,803	$51,766
38	16,531	$32,789
39	53,619	$23,940
40	4,585	$57,541
41	8,005	$39,482
42	5,216	$34,232
52	1,188	$29,320
53	590	$21,941
54	4,750	$30,214
55	16,945	$24,920
56	7,800	$28,299
57	48,665	$18,154
58	796	$28,691
59	2,676	$21,475
60	4,240	$16,415
61	1,368	$53,028
62	2,320	$42,000
63	1,150	$36,285
64	56,448	$33,845
65	115,423	$26,274
66	91,644	$19,975
67	1,403	$30,791
68	12,512	$21,801
69	104,325	$17,613
70	7,165	$33,370
71	10,283	$26,043
72	5,811	$19,097

MS-DRG	Number of Cases	Threshold
73	8,728	$27,013
74	32,760	$19,857
75	1,229	$33,946
76	861	$22,530
77	1,112	$33,096
78	1,386	$23,660
79	896	$18,688
80	2,095	$24,178
81	8,250	$15,979
82	1,664	$34,229
83	2,070	$28,417
84	2,527	$21,042
85	5,383	$34,777
86	10,921	$26,138
87	11,827	$18,483
88	730	$30,531
89	2,836	$22,350
90	3,285	$16,402
91	6,763	$29,354
92	15,467	$20,636
93	15,043	$15,988
94	1,533	$55,255
95	1,101	$41,891
96	749	$35,515
97	1,266	$50,373
98	1,065	$35,777
99	637	$30,000
100	16,012	$28,458
101	57,312	$17,754
102	1,373	$24,469
103	15,199	$15,977
113	592	$31,359
114	593	$19,667
115	1,110	$25,665
116	715	$23,533
117	1,406	$15,540
121	609	$21,777
122	666	$12,422
123	2,865	$17,881
124	684	$24,203

MS-DRG	Number of Cases	Threshold
125	4,742	$15,308
129	1,401	$38,054
130	1,063	$27,826
131	895	$36,608
132	910	$26,200
133	2,057	$31,616
134	3,781	$19,478
135	430	$34,413
136	503	$21,916
137	847	$26,995
138	926	$17,071
139	1,710	$19,625
146	696	$35,195
147	1,457	$25,206
148	924	$17,390
149	39,487	$14,828
150	945	$25,227
151	6,840	$12,717
152	2,363	$22,142
153	16,167	$14,126
154	1,857	$28,012
155	4,431	$20,298
156	4,969	$14,819
157	1,164	$28,373
158	3,158	$19,955
159	2,365	$14,144
163	13,502	$78,302
164	18,484	$47,957
165	14,267	$37,903
166	20,398	$57,270
167	21,074	$39,819
168	5,555	$30,197
175	12,032	$33,122
176	40,330	$25,127
177	57,526	$35,859
178	72,497	$29,849
179	26,495	$23,293
180	22,628	$33,012
181	32,425	$26,937
182	6,085	$21,762

MS-DRG	Number of Cases	Threshold
183	1,679	$29,889
184	4,279	$21,041
185	2,607	$14,730
186	8,586	$31,513
187	10,362	$25,629
188	4,840	$19,425
189	105,009	$28,877
190	57,361	$27,675
191	126,608	$22,656
192	193,798	$17,011
193	88,637	$29,447
194	274,002	$23,196
195	142,476	$16,909
196	5,173	$30,810
197	7,087	$25,433
198	4,822	$19,617
199	3,279	$33,342
200	8,321	$23,384
201	3,470	$16,338
202	32,849	$19,060
203	40,990	$13,891
204	26,244	$16,200
205	5,816	$26,189
206	22,615	$17,512
207	46,394	$81,122
208	79,797	$41,204
215	154	$151,766
216	8,437	$161,671
217	7,940	$116,693
218	2,963	$97,867
219	10,112	$131,302
220	14,302	$93,773
221	7,644	$81,213
222	2,862	$150,236
223	5,774	$116,596
224	1,930	$138,303
225	5,882	$109,289
226	7,078	$112,853
227	50,687	$88,692
228	3,099	$124,484

MS-DRG	Number of Cases	Threshold
229	4,351	$88,309
230	1,797	$72,663
231	1,484	$138,738
232	1,799	$107,841
233	16,996	$118,266
234	39,349	$86,707
235	9,680	$95,709
236	33,005	$68,284
237	22,981	$84,128
238	43,967	$53,458
239	13,900	$59,235
240	13,862	$40,599
241	2,927	$30,264
242	17,243	$63,738
243	40,609	$50,008
244	65,831	$42,222
245	6,081	$54,185
246	41,300	$65,056
247	272,543	$46,585
248	5,558	$58,102
249	29,332	$41,932
250	5,768	$53,604
251	39,992	$38,463
252	44,846	$48,386
253	52,457	$42,805
254	53,894	$34,650
255	2,624	$38,481
256	3,944	$29,789
257	694	$21,430
258	599	$49,941
259	7,342	$35,275
260	872	$47,350
261	2,921	$28,440
262	3,284	$21,635
263	792	$29,057
264	30,336	$39,273
280	61,020	$35,562
281	62,050	$27,923
282	57,249	$21,202
283	16,022	$31,166

MS-DRG	Number of Cases	Threshold
284	5,089	$23,429
285	3,008	$16,066
286	23,379	$40,316
287	173,151	$27,701
288	3,262	$48,403
289	1,471	$35,164
290	447	$27,561
291	184,689	$28,984
292	245,075	$22,187
293	200,858	$16,283
294	1,756	$20,506
295	1,631	$12,987
296	1,844	$26,653
297	893	$18,216
298	518	$11,608
299	17,570	$27,658
300	49,533	$20,057
301	37,733	$14,452
302	7,919	$23,176
303	81,896	$14,065
304	2,116	$24,255
305	36,019	$13,919
306	1,385	$27,627
307	6,479	$17,568
308	33,741	$27,332
309	85,320	$19,164
310	156,223	$13,820
311	25,143	$12,408
312	170,267	$16,986
313	222,163	$13,782
314	60,587	$30,470
315	33,354	$22,371
316	18,077	$15,239
326	11,616	$86,242
327	11,348	$49,564
328	8,994	$31,783
329	48,381	$78,387
330	68,497	$46,866
331	29,611	$34,881
332	1,897	$72,507

MS-DRG	Number of Cases	Threshold
333	6,490	$45,775
334	3,751	$33,992
335	7,194	$67,336
336	12,815	$43,034
337	8,636	$32,651
338	1,513	$58,118
339	3,289	$39,790
340	3,551	$29,763
341	878	$43,015
342	2,662	$32,037
343	6,796	$22,560
344	897	$51,699
345	3,090	$33,750
346	2,758	$25,650
347	1,577	$36,665
348	4,295	$27,844
349	5,539	$17,498
350	1,802	$41,248
351	4,663	$28,402
352	8,835	$18,578
353	3,076	$44,781
354	9,041	$30,877
355	16,621	$21,562
356	8,411	$57,529
357	8,336	$39,734
358	2,477	$30,907
368	3,069	$31,649
369	4,850	$24,300
370	3,104	$18,383
371	16,940	$31,947
372	23,722	$26,571
373	14,227	$19,299
374	9,505	$34,336
375	20,165	$26,493
376	4,486	$20,960
377	50,797	$30,746
378	118,928	$22,456
379	95,521	$17,322
380	2,934	$32,401
381	5,702	$25,732

MS-DRG	Number of Cases	Threshold
382	4,681	$18,936
383	1,307	$28,326
384	8,723	$19,941
385	2,119	$33,554
386	7,449	$24,853
387	5,105	$19,162
388	18,375	$29,409
389	47,827	$21,609
390	47,010	$15,176
391	47,836	$24,951
392	308,502	$16,603
393	24,053	$29,057
394	48,058	$22,377
395	24,695	$16,159
405	3,949	$82,207
406	5,420	$49,157
407	2,195	$36,266
408	1,682	$68,553
409	1,771	$46,888
410	693	$35,868
411	985	$65,611
412	1,098	$47,835
413	850	$37,471
414	5,643	$59,255
415	7,154	$40,657
416	6,018	$30,408
417	16,735	$46,510
418	28,654	$36,535
419	37,427	$27,109
420	738	$62,577
421	1,118	$37,072
422	359	$28,797
423	1,528	$64,735
424	934	$44,742
425	148	$35,273
432	16,397	$30,669
433	9,146	$21,794
434	931	$15,756
435	12,004	$32,775
436	14,157	$26,550

MS-DRG	Number of Cases	Threshold
437	4,304	$23,750
438	14,497	$31,776
439	25,932	$25,153
440	26,506	$17,450
441	14,036	$29,001
442	13,192	$22,508
443	6,445	$16,775
444	12,529	$31,104
445	17,390	$25,361
446	16,434	$18,758
453	852	$162,887
454	1,700	$108,936
455	1,715	$83,977
456	770	$132,661
457	2,084	$93,332
458	1,282	$76,740
459	3,212	$91,544
460	51,227	$61,564
461	1,071	$78,546
462	14,292	$59,077
463	5,317	$58,659
464	6,589	$40,817
465	2,748	$30,426
466	3,914	$70,273
467	14,340	$53,217
468	21,479	$45,760
469	29,879	$56,067
470	412,628	$41,647
471	2,241	$71,684
472	6,629	$48,438
473	22,659	$39,710
474	2,857	$47,799
475	3,709	$34,430
476	1,560	$23,529
477	2,262	$56,473
478	7,379	$41,535
479	10,118	$33,437
480	25,993	$50,045
481	74,669	$37,407
482	49,780	$31,682

MS-DRG	Number of Cases	Threshold
483	6,572	$44,230
484	17,287	$37,116
485	1,152	$55,605
486	2,066	$41,452
487	1,345	$33,445
488	2,541	$33,298
489	6,198	$25,879
490	21,668	$34,194
491	57,424	$22,157
492	4,761	$47,695
493	16,833	$36,100
494	29,419	$27,047
495	1,888	$49,247
496	5,499	$34,237
497	7,196	$26,140
498	1,258	$36,490
499	1,173	$20,709
500	1,359	$47,252
501	3,956	$30,666
502	6,635	$21,338
503	743	$38,514
504	2,274	$30,843
505	3,142	$22,627
506	921	$23,455
507	840	$33,141
508	2,717	$24,377
509	674	$24,413
510	994	$38,909
511	4,183	$30,425
512	12,088	$21,576
513	1,104	$28,452
514	1,175	$18,054
515	3,601	$50,791
516	11,512	$37,225
517	17,926	$30,519
533	835	$26,648
534	3,647	$14,482
535	6,888	$26,452
536	34,492	$14,330
537	694	$19,017

MS-DRG	Number of Cases	Threshold
538	1,139	$12,077
539	3,397	$33,217
540	4,317	$26,851
541	1,787	$20,216
542	6,196	$32,544
543	18,834	$24,660
544	12,389	$16,758
545	4,061	$33,836
546	6,159	$23,684
547	4,717	$16,961
548	592	$32,771
549	1,139	$25,057
550	855	$16,440
551	9,580	$29,107
552	88,568	$17,262
553	2,820	$24,400
554	20,429	$13,865
555	2,006	$21,701
556	19,316	$13,456
557	3,196	$28,869
558	14,252	$17,984
559	1,646	$27,886
560	4,208	$19,203
561	7,439	$12,631
562	5,051	$26,441
563	36,361	$14,373
564	1,622	$27,213
565	3,385	$19,726
566	2,673	$14,394
573	5,721	$44,181
574	12,468	$32,298
575	6,221	$24,293
576	563	$44,962
577	2,305	$31,201
578	3,228	$21,726
579	3,359	$42,784
580	11,019	$28,964
581	12,249	$19,890
582	5,787	$22,538
583	9,356	$17,024

MS-DRG	Number of Cases	Threshold
584	801	$29,768
585	1,687	$19,824
592	4,026	$29,343
593	13,080	$21,992
594	2,828	$15,050
595	1,092	$29,676
596	5,792	$18,108
597	555	$29,885
598	1,502	$23,607
599	342	$14,643
600	611	$21,165
601	841	$13,706
602	21,456	$26,696
603	132,037	$16,799
604	2,652	$25,279
605	22,943	$15,043
606	1,371	$23,075
607	7,242	$13,623
614	1,429	$44,375
615	1,594	$32,682
616	1,145	$57,766
617	6,944	$36,252
618	268	$26,622
619	675	$60,360
620	2,007	$41,188
621	6,560	$35,408
622	1,241	$43,105
623	3,392	$32,380
624	392	$23,639
625	1,107	$40,323
626	2,751	$27,124
627	14,146	$17,672
628	3,297	$50,940
629	4,125	$39,861
630	551	$30,359
637	16,431	$26,711
638	46,657	$17,852
639	36,178	$12,405
640	56,149	$23,948
641	189,293	$15,306

MS-DRG	Number of Cases	Threshold
642	1,570	$23,220
643	5,072	$30,688
644	12,220	$23,221
645	8,140	$17,134
652	10,695	$57,598
653	1,591	$83,573
654	3,387	$53,557
655	1,514	$40,260
656	3,739	$56,731
657	7,946	$38,721
658	7,957	$31,512
659	4,484	$50,345
660	7,985	$36,157
661	4,264	$28,963
662	998	$41,819
663	2,288	$29,509
664	4,543	$21,878
665	693	$47,203
666	2,405	$30,729
667	3,765	$17,825
668	3,768	$39,717
669	13,307	$27,864
670	12,685	$17,652
671	917	$28,730
672	940	$17,260
673	12,678	$43,306
674	13,848	$38,503
675	8,371	$31,046
682	76,428	$30,010
683	128,229	$25,096
684	28,358	$16,191
685	2,520	$18,480
686	1,596	$31,207
687	3,467	$24,323
688	1,098	$16,621
689	55,794	$25,635
690	201,347	$16,948
691	908	$32,082
692	653	$23,510

MS-DRG	Number of Cases	Threshold
693	2,256	$27,732
694	19,345	$16,454
695	982	$24,045
696	10,646	$13,740
697	585	$16,016
698	21,255	$27,675
699	27,064	$21,858
700	11,141	$15,265
707	6,053	$34,725
708	15,996	$27,483
709	796	$33,770
710	2,015	$28,020
711	953	$34,001
712	793	$18,806
713	12,009	$24,773
714	32,647	$14,452
715	662	$34,063
716	1,367	$26,199
717	666	$31,483
718	601	$17,543
722	881	$29,143
723	2,078	$23,828
724	648	$14,696
725	808	$23,676
726	3,956	$15,110
727	1,106	$26,379
728	6,224	$15,600
729	603	$22,516
730	533	$13,176
734	1,528	$39,515
735	1,278	$24,152
736	842	$68,890
737	3,487	$39,497
738	912	$26,791
739	980	$48,238
740	4,638	$31,707
741	6,330	$22,182
742	11,685	$29,883
743	34,686	$19,452

MS-DRG	Number of Cases	Threshold
744	1,634	$28,628
745	2,080	$18,005
746	2,664	$27,839
747	11,073	$19,176
748	21,289	$18,499
749	1,048	$42,919
750	477	$22,403
754	1,097	$31,826
755	3,219	$24,291
756	783	$15,311
757	1,326	$31,148
758	1,659	$24,086
759	1,141	$17,474
760	1,815	$17,766
761	1,844	$12,285
765	2,606	$19,738
766	2,664	$13,500
767	123	$14,158
768	10	$28,485
769	87	$30,005
770	188	$15,884
774	1,476	$11,268
775	5,343	$8,224
776	495	$14,028
777	180	$17,674
778	494	$7,925
779	107	$12,859
780	50	$5,097
781	3,062	$11,922
782	129	$7,495
790	1	$10,833
793	1	$7,090
799	631	$76,349
800	730	$45,475
801	581	$35,346
802	693	$51,863
803	1,030	$33,789
804	978	$23,443
808	8,276	$33,959

MS-DRG	Number of Cases	Threshold
809	15,783	$24,984
810	3,694	$19,852
811	18,481	$24,763
812	83,743	$16,735
813	15,112	$25,353
814	1,649	$29,809
815	3,483	$23,384
816	2,274	$16,506
820	1,490	$83,865
821	2,593	$40,857
822	2,108	$28,934
823	2,452	$64,905
824	3,130	$40,661
825	1,940	$29,667
826	566	$77,477
827	1,354	$40,261
828	851	$29,066
829	1,386	$44,427
830	520	$24,753
834	5,293	$50,478
835	1,458	$30,789
836	1,554	$23,578
837	1,638	$85,982
838	942	$41,591
839	1,368	$27,115
840	15,248	$37,650
841	11,355	$28,759
842	7,431	$22,903
843	1,498	$32,667
844	2,893	$25,181
845	988	$19,989
846	2,498	$37,579
847	23,816	$25,378
848	1,695	$18,894
849	1,507	$26,993
853	31,591	$74,761
854	6,945	$48,947
855	429	$35,398
856	6,215	$64,096

MS-DRG	Number of Cases	Threshold
857	10,284	$35,984
858	3,362	$28,311
862	7,481	$32,142
863	21,957	$20,215
864	19,959	$19,205
865	2,032	$28,094
866	9,474	$15,750
867	5,387	$37,568
868	2,507	$24,368
869	1,129	$18,549
870	13,815	$88,048
871	204,810	$33,442
872	92,533	$25,285
876	971	$40,650
880	10,578	$14,303
881	4,636	$10,640
882	1,673	$11,353
883	799	$16,323
884	21,747	$17,521
885	78,937	$14,233
886	377	$13,044
887	427	$17,908
894	4,627	$7,335
895	6,777	$14,018
896	5,447	$25,167
897	36,860	$12,339
901	924	$48,924
902	2,217	$31,735
903	1,687	$22,773
904	980	$39,732
905	779	$24,032
906	751	$22,406
907	8,164	$52,970
908	8,553	$34,755
909	5,427	$25,547
913	828	$26,522
914	7,082	$15,123
915	928	$24,230
916	5,418	$9,886

MS-DRG	Number of Cases	Threshold
917	14,498	$28,130
918	35,052	$13,329
919	10,672	$27,995
920	14,259	$20,512
921	9,672	$13,742
922	1,027	$26,635
923	4,264	$14,600
927	187	$176,300
928	819	$59,748
929	448	$32,846
933	158	$31,761
934	701	$23,844
935	2,209	$21,589
939	428	$42,833
940	732	$32,886
941	1,058	$25,659
945	5,485	$19,140
946	2,759	$16,452
947	6,597	$22,649
948	34,624	$14,331
949	767	$17,139
950	463	$11,233
951	1,008	$13,228
955	456	$82,510
956	3,769	$54,265
957	1,324	$98,340
958	1,221	$65,671
959	295	$44,675
963	1,509	$46,368
964	2,538	$32,378
965	1,105	$23,186
969	676	$74,013
970	159	$41,737
974	6,358	$38,805
975	4,516	$27,839
976	2,770	$20,952
977	5,016	$23,318
981	26,444	$75,138
982	19,320	$52,350

MS-DRG	Number of Cases	Threshold
983	6,143	$37,859
984	671	$56,002
985	1,108	$38,757
986	833	$27,923
987	8,040	$53,132
988	12,302	$35,639
989	6,162	$25,762
999	30	$11,270

[1]Cases taken from the FY 2006 MedPAR file; MS-DRGs are from GROUPER Version 25.0.

Table 11.--FY 2008 MS-LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGHT OF STAY, SHORT-STAY OUTLIER THRESHOLD, AND IPPS COMPARABLE THRESHOLD

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
001	Heart transplant or implant of heart assist system w MCC	0	0.0000	0.0	0.0	0.0
002	Heart transplant or implant of heart assist system w/o MCC	0	0.0000	0.0	0.0	0.0
003	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	280	4.2380	64.3	53.6	53.6
004	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	1,067	3.0249	46.7	38.9	38.9
005	Liver transplant w MCC or intestinal transplant	0	0.0000	0.0	0.0	0.0
006	Liver transplant w/o MCC	0	0.0000	0.0	0.0	0.0
007	Lung transplant	0	0.0000	0.0	0.0	0.0
008	Simultaneous pancreas/kidney transplant	0	0.0000	0.0	0.0	0.0
009	Bone marrow transplant	0	1.1417	29.0	24.2	24.2
010	Pancreas transplant	0	1.1417	29.0	24.2	0.0
011	Tracheostomy for face,mouth & neck diagnoses w MCC	0	1.5545	35.2	29.3	25.2
012	Tracheostomy for face,mouth & neck diagnoses w CC	1	1.5545	35.2	29.3	16.7
013	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	0	1.5545	35.2	29.3	11.2
020	Intracranial vascular procedures w PDX hemorrhage w MCC	0	1.5545	35.2	29.3	29.3

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
021	Intracranial vascular procedures w PDX hemorrhage w CC	0	0.5472	20.3	16.9	16.9
022	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0	0.5472	20.3	16.9	16.1
023	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant	0	1.5545	35.2	29.3	22.2
024	Cranio w major dev impl/acute complex CNS PDX w/o MCC	0	0.5472	20.3	16.9	15.8
025	Craniotomy & endovascular intracranial procedures w MCC	0	1.5545	35.2	29.3	22.1
026	Craniotomy & endovascular intracranial procedures w CC	2	1.5545	35.2	29.3	13.2
027	Craniotomy & endovascular intracranial procedures w/o CC/MCC	0	1.5545	35.2	29.3	7.5
028	Spinal procedures w MCC	6	1.1417	29.0	24.2	24.2
029	Spinal procedures w CC or spinal neurostimulators	4	1.1417	29.0	24.2	12.4
030	Spinal procedures w/o CC/MCC	2	0.5472	20.3	16.9	5.9
031	Ventricular shunt procedures w MCC	2	1.5545	35.2	29.3	22.9
032	Ventricular shunt procedures w CC	1	0.5472	20.3	16.9	9.4
033	Ventricular shunt procedures w/o CC/MCC	1	0.5472	20.3	16.9	4.7
034	Carotid artery stent procedure w MCC	0	1.5545	35.2	29.3	12.5
035	Carotid artery stent procedure w CC	0	1.1417	29.0	24.2	4.4
036	Carotid artery stent procedure w/o CC/MCC	0	1.1417	29.0	24.2	2.2
037	Extracranial procedures w MCC	12	1.5545	35.2	29.3	14.9
038	Extracranial procedures w CC	8	1.1417	29.0	24.2	5.8
039	Extracranial procedures w/o CC/MCC	0	1.1417	29.0	24.2	2.6
040	Periph/cranial nerve & other nerv syst proc w MCC	153	1.2704	36.2	30.2	22.7
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim	100	1.0810	34.3	28.6	12.3
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	9	0.7305	22.9	19.1	5.7
052	Spinal disorders & injuries w CC/MCC	78	1.0629	32.3	26.9	10.7
053	Spinal disorders & injuries w/o CC/MCC	18	1.0629	32.3	26.9	6.4
054	Nervous system neoplasms w MCC	50	0.7205	23.6	19.7	11.7
055	Nervous system neoplasms w/o MCC	67	0.6779	22.0	18.3	8.1
056	Degenerative nervous system disorders w MCC	1,335	0.7407	26.4	22.0	12.3
057	Degenerative nervous system disorders w/o MCC	2,607	0.6309	24.4	20.3	7.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
058	Multiple sclerosis & cerebellar ataxia w MCC	23	0.7305	22.9	19.1	12.5
059	Multiple sclerosis & cerebellar ataxia w CC	44	0.5595	22.6	18.8	8.0
060	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	22	0.5472	20.3	16.9	6.2
061	Acute ischemic stroke w use of thrombolytic agent w MCC	0	0.7897	24.2	20.2	16.0
062	Acute ischemic stroke w use of thrombolytic agent w CC	0	0.6563	22.7	18.9	9.6
063	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0	0.5472	20.3	16.9	6.8
064	Intracranial hemorrhage or cerebral infarction w MCC	126	0.7746	25.1	20.9	12.7
065	Intracranial hemorrhage or cerebral infarction w CC	119	0.6691	23.3	19.4	8.2
066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	22	0.5472	20.3	16.9	5.8
067	Nonspecific cva & precerebral occlusion w/o infarct w MCC	5	0.5472	20.3	16.9	10.1
068	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	8	0.5472	20.3	16.9	5.6
069	Transient ischemia	17	0.5472	20.3	16.9	4.7
070	Nonspecific cerebrovascular disorders w MCC	104	0.7897	24.2	20.2	12.7
071	Nonspecific cerebrovascular disorders w CC	86	0.6563	22.7	18.9	8.8
072	Nonspecific cerebrovascular disorders w/o CC/MCC	9	0.5472	20.3	16.9	5.8
073	Cranial & peripheral nerve disorders w MCC	86	0.7849	25.6	21.3	10.2
074	Cranial & peripheral nerve disorders w/o MCC	175	0.6260	23.4	19.5	6.9
075	Viral meningitis w CC/MCC	21	0.7305	22.9	19.1	12.1
076	Viral meningitis w/o CC/MCC	1	0.5472	20.3	16.9	6.5
077	Hypertensive encephalopathy w MCC	4	0.7305	22.9	19.1	11.4
078	Hypertensive encephalopathy w CC	9	0.7305	22.9	19.1	7.2
079	Hypertensive encephalopathy w/o CC/MCC	1	0.5472	20.3	16.9	5.3
080	Nontraumatic stupor & coma w MCC	40	0.6312	24.6	20.5	7.8
081	Nontraumatic stupor & coma w/o MCC	71	0.5618	23.1	19.3	5.3
082	Traumatic stupor & coma, coma >1 hr w MCC	27	0.8864	29.5	24.6	10.9
083	Traumatic stupor & coma, coma >1 hr w CC	12	0.7305	22.9	19.1	8.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	4	0.7305	22.9	19.1	4.9
085	Traumatic stupor & coma, coma <1 hr w MCC	105	0.9044	28.3	23.6	13.2
086	Traumatic stupor & coma, coma <1 hr w CC	89	0.7437	25.1	20.9	8.2
087	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	28	0.6361	20.4	17.0	5.3
088	Concussion w MCC	1	1.1417	29.0	24.2	9.9
089	Concussion w CC	2	1.1417	29.0	24.2	6.0
090	Concussion w/o CC/MCC	0	1.1417	29.0	24.2	3.7
091	Other disorders of nervous system w MCC	242	0.8019	25.6	21.3	10.7
092	Other disorders of nervous system w CC	191	0.6704	22.0	18.3	6.9
093	Other disorders of nervous system w/o CC/MCC	53	0.5811	20.1	16.8	4.9
094	Bacterial & tuberculous infections of nervous system w MCC	210	1.0328	27.9	23.3	20.8
095	Bacterial & tuberculous infections of nervous system w CC	110	0.9306	27.0	22.5	14.9
096	Bacterial & tuberculous infections of nervous system w/o CC/MCC	26	0.9306	27.0	22.5	10.1
097	Non-bacterial infect of nervous sys exc viral meningitis w MCC	58	0.9289	26.8	22.3	19.6
098	Non-bacterial infect of nervous sys exc viral meningitis w CC	33	0.8629	22.7	18.9	13.7
099	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	10	0.7305	22.9	19.1	10.1
100	Seizures w MCC	39	0.7904	26.5	22.1	10.1
101	Seizures w/o MCC	35	0.6177	21.4	17.8	5.8
102	Headaches w MCC	6	0.8249	25.0	20.8	8.1
103	Headaches w/o MCC	12	0.8249	25.0	20.8	5.0
113	Orbital procedures w CC/MCC	1	0.7305	22.9	19.1	9.2
114	Orbital procedures w/o CC/MCC	0	0.7305	22.9	19.1	4.1
115	Extraocular procedures except orbit	0	0.8249	25.0	20.8	7.2
116	Intraocular procedures w CC/MCC	0	0.8249	25.0	20.8	5.2
117	Intraocular procedures w/o CC/MCC	0	0.8249	25.0	20.8	2.8
121	Acute major eye infections w CC/MCC	8	0.7305	22.9	19.1	9.1
122	Acute major eye infections w/o CC/MCC	2	0.5472	20.3	16.9	6.3
123	Neurological eye disorders	3	0.5472	20.3	16.9	4.5
124	Other disorders of the eye w MCC	2	1.1417	29.0	24.2	8.4
125	Other disorders of the eye w/o MCC	9	0.8249	25.0	20.8	5.5
129	Major head & neck procedures w CC/MCC or major device	0	1.1977	26.4	22.0	8.1

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
130	Major head & neck procedures w/o CC/MCC	0	0.7305	22.9	19.1	4.8
131	Cranial/facial procedures w CC/MCC	2	1.5545	35.2	29.3	9.5
132	Cranial/facial procedures w/o CC/MCC	0	1.5545	35.2	29.3	4.0
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	3	0.7305	22.9	19.1	9.4
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	1	0.7305	22.9	19.1	3.2
135	Sinus & mastoid procedures w CC/MCC	0	0.7305	22.9	19.1	10.8
136	Sinus & mastoid procedures w/o CC/MCC	0	0.7305	22.9	19.1	3.9
137	Mouth procedures w CC/MCC	1	1.5545	35.2	29.3	8.7
138	Mouth procedures w/o CC/MCC	0	1.5545	35.2	29.3	3.7
139	Salivary gland procedures	1	1.5545	35.2	29.3	2.5
146	Ear, nose, mouth & throat malignancy w MCC	43	1.1977	26.4	22.0	16.9
147	Ear, nose, mouth & throat malignancy w CC	36	1.0416	24.9	20.8	9.3
148	Ear, nose, mouth & throat malignancy w/o CC/MCC	4	0.7305	22.9	19.1	5.6
149	Dysequilibrium	9	0.5472	20.3	16.9	4.2
150	Epistaxis w MCC	0	0.7305	22.9	19.1	8.8
151	Epistaxis w/o MCC	0	0.7305	22.9	19.1	4.5
152	Otitis media & URI w MCC	10	0.7305	22.9	19.1	7.4
153	Otitis media & URI w/o MCC	23	0.7305	22.9	19.1	5.2
154	Nasal trauma & deformity w MCC	55	0.7703	21.0	17.5	10.5
155	Nasal trauma & deformity w CC	45	0.7703	21.0	17.5	7.2
156	Nasal trauma & deformity w/o CC/MCC	10	0.7305	22.9	19.1	4.9
157	Dental & Oral Diseases w MCC	9	0.8249	25.0	20.8	11.3
158	Dental & Oral Diseases w CC	19	0.8249	25.0	20.8	7.1
159	Dental & Oral Diseases w/o CC/MCC	1	0.5472	20.3	16.9	4.8
163	Major chest procedures w MCC	27	2.2157	39.7	33.1	23.6
164	Major chest procedures w CC	10	1.5545	35.2	29.3	13.0
165	Major chest procedures w/o CC/MCC	0	1.5545	35.2	29.3	8.3
166	Other resp system O.R. procedures w MCC	1,572	2.4392	42.3	35.3	20.6
167	Other resp system O.R. procedures w CC	233	2.1594	38.0	31.7	13.1
168	Other resp system O.R. procedures w/o CC/MCC	11	1.1417	29.0	24.2	8.9
175	Pulmonary embolism w MCC	103	0.7160	22.0	18.3	11.6
176	Pulmonary embolism w/o MCC	139	0.5989	20.1	16.8	8.4

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
177	Respiratory infections & inflammations w MCC	2,953	0.8393	23.5	19.6	14.9
178	Respiratory infections & inflammations w CC	2,265	0.7671	22.2	18.5	11.7
179	Respiratory infections & inflammations w/o CC/MCC	370	0.6885	19.0	15.8	8.9
180	Respiratory neoplasms w MCC	162	0.8140	20.2	16.8	13.1
181	Respiratory neoplasms w CC	109	0.7103	19.3	16.1	9.7
182	Respiratory neoplasms w/o CC/MCC	19	0.5472	20.3	16.9	6.9
183	Major chest trauma w MCC	1	0.5472	20.3	16.9	11.5
184	Major chest trauma w CC	1	0.5472	20.3	16.9	7.3
185	Major chest trauma w/o CC/MCC	0	0.5472	20.3	16.9	5.0
186	Pleural effusion w MCC	137	0.8259	23.6	19.7	12.2
187	Pleural effusion w CC	63	0.7042	21.1	17.6	8.8
188	Pleural effusion w/o CC/MCC	14	0.7042	21.1	17.6	6.5
189	Pulmonary edema & respiratory failure	5,707	0.9743	24.0	20.0	10.1
190	Chronic obstructive pulmonary disease w MCC	1,657	0.6858	20.9	17.4	10.2
191	Chronic obstructive pulmonary disease w CC	1,558	0.6256	19.5	16.3	7.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	871	0.5832	17.2	14.3	6.2
193	Simple pneumonia & pleurisy w MCC	1,689	0.7088	21.6	18.0	10.9
194	Simple pneumonia & pleurisy w CC	2,110	0.6429	19.8	16.5	8.2
195	Simple pneumonia & pleurisy w/o CC/MCC	455	0.5962	18.2	15.2	6.3
196	Interstitial lung disease w MCC	114	0.6529	20.0	16.7	11.6
197	Interstitial lung disease w CC	95	0.6133	19.6	16.3	8.5
198	Interstitial lung disease w/o CC/MCC	44	0.5956	19.7	16.4	6.7
199	Pneumothorax w MCC	24	0.8249	25.0	20.8	13.8
200	Pneumothorax w CC	17	0.7305	22.9	19.1	8.3
201	Pneumothorax w/o CC/MCC	10	0.5472	20.3	16.9	6.5
202	Bronchitis & asthma w CC/MCC	96	0.6903	21.1	17.6	6.9
203	Bronchitis & asthma w/o CC/MCC	34	0.5650	17.1	14.3	5.3
204	Respiratory signs & symptoms	309	0.8187	22.0	18.3	4.4
205	Other respiratory system diagnoses w MCC	261	0.8207	22.4	18.7	9.0
206	Other respiratory system diagnoses w/o MCC	167	0.7667	21.5	17.9	5.5
207	Respiratory system diagnosis w ventilator support 96+ hours	12,448	2.0266	34.3	28.6	22.6
208	Respiratory system diagnosis w ventilator support <96 hours	1,890	1.5514	27.8	23.2	12.5
215	Other heart assist system implant	0	0.8249	25.0	20.8	20.5

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	0	1.5545	35.2	29.3	28.7
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	0	0.8249	25.0	20.8	17.7
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	0	0.8249	25.0	20.8	12.7
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	0	1.5545	35.2	29.3	22.6
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	0	0.8249	25.0	20.8	12.5
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	0	0.8249	25.0	20.8	8.7
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	0	1.5545	35.2	29.3	20.9
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	0	1.5545	35.2	29.3	11.0
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	0	1.5545	35.2	29.3	18.2
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	0	1.5545	35.2	29.3	9.2
226	Cardiac defibrillator implant w/o cardiac cath w MCC	11	1.5545	35.2	29.3	16.8
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	4	1.5545	35.2	29.3	4.1
228	Other cardiothoracic procedures w MCC	0	1.5410	35.0	29.2	23.2
229	Other cardiothoracic procedures w CC	0	1.2681	30.8	25.7	13.5
230	Other cardiothoracic procedures w/o CC/MCC	0	0.8249	25.0	20.8	10.2
231	Coronary bypass w PTCA w MCC	0	1.5545	35.2	29.3	20.9
232	Coronary bypass w PTCA w/o MCC	0	0.8249	25.0	20.8	13.1
233	Coronary bypass w cardiac cath w MCC	0	1.5545	35.2	29.3	21.0
234	Coronary bypass w cardiac cath w/o MCC	0	0.8249	25.0	20.8	12.2
235	Coronary bypass w/o cardiac cath w MCC	0	1.5545	35.2	29.3	17.0
236	Coronary bypass w/o cardiac cath w/o MCC	0	0.8249	25.0	20.8	9.0
237	Major cardiovasc procedures w MCC or thoracic aortic anuerysm repair	3	1.5545	35.2	29.3	19.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
238	Major cardiovasc procedures w/o MCC	3	0.8249	25.0	20.8	8.1
239	Amputation for circ sys disorders exc upper limb & toe w MCC	171	1.3794	37.4	31.2	24.7
240	Amputation for circ sys disorders exc upper limb & toe w CC	94	1.2872	36.1	30.1	16.6
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	5	1.1417	29.0	24.2	10.7
242	Permanent cardiac pacemaker implant w MCC	14	1.5545	35.2	29.3	14.5
243	Permanent cardiac pacemaker implant w CC	9	1.5545	35.2	29.3	8.5
244	Permanent cardiac pacemaker implant w/o CC/MCC	3	1.1417	29.0	24.2	4.6
245	AICD lead & generator procedures	2	0.7305	22.9	19.1	4.9
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	1	0.8249	25.0	20.8	9.1
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	0	0.8249	25.0	20.8	3.3
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	1	1.5545	35.2	29.3	10.3
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	0	1.5545	35.2	29.3	3.9
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	1	0.8249	25.0	20.8	12.7
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0	0.8249	25.0	20.8	4.6
252	Other vascular procedures w MCC	108	1.5410	35.0	29.2	15.1
253	Other vascular procedures w CC	56	1.2681	30.8	25.7	10.2
254	Other vascular procedures w/o CC/MCC	5	0.8249	25.0	20.8	4.3
255	Upper limb & toe amputation for circ system disorders w MCC	45	1.1713	33.7	28.1	16.7
256	Upper limb & toe amputation for circ system disorders w CC	37	0.9516	29.4	24.5	12.3
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC	1	0.9516	29.4	24.5	8.2
258	Cardiac pacemaker device replacement w MCC	1	1.5545	35.2	29.3	12.6
259	Cardiac pacemaker device replacement w/o MCC	0	1.5545	35.2	29.3	4.0
260	Cardiac pacemaker revision except device replacement w MCC	1	1.5545	35.2	29.3	17.4
261	Cardiac pacemaker revision except device replacement w CC	2	0.5472	20.3	16.9	6.4
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	0	0.5472	20.3	16.9	3.7
263	Vein ligation & stripping	1	0.8249	25.0	20.8	9.2

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
264	Other circulatory system O.R. procedures	595	1.0667	31.6	26.3	15.4
280	Acute myocardial infarction, discharged alive w MCC	107	0.7263	21.4	17.8	12.0
281	Acute myocardial infarction, discharged alive w CC	60	0.6931	22.8	19.0	7.8
282	Acute myocardia infarction, discharged alive w/o CC/MCC	7	0.6931	22.8	19.0	5.1
283	Acute myocardial infarction, expired w MCC	26	0.6609	17.0	14.2	9.0
284	Acute myocardial infarction, expired w CC	5	0.6609	17.0	14.2	5.4
285	Acute myocardial infarction, expired w/o CC/MCC	1	0.6609	17.0	14.2	3.3
286	Circulatory disorders except AMI, w card cath w MCC	15	1.1417	29.0	24.2	11.6
287	Circulatory disorders except AMI, w card cath w/o MCC	7	0.8249	25.0	20.8	5.0
288	Acute & subacute endocarditis w MCC	453	0.9082	26.4	22.0	19.7
289	Acute & subacute endocarditis w CC	225	0.8580	26.4	22.0	13.7
290	Acute & subacute endocarditis w/o CC/MCC	53	0.7664	25.5	21.3	10.6
291	Heart failure & shock w MCC	1,601	0.6968	21.4	17.8	10.7
292	Heart failure & shock w CC	1,183	0.6252	20.4	17.0	7.7
293	Heart failure & shock w/o CC/MCC	387	0.5775	18.5	15.4	5.6
294	Deep vein thrombophlebitis w CC/MCC	7	0.8249	25.0	20.8	8.6
295	Deep vein thrombophlebitis w/o CC/MCC	0	0.8249	25.0	20.8	6.7
296	Cardiac arrest, unexplained w MCC	0	0.6609	17.0	14.2	4.8
297	Cardiac arrest, unexplained w CC	0	0.6609	17.0	14.2	2.7
298	Cardiac arrest, unexplained w/o CC/MCC	0	0.6609	17.0	14.2	1.9
299	Peripheral vascular disorders w MCC	551	0.7152	24.8	20.7	11.2
300	Peripheral vascular disorders w CC	800	0.6150	22.2	18.5	8.2
301	Peripheral vascular disorders w/o CC/MCC	93	0.5557	19.4	16.2	6.0
302	Atherosclerosis w MCC	69	0.6170	21.9	18.3	6.9
303	Atherosclerosis w/o MCC	93	0.5673	20.5	17.1	3.9
304	Hypertension w MCC	12	0.8249	25.0	20.8	8.3
305	Hypertension w/o MCC	39	0.5856	22.6	18.8	4.4
306	Cardiac congenital & valvular disorders w MCC	54	0.8786	24.2	20.2	10.2
307	Cardiac congenital & valvular disorders w/o MCC	39	0.7767	23.1	19.3	5.5
308	Cardiac arrhythmia & conduction disorders w MCC	88	0.7431	24.7	20.6	9.3

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
309	Cardiac arrhythmia & conduction disorders w CC	76	0.5940	20.4	17.0	6.2
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	39	0.5184	17.0	14.2	4.2
311	Angina pectoris	4	0.7305	22.9	19.1	3.5
312	Syncope & collapse	44	0.5336	19.7	16.4	4.9
313	Chest pain	5	0.5472	20.3	16.9	3.1
314	Other circulatory system diagnoses w MCC	1,399	0.8123	23.1	19.3	11.8
315	Other circulatory system diagnoses w CC	451	0.7114	21.6	18.0	7.3
316	Other circulatory system diagnoses w/o CC/MCC	98	0.6243	18.9	15.8	4.7
326	Stomach, esophageal & duodenal proc w MCC	34	1.8646	36.2	30.2	28.1
327	Stomach, esophageal & duodenal proc w CC	9	1.5545	35.2	29.3	16.8
328	Stomach, esophageal & duodenal proc w/o CC/MCC	1	0.5472	20.3	16.9	7.2
329	Major small & large bowel procedures w MCC	24	1.5545	35.2	29.3	25.3
330	Major small & large bowel procedures w CC	20	1.5545	35.2	29.3	14.6
331	Major small & large bowel procedures w/o CC/MCC	1	0.5472	20.3	16.9	8.7
332	Rectal resection w MCC	0	1.5057	36.1	30.1	22.6
333	Rectal resection w CC	0	1.3309	30.7	25.6	13.0
334	Rectal resection w/o CC/MCC	0	0.8249	25.0	20.8	8.6
335	Peritoneal adhesiolysis w MCC	4	1.5545	35.2	29.3	22.9
336	Peritoneal adhesiolysis w CC	2	0.7305	22.9	19.1	14.6
337	Peritoneal adhesiolysis w/o CC/MCC	0	0.7305	22.9	19.1	9.3
338	Appendectomy w complicated principal diag w MCC	0	0.8884	24.1	20.1	16.7
339	Appendectomy w complicated principal diag w CC	0	0.7667	22.2	18.5	10.8
340	Appendectomy w complicated principal diag w/o CC/MCC	0	0.6856	19.9	16.6	6.6
341	Appendectomy w/o complicated principal diag w MCC	0	0.8884	24.1	20.1	12.0
342	Appendectomy w/o complicated principal diag w CC	0	0.7667	22.2	18.5	6.8
343	Appendectomy w/o complicated principal diag w/o CC/MCC	0	0.6856	19.9	16.6	3.4
344	Minor small & large bowel procedures w MCC	0	0.8884	24.1	20.1	19.1
345	Minor small & large bowel procedures w CC	0	0.7667	22.2	18.5	10.9

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
346	Minor small & large bowel procedures w/o CC/MCC	0	0.6856	19.9	16.6	7.4
347	Anal & stomal procedures w MCC	5	1.1417	29.0	24.2	13.8
348	Anal & stomal procedures w CC	3	0.8249	25.0	20.8	8.9
349	Anal & stomal procedures w/o CC/MCC	1	0.5472	20.3	16.9	4.7
350	Inguinal & femoral hernia procedures w MCC	1	1.5545	35.2	29.3	13.6
351	Inguinal & femoral hernia procedures w CC	1	1.1417	29.0	24.2	7.4
352	Inguinal & femoral hernia procedures w/o CC/MCC	1	0.8249	25.0	20.8	3.7
353	Hernia procedures except inguinal & femoral w MCC	0	0.8249	25.0	20.8	14.5
354	Hernia procedures except inguinal & femoral w CC	1	0.8249	25.0	20.8	8.2
355	Hernia procedures except inguinal & femoral w/o CC/MCC	0	0.8249	25.0	20.8	4.4
356	Other digestive system O.R. procedures w MCC	109	1.5057	36.1	30.1	22.5
357	Other digestive system O.R. procedures w CC	46	1.3309	30.7	25.6	13.3
358	Other digestive system O.R. procedures w/o CC/MCC	3	0.8249	25.0	20.8	7.6
368	Major esophageal disorders w MCC	22	1.1417	29.0	24.2	10.5
369	Major esophageal disorders w CC	8	1.1417	29.0	24.2	7.1
370	Major esophageal disorders w/o CC/MCC	1	1.1417	29.0	24.2	5.2
371	Major gastrointestinal disorders & peritoneal infections w MCC	666	0.8884	24.1	20.1	14.1
372	Major gastrointestinal disorders & peritoneal infections w CC	426	0.7667	22.2	18.5	10.6
373	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	52	0.6856	19.9	16.6	7.7
374	Digestive malignancy w MCC	122	0.8340	22.9	19.1	14.4
375	Digestive malignancy w CC	81	0.7563	19.7	16.4	9.7
376	Digestive malignancy w/o CC/MCC	9	0.5472	20.3	16.9	6.5
377	G.I. hemorrhage w MCC	94	0.7032	22.5	18.8	10.3
378	G.I. hemorrhage w CC	60	0.6334	21.5	17.9	6.8
379	G.I. hemorrhage w/o CC/MCC	20	0.5472	20.3	16.9	5.2
380	Complicated peptic ulcer w MCC	14	0.8249	25.0	20.8	11.4
381	Complicated peptic ulcer w CC	16	0.8249	25.0	20.8	7.9
382	Complicated peptic ulcer w/o CC/MCC	6	0.7305	22.9	19.1	5.5
383	Uncomplicated peptic ulcer w MCC	6	0.8249	25.0	20.8	9.1
384	Uncomplicated peptic ulcer w/o MCC	6	0.7305	22.9	19.1	5.9
385	Inflammatory bowel disease w MCC	32	0.8874	24.6	20.5	14.4

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
386	Inflammatory bowel disease w CC	26	0.7655	22.9	19.1	9.0
387	Inflammatory bowel disease w/o CC/MCC	5	0.7655	22.9	19.1	6.9
388	G.I. obstruction w MCC	191	0.8967	22.8	19.0	12.0
389	G.I. obstruction w CC	91	0.7893	21.9	18.3	8.0
390	G.I. obstruction w/o CC/MCC	12	0.7893	21.9	18.3	5.5
391	Esophagitis, gastroent & misc digest disorders w MCC	246	0.8509	24.4	20.3	8.7
392	Esophagitis, gastroent & misc digest disorders w/o MCC	266	0.6943	20.4	17.0	5.5
393	Other digestive system diagnoses w MCC	678	0.9915	25.5	21.3	11.4
394	Other digestive system diagnoses w CC	388	0.8523	22.0	18.3	7.7
395	Other digestive system diagnoses w/o CC/MCC	31	0.7214	20.9	17.4	5.3
405	Pancreas, liver & shunt procedures w MCC	9	1.5545	35.2	29.3	29.0
406	Pancreas, liver & shunt procedures w CC	2	1.5545	35.2	29.3	16.0
407	Pancreas, liver & shunt procedures w/o CC/MCC	1	1.1417	29.0	24.2	9.2
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	1	1.5545	35.2	29.3	23.7
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	1	1.5545	35.2	29.3	15.4
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	0	1.5545	35.2	29.3	10.6
411	Cholecystectomy w c.d.e. w MCC	0	1.1417	29.0	24.2	20.3
412	Cholecystectomy w c.d.e. w CC	1	1.1417	29.0	24.2	13.5
413	Cholecystectomy w c.d.e. w/o CC/MCC	0	1.1417	29.0	24.2	9.3
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	2	1.1417	29.0	24.2	18.4
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	3	1.1417	29.0	24.2	11.6
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	0	1.1417	29.0	24.2	7.5
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	7	1.5545	35.2	29.3	13.5
418	Laparoscopic cholecystectomy w/o c.d.e. w CC	5	1.1417	29.0	24.2	9.0
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	0	1.1417	29.0	24.2	5.0
420	Hepatobiliary diagnostic procedures w MCC	2	1.1417	29.0	24.2	24.2

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
421	Hepatobiliary diagnostic procedures w CC	1	0.8249	25.0	20.8	12.9
422	Hepatobiliary diagnostic procedures w/o CC/MCC	0	0.8249	25.0	20.8	7.3
423	Other hepatobiliary or pancreas O.R. procedures w MCC	23	1.1417	29.0	24.2	24.2
424	Other hepatobiliary or pancreas O.R. procedures w CC	5	0.8249	25.0	20.8	17.1
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0	0.8249	25.0	20.8	9.2
432	Cirrhosis & alcoholic hepatitis w MCC	98	0.6223	19.0	15.8	11.1
433	Cirrhosis & alcoholic hepatitis w CC	21	0.6223	19.0	15.8	7.7
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	1	0.5472	20.3	16.9	5.7
435	Malignancy of hepatobiliary system or pancreas w MCC	47	0.7422	20.2	16.8	12.6
436	Malignancy of hepatobiliary system or pancreas w CC	34	0.7086	19.6	16.3	9.5
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	4	0.7086	19.6	16.3	7.1
438	Disorders of pancreas except malignancy w MCC	251	1.0057	24.3	20.3	12.5
439	Disorders of pancreas except malignancy w CC	166	0.8437	21.9	18.3	8.5
440	Disorders of pancreas except malignancy w/o CC/MCC	28	0.7204	18.8	15.7	5.9
441	Disorders of liver except malig,cirr,alc hepa w MCC	116	0.7588	21.8	18.2	11.3
442	Disorders of liver except malig,cirr,alc hepa w CC	67	0.6925	21.2	17.7	8.1
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	12	0.6925	21.2	17.7	6.0
444	Disorders of the biliary tract w MCC	71	0.8181	24.0	20.0	10.7
445	Disorders of the biliary tract w CC	41	0.6977	21.7	18.1	7.6
446	Disorders of the biliary tract w/o CC/MCC	7	0.5472	20.3	16.9	5.2
453	Combined anterior/posterior spinal fusion w MCC	0	1.5545	35.2	29.3	24.9
454	Combined anterior/posterior spinal fusion w CC	1	1.5545	35.2	29.3	12.7
455	Combined anterior/posterior spinal fusion w/o CC/MCC	0	1.5545	35.2	29.3	7.1
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	1	1.5545	35.2	29.3	24.9
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	0	1.5545	35.2	29.3	11.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	0	1.5545	35.2	29.3	6.8
459	Spinal fusion except cervical w MCC	2	1.5545	35.2	29.3	14.7
460	Spinal fusion except cervical w/o MCC	3	1.5545	35.2	29.3	6.4
461	Bilateral or multiple major joint procs of lower extremity w MCC	0	1.5545	35.2	29.3	12.6
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	0	1.1417	29.0	24.2	5.8
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	507	1.3514	38.8	32.3	27.4
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	311	1.1906	36.3	30.3	16.8
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	60	1.0747	29.6	24.7	10.0
466	Revision of hip or knee replacement w MCC	3	1.5545	35.2	29.3	14.5
467	Revision of hip or knee replacement w CC	4	1.5545	35.2	29.3	8.0
468	Revision of hip or knee replacement w/o CC/MCC	0	1.5545	35.2	29.3	5.5
469	Major joint replacement or reattachment of lower extremity w MCC	2	1.5545	35.2	29.3	12.6
470	Major joint replacement or reattachment of lower extremity w/o MCC	2	1.5545	35.2	29.3	5.4
471	Cervical spinal fusion w MCC	5	1.5545	35.2	29.3	17.3
472	Cervical spinal fusion w CC	2	1.5545	35.2	29.3	7.0
473	Cervical spinal fusion w/o CC/MCC	0	1.5545	35.2	29.3	2.9
474	Amputation for musculoskeletal sys & conn tissue dis w MCC	91	1.3338	36.6	30.5	20.4
475	Amputation for musculoskeletal sys & conn tissue dis w CC	53	1.1390	32.7	27.3	13.9
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	8	1.1390	32.7	27.3	8.0
477	Biopsies of musculoskeletal system & connective tissue w MCC	13	1.5545	35.2	29.3	20.7
478	Biopsies of musculoskeletal system & connective tissue w CC	14	1.1417	29.0	24.2	11.9
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	5	1.1417	29.0	24.2	4.3
480	Hip & femur procedures except major joint w MCC	11	1.5545	35.2	29.3	14.1
481	Hip & femur procedures except major joint w CC	19	1.5545	35.2	29.3	8.4

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
482	Hip & femur procedures except major joint w/o CC/MCC	1	1.1417	29.0	24.2	6.8
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	0	1.5545	35.2	29.3	6.6
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	0	1.1417	29.0	24.2	3.6
485	Knee procedures w pdx of infection w MCC	10	1.5545	35.2	29.3	18.9
486	Knee procedures w pdx of infection w CC	9	1.1417	29.0	24.2	12.3
487	Knee procedures w pdx of infection w/o CC/MCC	1	1.1417	29.0	24.2	8.5
488	Knee procedures w/o pdx of infection w CC/MCC	2	1.5545	35.2	29.3	7.8
489	Knee procedures w/o pdx of infection w/o CC/MCC	0	1.5545	35.2	29.3	4.7
490	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	7	1.1417	29.0	24.2	7.6
491	Back & neck proc exc spinal fusion w/o CC/MCC	0	1.1417	29.0	24.2	3.4
492	Lower extrem & humer proc except hip,foot,femur w MCC	5	1.5545	35.2	29.3	13.6
493	Lower extrem & humer proc except hip,foot,femur w CC	19	1.1417	29.0	24.2	8.2
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1	0.8249	25.0	20.8	5.1
495	Local excision & removal int fix devices exc hip & femur w MCC	32	1.3650	38.1	31.8	18.2
496	Local excision & removal int fix devices exc hip & femur w CC	25	1.1981	36.8	30.7	9.8
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	3	1.1417	29.0	24.2	4.9
498	Local excision & removal int fix devices of hip & femur w CC/MCC	8	1.5545	35.2	29.3	13.4
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC	2	0.7305	22.9	19.1	4.9
500	Soft tissue procedures w MCC	46	1.3212	35.2	29.3	18.8
501	Soft tissue procedures w CC	28	1.2903	30.7	25.6	9.6
502	Soft tissue procedures w/o CC/MCC	3	0.8249	25.0	20.8	4.5
503	Foot procedures w MCC	18	1.1417	29.0	24.2	14.6
504	Foot procedures w CC	13	0.8249	25.0	20.8	10.5
505	Foot procedures w/o CC/MCC	1	0.5472	20.3	16.9	5.3
506	Major thumb or joint procedures	0	0.7305	22.9	19.1	5.0
507	Major shoulder or elbow joint procedures w CC/MCC	3	0.8249	25.0	20.8	8.4
508	Major shoulder or elbow joint procedures w/o CC/MCC	0	0.8249	25.0	20.8	3.0

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
509	Arthroscopy	0	0.5472	20.3	16.9	4.2
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	0	1.1417	29.0	24.2	10.7
511	Shoulder,elbow or forearm proc,exc major joint proc w CC	4	1.1417	29.0	24.2	6.2
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	1	0.5472	20.3	16.9	3.1
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	4	1.5545	35.2	29.3	8.4
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	4	0.7305	22.9	19.1	4.0
515	Other musculoskelet sys & conn tiss O.R. proc w MCC	49	1.3230	34.8	29.0	18.1
516	Other musculoskelet sys & conn tiss O.R. proc w CC	21	1.1417	29.0	24.2	10.1
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	6	0.8249	25.0	20.8	4.5
533	Fractures of femur w MCC	3	0.8249	25.0	20.8	11.2
534	Fractures of femur w/o MCC	7	0.7305	22.9	19.1	6.3
535	Fractures of hip & pelvis w MCC	19	0.7305	22.9	19.1	10.1
536	Fractures of hip & pelvis w/o MCC	33	0.5998	23.7	19.8	6.0
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0	0.5472	20.3	16.9	7.3
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0	0.5472	20.3	16.9	4.8
539	Osteomyelitis w MCC	936	0.9013	29.7	24.8	16.2
540	Osteomyelitis w CC	767	0.8107	28.7	23.9	11.3
541	Osteomyelitis w/o CC/MCC	252	0.7787	26.9	22.4	8.9
542	Pathological fractures & musculoskelet & conn tiss malig w MCC	56	0.7359	21.7	18.1	14.0
543	Pathological fractures & musculoskelet & conn tiss malig w CC	61	0.6347	21.3	17.8	9.4
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	17	0.5472	20.3	16.9	6.8
545	Connective tissue disorders w MCC	57	0.8501	23.9	19.9	14.7
546	Connective tissue disorders w CC	38	0.6492	20.7	17.3	8.7
547	Connective tissue disorders w/o CC/MCC	14	0.5472	20.3	16.9	6.1
548	Septic arthritis w MCC	167	0.8584	28.2	23.5	15.0
549	Septic arthritis w CC	199	0.7347	26.4	22.0	9.8
550	Septic arthritis w/o CC/MCC	66	0.6704	23.5	19.6	7.2
551	Medical back problems w MCC	107	0.7305	26.6	22.2	11.6
552	Medical back problems w/o MCC	241	0.6022	22.8	19.0	6.5
553	Bone diseases & arthropathies w MCC	24	0.8249	25.0	20.8	9.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
554	Bone diseases & arthropathies w/o MCC	66	0.4822	20.5	17.1	5.8
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	13	0.7305	22.9	19.1	7.8
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	16	0.7305	22.9	19.1	5.0
557	Tendonitis, myositis & bursitis w MCC	86	0.8177	25.9	21.6	11.0
558	Tendonitis, myositis & bursitis w/o MCC	113	0.6919	21.4	17.8	6.6
559	Aftercare, musculoskeletal system & connective tissue w MCC	1,370	0.7157	26.2	21.8	11.9
560	Aftercare, musculoskeletal system & connective tissue w CC	2,078	0.6393	24.6	20.5	7.5
561	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	970	0.5889	21.7	18.1	4.2
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	6	1.1417	29.0	24.2	10.4
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	22	0.5472	20.3	16.9	5.7
564	Other musculoskeletal sys & connective tissue diagnoses w MCC	241	0.8134	24.9	20.8	11.6
565	Other musculoskeletal sys & connective tissue diagnoses w CC	239	0.7382	24.8	20.7	8.1
566	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	62	0.6862	22.1	18.4	5.9
573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1,864	1.3068	38.0	31.7	22.2
574	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1,911	1.1567	37.1	30.9	14.9
575	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	193	0.9938	31.7	26.4	9.4
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	22	1.5545	35.2	29.3	20.3
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	24	1.1417	29.0	24.2	9.9
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	5	0.7305	22.9	19.1	5.4
579	Other skin, subcut tiss & breast proc w MCC	493	1.2793	36.8	30.7	18.5
580	Other skin, subcut tiss & breast proc w CC	418	1.1001	34.8	29.0	9.0
581	Other skin, subcut tiss & breast proc w/o CC/MCC	29	0.9100	29.9	24.9	3.9

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
582	Mastectomy for malignancy w CC/MCC	2	1.5545	35.2	29.3	4.3
583	Mastectomy for malignancy w/o CC/MCC	0	1.5545	35.2	29.3	2.6
584	Breast biopsy, local excision & other breast procedures w CC/MCC	2	1.1417	29.0	24.2	9.5
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0	1.1417	29.0	24.2	3.2
592	Skin ulcers w MCC	2,994	0.8875	27.1	22.6	14.2
593	Skin ulcers w CC	3,139	0.7877	26.8	22.3	10.0
594	Skin ulcers w/o CC/MCC	405	0.7342	24.3	20.3	7.7
595	Major skin disorders w MCC	30	0.7525	24.5	20.4	13.2
596	Major skin disorders w/o MCC	53	0.6155	23.8	19.8	7.6
597	Malignant breast disorders w MCC	13	0.8249	25.0	20.8	13.7
598	Malignant breast disorders w CC	17	0.7305	22.9	19.1	9.0
599	Malignant breast disorders w/o CC/MCC	4	0.7305	22.9	19.1	5.7
600	Non-malignant breast disorders w CC/MCC	12	0.7305	22.9	19.1	8.5
601	Non-malignant breast disorders w/o CC/MCC	9	0.7305	22.9	19.1	6.0
602	Cellulitis w MCC	758	0.6643	22.5	18.8	11.1
603	Cellulitis w/o MCC	1,487	0.5528	19.4	16.2	7.3
604	Trauma to the skin, subcut tiss & breast w MCC	23	0.8249	25.0	20.8	8.8
605	Trauma to the skin, subcut tiss & breast w/o MCC	59	0.5685	21.2	17.7	5.4
606	Minor skin disorders w MCC	60	0.8324	23.2	19.3	9.5
607	Minor skin disorders w/o MCC	84	0.6776	22.6	18.8	5.9
614	Adrenal & pituitary procedures w CC/MCC	0	1.2008	33.1	27.6	11.6
615	Adrenal & pituitary procedures w/o CC/MCC	0	0.7305	22.9	19.1	5.1
616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	62	1.4505	41.0	34.2	24.2
617	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	117	1.2414	33.3	27.8	14.5
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	2	0.8249	25.0	20.8	9.9
619	O.R. procedures for obesity w MCC	2	0.8249	25.0	20.8	14.6
620	O.R. procedures for obesity w CC	3	0.8249	25.0	20.8	6.3
621	O.R. procedures for obesity w/o CC/MCC	0	0.8249	25.0	20.8	3.6
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	165	1.1462	35.6	29.7	21.1

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	341	1.0197	32.2	26.8	13.5
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	13	0.8249	25.0	20.8	9.4
625	Thyroid, parathyroid & thyroglossal procedures w MCC	0	1.3385	36.6	30.5	12.4
626	Thyroid, parathyroid & thyroglossal procedures w CC	0	1.2008	33.1	27.6	5.0
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0	0.7305	22.9	19.1	2.1
628	Other endocrine, nutrit & metab O.R. proc w MCC	54	1.3385	36.6	30.5	20.1
629	Other endocrine, nutrit & metab O.R. proc w CC	90	1.2008	33.1	27.6	14.3
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	4	0.7305	22.9	19.1	8.4
637	Diabetes w MCC	363	0.7726	25.8	21.5	9.8
638	Diabetes w CC	1,062	0.6757	24.0	20.0	6.7
639	Diabetes w/o CC/MCC	92	0.6064	20.6	17.2	4.7
640	Nutritional & misc metabolic disorders w MCC	607	0.7879	23.2	19.3	9.1
641	Nutritional & misc metabolic disorders w/o MCC	615	0.6889	22.0	18.3	6.0
642	Inborn errors of metabolism	4	0.7305	22.9	19.1	8.3
643	Endocrine disorders w MCC	29	0.7358	24.9	20.8	12.4
644	Endocrine disorders w CC	18	0.7358	24.9	20.8	8.6
645	Endocrine disorders w/o CC/MCC	6	0.5472	20.3	16.9	6.1
652	Kidney transplant	0	0.0000	0.0	0.0	0.0
653	Major bladder procedures w MCC	0	1.1417	29.0	24.2	24.2
654	Major bladder procedures w CC	0	0.7305	22.9	19.1	14.7
655	Major bladder procedures w/o CC/MCC	0	0.5472	20.3	16.9	10.0
656	Kidney & ureter procedures for neoplasm w MCC	0	0.8249	25.0	20.8	16.8
657	Kidney & ureter procedures forneoplasm w CC	1	0.8249	25.0	20.8	9.2
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	0	0.8249	25.0	20.8	5.7
659	Kidney & ureter procedures for non-neoplasm w MCC	9	1.1417	29.0	24.2	18.5
660	Kidney & ureter procedures for non-neoplasm w CC	4	0.7305	22.9	19.1	10.6
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1	0.5472	20.3	16.9	5.1
662	Minor bladder procedures w MCC	2	0.8249	25.0	20.8	17.7
663	Minor bladder procedures w CC	0	0.8249	25.0	20.8	8.5

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
664	Minor bladder procedures w/o CC/MCC	1	1.5545	35.2	29.3	3.0
665	Prostatectomy w MCC	2	0.8249	25.0	20.8	20.2
666	Prostatectomy w CC	0	0.8249	25.0	20.8	10.7
667	Prostatectomy w/o CC/MCC	1	1.1417	29.0	24.2	4.0
668	Transurethral procedures w MCC	8	1.5545	35.2	29.3	14.4
669	Transurethral procedures w CC	5	1.5545	35.2	29.3	7.0
670	Transurethral procedures w/o CC/MCC	0	0.8249	25.0	20.8	3.7
671	Urethral procedures w CC/MCC	0	0.7305	22.9	19.1	9.6
672	Urethral procedures w/o CC/MCC	0	0.5472	20.3	16.9	3.8
673	Other kidney & urinary tract procedures w MCC	226	1.3255	33.6	28.0	17.6
674	Other kidney & urinary tract procedures w CC	95	1.2557	30.6	25.5	11.1
675	Other kidney & urinary tract procedures w/o CC/MCC	6	1.1417	29.0	24.2	2.7
682	Renal failure w MCC	1,328	0.8553	23.6	19.7	12.1
683	Renal failure w CC	785	0.7752	21.8	18.2	9.0
684	Renal failure w/o CC/MCC	124	0.7121	20.5	17.1	5.9
685	Admit for renal dialysis	51	0.7726	26.0	21.7	5.4
686	Kidney & urinary tract neoplasms w MCC	31	0.8933	23.6	19.7	13.2
687	Kidney & urinary tract neoplasms w CC	17	0.7305	22.9	19.1	8.5
688	Kidney & urinary tract neoplasms w/o CC/MCC	3	0.5472	20.3	16.9	5.1
689	Kidney & urinary tract infections w MCC	763	0.6624	22.9	19.1	9.9
690	Kidney & urinary tract infections w/o MCC	724	0.5655	20.2	16.8	6.6
691	Urinary stones w esw lithotripsy w CC/MCC	4	1.5545	35.2	29.3	6.6
692	Urinary stones w esw lithotripsy w/o CC/MCC	0	1.5545	35.2	29.3	3.4
693	Urinary stones w/o esw lithotripsy w MCC	16	0.7305	22.9	19.1	8.4
694	Urinary stones w/o esw lithotripsy w/o MCC	12	0.7305	22.9	19.1	3.9
695	Kidney & urinary tract signs & symptoms w MCC	4	0.8249	25.0	20.8	9.1
696	Kidney & urinary tract signs & symptoms w/o MCC	1	0.5472	20.3	16.9	5.0
697	Urethral stricture	0	0.5472	20.3	16.9	5.1
698	Other kidney & urinary tract diagnoses w MCC	269	0.7919	22.6	18.8	10.9
699	Other kidney & urinary tract diagnoses w CC	179	0.7293	22.1	18.4	7.7

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
700	Other kidney & urinary tract diagnoses w/o CC/MCC	27	0.6052	19.6	16.3	5.4
707	Major male pelvic procedures w CC/MCC	0	0.7305	22.9	19.1	6.9
708	Major male pelvic procedures w/o CC/MCC	0	0.5472	20.3	16.9	3.5
709	Penis procedures w CC/MCC	6	1.1417	29.0	24.2	10.3
710	Penis procedures w/o CC/MCC	0	1.1417	29.0	24.2	2.7
711	Testes procedures w CC/MCC	8	1.1417	29.0	24.2	13.2
712	Testes procedures w/o CC/MCC	0	1.1417	29.0	24.2	4.6
713	Transurethral prostatectomy w CC/MCC	1	1.5545	35.2	29.3	6.5
714	Transurethral prostatectomy w/o CC/MCC	1	0.5472	20.3	16.9	2.9
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	1	1.5545	35.2	29.3	10.1
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	0	1.5545	35.2	29.3	2.0
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	17	1.1417	29.0	24.2	12.4
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	2	0.5472	20.3	16.9	4.1
722	Malignancy, male reproductive system w MCC	12	0.8249	25.0	20.8	12.1
723	Malignancy, male reproductive system w CC	9	0.7305	22.9	19.1	8.6
724	Malignancy, male reproductive system w/o CC/MCC	1	0.5472	20.3	16.9	5.3
725	Benign prostatic hypertrophy w MCC	2	1.1417	29.0	24.2	9.0
726	Benign prostatic hypertrophy w/o MCC	3	0.5472	20.3	16.9	5.5
727	Inflammation of the male reproductive system w MCC	37	0.7754	25.9	21.6	10.4
728	Inflammation of the male reproductive system w/o MCC	56	0.6172	20.8	17.3	6.2
729	Other male reproductive system diagnoses w CC/MCC	34	1.0319	26.6	22.2	8.4
730	Other male reproductive system diagnoses w/o CC/MCC	2	0.7305	22.9	19.1	4.9
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	0	1.1417	29.0	24.2	11.8
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0	0.5472	20.3	16.9	5.3
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	0	1.1417	29.0	24.2	21.5
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	0	0.8249	25.0	20.8	11.0

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	0	0.5472	20.3	16.9	5.6
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	0	1.1417	29.0	24.2	15.9
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	0	0.8249	25.0	20.8	7.7
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	0	0.5472	20.3	16.9	4.5
742	Uterine & adnexa proc for non-malignancy w CC/MCC	0	0.8249	25.0	20.8	6.9
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0	0.5472	20.3	16.9	3.3
744	D&C, conization, laparascopy & tubal interruption w CC/MCC	1	0.8249	25.0	20.8	9.3
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0	0.8249	25.0	20.8	3.8
746	Vagina, cervix & vulva procedures w CC/MCC	3	0.8249	25.0	20.8	6.4
747	Vagina, cervix & vulva procedures w/o CC/MCC	0	0.8249	25.0	20.8	2.8
748	Female reproductive system reconstructive procedures	0	0.8249	25.0	20.8	2.6
749	Other female reproductive system O.R. procedures w CC/MCC	3	0.8249	25.0	20.8	16.3
750	Other female reproductive system O.R. procedures w/o CC/MCC	0	0.8249	25.0	20.8	5.1
754	Malignancy, female reproductive system w MCC	14	1.1417	29.0	24.2	14.7
755	Malignancy, female reproductive system w CC	15	0.8249	25.0	20.8	9.1
756	Malignancy, female reproductive system w/o CC/MCC	1	0.5472	20.3	16.9	5.1
757	Infections, female reproductive system w MCC	29	0.8375	22.6	18.8	13.9
758	Infections, female reproductive system w CC	25	0.8317	27.2	22.7	9.5
759	Infections, female reproductive system w/o CC/MCC	4	0.5472	20.3	16.9	7.2
760	Menstrual & other female reproductive system disorders w CC/MCC	3	1.1417	29.0	24.2	6.0
761	Menstrual & other female reproductive system disorders w/o CC/MCC	1	0.5472	20.3	16.9	3.8
765	Cesarean section w CC/MCC	0	0.8249	25.0	20.8	7.4
766	Cesarean section w/o CC/MCC	0	0.7305	22.9	19.1	4.3
767	Vaginal delivery w sterilization &/or D&C	0	0.7305	22.9	19.1	4.1

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
768	Vaginal delivery w O.R. proc except steril &/or D&C	0	0.7305	22.9	19.1	8.9
769	Postpartum & post abortion diagnoses w O.R. procedure	1	0.7305	22.9	19.1	8.6
770	Abortion w D&C, aspiration curettage or hysterotomy	0	0.7305	22.9	19.1	3.5
774	Vaginal delivery w complicating diagnoses	0	0.7305	22.9	19.1	4.5
775	Vaginal delivery w/o complicating diagnoses	0	0.7305	22.9	19.1	3.1
776	Postpartum & post abortion diagnoses w/o O.R. procedure	3	1.1417	29.0	24.2	5.4
777	Ectopic pregnancy	0	0.7305	22.9	19.1	3.0
778	Threatened abortion	0	0.5472	20.3	16.9	4.2
779	Abortion w/o D&C	0	0.5472	20.3	16.9	3.6
780	False labor	0	0.5472	20.3	16.9	2.7
781	Other antepartum diagnoses w medical complications	1	1.1417	29.0	24.2	5.9
782	Other antepartum diagnoses w/o medical complications	0	0.5472	20.3	16.9	3.6
789	Neonates, died or transferred to another acute care facility	0	0.5472	20.3	16.9	1.5
790	Extreme immaturity or respiratory distress syndrome, neonate	0	0.5472	20.3	16.9	16.9
791	Prematurity w major problems	0	1.1417	29.0	24.2	13.3
792	Prematurity w/o major problems	0	0.5472	20.3	16.9	8.6
793	Full term neonate w major problems	0	1.1417	29.0	24.2	17.6
794	Neonate w other significant problems	0	1.1417	29.0	24.2	1.7
795	Normal newborn	0	0.5472	20.3	16.9	3.1
799	Splenectomy w MCC	0	1.1417	29.0	24.2	23.5
800	Splenectomy w CC	0	0.8249	25.0	20.8	13.0
801	Splenectomy w/o CC/MCC	0	0.8249	25.0	20.8	7.5
802	Other O.R. proc of the blood & blood forming organs w MCC	7	1.5545	35.2	29.3	21.4
803	Other O.R. proc of the blood & blood forming organs w CC	3	0.7305	22.9	19.1	10.8
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	0	0.7305	22.9	19.1	5.2
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	26	0.8009	20.7	17.3	12.8
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC	23	0.8009	20.7	17.3	7.9
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	3	0.8009	20.7	17.3	6.2
811	Red blood cell disorders w MCC	36	0.6655	23.2	19.3	9.0
812	Red blood cell disorders w/o MCC	45	0.5699	19.5	16.3	5.9
813	Coagulation disorders	48	0.8015	21.5	17.9	8.3

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
814	Reticuloendothelial & immunity disorders w MCC	40	0.7474	22.6	18.8	11.7
815	Reticuloendothelial & immunity disorders w CC	18	0.7305	22.9	19.1	7.8
816	Reticuloendothelial & immunity disorders w/o CC/MCC	5	0.7305	22.9	19.1	5.3
820	Lymphoma & leukemia w major O.R. procedure w MCC	0	0.8249	25.0	20.8	20.8
821	Lymphoma & leukemia w major O.R. procedure w CC	2	0.8249	25.0	20.8	13.3
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	0	0.8249	25.0	20.8	5.9
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	12	1.1417	29.0	24.2	24.2
824	Lymphoma & non-acute leukemia w other O.R. proc w CC	3	1.1417	29.0	24.2	14.8
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	1	0.5472	20.3	16.9	7.8
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	1	0.8249	25.0	20.8	20.8
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	0	0.8249	25.0	20.8	12.4
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0	0.8249	25.0	20.8	5.9
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	9	1.5545	35.2	29.3	17.8
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	0	1.5545	35.2	29.3	5.5
834	Acute leukemia w/o major O.R. procedure w MCC	20	1.1417	29.0	24.2	24.2
835	Acute leukemia w/o major O.R. procedure w CC	3	0.8249	25.0	20.8	13.5
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC	1	0.5472	20.3	16.9	8.0
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	1	1.5545	35.2	29.3	29.3
838	Chemo w acute leukemia as sdx w CC or high dose chemo agent	2	0.8249	25.0	20.8	13.7
839	Chemo w acute leukemia as sdx w/o CC/MCC	0	1.5545	35.2	29.3	9.1
840	Lymphoma & non-acute leukemia w MCC	175	0.8718	20.8	17.3	16.1
841	Lymphoma & non-acute leukemia w CC	64	0.8026	20.1	16.8	10.7
842	Lymphoma & non-acute leukemia w/o CC/MCC	10	0.7305	22.9	19.1	6.9

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
843	Other myeloprolif dis or poorly diff neopl diag w MCC	19	1.1417	29.0	24.2	14.5
844	Other myeloprolif dis or poorly diff neopl diag w CC	13	1.1417	29.0	24.2	9.7
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	3	1.1417	29.0	24.2	6.8
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	32	1.6788	37.4	31.2	13.8
847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	61	1.4350	27.6	23.0	5.0
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	1	0.7305	22.9	19.1	4.6
849	Radiotherapy	141	0.8994	23.5	19.6	9.5
853	Infectious & parasitic diseases w O.R. procedure w MCC	703	1.7687	38.1	31.8	27.6
854	Infectious & parasitic diseases w O.R. procedure w CC	95	1.4381	30.8	25.7	17.4
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	1	0.7305	22.9	19.1	12.2
856	Postoperative or post-traumatic infections w O.R. proc w MCC	335	1.4470	36.1	30.1	26.5
857	Postoperative or post-traumatic infections w O.R. proc w CC	232	1.1886	31.5	26.3	14.1
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	28	1.1109	28.4	23.7	9.5
862	Postoperative & post-traumatic infections w MCC	1,178	0.8670	25.2	21.0	13.4
863	Postoperative & post-traumatic infections w/o MCC	1,304	0.7478	23.4	19.5	8.2
864	Fever of unknown origin	16	0.7305	22.9	19.1	6.4
865	Viral illness w MCC	56	0.7823	21.8	18.2	11.0
866	Viral illness w/o MCC	33	0.6431	21.2	17.7	5.4
867	Other infectious & parasitic diseases diagnoses w MCC	292	1.0954	23.6	19.7	16.2
868	Other infectious & parasitic diseases diagnoses w CC	79	0.8869	22.0	18.3	9.3
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC	11	0.5472	20.3	16.9	6.8
870	Septicemia w MV 96+ hours	588	1.9505	30.5	25.4	23.6
871	Septicemia w/o MV 96+ hours w MCC	3,883	0.8299	23.5	19.6	13.0
872	Septicemia w/o MV 96+ hours w/o MCC	1,543	0.7340	21.9	18.3	9.1
876	O.R. procedure w principal diagnoses of mental illness	5	0.7305	22.9	19.1	19.1
880	Acute adjustment reaction & psychosocial dysfunction	19	0.5472	20.3	16.9	5.0
881	Depressive neuroses	15	0.5472	20.3	16.9	6.6

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
882	Neuroses except depressive	16	0.5472	20.3	16.9	6.9
883	Disorders of personality & impulse control	15	0.5472	20.3	16.9	11.8
884	Organic disturbances & mental retardation	200	0.4883	23.3	19.4	8.3
885	Psychoses	1,390	0.4140	23.8	19.8	12.3
886	Behavioral & developmental disorders	18	0.5472	20.3	16.9	9.4
887	Other mental disorder diagnoses	0	0.5472	20.3	16.9	7.1
894	Alcohol/drug abuse or dependence, left ama	1	0.5472	20.3	16.9	4.5
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1	0.5472	20.3	16.9	16.8
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	10	0.8249	25.0	20.8	10.6
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	23	0.5472	20.3	16.9	6.4
901	Wound debridements for injuries w MCC	222	1.3395	35.2	29.3	23.7
902	Wound debridements for injuries w CC	160	1.1605	33.5	27.9	12.9
903	Wound debridements for injuries w/o CC/MCC	23	0.7305	22.9	19.1	7.9
904	Skin grafts for injuries w CC/MCC	90	1.3351	40.8	34.0	18.8
905	Skin grafts for injuries w/o CC/MCC	6	0.7305	22.9	19.1	7.7
906	Hand procedures for injuries	1	0.5472	20.3	16.9	4.9
907	Other O.R. procedures for injuries w MCC	85	1.6622	36.8	30.7	19.4
908	Other O.R. procedures for injuries w CC	45	1.3966	34.1	28.4	11.3
909	Other O.R. procedures for injuries w/o CC/MCC	5	0.8249	25.0	20.8	5.7
913	Traumatic injury w MCC	51	0.8462	26.9	22.4	10.0
914	Traumatic injury w/o MCC	72	0.6448	21.9	18.3	5.3
915	Allergic reactions w MCC	0	0.5472	20.3	16.9	7.5
916	Allergic reactions w/o MCC	1	0.5472	20.3	16.9	3.2
917	Poisoning & toxic effects of drugs w MCC	7	0.7305	22.9	19.1	8.3
918	Poisoning & toxic effects of drugs w/o MCC	6	0.7305	22.9	19.1	4.2
919	Complications of treatment w MCC	1,072	0.9858	26.3	21.9	10.1
920	Complications of treatment w CC	826	0.8518	24.6	20.5	6.8
921	Complications of treatment w/o CC/MCC	95	0.7511	23.0	19.2	4.5
922	Other injury, poisoning & toxic effect diag w MCC	5	0.5472	20.3	16.9	10.0
923	Other injury, poisoning & toxic effect diag w/o MCC	9	0.5472	20.3	16.9	5.0

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	0	1.5545	35.2	29.3	29.3
928	Full thickness burn w skin graft or inhal inj w CC/MCC	10	1.1417	29.0	24.2	24.2
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC	1	0.7305	22.9	19.1	13.1
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	7	1.5545	35.2	29.3	8.5
934	Full thickness burn w/o skin grft or inhal inj	48	0.6998	24.2	20.2	11.1
935	Non-extensive burns	40	0.7525	24.9	20.8	8.8
939	O.R. proc w diagnoses of other contact w health services w MCC	381	1.2500	33.8	28.2	18.9
940	O.R. proc w diagnoses of other contact w health services w CC	212	1.1066	33.8	28.2	10.5
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	36	0.9719	28.8	24.0	4.8
945	Rehabilitation w CC/MCC	2,241	0.5867	22.2	18.5	16.3
946	Rehabilitation w/o CC/MCC	472	0.4935	18.9	15.8	11.7
947	Signs & symptoms w MCC	80	0.6340	22.7	18.9	7.9
948	Signs & symptoms w/o MCC	137	0.5642	23.4	19.5	5.3
949	Aftercare w CC/MCC	4,564	0.6693	22.1	18.4	6.1
950	Aftercare w/o CC/MCC	759	0.5735	18.5	15.4	5.1
951	Other factors influencing health status	38	1.5837	26.2	21.8	5.0
955	Craniotomy for multiple significant trauma	0	1.5545	35.2	29.3	21.9
956	Limb reattachment, hip & femur proc for multiple significant trauma	1	0.7305	22.9	19.1	14.4
957	Other O.R. procedures for multiple significant trauma w MCC	3	1.5545	35.2	29.3	29.1
958	Other O.R. procedures for multiple significant trauma w CC	1	1.1417	29.0	24.2	17.9
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	0	1.1417	29.0	24.2	9.9
963	Other multiple significant trauma w MCC	14	1.5545	35.2	29.3	16.5
964	Other multiple significant trauma w CC	10	0.7305	22.9	19.1	10.2
965	Other multiple significant trauma w/o CC/MCC	1	0.5472	20.3	16.9	6.5
969	HIV w extensive O.R. procedure w MCC	10	1.5545	35.2	29.3	29.3
970	HIV w extensive O.R. procedure w/o MCC	0	1.5545	35.2	29.3	15.8
974	HIV w major related condition w MCC	162	0.8908	21.9	18.3	17.5

MS-LTC-DRG	MS-DRG Title	FY 2006 LTCH Cases	Relative Weight[1]	Geometric Average Length Of Stay	Short Stay Outlier Threshold[2]	IPPS Comparable Threshold[3]
975	HIV w major related condition w CC	74	0.7492	21.3	17.8	11.5
976	HIV w major related condition w/o CC/MCC	35	0.7382	18.0	15.0	7.7
977	HIV w or w/o other related condition	22	0.7305	22.9	19.1	8.3
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	1,073	2.2339	42.0	35.0	24.6
982	Extensive O.R. procedure unrelated to principal diagnosis w CC	282	1.8277	37.6	31.3	16.3
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	19	1.1417	29.0	24.2	9.0
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	14	1.5545	35.2	29.3	23.7
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC	13	1.1417	29.0	24.2	16.6
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1	1.1417	29.0	24.2	8.5
987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	389	1.6972	37.9	31.6	21.9
988	Non-extensive O.R. proc unrelated to principal diagnosis w CC	184	1.3386	33.2	27.7	13.2
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	19	0.8249	25.0	20.8	6.7
998	Principal diagnosis invalid as discharge diagnosis	0	0.0000	0.0	0.0	0.0
999	Ungroupable	0	0.0000	0.0	0.0	0.0

[1] Transition blended relative weights for FY 2008 determined as described in Step 7 in section II.I.4. of the preamble of this final rule.

[2] The "short-stay outlier threshold" is calculated as 5/6ths of the geometric average length of stay of the LTC-DRG (as specified at §412.529(a), in conjunction with new §412.503).

[3] The "IPPS-comparable threshold" is calculated as one standard deviation from the geometric average length of stay of the same DRG under the IPPS as specified at §412.529(c)(3)(i). Note, as discussed in the RY 2008 LTCH PPS final rule (72 FR 26907), for some MS-LTC-DRGs, it was sometimes necessary to supplement IPPS hospital statistical data due to a low volume of IPPS cases, and for some MS-LTC-DRGs although IPPS hospital data may be available, a value of zero was assigned. In addition, we note that the "IPPS comparable threshold" is only applicable in the context of the payment adjustment for short-stay outliers (SSOs) at §412.529. A LTCH case that has a covered length of stay that exceeds the "SSO threshold" (and therefore is not an SSO case) but is within the value of the "IPPS comparable threshold" computed from IPPS statistical data would not be subject to the SSO adjustments at §412.529. So that it is clear that the "IPPS comparable threshold" only applies to LTCH cases that are SSOs, in instances where the value of the "IPPS comparable threshold" computed from IPPS statistical data for an MS-LTC-DRG is greater than the" SSO threshold" for the same MS-LTC-DRG, in this table we have substituted the computed value of the "IPPS comparable threshold" for the MS-LTC-DRG with the value of the "SSO threshold" (in column 6) for the same MS-LTC-DRG.

Appendix A - Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule 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, and Executive Order 13422) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the changes for FY 2008 operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The market basket update to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule with comment period, will result in an approximate $3.8 billion increase in FY 2008 operating and capital payments. This amount does not reflect changes in hospital admissions or case-mix intensity in operating PPS payments, which will also affect overall payment changes. It does assume that the -1.2 percent adjustment to the IPPS standardized amounts for adoption of the MS-DRGs will be

completely offset by increases in case-mix that are the result of documentation and

coding changes and not real increases in patient severity of illness.

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 $31.5 million or less in any 1 year. (For details on the latest standards for

heath care providers, we refer readers to page 33 of the Table of Small Business Size

Standards at the Small Business Administration Web site at:

http://www.sba.gov/services/contractingopportunities/sizestandardstopics/tableofsize/index.html.)

For purposes of the RFA, all hospitals and other providers and suppliers are considered to

be small entities. Individuals and States are not included in the definition of a small

entity. We believe that this final rule with comment period will have a significant impact

on small entities as explained in this Appendix. Because we acknowledge that many of

the affected entities are small entities, the analysis discussed throughout the preamble of

this final rule with comment period constitutes our final regulatory flexibility analysis. In

the proposed rule, we solicited comments on our estimates and analysis of the impact of

the proposed rule on those small entities. We address any public comments that we

received on the impact of the changes we are finalizing in the applicable sections of this

appendix.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact

analysis for any proposed or final rule that may have a significant impact on the

operations of a substantial number of small rural hospitals. This analysis must conform

to the provisions of section 604 of the RFA. With the exception of hospitals located in

certain New England counties, for purposes of section 1102(b) of the Act, we now define

a small rural hospital as a hospital that is located outside of an urban area and has fewer

than 100 beds. Section 601(g) of the Social Security Amendments of 1983

(Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the

adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these

hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) also

requires that agencies assess anticipated costs and benefits before issuing any rule whose

mandates require spending in any 1 year of $100 million in 1995 dollars, updated

annually for inflation. That threshold level is currently approximately $120 million. This

final rule with comment period will not mandate any requirements for State, local, or

tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet

when it promulgates a proposed rule (and subsequent final rule) that imposes substantial

direct requirement costs on State and local governments, preempts State law, or otherwise

has Federalism implications. As stated above, this final rule with comment period would

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 with comment period 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 2008, on various hospital groups.

We estimate the effects of individual policy changes by estimating payments per case

while holding all other payment policies constant. We use the best data available, but,

generally, we do not attempt to make adjustments for future changes in such variables as

admissions, lengths of stay, or case-mix. However, we believe that adoption of the MS-

DRGs in this final rule with comment period will create a risk of increased aggregate

levels of payment as a result of more comprehensive documentation and coding. As

explained earlier in this final rule with comment period, 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. Using this authority, the Medicare Actuary

estimates that a negative adjustment of 4.8 percent will be necessary to maintain budget

neutrality for the transition to the MS-DRGs. However, with the 2-year implementation

of the MS-DRG system, the 4.8 percent adjustment will be made over 3 years.

Therefore, we are reducing the IPPS standardized amount by 1.2 percent for FY 2008.

We will revisit the adjustment in 2 years if projected and actual data are different. The

payment impacts shown below illustrate the impact of changes in hospital payment,

including the -1.2 percent adjustment to the IPPS standardized amounts both prior to and

following the estimated growth in case-mix. As we had done in the previous rules, we

solicited comments and information about the anticipated effects of the proposed changes

on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and

capital-related costs encompass most general short-term, acute care hospitals that

participate in the Medicare program. There were 35 Indian Health Service hospitals in

our database, which we excluded from the analysis due to the special characteristics of

the prospective payment methodology for these hospitals. Among other short-term, acute

care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS

under the waiver at section 1814(b) (3) of the Act.

As of July 2007, there are 3,534 IPPS hospitals to be included in our analysis. This represents about 59 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,286 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,198 specialty hospitals and 2,262 specialty units that are excluded from the IPPS. These specialty hospitals include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals. Changes in payments for IPFs and IRFs are made through other separate rulemaking. Payment impacts for these specialty hospitals and units, other than the reasonable cost-based updates for IPFs paid under a blend, are not included in this final rule with comment period. There is also a separate rule to update and make changes to the LTCH PPS for its July 1 to June 30 rate year. However, we have traditionally used the IPPS rule to update the LTCH relative weights because the LTCH PPS uses the same DRGs as the IPPS, resulting in the LTCH relative weights being recalibrated according to the same schedule as the IPPS (that is, for each Federal fiscal year). The impacts of our policy changes on LTCHs, where applicable, are discussed below.

V. Effects on Excluded Hospitals and Hospital Units

As of July 2007, there were 1,198 hospitals excluded from the IPPS. Of these 1,187 hospitals, 485 IPFs, 4 LTCHs, 82 children's hospitals, 11 cancer hospitals, and 15 RNHCIs are either being paid, on a reasonable cost basis or have a portion of the PPS payment based on reasonable cost principles subject to the rate-of-increase ceiling under §413.40. The remaining providers, 215 IRFs and 386 LTCHs, are paid 100 percent of the

Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. As stated

above, IRFs and IPFs that are not under a transition period are not affected by this final

rule with comment period. (IPFs under a transition period do have a portion of their PPS

payment based on reasonable cost principles and thus are affected by this final rule with

comment period.) The impacts of the changes to LTCHs are discussed separately below.

In addition, there are 1,276 IPFs co-located in hospitals otherwise subject to the IPPS,

paid on a blend of the IPF PPS per diem payment and the reasonable cost-based payment

and 986 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 2008. For these hospitals

(cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, the

update is the percentage increase in the FY 2008 IPPS operating market basket, which is

3.3 percent, based on Global Insights, Inc.'s 2007 second quarter forecast of the IPPS

operating market basket increase. In addition, in accordance with §403.752(a) of the

regulations, RNHCIs are paid under §413.40, which also uses section 1886(b)(3)(B)(ii) of

the Act to update target amounts by the rate-of-increase percentage. For RNHCIs, the

update is the percentage increase in the FY 2008 IPPS operating market basket increase,

which is 3.3 percent, based on Global Insight, Inc.'s 2007 second quarter forecast of the
IPPS operating market basket increase.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs
that elected to be paid based on 100 percent of the LTCH PPS are paid, based on a
Federal prospective payment amount that is updated annually. Existing LTCHs received
a PPS blended payment that consisted of the Federal prospective payment rate and a
reasonable cost-based payment rate over a 5-year transition period, unless the LTCH
elected 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. 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 PPS amount calculated under reasonable cost principles.
FY 2007 was the fifth year of the 5-year transition period established under §412.533.
Because the reasonable cost-based amount is zero percent for cost reporting periods
beginning during FY 2008, no LTCH will have a portion of its PPS payment that is based
in part on reasonable cost subject to the rate-of-increase ceiling during FY 2008 or
thereafter. Thus, there is no longer a need for an update factor for LTCHs' TEFRA target
amount for FY 2008.

The final rule implementing the IPF PPS (69 FR 66922) established a 3-year
transition to the IPF PPS during which some providers will received a blend of the IPF
PPS per diem payment and the TEFRA reasonable cost-based payment. Under this final
rule with comment period, the FY 2008 rate-of-increase percentage that is applied to

FY 2007 target amounts in order to calculate FY 2008 target amounts is 3.3 percent,

based on Global Insight, Inc.'s 2007 second quarter forecast of the excluded hospital

market basket increase.

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.

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

A. Basis and Methodology of Estimates

In this final rule with comment period, 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.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2008 operating payments will increase 3.5 percent compared to FY 2007, largely due to the statutorily mandated update to the IPPS rates. This amount reflects an adjustment of -1.2 percent to the IPPS standardized amounts to offset an anticipated increase in payments resulting from improved documentation and coding that does not represent real increases in underlying resource demands and patient acuity due to the adoption of MS-DRGs. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this final rule with comment period. 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 2006 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2006 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 2008 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

● The effects of the annual reclassification of diagnoses and procedures,

transition to the MS-DRG system, the recalibration of the DRG relative weights

(including the expansion to 15 charge to cost ratios) as required by section 1886(d)(4)(C)

of the Act.

● The effects of the changes in hospitals' wage index values reflecting wage data

from hospitals' cost reporting periods beginning during FY 2004, compared to the

FY 2003 wage data.

● The effects of the wage and recalibration budget neutrality factors.

● The effects of the expiration of the labor market area transition for those

hospitals that were urban under the old labor market area designations and are now

considered rural hospitals.

● The effects of geographic reclassifications by the MGCRB that will be

effective in FY 2008.

● The effects of the adjustment to the application of the rural floor budget

neutrality provision on the wage index instead of on the standardized amount.

● The effects of application of an imputed rural floor to States that have no rural

areas and to States that have rural areas but no IPPS hospitals are located in those areas

(69 FR 49109).

● The effects of the September 30, 2007 expiration of section 508 of

Pub. L. 108-173, which allowed qualifying hospitals to 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).

● 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.

● The effect of the budget neutrality adjustment being made for the adoption of

the MS-DRGs under section 1886(d)(3)(A)(iv) of the Act for the change in aggregate

payments that is a result of changes in the coding or classification of discharges that do

not reflect real changes in case-mix.

● The total estimated change in payments based on FY 2008 policies relative to

payments based on FY 2007 policies.

To illustrate the impacts of the FY 2008 changes, our analysis begins with a

FY 2007 baseline simulation model using: the FY 2008 update of 3.3 percent; the

FY 2007 DRG GROUPER (Version 24.0); the most current CBSA designations for

hospitals based on OMB's MSA definitions; the FY 2007 wage index; and no MGCRB

reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and

outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of 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 in a

form and manner and at a time specified by the Secretary. At the time this impact was

prepared, 146 providers did not receive the full market basket rate-of-increase for

FY 2007 because they failed the quality data submission process. For purposes of the

simulations shown below, we modeled the payment changes for FY 2008 using a reduced

update for these 146 hospitals. However, we do not have enough information to

determine which hospitals will not receive the full market basket rate-of-increase for

FY 2008 at this time.

Each policy change, statutorily or otherwise, is then added incrementally to this

baseline, finally arriving at an FY 2008 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 2007 to FY 2008. Three factors not discussed separately have significant impacts

here. The first is the update to the standardized amount. In accordance with section

1886(b)(3)(B)(i) of the Act, we are updating the standardized amounts for FY 2008 using

the most recently forecasted hospital market basket increase for FY 2008 of 3.3 percent.

(Hospitals that fail to comply with the quality data submission requirements to receive

the full update will receive an update reduced by 2.0 percentage points to 1.3 percent.)

Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts

for SCHs and for MDHs are also equal to the market basket increase, or 3.3 percent.

A second significant factor that affects the changes in hospitals' payments per

case from FY 2007 to FY 2008 is the change in a hospital's geographic reclassification

status from one year to the next. That is, payments may be reduced for hospitals

reclassified in FY 2007 that are no longer reclassified in FY 2008. Conversely, payments

may increase for hospitals not reclassified in FY 2007 that are reclassified in FY 2008.

Particularly with the expiration of section 508 of Pub. L. 108-173, the reclassification

provision, 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.

A third significant factor is that we currently estimate that actual outlier payments

during FY 2007 will be 4.6 percent of total DRG payments. When the FY 2007 final rule

was published, we projected FY 2007 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 2008 (as discussed in the Addendum to this final rule with comment period) are

reflected in the analyses below comparing our current estimates of FY 2007 payments per

case to estimated FY 2008 payments per case (with outlier payments projected to equal

5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the changes for FY 2008. 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 3,534 hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their

geographic location: all urban, which is further divided into large urban and other urban;

and rural. There are 2,539 hospitals located in urban areas included in our analysis.

Among these, there are 1,406 hospitals located in large urban areas (populations over

1 million), and 1,133 hospitals in other urban areas (populations of 1 million or fewer).

In addition, there are 995 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 2008

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 section 1886(d)(8)(B) and

section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,578,

1,425, 1,153 and 956, 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 2,480 nonteaching hospitals in our analysis, 815 teaching

hospitals with fewer than 100 residents, and 239 teaching hospitals with 100 or more

residents.

In the DSH categories, hospitals are grouped according to their DSH payment

status, and whether they are considered urban or rural for DSH purposes. The next

category groups together hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs), as well as rural hospitals not receiving a special payment designation. There were 194 RRCs, 367 SCHs, 150 MDHs, 99 hospitals that are both SCHs and RRCs, and 8 hospitals that are both an MDH and an RRC.

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 2008. The second grouping shows the MGCRB rural reclassifications.

The final two groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2004 Medicare cost reports.

TABLE I.--IMPACT ANALYSIS OF CHANGES FOR FY 2008

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
All Hospitals	3534	0.4	-0.1	0	0	0	0	0	-0.1	0	2.3	3.5
By Geographic Location:												
Urban hospitals	2539	0.5	-0.1	0.1	0	-0.2	0	0	-0.1	0	2.6	3.9
Large urban areas	1406	0.9	-0.1	0.4	0	-0.3	0	0	-0.1	0	3.1	4.3
Other urban areas	1133	0.1	0	-0.2	0	-0.1	0.1	0	-0.2	0	2	3.2
Rural hospitals	995	-0.9	-0.1	-1.2	-0.2	1.8	-0.1	0	0	0.1	0	1.2
Bed Size (Urban):												
0-99 beds	630	-0.4	0	-0.6	-0.1	-0.4	0.1	0	-0.2	0	0.8	2.1
100-199 beds	851	0.6	0	0.3	0	-0.2	0.1	0	-0.2	0	2.3	3.6
200-299 beds	480	0.5	0	0.1	0	-0.2	0	0	-0.1	0	2.4	3.7
300-499 beds	411	0.6	0	0.2	0	-0.2	0	0	-0.1	0	3	4.2
500 or more beds	167	0.7	-0.3	0.1	0	-0.3	-0.1	-0.1	-0.1	0	2.9	4.1
Bed Size (Rural):												
0-49 beds	337	-1.8	-0.1	-1.9	-0.1	0.5	-0.1	0	-0.1	0.2	-1.6	-0.4
50-99 beds	372	-1.2	-0.1	-1.4	-0.1	1	-0.1	0	0	0.1	-0.3	0.9
100-149 beds	173	-0.8	0	-1.1	-0.4	2.3	-0.1	0	0	0.1	0.4	1.6
150-199 beds	68	-0.5	0	-0.8	0	2.5	-0.1	0	0	0	0.3	1.5
200 or more beds	45	-0.5	-0.1	-0.8	0	2.7	-0.1	0	0	0	0.9	2.1
Urban by Region:												
New England	122	0.1	0.5	0.3	0	0.5	0.9	-0.1	-0.2	0.1	2.4	3.6
Middle Atlantic	350	0.6	-0.3	-0.1	0	0.2	-0.2	0.3	-0.5	0	2.3	3.5

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
South Atlantic	390	0.6	-0.1	0.1	0	-0.4	-0.1	-0.1	0	0	2.7	4
East North Central	395	0.6	-0.2	0.1	0	-0.3	-0.1	-0.1	-0.1	0	2.4	3.7
East South Central	166	0.1	-0.4	-0.6	0	-0.3	-0.1	-0.1	0	0	2.1	3.3
West North Central	157	0	0.1	-0.2	0	-0.7	-0.2	-0.1	0	0	2.2	3.5
West South Central	355	0.7	-0.3	0.1	0	-0.6	-0.1	-0.1	0	0	2.6	3.8
Mountain	153	0.6	0	0.3	-0.1	-0.2	-0.1	-0.1	0	0	2.3	3.6
Pacific	398	0.9	0.5	1.1	0	-0.3	0.6	-0.1	-0.1	0	3.9	5.2
Puerto Rico	53	1.1	-0.3	0.4	0	-0.6	-0.1	0	0	0	2.9	4.2
Rural by Region:												
New England	23	-0.8	-1.2	-2.2	0	2.6	-0.1	0	0	0	0	1.2
Middle Atlantic	72	-1	0.2	-1	0.2	1.9	-0.1	0	-0.1	0	-0.2	1
South Atlantic	173	-0.4	-0.1	-0.8	-0.2	2.1	-0.1	0	0	0.1	0.8	2
East North Central	122	-1	0.1	-1.1	-0.1	1.3	-0.1	0	0	0.1	-0.1	1.1
East South Central	177	-0.9	-0.3	-1.4	-0.2	2.3	-0.2	-0.1	0	0.1	0.5	1.7
West North Central	115	-1.1	0	-1.2	0	1.2	-0.1	0	0	0	-0.2	1
West South Central	199	-1.4	-0.2	-1.8	-0.5	2.2	-0.1	0	0	0.1	-1.3	-0.1
Mountain	77	-0.8	0.2	-0.6	0	0.5	-0.1	0	0	0	-0.3	0.9
Pacific	37	-0.7	0.8	-0.1	0	1.7	-0.1	0	-0.2	0	1.3	2.5
By Payment Classification:												

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
Urban hospitals	2578	0.5	-0.1	0.1	0	-0.2	0	0	-0.1	0	2.6	3.8
Large urban areas	1425	0.8	-0.1	0.4	0	-0.3	0	0	-0.1	0	3.1	4.3
Other urban areas	1153	0.1	0	-0.2	0	0	0.1	0	-0.2	0	2	3.2
Rural areas	956	-0.9	-0.1	-1.2	-0.2	1.7	-0.1	0	-0.1	0.1	0	1.2
Teaching Status:												
Nonteaching	2480	0.1	0	-0.2	0	0.2	0.1	0	-0.1	0	1.8	3
Fewer than 100 residents	815	0.4	-0.1	0	0	-0.1	0	0	-0.1	0	2.4	3.7
100 or more residents	239	0.9	-0.2	0.3	0	-0.2	-0.1	0	-0.2	0	3.2	4.4
Urban DSH:												
Non-DSH	859	0	-0.2	-0.5	0	-0.1	0	0.1	-0.2	0	1.6	2.8
100 or more beds	1512	0.7	0	0.3	0	-0.2	0	0	-0.1	0	2.9	4.1
Less than 100 beds	355	-0.2	0.2	-0.3	-0.1	-0.1	0.1	-0.1	-0.1	0	1.7	3
Rural DSH:												
SCH	384	-1.4	0	-1.5	0	0.2	0	0	0	0.1	-0.8	0.4
RRC	203	-0.5	0	-0.8	-0.2	2.9	-0.1	0	-0.1	0	0.6	1.8
100 or more beds	46	-0.3	-0.1	-0.8	-0.8	1.5	-0.2	-0.1	-0.1	0.3	1.3	2.5
Less than 100 beds	175	-1.1	-0.1	-1.4	-0.4	1.2	-0.2	-0.1	-0.1	0.3	0.2	1.5
Urban teaching and DSH:												
Both teaching and DSH	807	0.7	-0.1	0.3	0	-0.3	0	0	-0.1	0	3	4.2
Teaching and no DSH	186	0.1	-0.3	-0.5	0	0	-0.1	0.1	-0.4	0.1	1.9	3.1

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
No teaching and DSH	1060	0.5	0.1	0.3	0	-0	0.1	0	0	0	2.5	3.8
No teaching and no DSH	525	0.1	-0.1	-0.3	0	-0.3	0	0	-0.1	0	1.6	2.9
Special Hospital Types:												
RRC	194	-0.3	-0.1	-0.7	-0.2	3.2	-0.1	-0.1	0	0	1.5	2.7
SCH	367	-1.4	0	-1.4	-0.1	0.1	0	0	0	0	-1	0.2
MDH	150	-1.6	-0.1	-1.8	0	0.3	-0.1	0	0	0.1	-0.6	0.6
SCH and RRC	99	-0.8	0	-0.9	0	0.7	-0.1	0	0	0	-0.4	0.8
MDH and RRC	8	-1.5	0	-1.5	0	0.8	-0	0	0	0	-1.1	0.1
Type of Ownership:												
Voluntary	2064	0.4	-0.1	-0.1	0	0	0	0	-0.1	0	2.2	3.5
Proprietary	823	0.5	0.1	0.3	0	0	0	0	-0.1	0	2.6	3.9
Government	597	0.4	0.1	0.2	0	-0	0.1	-0.1	0	0	2.4	3.6
Medicare Utilization as a Percent of Inpatient Days:												
0-25	230	1.5	0	1.2	0	-0.3	-0.1	-0.1	0	0	4.2	5.5
25-50	1289	0.7	0	0.3	0	-0.3	0	0	-0.1	0	3	4.3
50-65	1451	0	-0.1	-0.4	0	0.4	0	0	-0.1	0	1.6	2.9
Over 65	440	-0.7	-0.2	-1.2	0	0.4	-0.1	0	-0.3	0	0.5	1.8

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
FY 2008 Reclassifications by the Medicare Geographic Classification Review Board:												
All Reclassified Hospitals	757	0.1	0	-0.2	-0.1	2.2	-0.1	0	-0.2	0	1.8	3.1
Non-Reclassified Hospitals	2777	0.5	-0.1	0.1	0	-0.6	0	0	-0.1	0	2.5	3.7
Urban Hospitals Reclassified	393	0.5	0	0.1	0	2	-0.1	0	-0.3	0	2.4	3.6
Urban Nonreclassified, FY 2008:	2145	0.6	-0.1	0.1	0	-0.7	0	0	-0.1	0	2.7	3.9
All Rural Hospitals Reclassified Full Year FY 2008:	364	-0.7	0	-1	-0.2	2.9	-0.1	0	0	0	0.6	1.8
Rural Nonreclassified Hospitals Full Year FY 2008:	569	-1.2	-0.2	-1.5	-0.1	-0.2	-0.1	0	-0.1	0.2	-1	0.2
All Section 401 Reclassified Hospitals:	29	-0.8	0.1	-0.8	0	-0.8	-0	0	-0.6	0	-0.9	0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	-0.7	-0.3	-1.3	0	3.3	-0.1	0	0	0	0.7	1.9
Former 508 Hospitals	107	0.5	-0.5	-0.3	0	0.4	-0.1	0	-2.5	0.1	-0.7	0.5
Specialty Hospitals												

	No. of Hospitals[1] (1)	FY 2008 Transitional 2/3 Cost 1/3 Charge Weights & DRG Changes[2] (2)	FY 2008 Wage Data[3] (3)	FY 2008 DRG, Rel. Wts. and Wage Index Changes[4] (4)	FY 2008 Wage Index Expiration for the Transition for Hospitals Moving from Urban to Rural[5] (5)	FY 2008 MGCRB Reclass-ifications[6] (6)	Application of the Rural Floor[7] (7)	Application of Imputed Rural Floor[8] (8)	Expiration of Section 508 Provider Reclassification[9] (9)	FY 2008 Out-Migration Adjustment[10] (10)	All FY 2008 Changes w/ CMI Adjustment Prior to Estimated Growth[11] (11)	All FY 2008 Changes w/ CMI Adjustment and Estimated Growth[12] (12)
Cardiac specialty Hospitals	22	-2.5	-0.3	-2.9	0	-0.7	0.1	-0.1	0	0	-0.3	0.9

[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 2006, and hospital cost report data are from reporting periods beginning in FY 2005 and FY 2004.

[2] This column displays the payment impact of the changes to the V25 GROUPER and the recalibration of the DRG weights based on FY 2006 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the payment impact of updating the wage index data to the FY 2004 cost report data.

[4] This column displays the payment impact of the budget neutrality factor for DRG and wage index changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[5] Shown here are the effects of the end of the three-year provision where rural hospitals that were formerly located in urban areas will now receive the wage index of the MSA that they are currently located in for FY 2008.

[6] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2008 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2008. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991695.

[7] This column displays the effects of the changes in the rural floor budget neutrality adjustment applied on the wage index instead of on the standardized amount. The column reflects a rural floor budget neutrality factor of 0.996660.

[8] This column displays the payment impact of the application of the imputed rural floor applied to the wage index for providers located in states without rural areas.

[9] This column displays the payment impact of the expiration of section 508 of Pub. L. 108-17, which had allowed qualifying hospitals to reclassify to receive the wage index of another area in their state.

[10] This column displays the impact of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[11] This column shows changes in payments from FY 2007 to FY 2008 including a 0.988 case mix index adjustment for coding and documentation improvements that are anticipated with the adoption of the MS-DRGs prior to the estimated growth occurring. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 ,8, 9,10 and (the changes displayed in Columns 2 and 3 are included in Column 4).

[12] This column shows changes in payments from FY 2007 to FY 2008 with a case-mix index adjustment and the estimated growth for improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4,5 ,6 ,7 ,8, 9,10 and (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the FY 2008 update, and changes in hospitals' reclassification status in FY 2008 compared to FY 2007. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

C. Effects of the Changes to the DRG Reclassifications and Relative Cost-Based

Weights (Column 2)

In Column 2 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 with comment period. 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 with comment period, we are

continuing the 3-year transition from charge-based to cost-based relative weights. In

addition, we are implementing the MS-DRGs in a two year transition that will increase

the number of DRGs from 538 to 745. For FY 2008, the first year of the transition, 50

percent of the relative weight for a DRG is based on the two-thirds cost weight/one-third

charge weight calculated using FY 2006 MedPAR data grouped to the Version 24.0

(FY 2007) DRGs. The remaining 50 percent of the FY 2008 relative weight for a DRG is

based on the two-thirds cost weight/one-third charge weight calculated using FY 2006

MedPAR grouped to the Version 25.0 MS-DRGs. Furthermore, the relative weights have

been calculated using 15 cost centers as described in Section H of the preamble whereas

the relative weights in FY 2007 were calculated using 13 cost centers. In column 2, we

compare aggregate payments using the blended FY 2008 relative weights (2/3 cost, 1/3

charge, 50 percent MS-DRGs and 50 percent CMS DRGs) for the MS-DRGs to the

FY 2007 blended relative weights (1/3 cost, 2/3 charge) for the CMS DRGs. The

methods of calculating the relative weights and the reclassification changes to the

GROUPER are described in more detail in section II.H. of the preamble to this final rule

with comment period. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act,

we are applying 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

budget neutrality factor of 0.996563 is applied to payments in Column 4 and not Column

2 because it is a combined DRG reclassification and recalibration and wage index budget

neutrality factor.

The changes to the relative weights and DRGs shown in column 2 are prior to any

offset for budget neutrality. The "All Hospitals" line indicates that changes in this

column will increase payments by 0.4 percent. However, as stated earlier, the changes

shown in this column are combined with revisions to the wage index and a single budget

neutrality adjustment is made for these changes and shown in column 4. Thus, the

impact after accounting only for budget neutrality for changes to the DRG relative

weights and classification is somewhat lower than the figures shown in this column

(approximately 0.4 percent). We estimate that changes to the relative weights and DRGs

will increase payments to hospitals located in large urban areas (populations over

1 million) by approximately 0.9 percent before applying an adjustment for budget

neutrality. These changes generally increase payments to hospitals in all urban areas (0.5

percent) and large teaching hospitals (0.9 percent) before applying an adjustment for

budget neutrality. Rural hospitals will generally experience a decrease in payments from

these changes (-0.9 percent) before applying an adjustment for budget neutrality. Cardiac

specialty hospitals would experience the greatest decline in payments (-2.5 percent)

before applying an adjustment for budget neutrality from the changes to blended MS-

DRGs and the blended relative cost weights.

D. Effects of Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2008 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004.

The estimated impact of the wage data on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage changes in payments when going from a model using the FY 2007 wage index, based on FY 2003 wage data and having a 100-percent occupational mix adjustment applied, to a model using the FY 2008 pre-reclassification wage index, also having a 100-percent occupational mix adjustment applied, based on FY 2004 wage data. The wage data collected on the FY 2004 cost report include overhead costs for contract labor that were not collected on FY 2003 and earlier cost reports. The impacts below incorporate the effects of the FY 2004 wage data collected on hospital cost reports, including additional overhead costs for contract labor compared to the wage data from FY 2003 cost reports that were used to calculate the FY 2007 wage index.

Column 3 shows the impacts of updating the wage data using FY 2004 cost reports. Overall, the new wage data will lead to a -0.1 percent change for all hospitals before application of the wage and DRG recalibration budget neutrality adjustment shown in column 4. Thus, the figures in this column are approximately 0.1 below what they otherwise would be if they also illustrated a budget neutrality adjustment solely for changes to the wage index. Among the regions, the largest increase is in the rural Pacific

region, which experiences a 0.8 percent increase before applying an adjustment for

budget neutrality. The largest decline from updating the wage data is seen in rural New

England region (a 1.2 percent decrease) before applying an adjustment for budget

neutrality. The decrease in the pre-reclassified wage index for rural New England is due

to a change in our policy regarding how the wage data for New England deemed county

hospitals are treated in the wage index calculation, as discussed in section III.I.10. of the

preamble of this final rule with comment period. Also discussed in that section, the

policy change does not affect the post-reclassified wage data that are used in setting the

IPPS rates and reflected in Tables 4A, 4B, and 4C of the Addendum to this final rule with

comment period. Thus, even though the pre-reclassified wage index will decline because

of the change we made to our policy with respect to New England deemed counties, it

will have no effect under the IPPS because we use the post-reclassified wage indices for

payment. However, non-PPS payment systems (SNF, IRF, and HHA, among others) that

use the pre-reclassified wage index may be affected by this policy change. However, we

are limiting this policy change for New England deemed counties only to IPPS hospitals

because it was only addressed in the FY 2008 IPPS proposed rule. Any change to

non-PPS provider wage indices will be addressed in the respective payment rules for

these payment systems.

In looking at the wage data itself, the national average hourly wage increased 4.3

percent compared to FY 2007. Therefore, the only manner in which to maintain or

exceed the previous year's wage index was to match or exceed the national 4.3 percent

increase in average hourly wage. Of the 3,475 hospitals with wage data for both FYs

2007 and 2008, 1,712, or 49.3 percent, experienced an average hourly wage increase of

4.3 percent or more.

The following chart compares the shifts in wage index values for hospitals for

FY 2008 relative to FY 2007. Among urban hospitals, 40 will experience an increase of

more than 5 percent and less than 10 percent and 4 will experience an increase of more

than 10 percent. Among rural hospitals, 37 will experience an increase of more than

5 percent and less than 10 percent, and 3 will experience an increase of more than 10

percent. However, 940 rural hospitals will experience increases or decreases of less than

5 percent, while 2,384 urban hospitals will experience increases or decreases of less than

5 percent. Fifty urban hospitals will experience decreases in their wage index values of

more than 5 percent and less than 10 percent. Fifteen urban hospitals will experience

decreases in their wage index values of greater than 10 percent. Two rural hospitals will

experience decreases of more than 5 percent, but less than 10 percent. No rural hospitals

will experience decreases of more than 10 percent. These figures are changes in the wage

index only which adjusts only 69.7 or 62 percent of a hospital's total payment depending

upon whether the wage index is greater or less than 1.0. Therefore, these figures are

illustrating a somewhat larger change in the wage index than would occur to the

hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage Change in Area Wage Index Values	Number of Hospitals	
	Urban	Rural
Increase more than 10 percent	4	3
Increase more than 5 percent and less than 10 percent	40	37
Increase or decrease less than 5 percent	2,384	940
Decrease more than 5 percent and less than 10 percent	50	2
Decrease more than 10 percent	15	0

E. Combined Effects of DRG and Wage Index Changes (Column 4)

        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 with

comment period, in determining the budget neutrality factor, we equated simulated

aggregate payments for FY 2007 and FY 2008 using the FY 2006 Medicare utilization

data after applying the changes to the DRG relative weights and the wage index.

        We computed a wage and DRG recalibration budget neutrality factor of 0.996563.

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 4. The estimated changes shown in this column reflect the combined

effects of the changes in Columns 2 and 3 and the budget neutrality factor for the revised

FY 2008 wage index. Due to the changes to the application of the rural floor budget

neutrality, this column does not include the wage index floor for urban areas as required

by section 4410 of Pub. L. 105-33. The effects of that provision are included in

Column 7. There also may be some variation of plus or minus 0.1 percentage point due

to rounding.

F. Effects of the Expiration 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 5)

The policy adopted in FY 2005 for urban hospitals that became rural under the new labor market area definitions is to expire in FY 2008. In FY 2005, we adopted a policy that allowed urban hospitals that became rural under the new labor market area regions 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. Beginning in FY 2008, these hospitals will receive their statewide rural wage index or their FY 2008 MGCRB reclassified wage index. Column 5 shows the impact of the expiration of the labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. The rural hospital row shows a 0.2 percent decrease from the end of the provision as these hold harmless hospitals are now considered geographically rural and are now receiving the wage index of the MSA where they are currently located.

G. Effects of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The changes in Column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2008 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. Hospitals may appeal denials of MGCRB decisions to the CMS

Administrator. Further, hospitals have 45 days from publication of the IPPS rule in the

Federal Register to decide whether to withdraw or terminate an approved geographic

reclassification for the following year. This column reflects all MGCRB decisions,

Administrator appeals and decisions of hospitals for FY 2008 geographic

reclassifications.

    The overall effect of geographic reclassification is required by section

1886(d)(8)(D) of the Act to be budget neutral. Therefore, we are applying an adjustment

of 0.991695 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 with comment

period.) Geographic reclassification generally benefits hospitals in rural areas. We

estimate that geographic reclassification will increase payments to rural hospitals by an

average of 1.8 percent.

H. Effects of the Adjustment to the Application of the Rural Floor (Column 7)

    As discussed in section III.G. of the preamble of this final rule with comment

period, section 4410 of Pub. L. 105-33 established the rural floor by requiring that the

wage index for a hospital in any urban area cannot be less than the area wage index

determined for the state's rural area. Since FY 1998, we have implemented this provision

by adjusting the standardized amounts. In this final rule with comment period, we are

changing how we apply budget neutrality to the rural floor beginning in FY 2008. Rather

than applying a budget neutrality adjustment to the standardized amount, a uniform

budget neutrality adjustment is applied to the wage index. Therefore, we are applying an

adjustment to the wage index of 0.996660 (-0.33 percent) to ensure that the rural floor

adjustments are budget neutral as indicated by the zero effect on payments to hospitals overall.

Column 7 shows the projected impact of change in the application of the rural floor. The column compares the post-reclassification FY 2008 wage index of providers before the rural floor adjustment and the post-reclassification FY 2008 wage index of providers with the rural floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) will experience a decrease in payments due to the budget neutrality adjustment. We project rural hospitals will experience a 0.1 percent decrease in payments. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments. The rural floor will benefit 69 percent of the hospitals in New Hampshire (9) and 39 percent of the hospitals in Connecticut (13), explaining the average increase of 0.9 percent shown in the table for hospitals located in New England. The average increase among hospitals in the Pacific region is estimated at 0.6 percent and is explained by application of the rural floor to 62 percent of the hospitals in California (207) and 18 percent of the hospitals in Washington (9).

I. Effects of Application of the Imputed Rural Floor (Column 8)

The FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed rural floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed rural floor was established for States that do not have rural areas or

rural IPPS hospitals. In this final rule, we are extending the imputed rural floor for one

additional year through FY 2008.

Column 8 shows the effects of application the imputed rural floor. Only hospitals

located in New Jersey had been affected by the provision. Therefore only urban providers

in the Mid-Atlantic region (NJ) will experience an increase by 0.3 percent, from the

imputed rural floor being applied in that State.

J. Effects of the Expiration of Section 508 of Pub. L. 108-173 (Column 9)

Section 508 of Pub. L. 108-173 will expire on September 30, 2007. As stated in

the FY 2007 IPPS final rule (71 FR 48333), 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. In the final rule, 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. However,

Division B, Title I, section 106(a) of the MIEA-TRHCA (Pub. L. 109-432) extended any

geographic reclassifications of hospitals that would expire on March 31, 2007, by

6 months until September 30, 2007. For FY 2008, the providers that had been

reclassified under section 508 in FY 2007 will receive payment using the wage index for

the area where they are currently located. The impact of the expiration of the policy is

modeled in Column 8 of Table I. Section 508 of Pub. L. 108-173 was not a budget

neutral provision of the statute. Its enactment increased total payments for Medicare

inpatient hospital services. Therefore, relative to FY 2007, the expiration of section 508

of Pub. L. 108-173 will reduce Medicare inpatient hospital payments by an estimated 0.1

percent.

K. Effects of the Wage Index Adjustment for Out-Migration (Column 10)

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, post-reclassification and the higher wage index work area(s), weighted by the

overall percentage of workers who are employed in an area with a higher wage index.

With the out-migration adjustment, rural providers will experience a 0.1 percent increase

in payments in FY 2008 relative to no adjustment at all. We included these additional

payments to providers in the impact table shown above, and we estimate the impact of

these providers receiving the out-migration increase to be approximately $26 million.

L. Effects of All Changes with CMI Adjustment Prior to Estimated Growth (Column 11)

Column 11 compares our estimate of payments per case between FY 2007 and

FY 2008 with all changes reflected in this final rule with comment period for FY 2008,

including a 0.988 adjustment to the payment rates to account for anticipated

improvements in documentation and coding that is expected to increase case-mix. We

generally apply an adjustment to the DRGs to ensure budget neutrality assuming constant

utilization. However, with the 2-year transition to the MS-DRGs, the number of DRGs

expands from 538 to 745. Therefore, the Office of the Actuary estimates an increase in

the CMI due to improved coding and we have applied an additional adjustment to achieve

budget neutrality. However, because we modeled the impact, including the adjustment

for anticipated case-mix increase but not the actual case-mix increase itself in column 11,

this column illustrates a total payment change that is less than what is anticipated to

occur.

M. Effects of All Changes with CMI Adjustment and Estimated Growth (Column 12)

Column 12 compares our estimate of payments per case between FY 2007 and

FY 2008, incorporating all changes reflected in this final rule with comment period for

FY 2008 (including statutory changes). This column includes all of the policy changes

and assumes the 1.2 percent increase in case-mix from improved documentation and

coding will occur equally across all hospitals.

Column 12 reflects the impact of all FY 2008 changes relative to FY 2007,

including those shown in Columns 2 through 10. The average increase for all hospitals is

approximately 3.5 percent. This increase includes the effects of the 3.3 percent market

basket update. It also reflects the 0.5 percentage point difference between the projected

outlier payments in FY 2008 (5.1 percent of total DRG payments) and the current

estimate of the percentage of actual outlier payments in FY 2007 (4.6 percent), as

described in the introduction to this Appendix and the Addendum to this final rule with

comment period. As a result, payments are projected to be 0.5 percentage points lower in

FY 2007 than originally estimated, resulting in a 0.5 percentage point greater increase for

FY 2008 than would otherwise occur. In addition, the impact of expiration of section 508

of Pub. L. 108-173 reclassification accounts for a 0.1 percent decrease in estimated

payments. As stated earlier, section 1886(d)(13) of the Act 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. This provision of the statute is not budget neutral. Although

the out-migration adjustment will increase payments to some hospitals in FY 2008

relative to not having an adjustment at all, the total number of hospitals receiving the

adjustment will be less in FY 2008 than FY 2007, resulting in a 0.1 percent reduction in

total IPPS payments. 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 12 may not equal the product of the percentage changes described

above.

The overall change in payments per case for hospitals in FY 2008 is estimated to

increase by 3.5 percent. Hospitals in urban areas will experience an estimated 3.8 percent

increase in payments per case compared to FY 2007. Hospitals in large urban areas will

experience an estimated 4.3 percent increase and hospitals in other urban areas will

experience an estimated 3.2 percent increase in payments per case in FY 2008. Hospital

payments per case in rural areas are estimated to increase 1.2 percent. The increases that

are larger than the national average for larger urban areas and smaller than the national

average for other urban and rural areas are largely attributed to the differential impact of

adopting MS-DRGs.

Among urban census divisions, the largest estimated payment increases will be

5.2 percent in the Pacific region (generally attributed to MS-DRGs, wage data and

application of the rural floor) and 4.2 percent in Puerto Rico (mostly due to MS-DRGs).

The smallest urban increase is estimated at 3.3 percent in the East South Central region

(because of MS-DRGs, new wage data, MGCRB reclassification and application of the

rural floor).

Among rural regions in Column 12, the providers in the West South Central

region experience an estimated decrease in payments by 0.1 percent (mostly due to

MS-DRGs). The Pacific and South Atlantic regions will have the highest increases

among rural regions with 2.5 and 2.0 percent estimated increases, respectively. Again,

increases in rural areas are generally less than the national average due to the adoption of

MS-DRGs.

Among special categories of rural hospitals in Column 12, the SCH providers will

receive an estimated increase in payments of 0.2 percent, and the RRCs will experience

an estimated increase in payments by 2.7 percent.

Urban hospitals reclassified for FY 2008 are anticipated to receive an increase of

3.6 percent, while urban hospitals that are not reclassified for FY 2008 are expected to

receive an increase of 3.9 percent. Rural hospitals reclassifying for FY 2008 are

anticipated to receive a 1.8 percent payment increase.

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

For FY 2008, 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

will receive the low-volume adjustment for FY 2008. We estimate the impact of these

providers receiving the additional 25-percent payment increase to be approximately

$36,000.

O. Impact Analysis of Table II

Table II presents the projected impact of the changes for FY 2008 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 2007 with the average estimated payments per

case for FY 2008, 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 12 of Table I.

TABLE II.--IMPACT ANALYSIS OF CHANGES FOR FY 2008
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PAYMENTS PER CASE)

	Number of Hospitals (1)	Average FY 2007 Payment Per Case[1] (2)	Average FY 2008 Payment Per Case[1] (3)	All FY 2008 Changes (4)
All hospitals	3534	$8,960	$9,278	3.5
By Geographic Location:....................................				
Urban hospitals...	2539	$9,304	$9,663	3.9
Large urban areas (populations over 1 million)........	1406	$9,702	$10,122	4.3
Other urban areas (populations of 1 million or fewer)	1133	$8,826	$9,110	3.2
Rural hospitals	995	$6,993	$7,081	1.2
Bed Size (Urban):				
0-99 beds...	630	$7,148	$7,297	2.1
100-199 beds..	851	$7,882	$8,162	3.6
200-299 beds..	480	$8,777	$9,100	3.7
300-499 beds..	411	$9,722	$10,132	4.2
500 or more beds..	167	$11,695	$12,179	4.1
Bed Size (Rural):				
0-49 beds...	337	$6,049	$6,026	-0.4
50-99 beds..	372	$6,480	$6,539	0.9
100-149 beds..	173	$6,816	$6,925	1.6
150-199 beds..	68	$7,598	$7,715	1.5
200 or more beds...	45	$8,686	$8,869	2.1
Urban by Region:				
New England..	122	$9,748	$10,098	3.6
Middle Atlantic	350	$10,177	$10,533	3.5
South Atlantic	390	$8,796	$9,144	4
East North Central..	395	$8,868	$9,193	3.7
East South Central..	166	$8,428	$8,706	3.3
West North Central	157	$9,016	$9,329	3.5
West South Central	355	$8,791	$9,128	3.8

	Number of Hospitals (1)	Average FY 2007 Payment Per Case[1] (2)	Average FY 2008 Payment Per Case[1] (3)	All FY 2008 Changes (4)
Mountain	153	$9,393	$9,728	3.6
Pacific	398	$11,082	$11,657	5.2
Puerto Rico	53	$4,364	$4,546	4.2
Rural by Region:				
New England	23	$9,613	$9,727	1.2
Middle Atlantic	72	$7,367	$7,437	1
South Atlantic	173	$6,557	$6,688	2
East North Central	122	$7,418	$7,499	1.1
East South Central	177	$6,355	$6,463	1.7
West North Central	115	$7,578	$7,652	1
West South Central	199	$6,318	$6,313	-0.1
Mountain	77	$7,536	$7,605	0.9
Pacific	37	$8,552	$8,764	2.5
By Payment Classification:				
Urban hospitals	2578	$9,284	$9,641	3.8
Large urban areas (populations over 1 million)	1425	$9,688	$10,107	4.3
Other urban areas (populations of 1 million or fewer)	1153	$8,798	$9,081	3.2
Rural areas	956	$7,053	$7,141	1.2
Teaching Status:				
Non-teaching	2480	$7,607	$7,835	3
Fewer than 100 Residents	815	$9,036	$9,369	3.7
100 or more Residents	239	$12,934	$13,499	4.4
Urban DSH:				
Non-DSH	859	$8,109	$8,335	2.8
100 or more beds	1512	$9,778	$10,179	4.1
Less than 100 beds	355	$6,616	$6,813	3
Rural DSH:				
SCH	384	$6,906	$6,932	0.4
RRC	203	$7,574	$7,712	1.8
100 or more beds	46	$6,013	$6,164	2.5
Less than 100 beds	175	$5,344	$5,423	1.5
Urban teaching and DSH:				
Both teaching and DSH	807	$10,700	$11,150	4.2
Teaching and no DSH	186	$8,821	$9,097	3.1
No teaching and DSH	1060	$8,006	$8,309	3.8
No teaching and no DSH	525	$7,646	$7,867	2.9
Rural Hospital Types:				
RRC	194	$7,606	$7,813	2.7
SCH	367	$7,437	$7,455	0.2
MDH	150	$6,489	$6,529	0.6
SCH and RRC	99	$8,713	$8,780	0.8
MDH and RRC	8	$8,373	$8,383	0.1
Type of Ownership:				
Voluntary	2064	$9,094	$9,409	3.5
Proprietary	823	$8,144	$8,458	3.9
Government	597	$9,211	$9,542	3.6
Medicare Utilization as a Percent of Inpatient Days:				

	Number of Hospitals (1)	Average FY 2007 Payment Per Case[1] (2)	Average FY 2008 Payment Per Case[1] (3)	All FY 2008 Changes (4)
0-25	230	$12,615	$13,304	5.5
25-50	1289	$10,114	$10,545	4.3
50-65	1451	$7,880	$8,105	2.9
Over 65	440	$7,186	$7,312	1.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2008 Reclassifications:				
All Reclassified Hospitals FY 2008	757	$8,650	$8,915	3.1
All Non-Reclassified Hospitals FY 2008	2777	$9,055	$9,389	3.7
Urban Reclassified Hospitals FY 2008:.............	393	$9,286	$9,623	3.6
Urban Non-reclassified Hospitals FY 2008:.....	2145	$9,308	$9,671	3.9
Rural Reclassified Hospitals FY 2008:......	364	$7,491	$7,624	1.8
Rural Nonreclassified Hospitals FY 2008:	569	$6,327	$6,340	0.2
All Section 401 Reclassified Hospitals:	29	$8,245	$8,270	0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))...	63	$6,683	$6,809	1.9
Former Section 508 Hospitals	107	$9,745	$9,795	0.5
Specialty Hospitals				
Cardiac Specialty Hospitals	22	$10,707	$10,799	0.9

[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 with comment period. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Effects of Policy on Hospital-Acquired Conditions, Including Infections

In section II.F. of the preamble of this final rule with comment period, we discuss our implementation of section 5001(c) of Pub. L. 109-171, which requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (2) 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 application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for DRG reclassifications and recalibration. Therefore, we do our budget neutrality calculations as though the payment provision did not apply but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision will result in cost savings to the Medicare program.

We note that the provision will only apply when the selected conditions are the only secondary diagnosis present on the claim that will lead to higher payment. Therefore, if a nonselected secondary diagnosis that leads to the same higher payment is on the claim, the case will continue to be assigned to the higher paying DRG and there will be no savings to Medicare from the case. Patients will generally have multiple secondary diagnoses during a hospital stay. Patients having one MCC or CC will frequently have additional conditions that also lead to higher payment. Therefore, in only a small percentage of the cases will the patient have only one secondary diagnosis that would lead to higher payment The statute does not allow the payment provision to go into effect until October 1, 2008. For this reason, there will be no saving for FY 2008. Any savings associated with this provision will not be realized until FY 2009. We estimate this provision will save $20 million per year beginning October 1, 2008. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings:
FY 2008	$0
FY 2009	$20
FY 2010	$20
FY 2011	$20
FY 2012	$20

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

In section II.I. of the preamble to this final rule with comment period, we discuss

the adoption of the MS-LTC–DRGs (Version 25.) of the CMS GROUPER). We also

discuss that we are implementing a 2-year transition to MS-LTC-DRGs, in which we

determined transition blended MS-LTC-DRG relative weights for FY 2008. We

established in the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884),

beginning with the update for FY 2008, that the annual update to the classification and

relative weights under the LTCH PPS will be done in a budget neutral manner, such that

estimated aggregate LTCH PPS payments will be unaffected; that is, they will be neither

greater than nor less than the estimated aggregate LTCH PPS payments that would have

been made without the MS-LTC-DRG classification and relative weight changes.

However, if the budget neutrality policy had not been adopted, we would not have

multiplied each MS-LTC-DRG transition blended relative weight by 1.020905 in the first

step of the budget neutrality process (normalization), and we would not have applied a

budget neutrality factor of 0.996467 to the transition blended relative weights after

normalization based on the most recent available claims data (FY 2006 MedPAR files)

for the 376 LTCHs in our database. With the adoption of this budget neutrality policy,

we estimate that with the changes to the MS-LTC-DRG classifications and relative

weights for FY 2008, there will be no change in aggregate LTCH PPS payments. In

applying the budget neutrality adjustment described above, we assumed constant

utilization.

C. Effects of New Technology Add-On Payments

        In section II.J. of the preamble to this final rule, we discuss add-on payments for

new medical services and technologies. As explained in that section, Add-on payments

for new technology under section 1886(d)(5)(K) of the Act are not required to be budget

neutral. As discussed earlier in this final rule with comment period, we are not approving

Wingspan® for new technology add-on payments for FY 2008. Thus, we will not make

any IPPS add-on payments for this technology in FY 2008. In addition, for FY 2008, we

have discontinued new technology add-on payments for GORE TAG, Restore®, and X

STOP. In the FY 2007 IPPS final rule (71 FR 48344), we estimated that FY 2007 IPPS

new technology add-on payments would be $16.61 million, $6.01 million, and $9.35

million, respectively, for these technologies. We have no additional information to

further refine these estimates. Therefore, we estimate that Medicare's new technology

add-on payments will decline by approximately $32 million (the sum of our estimates for

FY 2007) in FY 2008 compared to FY 2007.

D. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital

Payment Update

        In section IV.A. of the preamble of this final rule with comment period, we

discuss the requirements for hospitals to report quality data in order for hospitals to

receive the full annual hospital payment update for FY 2008 and FY 2009. We also note

that, for the FY 2008 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 2006. These data were due to the QIO Clinical

Warehouse by August 15, 2006 (first quarter CY 2006 discharges), November 15, 2006

(second quarter CY 2006 discharges), and February 15, 2007 (third quarter CY 2006

discharges). We have continued our efforts to ensure that QIOs provide assistance to all

hospitals that wish to submit data. In the preamble of this final rule with comment

period, we are finalizing additional validation criteria to ensure that the quality data being

sent to CMS are accurate. The requirement of 5 charts per hospital will result in

approximately 21,500 charts per quarter total submitted to the agency. We reimburse

hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at

the rate of 12 cents per page for copying and approximately $4.00 per chart for postage.

Our experience shows that the average chart received at the CDAC is approximately

150 pages. Thus, the agency will have expenditures of approximately $473,200 per

quarter to collect the charts. Given that we reimburse for the data collection effort, we

believe that a requirement for five charts per hospital per quarter represents a minimal

burden to the participating hospital.

E. Effects of Policy on Cancellation of Classification of Acquired Rural Status and Rural

Referral Centers

        In section IV.C.2. of the preamble of this final rule with comment period, we are

revising our regulations to change the effective date of cancellation of acquired rural

status for hospitals classified as rural referral centers based on acquired rural status. The

current effective date is the hospital's next full cost reporting period following the date of

its request for cancellation. The new effective date will be the beginning of the Federal

fiscal year following both the date of the hospital's request for cancellation and at least

one 12-month cost reporting period in which it has been in acquired rural status.

Currently, there are about 100 IPPS hospitals that have acquired rural status and about 7

hospitals that became rural referral centers based on acquired rural status. During this

fiscal year (FY 2007), we have only received requests for cancellations from about five

hospitals, all of which became rural referral centers after acquiring rural status. However,

this number may increase if the current policy is not changed. We anticipate that the

policy change will not have a significant impact on IPPS hospitals.

F. Effects of Policy on Payment for IME and Direct GME

In section IV.D.3. of the preamble of this final rule with comment period, we

discuss our policy related to whether vacation and sick leave as well as orientation should

be included in the FTE count for IME and direct GME payment purposes. We had

proposed that, for cost reporting periods beginning on or after October, 1, 2007, for direct

GME and IME, time spent by residents on vacation or sick leave be removed from the

total time considered to constitute an FTE resident. In addition, we proposed to continue

our existing policy to count time spent by residents in orientation activities for both IME

and direct GME payment purposes and proposed to change our policy to begin counting

time spent by residents in orientation activities in nonhospital settings for purposes of

both IME and direct GME payments (where the hospital otherwise met the regulatory

requirements to count time spent by residents in the nonhospital setting). However, as

explained in section IV.D.3. of the preamble of this final rule with comment period,

because of concerns related to implementation issues raised by the commenters, at this

time we are not finalizing our proposal to remove vacation and sick leave from the total

time considered to constitute an FTE resident. Therefore, there is no impact for this

provision. In addition, there is no impact from the clarification of the policy for

orientation time because it is not a change in policy. We anticipate the additional time

counted by hospitals for orientation activities in nonhospital settings under the revised

policy will be negligible and will have minimal impact.

G. Effects of Policy Changes Relating to Emergency Services under EMTALA During

an Emergency Period

In section IV.F. of the preamble of this final rule with comment period, we are

amending the EMTALA regulations regarding EMTALA implementation in emergency

areas during an emergency period. Section 1135 of the Act authorizes the Secretary to

temporarily waive or modify the application of several requirements and their

implementing regulations as they relate to actions taken in an emergency area during an

emergency period. The EMTALA regulations (§489.24(a)(2)) now specify that sanctions

for inappropriate transfer during a national emergency do not apply to a hospital with a

dedicated emergency department located in an emergency area.

To make our regulations better reflect the scope of the authority under section

1135 of the Act, we are revising them to clarify that such waivers also may apply to

sanctions for the redirection or relocation of an individual to an alternate location to

receive a medical screening examination where that direction or relocation occurs

pursuant to a State emergency preparedness plan. We also are revising the regulations to

incorporate changes made by the Pandemic and All-Hazards Preparedness Act. That

legislation amended section 1135 of the Act to state that, in the case of a public health

emergency that involves a pandemic infectious disease, sanctions for the direction or

relocation of an individual to an alternative location for screening may be waived based

on either a State emergency preparedness plan or a State pandemic preparedness plan,

whichever applies in the State. In addition, section 1135 of the Act was amended to

create an exception to the otherwise applicable 72-hour limitation on the duration of

waivers or modifications of sanctions for EMTALA violations in cases where a public

health emergency involves a pandemic infectious disease (such as pandemic influenza).

As described more fully earlier in this preamble, these changes are not

discretionary and do not impose any substantive new requirements. On the contrary, they

merely update our regulations to make them consistent with current statutory

requirements. Because of this, we are estimating no impact on Medicare expenditures

and no significant impact on hospitals with emergency departments.

H. Effects of Policy on Disclosure of Physician Ownership in Hospitals and Patient

Safety Measures

In section IV.G. of the preamble of this final rule with comment period, we

discuss our adoption of a requirement relating to disclosure of physician ownership in

hospitals and to increase patient safety measures. In the strategic and implementing plan

included in our "Final Report to the Congress and Strategic and Implementing Plan"

required under section 5006 of the Deficit Reduction Act of 2005, we stated that we

would adopt a disclosure requirement that would require hospitals to disclose to patients

whether they are physician-owned and, if so, the names of the physician-owners. In

addition, we recognize that patients should be made aware of whether or not a physician

is present in the hospital at all times, and the hospital's plans to address patients'

emergency medical conditions when a physician is not present.

In section IX.B. of the preamble of this final rule with comment period, we have

revised our proposed estimate of the cost to affected hospitals of these disclosures to

more accurately reflect the volume of disclosures anticipated. Despite these changes, we

continue to believe this final rule with comment period change will impose only minimal

additional costs on hospitals. We believe the cost of implementing these provisions

borne by hospitals will be limited to the ongoing cost of providing written notices to

patients. In addition, the changes concerning disclosure of physician ownership in

hospitals are consistent with current practices of members of the physician-owned

specialty hospital associations. Therefore, we do not believe that these changes will have

any significant economic impact on hospitals.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.H. of the preamble to this final rule with comment period, 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.H. of the preamble to this final rule with

comment period, 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 2008 that will be made to each

participating hospital under the demonstration will be approximately $1,075,765. 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 $9,681,893. The adjustment factor to the Federal rate used in calculating Medicare

inpatient prospective payments as a result of the demonstration is 0.999903.

J. Effects of Policy on Services Furnished to Beneficiaries in Custody of Penal

Authorities

        In section VII. of the preamble of this final rule with comment period, we discuss

our revision of our regulations relating to the special conditions under which Medicare

payment may be made for services furnished to individuals in custody of penal

authorities. We are indicating that, for purposes of Medicare payment, individuals who

are in custody include, but are not limited to, individuals who are under arrest,

incarcerated, imprisoned, escaped from confinement, under supervised release, on

medical furlough, required to reside in mental health facilities, required to reside in

halfway houses, required to live under home detention, or confined completely or

partially in any way under a penal statute or rule. This definition is in accordance with

how custody has been defined by Federal courts for purposes of the habeas corpus

protections of the Constitution and is consistent with current CMS policy. We anticipate

that this change will have no measurable impact on Medicare expenditures.

VIII. Impact of Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see §412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see §412.344). As we state in section V. of the preamble of this final rule with comment period, 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 includes a large urban add-on adjustment. However, as discussed above and in section V. of the preamble of this final rule with comment period, we are eliminating the large urban add-on adjustment to capital IPPS payments in FY 2008. The basic methodology for calculating capital IPPS payments in FY 2008 is as follows:

(Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in

Alaska and Hawaii) x (1 + Disproportionate Share Adjustment Factor + 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 2007 update of the FY 2006 MedPAR file and the March 2007 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 2007 update of the most recently available hospital cost report data (FYs 2004

and 2005) to categorize hospitals. Our analysis has several qualifications. We use the

best data available and make assumptions about case-mix and beneficiary enrollment as

described below. In addition, as discussed in section III. of the Addendum to this final

rule with comment period, we are adjusting the capital rates to account for improvements

in documentation and coding under the MS-DRGs in FY 2008. Furthermore, due to the

interdependent nature of the IPPS, it is very difficult to precisely quantify the impact

associated with each change. In addition, we draw upon various sources for the data used

to categorize hospitals in the tables. In some cases (for instance, the number of beds),

there is a fair degree of variation in the data from different sources. We have attempted

to construct these variables with the best available sources overall. However, for

individual hospitals, some miscategorizations are possible.

Using cases from the March 2007 update of the FY 2006 MedPAR file, we

simulated payments under the capital PPS for FY 2007 and FY 2008 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 with comment

period, 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. (We

note that, consistent with the elimination of the large urban add-on beginning in FY 2008,

discussed in section V.B. of the preamble of this final rule with comment period, such

estimated payments under this policy are only reflected in the payments we modeled for

FY 2007 and were not included in the payments we modeled for FY 2008.) 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 2007 and 2008. (We note that this does not reflect the adjustment to the capital

rates to account for assumed growth in case mix due to improvement in documentation

and coding under the MS-DRGs, as discussed in section III. of the Addendum of this

final rule with comment period.)

● We estimate that the Medicare discharges will be 13.1 million in FY 2007 and

13.4 million in FY 2008 for an estimated 2.3 percent increase from FY 2007 to FY 2008.

● The capital Federal rate was updated beginning in FY 1996 by an analytical

framework that considers changes in the prices associated with capital-related costs and

adjustments to account for forecast error, changes in the case-mix index, allowable

changes in intensity, and other factors. As discussed in section V. of the preamble and

section III.A. of the Addendum to this final rule with comment period, the FY 2008

update for all hospitals is 0.9 percent.

● In addition to the FY 2008 update factors, the FY 2008 capital Federal rate for

both urban and rural hospitals was calculated based on a GAF/DRG budget neutrality

factor of 0.9997, an outlier adjustment factor of 0.9517, and an exceptions adjustment

factor of 0.9997.

● For FY 2008, as discussed in section V. of the preamble and section III.A. of

the Addendum to this final rule with comment period, the FY 2008 capital rates for all

hospitals was further adjusted by a factor of 0.988 (or 1.2 percent) to maintain budget

neutrality for the implementation of the MS-DRGs by eliminating the effect of changes in

coding or classification of discharges that do not reflect real case-mix changes.

B. Results

We used the actuarial model described above to estimate the potential impact of

our changes for FY 2008 on total capital payments per case, using a universe of 3,534

hospitals. As described above, the individual hospital payment parameters are taken from

the best available data, including the March 2007 update of the FY 2006 MedPAR file,

the March 2007 update to the PSF, and the most recent cost report data from the March

2007 update of HCRIS. In Table III, we present a comparison of total payments per case

for FY 2007 compared to FY 2008 based on the FY 2008 payment policies. Column 2

shows estimates of payments per case under our model for FY 2007. Column 3 shows

estimates of payments per case under our model for FY 2008. Column 4 shows the total

percentage change in payments from FY 2007 to FY 2008. The change represented in

Column 4 includes the 0.9 percent update to the capital Federal rate for all hospitals, a 1.0

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), reclassifications by the

MGCRB, and the additional 1.2 percent reduction to all of the rates to account for

improvements in documentation and coding or other changes in coding that do not reflect

real changes in case-mix for implementation of the MS-DRGs. 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 0.6 percent in FY 2008. In addition to the 0.9 percent update to the

capital Federal rate, this projected increase in capital payments per case can be attributed

to the implementation of the MS-DRGs, including the transition relative weights, as

discussed in sections II.B. through E. of the preamble of this final rule with comment

period.

The results of our comparisons by geographic location and by region are

consistent with the results we expected after eliminating the large urban add-on

adjustment. The geographic comparison shows that all urban hospitals are expected to

experience a 0.6 percent increase in capital IPPS payments per case, while large urban

areas are expected to experience no change in capital IPPS payments per case. Capital

IPPS payments per case for rural hospitals are expected to increase 0.3 percent. The

difference is mostly due to the MS-DRGs. Specifically, based on existing hospital claims

data, under the MS-DRGs, the better recognition of severity of illness is expected to

increase payments to urban hospitals that treat a more acutely ill mix of patients.

Similarly, however, the improved recognition of severity of illness will decrease

payments to rural hospitals because they are treating less severely ill patients. Therefore,

we project a lower increase in estimated payments for rural hospitals due to the DRG

changes as compared to urban hospitals. In addition to the effect of the DRG changes,

the capital impact is also somewhat affected by the wage-index changes because the GAF

values are derived from the wage index. Furthermore, the outlier threshold also affects

payments. Because the FY 2008 outlier threshold is lower than the FY 2007 outlier

threshold, payments will increase, further explaining why, after eliminating the large

urban add-on adjustment of 3.0 percent, we estimate no change in payments from

FY 2007 to FY 2008 for large urban hospitals. For rural hospitals, another factor

contributing to the smaller increase in payments for rural hospitals is the expiration of the

3-year hold harmless provision for urban hospitals that were converted to rural under the

CBSAs in FY 2005. The policy allowed urban hospitals under the old labor market area

designations that became rural under the CBSAs to receive payment using the wage

index of the MSA where they were previously classified as urban for 3 years: FY 2005

through FY 2007. Beginning in FY 2008, these rural hospitals will receive the wage

index for the area that they are currently located in. As a result, rural hospitals will

experience a smaller increase in payments than urban hospitals because of the addition of

these formerly urban hospitals.

More than half of all regions are estimated to experience an increase in total

capital payments per case from FY 2007 to FY 2008. These increases vary by region and

range from a 2.4 percent increase in the Pacific rural region to a 0.3 percent increase in

the East North Central urban region, the Middle Atlantic rural region, and Puerto Rico.

Two urban regions are projected to experience a decrease in capital payments with the

difference mostly due to changes in the GAF and the elimination of the large urban

add-on adjustment: -0.6 percent in the Middle Atlantic urban region and -0.2 percent in

the New England urban region. In the rural regions experiencing a decrease in total

capital payments per case, the range is from a 0.8 percent decrease in the West South

Central rural region to a 0.1 percent decrease in the East North Central rural region. For

most of the rural regions projected to experience a decrease in capital payments, it is

mostly due to changes in the GAF, as well as changes due to the adoption of the MS-

DRGs. The change in payments per case for all hospitals is 0.6 percent.

By type of ownership, voluntary hospitals are estimated to experience an increase

of 0.3 percent in capital payments per case, while both proprietary and government

hospitals are estimated to experience a 1.2 percent increases in payments. Voluntary

hospitals are projected to have a slightly smaller increase in capital payments than

government and proprietary hospitals, mostly due to the elimination of the large urban

add-on adjustment and changes in the GAF.

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 2008.

Reclassification for wage index purposes also affects the GAF because that factor is

constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2008, we show

the average payments per case for reclassified hospitals for FY 2007. Rural

nonreclassified hospitals are expected to have the largest decrease in payments of

0.4 percent, as compared to the 0.1 percent decrease for the other reclassified hospitals

for FY 2008. This difference is mostly due to changes in the GAF. All urban

nonreclassified hospitals and all rural reclassified hospitals are expected to experience an

increase in payments of 0.7 percent, while all urban reclassified hospitals are expected to

experience a 0.5 percent increase in capital payments per case. This difference is mostly

due to the elimination of the large urban add-on as well as changes in the GAF.

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE				
[FY 2007 Payments Compared To FY 2008 Payments]				
	Number of hospitals	Average FY 2007 payments/ case	Average FY 2008 payments/ case	Change
By Geographic Location:				
All hospitals..	3,534	748	752	0.6
Large urban areas (populations over 1 million)	1,406	830	829	0.0
Other urban areas (populations of 1 million of fewer).......................................	1,133	737	748	1.5
Rural areas	995	520	521	0.3
Urban hospitals..	2,539	788	793	0.6
0-99 beds..	630	619	621	0.4
100-199 beds..	851	674	678	0.6
200-299 beds..	480	744	748	0.5
300-499 beds..	411	818	824	0.8
500 or more beds..	167	983	990	0.6
Rural hospitals	995	520	521	0.3
0-49 beds..	337	425	423	-0.5
50-99 beds..	372	477	478	0.1
100-149 beds..	173	517	519	0.5
150-199 beds..	68	575	575	0.1
200 or more beds..	45	649	654	0.7
By Region:				
Urban by Region..	2,539	788	793	0.6
New England...	122	838	837	-0.2
Middle Atlantic..	350	862	857	-0.6
South Atlantic..	390	747	755	1.1
East North Central	395	773	775	0.3
East South Central..	166	711	714	0.4
West North Central	157	771	774	0.5
West South Central...	355	737	744	1.0
Mountain	153	788	800	1.5

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2007 Payments Compared To FY 2008 Payments]				
	Number of hospitals	Average FY 2007 payments/ case	Average FY 2008 payments/ case	Change
Pacific	398	899	916	1.9
Puerto Rico	53	345	346	0.3
Rural by Region	995	520	521	0.3
New England	23	711	709	-0.3
Middle Atlantic	72	529	531	0.3
South Atlantic	173	502	507	0.9
East North Central	122	550	549	-0.1
East South Central	177	481	480	-0.2
West North Central	115	549	552	0.5
West South Central	199	473	469	-0.8
Mountain	77	520	528	1.6
Pacific	37	627	642	2.4
By Payment Classification:				
All hospitals	3,534	748	752	0.6
Large urban areas (populations over 1 million)	1,425	828	828	0.0
Other urban areas (populations of 1 million of fewer)	1,153	736	747	1.5
Rural areas	956	520	522	0.2
Teaching Status:				
Non-teaching	2,480	632	636	0.7
Fewer than 100 Residents	815	761	764	0.4
100 or more Residents	239	1,076	1,083	0.6
Urban DSH:				
100 or more beds	1,512	812	820	0.9
Less than 100 beds	355	552	554	0.4
Rural DSH:				
Sole Community (SCH/EACH)	384	465	467	0.3
Referral Center (RRC/EACH)	203	573	576	0.5
Other Rural:				
100 or more beds	46	485	487	0.4
Less than 100 beds	175	431	430	-0.4
Urban teaching and DSH:				
Both teaching and DSH	807	888	895	0.7
Teaching and no DSH	186	798	792	-0.7
No teaching and DSH	1,060	667	675	1.1
No teaching and no DSH	525	697	699	0.3
Rural Hospital Types:				
Non special status hospitals	2,452	791	796	0.6
RRC/EACH	53	698	707	1.3
SCH/EACH	42	641	643	0.3
Medicare-dependent hospitals (MDH)	16	446	440	-1.3
SCH, RRC and EACH	15	746	764	2.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2008 Reclassifications:				
All Urban Reclassified	393	786	790	0.5
All Urban Non-Reclassified	2,145	788	793	0.7
All Rural Reclassified	364	564	568	0.7
All Rural Non-Reclassified	569	455	453	-0.4
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	516	515	-0.1
Type of Ownership:				
Voluntary	2,064	765	768	0.3
Proprietary	823	681	689	1.2
Government	597	732	741	1.2
Medicare Utilization as a Percent of Inpatient Days:				
0-25	230	979	991	1.3
25-50	1,289	845	851	0.8
50-65	1,451	664	667	0.4

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE				
[FY 2007 Payments Compared To FY 2008 Payments]				
	Number of hospitals	Average FY 2007 payments/ case	Average FY 2008 payments/ case	Change
Over 65	440	597	595	-0.3

IX. Alternatives Considered

This final rule with comment period contains a range of policies. The preamble of this final rule with comment period 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.

X. Overall Conclusion

The changes we are making in this final rule with comment period 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 2008. 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, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 3.5 percent in operating payments, an estimated increase of $3.56 billion, which includes hospital reporting of quality data program costs ($1.89 million) and all operating payment policies as described in section VI. of this Appendix. Capital payments are estimated to increase by 0.6 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that capital payments will increase by $282 million in FY 2008 compared to FY 2007. The operating and capital payments should result in a net increase of $3.837 billion to IPPS providers. The discussions presented in the previous pages, in

combination with the rest of this final rule with comment period, constitute a regulatory

impact analysis.

XI. Accounting Statement

As required by OMB Circular A-4 (available at

http://www.whitehousegov/omb/circulars/a004/a-4.pdf), in Table IV below, we have

prepared an accounting statement showing the classification of the expenditures

associated with the provisions of this final rule with comment period. This table provides

our best estimate of the increase in Medicare payments to providers as a result of the

changes to the IPPS presented in this final rule with comment period. All expenditures

are classified as transfers to Medicare providers.

**Table IV.—Accounting Statement: Classification of Estimated Expenditures
from FY 2007 to FY 2008**

Category	Transfers
Annualized Monetized Transfers	**$3.837 Billion**
From Whom to Whom	**Federal Government to IPPS Medicare Providers**
Total	**$3.837 Billion**

XII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of

Management and Budget reviewed this final rule with comment period.

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into

consideration the recommendations of the MedPAC, recommend update factors for

inpatient hospital services for each fiscal year that take into account the amounts

necessary for the efficient and effective delivery of medically appropriate and necessary

care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish

update factors recommended by the Secretary in the proposed and final IPPS rules,

respectively. Accordingly, we are publishing our final recommendations for the 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, as well as LTCHS, IPFs, and IRFs. We also discuss our response to MedPAC's

recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2008

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of

Pub. L. 109-171, sets the FY 2008 percentage increase in the operating cost standardized

amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all

areas, subject to the hospital submitting quality information under rules established by the

Secretary in accordance with 1886(b)(3)(B)(viii) of the Act. For hospitals that do not

provide these data, the update is equal to the market basket percentage increase less 2.0

percentage points. Consistent with current law, based on Global Insight, Inc.'s second

quarter 2007 forecast of the FY 2008 market basket increase, the FY 2008 update to the

standardized amount will be 3.3 percent (that is, the current estimate of the market basket

rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in

accordance with our rules. For hospitals that do not submit quality data, the update to the

standardized amount will be 1.3 percent (that is, the current estimate of the market basket

rate-of-increase minus 2.0 percentage points).

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2008 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). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs will be 3.3 or 1.3 percent depending upon whether the hospital submits quality data.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with §403.752(a) of the regulations, RNHCIs are paid under §413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of 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. As discussed below, for cost reporting periods beginning on or after October 1, 2006, LTCHs that are not defined as new under §412.23(e)(4), and that had not elected to be paid under 100 percent of the Federal rate are paid 100 percent of the adjusted Federal PPS rate. Therefore, because no portion of LTCHs' prospective payments will be based on reasonable cost concepts for cost reporting periods beginning on or after October 1, 2006, we are not establishing a rate-of-increase percentage for FY 2008 for LTCHs to be used under §413.40. In addition, section 124 of Pub. L. 106-113 provides the statutory authority for updating all aspects of the payment rates for

IPFs. Under this broad authority, IPFs that are not defined as new under §412.426(c) will

be paid under a blend methodology for cost reporting periods beginning on or after

January 1, 2005, and before January 1, 2008. The methodology blends the estimated

Federal per diem payment amount and a facility-specific payment amount. The portion

of the IPF PPS payment that is based on reasonable cost principles is updated in

accordance with 42 CFR Part 413, which uses section 1886(b)(3)(B)(ii) of the Act to

determine the percentage increase in the rate-of-increase limits. For the reasonable

cost-based portion of an IPF's PPS blended payments, we are providing our current

estimate of the excluded hospital market basket increase (3.3 percent) to update the target

amounts. New IPFs are paid based on 100 percent of the Federal per diem payment

amount.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining

three types of hospitals still reimbursed under the reasonable cost methodology. We are

providing our current estimate of the FY 2008 IPPS operating market basket percentage

increase (3.3 percent) to update the target limits for children's hospitals, cancer hospitals,

and RNHCIs.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs

have been paid under the LTCH PPS, 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"). (See 67 FR 55954.) An existing LTCH could have elected to be paid at

100 percent of the adjusted Federal prospective rate at the start of any of its cost reporting

periods during the transition period. During this transition period, if an existing LTCH

did not elect to be paid at 100 percent of the adjusted Federal prospective payment rate, it

received a PPS payment that consisted of a blend of its reasonable cost-based payment and the Federal prospective payment rate. For cost reporting periods beginning on or after October 1, 2006, no portion of a LTCH's PPS payments can be based on reasonable cost concepts. Consequently, there is no need to update the target limit under §413.40 effective October 1, 2007, for LTCHs.

In the RY 2008 LTCH PPS final rule (72 FR 26887 through 26890), we finalized an update of 0.71 percent (that is, the latest estimate of the market basket rate-of-increase of 3.2 percent minus an adjustment factor of 2.49 percentage points for case-mix growth due to improved coding) to the LTCH PPS Federal rate for RY 2008.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. For cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008, existing IPFs (those not defined as "new" under §412.426(c)) are paid based on a blend of the reasonable cost-based PPS payments and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, existing IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2008, the portion of the IPF PPS transitional blend payment based on reasonable costs will be determined by updating the IPF's TEFRA limit by the current estimate of the excluded hospital market basket, which is estimated to be 3.3 percent. The update factor of 3.2 percent to the Federal per diem rate for July 1, 2007 through June 30, 2008, based

on Global Insight, Inc.'s first quarter 2007 forecast of the RPL market basket increase,

was provided in the rate year (RY) 2008 IPF PPS update notice (72 FR 25608).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after

January 1, 2002. For cost reporting periods beginning on or after October 1, 2002

(FY 2003), and thereafter, the Federal prospective payments to IRFs are based on

100 percent of the adjusted Federal IRF prospective payment amount, updated annually

(69 FR 45721). Under section 1886(j)(3)(C) of the Act, the FY 2008 IRF PPS update

will equal 3.2 percent based on Global Insight, Inc.'s second quarter 2007 forecast of the

RPL market basket increase with historical data through the first quarter of 2007.

III. Secretary's Final Recommendation

MedPAC is recommending an inpatient hospital update equal to the market basket

rate of increase for FY 2008. MedPAC's rationale for this update recommendation is

described in more detail below. Using the 2007 second quarter forecast from

Global Insight, Inc. of the FY 2008 market basket increase and an adjustment factor

based on the FY 2008 President's Budget, we are recommending an update to the

standardized amount of 2.65 percent (that is, the market basket rate-of-increase of 3.3

percent minus an adjustment factor of 0.65 percentage points).   We are recommending

that this same update factor apply to SCHs and MDHs. Our rationale for this

recommended update is described below.

In addition to making a recommendation for IPPS hospitals, in accordance with

section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other

types of hospitals. Consistent with the President's Budget, we are recommending an

update based on the IPPS market basket increase for children's hospitals, cancer

hospitals, and RNHCIs of 3.3 percent, based on Global Insight, Inc.'s 2007 second

quarter forecast of the IPPS operating market basket increase. For IPFs that are currently

paid on a PPS blended payment basis, a portion of which is based on reasonable cost-

principles and Federal prospective payment amounts, we are recommending an update

factor of 3.3 percent for the portion of the payment that is based on reasonable costs.

Consistent with the President's Budget, based on Global Insight, Inc.'s first quarter 2007

forecast of the RPL market basket increase, we are recommending an update equal to the

market basket increase of 3.2 percent for the Federal per diem payment amount.

In the RY 2008 LTCH PPS final rule (72 FR 26887 through 26890), we

implemented, and in this final rule with comment period recommend, an update of 0.71

percent (that is, the most recent estimate of the market basket rate-of-increase of 3.2

percent minus an adjustment factor of 2.49 percentage points for case-mix growth due to

improved coding) to the Federal rate for RY 2008. Finally, consistent with the

President's FY 2008 Budget, we are recommending that the Federal rate to the IRF PPS

remain unchanged for FY 2008.

For fiscal years prior to FY 2008, section 1886(e)(3) of the Act directed the

Secretary to report to the Congress an initial estimate of his recommendation of an

appropriate payment inflation update for inpatient hospital services for the upcoming

fiscal year not later than March 1. Section 1886(d)(4)(C) of the Act further required the

Secretary to include recommendations with respect to adjustments to the DRG weighting

factors in the March 1 Report to Congress. In addition, sections 1886(e)(4)(A) and

(e)(5)(B) of the Act require that the Secretary recommend update factors in each of the

IPPS proposed and final rules, taking into account MedPAC's recommendation. Thus,

the statute required the Secretary to make update recommendations in both a March 1

Report to Congress, and later in the IPPS proposed and final rules. Historically, the only

difference between the recommendation we provided in the March 1 Report to Congress

and the IPPS proposed rule was the use of a later estimate of the market basket increase

for the proposed rule. Section 106(c) of MIEA-TRHCA eliminated the requirement to

make the Report to Congress recommending an update and adjustments to DRG

weighting factors by March 1. In accordance with section 106(c) of MIEA-TRHCA, we

are making the Secretary's only recommendation for an update factor in the IPPS rules.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating

Payments in Traditional Medicare

In its March 2007 Report to Congress, MedPAC assessed the adequacy of current

payments and costs, and the relationship between payments and an appropriate cost base,

utilizing an established methodology used by MedPAC in the past several years.

MedPAC recommended an update to the hospital inpatient rates equal to the

increase in the hospital market basket in FY 2008, concurrent with implementation of a

quality incentive payment program. MedPAC also recommended that CMS put pressure

on hospitals to control their costs rather than accommodate the current rate of cost

growth.

MedPAC noted that, notwithstanding negative overall Medicare margins, most of

the indicators of Medicare payment adequacy to hospitals are positive, including

beneficiaries' access to care, increased access to capital, and service volume increases.

MedPAC also noted that this recommendation "should have no impact on beneficiary

access to care and is not expected to affect providers' willingness and ability to provide

care to Medicare beneficiaries."

Response: We agree with MedPAC that hospitals should control costs rather than

accommodate the current rate of growth. An update equal to less than the market basket

will pressure hospitals to control their costs, consistent with MedPAC's recommendation.

As MedPAC noted, rising hospital costs are resulting in margins for some hospitals that

are below zero. As discussed in section II. of the preamble of this final rule with

comment period, CMS is refining the DRGs to better account for severity illness and is

basing the DRG weights on cost rather than charges. We believe that these refinements

will better match Medicare payments to the cost of care and provide incentives for

hospitals to be more efficient in controlling costs. For these reasons, we are

recommending an inpatient hospital update equal to the market basket increase minus an

adjustment factor of 0.65 percentage points for hospitals paid under the IPPS for FY

2008.

We note that, because the operating and capital prospective payment systems

remain separate, we are continuing to use separate updates for operating and capital

payments. The update to the capital payment rate is discussed in section III. of the

Addendum to this final rule with comment period.